Division of Health Service Regulation

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				7. 35.LBING.		۲
		MHL040-015	B. WING			4/2024
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EDWARD	S GROUP HOME		「GREENE S LL, NC 2858			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	rs	V 000			
	on September 24, 2	w up survey was completed 2024. Deficiencies were cited.				
		sed for the following service C 27G .5600A Supervised h Mental Illness.				
		sed for 6 and has a current urvey sample consisted of				
V 118	27G .0209 (C) Med	ication Requirements	V 118			
	V 118 27G .0209 (C) Medication Requirements 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 administering the drug;					
		ne drug is administered; and of person administering the				

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

TITLE (X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			71. BOILBING.			
		MHL040-015	B. WING		1	4/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EDWARI	OS GROUP HOME		GREENE S			
(V4) ID	SLIMMADV STA	TEMENT OF DEFICIENCIES	LL, NC 2858	PROVIDER'S PLAN OF CORRECTI	ON	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 1	V 118			
	checks shall be rec	for medication changes or orded and kept with the MAR appointment or consultation				
	facility failed to adm written order of a pl the MARs were kep	et as evidenced by: views and interviews, the ninister medications on the nysician and failed to ensure of current affecting three of s (#1. #2. #4). The findings				
	-49 year old male. -Admitted on 1/3/20	zoaffective Disorder- Bipolar				
	orders dated 7/14/2 -Benztropine Mesyl dailyChlorpromazine 20 dailyDocusate Sodium dailyFluvoxamine Male bedtimeGS Senna Laxative-Haloperidol 10mg, daily.	of client #1's signed physician 24 revealed: ate 1mg, (tremors) 1 twice 20mg, (schizophrenia) 1 twice 100mg, (constipation) 1 twice ate 50mg, (anxiety) 1 at e 8.6mg, (constipation) 1 daily. (schizophrenia) 1 3 times amg, (seizures) 1 twice daily.				

Division of Health Service Regulation

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Division of Health Service Regulation

DIVISION	of Health Service Re	egulation				
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					F	,
		MHL040-015	B. WING		1	4/2024
		WITE040-015			09/2	4/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		306 WES	Γ GREENE S	TREET		
EDWARI	DS GROUP HOME	SNOW HI	LL, NC 2858	30		
(V4) ID	STIMMADV STA	TEMENT OF DEFICIENCIES	-	PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX		/ MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
				DEFICIENCY)		
\/ 118	Continued From pa	ge 2	V 118			
V 110	Continued i Tom pa	ge z	V 110			
		ncg, (thyroid) 1 daily.				
	-Oxcarbazepine 60	0mg, (seizures) 1 twice daily.				
	-Vitamin D3 1,000 l	Jnits, (supplement) 1 daily.				
		of client #1's MARs from				
	7/1/24 - 9/24/24 rev					
	medications were n	ot documented as				
	administered:					
		ate 1mg, 8/31/24 at 8:00am				
	and 8:00pm.					
		00mg, 8/31/24 at 8:00am and				
	8:00pm.					
		100mg, 8/31/24 at 8:00am				
	and 8:00pm					
		ate 50mg, 8/31/24 at 8:00pm.				
		e 8.6mg, 8/31/24 at 8:00am				
		8/31/24 at 8:00am, 2:00pm				
	and 8:00pm.	0/04/04 + 0.00				
		mg, 8/31/24 at 8:00am and				
	8:00pm.	0/04/04 - 1-0-00				
		ncg, 8/31/24 at 8:00am				
	•	0mg, 8/31/24 at 8:00am and				
	8:00pm.	l-:t- 0/04/04 -t 0:00				
	-vitamin D3 1,000 t	Jnits, 8/31/24 at 8:00am.				
	Interview on 9/24/2	4 aliant #1 atatad:				
	-He received his mo					
	-i le received ills illi	edications daily.				
	Finding #2					
		of client #2's record revealed:				
	-60 year old male.					
	-Admitted on 6/15/2	22.				
		zoaffective Disorder				
	O .	Obsessive Compulsive				
		ked obsession thoughts and				
	Mild Intellectual Dis					
	Review on 9/24/24	of client #2's signed physician				
	orders dated 2/27/2					
	-Amitiza 24 microgr	rams (mcg) (constipation)				

