STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G168	A. BUILDING _____ B. WING _____	07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHBAY GROUP HOME	1907 NORTHBAY DRIVE BROWN SUMMIT, NC 27214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record reviews and interview, the facility failed to assure all drugs were administered without error for 4 of 5 clients (#1, #2, #4, and #5) observed during medication administration. The findings are: A. The facility failed to administer prescribed medication for client #1 without error. For example: Observations in the group home on 7/18/23 at 7:07 AM revealed staff E to assist client #1 into the medication administration room. Client #1 had to calm down prior to entering the room. Continued observations revealed staff E to inform client #1 what medication he was receiving and to prompt client #1 to assist with his medications; however, the client refused. Further observations revealed staff E to pour a capful of Miralax 527 GM into a pre-poured cup of water. Subsequent observations revealed staff E to empty medication packet containing Levothyroxine 125 MCG, and for client #1 to take medication whole with water containing Miralax. Observations at 8:09 AM revealed staff F to prompt client #1 to the medication administration room. Continued observation revealed staff E to assist client #1 to the medication room as staff F poured Miralax 527 GM powder into a cup of water pre-poured. Further observations revealed staff F to obtain Multi Vitamin Plus Iron and Haloperidol 5 MG tab tearing packets and pouring	W 369	For Clients #1, #2, #4 and #5, the RN will provide in-service training to all staff on administering medications. Topics will include following doctor orders, appropriate medication administration techniques, etc The RN will provide an outline to staff of all elements covered. Staff will be instructed to access the MAR, then secure the pill packet before administering the medications. Staff will then crosswalk the pill packet to the MAR to confirm the correct medication(s) and compare the name of medication(s) listed on the pill packet to what is documented on the MAR, all prior to administering to the client (s). In addition, staff will be instructed to present the pill packet with the listed name of medication(s) to any reviewer during the medication pass to validate the contents of each pill package. All the medications noted in the statement of deficiencies (SOD), including meds that were indicated to be administered by staff, and the medications that were indicated to not have been administered are all packaged together in the same pill packet. This is the packaging process for the pharmacy dispensing of all medications to this Provider. The RN implements a protocol to check pill packets once medications are dispensed to confirm the correct number and type of medications prior to releasing the medications to the home. This process will continue to ensure appropriate packaging of medications. DHSR - Mental Health AUG 0 8 2023 Lic. & Cert. Section	09/17/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Roger W. Giles

TITLE: QM Director

(X6) DATE: 8/3/23

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 369	Continued From page 1 into medicine cup. Subsequent observations revealed client #1 to take medications whole with water containing Miralax. Surveyor confirmed with staff F that client #1 only receives one dosage of Miralax daily and client #1 was given an extra dosage of Miralax in error. Review of records for client #1 on 7/18/23 revealed physician orders dated 1/1/23 through 12/31/23. Review of the physician orders revealed medications to administer at 6:30 AM and 8:00 AM to be Vitamin-D3 25 MCG 1,000-Unit tab, Multi Vitamin Plus Iron, Levothyroxine 125 MCG, Benztropine MES 1 MG tab, and Haloperidol 5 MG tab. During the observation staff E and staff F was not observed to administer Vitamin-D3 25 MCG 1,000-Unit tab and Benztropine MES 1 MG tab. Interview with the facility nurse on 7/18/23 verified the physician orders dated 1/1/23 through 12/31/23 to be current. Continued Interview with the facility nurse confirmed that staff should have administered all medications as prescribed by physician. Further interview with the facility nursed confirmed that the nurse was not notified of missed medications. B. The facility failed to administer prescribed medication for client #2 without error. For example: Observations in the group home on 7/18/23 at 7:35 AM revealed staff F to prompt client #2 to the medication administration room. Continued observations revealed staff F to pour 1 capful of Polyethylene Glycol 3350 into a coup of water and stir. Further observation revealed staff to prompt client #2 to assist with obtaining basket;	W 369	The nurse will monitor accurate medication administration procedures via face to face med pass monitoring monthly. Clinical Supervisors (QPs) & Program Managers will be involved in observing medication passes twice weekly to ensure adherence to medication administration policies and practices.	

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W 369	Continued From page 2	W 369		

however, the client refused, and staff F educated and poured Lorazepam 0.5 MG, Divalproex SOD DR 500 MG, Docusate Sodium 100 MG, and Fexofenadine HCL 180 MG into a medicine cup. Subsequent observation revealed client #2 to take medications whole with water containing Polyethylene Glycol 3350. Additionally, staff F had client F to remove his shirt and to lower his bottom clothing and to apply Triamcinolone 0.1% cream to face, both arms, back and both legs.

Review of records for client #2 on 7/18/23 revealed physician orders dated 1/1/23 through 12/31/23. Review of the physician orders revealed medications to administer at 8:00 AM to be Lorazepam 0.5 MG, Folic Acid 1 MG tab, Boost, Naltrexone 50 MG Tab, Fexofenadine HCL 180 MG tab, Docusate Sodium 100 MG, Olanzapine 2.5 MG tab, Divalproex SOD DR 500 MG, Clobetasol 0.05% cream, Propranolol 20 MG tab, Aquaphor ointment, Gavilax Powder/Miralax Powder 255GM Small, and Triamcinolone 0.1% ointment. During the observation staff F was not observed to administer Folic Acid 1 MG tab, Naltrexone 50 MG Tab, Olanzapine 2.5 MG tab, Clobetasol 0.05% cream, and Propranolol 20 MG tab.

