STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7 501251110.			
		mhl047-010	B. WING		09/0	6/2023
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HOKE COUNTY GROUP HOME #2 106 SOUTH RAEFORD,						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	6, 2023. A deficiend					
	This facility is licensed for the following service category: 10A NCAC 27G Supervised Living for Adults with Developmental Disabilities.					
		sed for 6 and currently has a urvey sample consisted of clients.				
V 118	27G .0209 (C) Med	lication Requirements	V 118			
	10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug;					
	(C) instructions for (D) date and time to	, and quantity of the drug; administering the drug; he drug is administered; and of person administering the				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		mhl047-010	B. WING		09/0	6/2023	
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 106 SOUTH WRIGHT STREET						
HOKE C	OUNTY GROUP HOM	ト 女ソ	D, NC 28376				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
V 118	(5) Client requests checks shall be red file followed up by a with a physician. This Rule is not me Based on record reinterviews the facili Medication Adminis kept current affectii (#2) and B) Ensure according to the ph audited clients (#2. Review on 9/6/23 or	for medication changes or corded and kept with the MAR appointment or consultation et as evidenced by: view, observation, and ty failed to: A) Ensure the stration Record (MAR) was ag one of three audited clients medication was available ysician order for one of three) The findings are f Client #2's record revealed:	V 118	DEFICIENCY)			
	-Admission date of -Diagnoses of Autis Major Depressive I Seizures; Fragile C Bee and Food Aller Review on 9/6/23 odated 4/24/23 reverablet twice dailyBaclofen 5 mg Observation on 9/6 medications box re -Benztropine 0Baclofen 5 mg Review on 9/6/23 of	1/24/22. sm; Mentally Handicapped; Disorder; Bipolar II; Epileptic hromosome Deletion (16); gies. f Client #2's physician's orders aled: 5 milligrams (mg)- Take one - Take one tablet twice daily. //23 at 1:15 pm of Client #2's					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		mhl047-010	B. WING		09/0	06/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		31-3-3
		106 SOUT	H WRIGHT	,		
HOKE C	OUNTY GROUP HOM	E #2 RAEFORI	D, NC 28376	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 118	-July: -Benztropine 0. administered from -September: -Baclofen 5 mg administered 9/1 @ -Document 9/3 @ 8am -Document 8pm-9/6-8am. Interview on 9/6/23 -She had been wor monthsShe administered -She had administered -She had administered -She was not aware was not documente 7/11-7/31. She was not aware not available in her recently delivered b Interview on 9/6/23 revealed: -Facility had recent from one company -She was not aware had not been recor 7/11-7/31She was not aware had not been recore 7/11-7/31She was not aware missingStaff had informed received her last do and the package ha Package was unab -She was under the package had been	25 mg was not documented as 7/11-7/31. 25 Documented as 8 8am. 26 as "on leave"-9/1 @ 8pm- 27 as administered 9/3 @ 28 with Staff #3 revealed: 29 king at the facility for about 6 20 client's medications. 20 ared Client #2's medications 20 as administered from 21 that Client #2's Baclofen was box nor in box of medications by the pharmacy. 29 with the House Manager 20 all y changed electronic MARs to another. 20 as administered from 21 that Client #2's Benztropine ded as administered from 22 another. 23 that Client #2's Baclofen was 1 her that Client #2's Baclofen was 1 her that Client #2 had 20 bage from the package today and been thrown away.	V 118			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		mhl047-010	B. WING		09/	06/2023
	PROVIDER OR SUPPLIER OUNTY GROUP HOM	F #2 106 SOU	DRESS, CITY, STH WRIGHT STORY			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
V 118	month. but it was not - Pharmacy had been Baclofen was re-ord - Staff should have not accuracy when the - She acknowledged ensure medication or physician order for (#2); - She acknowledged the Medication Admikept current for Clief Due to the failure to medication administ medication available	ot there. en contacted and Client #2's dered. reviewed medications for new box arrived. If that the facility failed to was available according to the one of three audited clients If the facility failed to ensure hinistration Record (MAR) was	V 118			

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