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DIVISION	of Health Service Re	egulation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMP	LETED
						,
			B. WING		F	
		MHL040-015	B. WING		09/2	4/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
EDWAR	OS GROUP HOME		T GREENE S			
		SNOW HI	LL, NC 2858	30		
(X4) ID	-	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	FRIATE	DAIL
				,		
V 118	Continued From pa	ige 3	V 118			
	•	·				
	twice daily.					
		High Blood Pressure) daily.				
	-Atorvastatin 40 mg					
		ate 150 mg (OCD) every				
	morning.					
	-Risperidone 0.25 r	ng (Schizophrenia) daily.				
	-Senna Plus 8.6/50	mg (constipation) daily.				
	-Tegretol 200 mg (r	mental) twice daily.				
		•				
	Review on 9/24/24	of client #2's MARs from				
	7/1/24 - 9/24/24 rev	ealed the following				
	medications were n	•				
	administered:					
		n 7/31/24, 8/27/24 (pm),				
	8/28/24 - 8/31/24.	(,				
		on 7/31/24, 8/28/24 - 8/31/24.				
		g on 7/31/24, 8/28/24 - 8/31/24.				
		rate 150 mg on 7/31/24,				
	8/28/24 - 8/31/24.	ate 100 mg on 170 1/24,				
		ng on 7/31/24, 8/28/24 -				
	8/31/24.	119 011 770 1724, 0720724				
		mg on 7/30/24, 7/31/24,				
	8/28/24 - 8/31/24.	111g 011 7/30/24, 7/31/24,				
		7/24/24 0/27/24 (0pm)				
		n 7/31/24, 8/27/24 (8pm),				
	8/28/24 - 8/31/24.					
	Interview on 0/24/2	4 client #2 stated:				
	Interview on 9/24/2					
		edications every morning and				
	afternoon.					
	Fig. dia #0					
	Finding #3	6 12 4 1/41				
		of client #4's record revealed:				
	-42 year old male.	- 4				
	-Admitted on 7-16-2					
	-Diagnosis Schizop	hrenia Paranoid type.				
		of client #4's signed physician				
	orders dated 7/14/2					
	-Haloperidol 5mg (r	mental) twice daily.				
	-Cholecalciferol (su	ıpplement) daily.				

Division of Health Service Regulation

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Division of Health Service Regulation

DIVISION	of Health Service Re	guiation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	IDENTIFICATION		A. BUILDING:			
		MUI 040 045	B. WING		F	
		MHL040-015	2		09/2	4/2024
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EDWAR	OS GROUP HOME		GREENE S L, NC 2858			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 4	V 118			
	times a dayBenztropine 1mg (-Trazodone 100mg -Clozapine 10mg (S -Olanzapine 10mg (S -Olanzapine 10mg (S -Olanzapine 10mg (S -Olanzapine 10mg (S -Vilva - 9/24/24 rev medications were n administered: -Haloperidol 5mg 7 (6pm) -Cholecalciferol on 8-27-24 (8pm) -Chlorpromazine 10 (6pm), 8-27-24 (2pi -Benztropine 1mg o -Trazodone 100mg 7-31-24(8pm) 8-27Clozapine 10mg oi	(Depression) at bedtime. Schizophrenia) bedtime. (mental) bedtime. (mental) bedtime. (of client #4's MARs from realed the following of documented as -30-24 (6pm), 7-31-24 (8am) 8-24-24, 8-25-24, 8-26-24, (9pm) on 7-31-24 (8pm) on 7-30-24 (8pm) on 7-31-24 ((8pm) on 7-30-24 (8pm)				
	Interview on 9/24/24 -He received his me					
	Interview on 9/24/24 -The clients receive orderedShe forgot to docu	d their medications as				
	-The blanks in the N the staff. -She checks to mak in bubble packs.	4 the Qualified ered Nurse/Licensee stated: MAR may be an oversight by see sure no medications are left ed to immediately document				

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administration of medications.

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Division of Health Service Regulation

AND DUAN OF CODDECTION TO TREATMENT AND DUAN OF CODDECTION TO THE PROPERTY OF		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND FLAN	OF CONNECTION	IDENTIFICATION NOWIBER.	A. BUILDING:		COM	LLILD	
		MHL040-015	B. WING		I	२ 24/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
EDWAR	OS GROUP HOME		GREENE S				
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
TAG	27G .0303(c) Facility 10A NCAC 27G .03 EXTERIOR REQU (c) Each facility and maintained in a saft manner and shall be odor. This Rule is not m Based on record reinterviews the facility safe, clean and attractive was a green home. There was a green home. There were two of substance on the content of the content of the content of the content of the wall. Approximately separated from the Baseboards in the Air conditioning grorangish-brownish area. In the living room a content of the living room a content of the wall.	ity and Grounds Maintenance 303 LOCATION AND IREMENTS d its grounds shall be fe, clean, attractive and orderly be kept free from offensive et as evidenced by: eview, observations and ty was not maintained in a fractive manner. The findings 4/24 at approximately he facility revealed: n substance on the siding of fice chairs with a black futside handicap ramp. imately two inches of white n edge of the roof. be covered from the top to ger by the door. free had food under the table. the wall paper was not affixed mately 3 inches was	V 736		ROPRIATE	DATE	
	surface area of cur clear plastic cover. -There was a greer	tains. The sofa had a loose					