Interview with the facility nurse on 7/18/23 verified the physician orders dated 1/1/23 through 12/31/23to be current. Continued Interview with the facility nurse confirmed that staff should have administered all medications as prescribed by physician. Further interview with the facility nursed confirmed that the nurse was not notified of missed medications.

C. The facility failed to administer prescribed medication for client #4 without error. For

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W 369	Continued From page 3 example: Observation in the group home on 7/18/23 at 7:20 AM revealed staff F to prompt client #4 the medication administration room. Continued observation revealed that client #4 sanitized hands and took cream out of closet. Further observation revealed staff F to pour a capful of Miralax into a cup of water and client #4 to stir with butter knife. Subsequent observations revealed staff F to tear packet containing Docusate Calcium, Vitamin D3, Diazepam 10 MG, and Oxcarbazepine 300 MG. Additionally, staff F applied Erythromycin to client #4's legs on the front and back of legs. Review of records for client #4 on 7/18/23 revealed physician orders dated 1/1/23 through 12/31/23. Review of the physician orders revealed medications to administer at 7:00 AM and 8:00 AM to be Fluvoxamine Maleate 100 MG, Betameth .05%: Minerin 1:1, Vitamin D3 400 Unit tab, Hydrocortisone 2.5% cream, Gavilax Powder/Miralax Powder, Doxycycline Hyclate 100, Docusate calcium 240 MG Capsule, Benefiber sugar free powder, Permethrin 5% cream, Erythromycin-Benzol Gel, Diazepam 10 MG Zenith, Oxcarbazepine 300 MG tab, and Mupirocin 2% ointment. During the survey observation staff F was not observed to administer Fluvoxamine Maleate 100 MG, Betameth .05%: Minerin 1:1, Hydrocortisone 2.5% cream, Doxycycline Hyclate 100, Benefiber sugar free powder, Permethrin 5% cream, and Mupirocin 2% ointment. Interview with the facility nurse on 7/18/23 verified the physician orders dated 1/1/23 through 12/31/23to be current. Continued Interview with	W 369		

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W 369	Continued From page 4 the facility nurse confirmed that staff should have administered all medications as prescribed by physician. Further interview with the facility nursed confirmed that the nurse was not notified of missed medications. D. The facility failed to administer prescribed medication for client #5 without error. For example: Observation in the group home on 7/18/23 at 6:58 AM revealed staff E to have client #5 enter the medication administration room. Continued observation revealed staff E to have client #5 identify the medication in the packet. Further observation revealed staff E to empty medication packet containing Levothyroxine 200 MCG into a medicine cup, client #5 took whole with a cup of pre-poured water, and for the client #5 to exit the room. Observations at 7:56 AM revealed staff F to prompt client #5 to the medication administration room. Continued observations revealed staff F to pour a capful of Gavilax Powder prescribed to client #5 into a cup of water. Further observations revealed staff F to remove medication basket from the closet and to tear packets containing Furosemide 20 MG tab and Hydroxyzine HCL 25 MG tab and place in a medicine cup. Subsequent observations revealed client #5 to take the medications whole with the water containing Gavilax powder and for staff F to apply Cerave moisturizing cream to head and face with client #5's assistance. Review of records for client #5 on 7/18/23 revealed physician orders dated 1/1/23 through 12/31/23. Review of the physician orders	W 369		

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W 369	Continued From page 5 revealed medications to administer at 6:30 AM and 8:00 AM to be Gavilax Powder/Miralax Powder, Metoprolol Succ ER 50 MG, Minocycline 100 MG Capsule, Vitamin D3 25 MCG 1,000-unit tab, Meloxicam 15 MG Tablet, Furosemide 20 MG Tablet, Levothyroxine 75 MCG tab, Levothyroxine 200 MCG tab, Miconazole 2% spray powder, Hydroxyzine HCL 25 MG tab, and Cerave moisturizing cream. During the survey observation staff E and staff F was not observed to administer Metoprolol Succ ER 50 MG, Minocycline 100 MG Capsule, Vitamin D3 25 MCG 1,000-unit tab, Meloxicam 15 MG Tablet, and Levothyroxine 75 MCG tab. Interview with staff F revealed client #5 to be prescribed Gavilax Powder. Continued interview with staff F revealed that she gave client #1's prescribed Gavilax Powder to client #5 because she did not see client #5's bottle and staff will speak to the person that brings the medications to the group home. Interview with the facility nurse on 7/18/23 verified the physician orders dated 1/1/23 through 12/31/23to be current. Continued Interview with the facility nurse confirmed that staff should have administered all medications as prescribed by physician. Further interview with the facility nurse revealed that staff should not administer another client's medication.	W 369		