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DIVISION	of Health Service Re	egulation				
		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					F	,
		MHL040-015	B. WING			4/2024
		WITE040-015			03/2	4/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		306 WEST	GREENE S	TREET		
EDWARI	OS GROUP HOME		LL, NC 2858			
0.0.15	CUMMA DV CTA				ON.	0.(5)
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
V/ 726	Continued From no	an 6	V 736			
V 730	Continued From pa	ge o	V 730			
	-There were cob we	ebs approximately five inches				
	down the corner of	the wall.				
		there were nine raised tiles				
		in front of the sink area with a				
	black chair covering					
		easey substance that covered				
		tove area and the cabinets				
	where food is store	d.				
	-The main bathroor	n in hall area on the right,				
		ubstance with a cotton				
	spore-like appearar	nce and two				
		n 6 inches in diameter circular				
	stains on the ceiling	g . There were missing floor				
		pathroom. There was an				
	uncovered wall outl	et next to the mirror and no				
	light fixture cover a	bove the mirror.				
	-In the bedroom on	the left side of hallway shared				
	by client #1 and clie	ent #4 there were a multitude				
	of clusters of black	circular cotton textured with				
	spore-like appearar	nce that covered				
	approximately 2 fee	et by 4 feet from the entrance				
	to the middle ceiling					
		dresser was missing knobs				
	on the right middle	and top drawers. Middle				
	Cochen or aroccor t	here were no handles on the				
		wer and there was no knobs				
		e middle section. The left side				
	of dresser had no k	nobs on the dresser drawer.				
		oungent and foul odor from the				
	front through the er					
		ge blue tarp on his bed. The				
		ext to the window had 6				
	missing knobs on the					
		om at the front of the home				
	had broken blind sl	ates on both windows blinds.				
	01					
		proximately 3:25pm of client				
		pedroom revealed a can of				
		sser, a paint pan with a roller				
	brush in it covered	in paint, a ladder, ceiling				

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If continuation sheet 7 of 10 2Q2F11

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AND DI AN OF CORRECTION \ \ \ \ IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			7. BOILDING.		l ,	٦
		MHL040-015	B. WING		I	24/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
EDWARI	OS GROUP HOME		GREENE S L, NC 2858			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 736	Continued From pa	ge 7	V 736			
	where black, discolar had been painted of still visible through the table had 1 can of paint brush and 1 woundered. No clear was no smell of a contraction of the ceiling. Interview on 9/24/24 he did not clean the instructed to paint contraction on the ceiling. Interview on 9/24/24 Registered Nurse/L residue in client #1 being "taken cared It's been treated."	ored and textured residue was ver but textured areas were the paint. The dining room paint, 1 blue roller brush, 1 rood mixing stick that was ning agent observed. There leaning agent. 4 the maintenance staff stated a ceiling and was just over the dark residue that was and client #4's bedroom was of now. She had not seen it.				
V 768	10A NCAC 27G .03 EQUIPMENT (d) Indoor space relicensed prior to Ocminimum square fo at that time. Unless Rules, residential fat, 1988 shall meet requirements: (4) In facilities accommodations for	equirements: Facilities tober 1, 1988 shall satisfy the otage requirements in effect so otherwise provided in these acilities licensed after October the following indoor space is with overnight or persons other than clients, ons shall be separate from	V 768			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
712 . 271	A. BUILDING:						
		MHL040-015	B. WING			२ 24/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
EDWARI	OS GROUP HOME		GREENE S LL, NC 2858				
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 768	Based on record reinterview, the facilit accommodations for were separate from are: Review on 9/24/24 revealed a licensed. Observations on 9/12:15 pm a facility 1-1 client bedroom to 1-1 client bedroom to 1-1 client bedrooms with 2 beds. Interview on 9/24/2-He lived in the hone #1 and the "other late Interview on 9/24/2-He lived in the hone #1 and the "the girl Interview on 9/24/2-He lived in the hone #1 and the "the girl Interview on 9/24/2-He lived in the hone staff #1. -The girl was visiting Interview on 9/24/2-Her "friend" was accouple of days. -The "friend" slept it rooms. -The "friend" arrived tomorrow.	eview, observation and y failed to ensure overnight or persons other than clients in client bedrooms. The findings of the facility's license if capacity of 6 clients. 24/24 between 11:30 am - tour revealed: off the living room with 1 bed. of the left with 1 bed with end" of staff #1. at the rear of the facility each 4 client #1 stated: ne with client's #2, #3, #4, staff ady." 4 client #2 stated: ne with client's #2, #3, #4, staff [staff #1] is training." 4 client #4 stated: ne with client's #2, #3, #4 and and staff #1 for a couple of days. 4 staff #1 stated: the facility helping her for a mone of the vacant client dispersion of the vacant client dispersion.	V 768				
	Interview on 9/24/2 stated:	4 the Qualified Professional					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		MHL040-015	B. WING		09/2	2 4/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET A	ODRESS CITY S	STATE, ZIP CODE			
			ST GREENE S				
EDWARI	DS GROUP HOME		ILL, NC 2858				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 768	Continued From pa	ge 9	V 768				
	-The "cleaning lady -The cleaning lady the facility.						

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