

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL040-026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 10/31/2024
NAME OF PROVIDER OR SUPPLIER EDWARDS GROUP HOME #3		STREET ADDRESS, CITY, STATE, ZIP CODE 1233 APPLE TREE ROAD STANTONSBURG, NC 27883		
(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) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and follow up survey was completed on October 31, 2024. Deficiencies cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients.	V 000		
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; (D) date and time the drug is administered; and (E) name or initials of person administering the drug.	V 118		

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 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL040-026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 10/31/2024
NAME OF PROVIDER OR SUPPLIER EDWARDS GROUP HOME #3		STREET ADDRESS, CITY, STATE, ZIP CODE 1233 APPLE TREE ROAD STANTONSBURG, NC 27883		
(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) COMPLETE DATE
V 118	<p>Continued From page 1</p> <p>(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to keep MARs current for 3 of 3 current clients (client #1, #2, and #4). The findings are:</p> <p>Finding #1 Review on 10/29/24 of client #1's record revealed: -Admission date 09/25/05. -Diagnoses of Schizophrenia Paranoid Type</p> <p>Review on 10/29/24 and 10/31/24 of client #1's Physician orders revealed: 08/21/24 -Benzotropine 2mg (treat symptoms of Parkinson's disease) Take 1 tablet by mouth at bedtime. -Fluphenazine 10mg (treats Schizophrenia) Take 1 tablet by mouth twice daily. 07/12/24 -Chlorhexidine Oral Rinse (antiseptic/disinfectant) Dip qtip in solution. 09/04/24 -Mupirocin Ointment (antibiotic ointment) Apply topically two times a day for 7 days.</p> <p>Review on 10/29/24 of the October 2024 MAR revealed no initials on the following dates to indicate the medication had been administered: -Benzotropine 2mg-10/28/24 at 8pm.</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL040-026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 10/31/2024
NAME OF PROVIDER OR SUPPLIER EDWARDS GROUP HOME #3			STREET ADDRESS, CITY, STATE, ZIP CODE 1233 APPLE TREE ROAD STANTONSBURG, NC 27883		
(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) COMPLETE DATE
V 118	<p>Continued From page 2</p> <p>-Fluphenazine 10mg-10/28/24 at 8pm, 10/29/24 at 8am.</p> <p>Review on 10/29/24 of the October 2024 MAR revealed:</p> <p>-Chlorhexidine Oral Rinse -Initials from October 1-29.</p> <p>-Mupirocin Ointment-Initial's from October 1-29.</p> <p>-Client #1 was no longer taking the medications and the medications were not present in the home.</p> <p>-Staff were initialing a medication that was not being given.</p> <p>During interview on 10/29/24 client #1 revealed:</p> <p>-He received his medications daily.</p> <p>Finding #2</p> <p>-Review on 10/29/24 and 10/31/24 of client #2's record revealed:</p> <p>-Admission date 01/08/21.</p> <p>-Diagnoses of Schizophrenia Paranoid Type, Seizure Disorder.</p> <p>Review on 10/29/24 of client #2's Physician orders revealed:</p> <p>10/01/24</p> <p>-Divalproex 500mg (Bipolar) Take 1 tablet by mouth in the morning and take 2 tablets by mouth at bedtime.</p> <p>Review on 10/29/24 at 11:01am of client #2's October 2024 MAR revealed no initial on the MAR to indicate the medication had been administered on the following date:</p> <p>-Divalproex 500mg-10/29/24 at 8am.</p> <p>During interview on 10/29/24 client #2 revealed:</p> <p>-He received his medications daily.</p>	V 118			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL040-026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 10/31/2024
NAME OF PROVIDER OR SUPPLIER EDWARDS GROUP HOME #3		STREET ADDRESS, CITY, STATE, ZIP CODE 1233 APPLE TREE ROAD STANTONSBURG, NC 27883		
(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) COMPLETE DATE
V 118	<p>Continued From page 3</p> <p>Finding #3 Review on 10/29/24 of client #4's record revealed: -Admission date of 10/25/24. -Diagnoses of Psychotic Disorder, Personality Disorder-Antisocial, Mild Intellectual Developmental Disability, Obesity and History of Seizures.</p> <p>Review on 10/29/24 of client #4's Physician orders revealed: 10/25/24 -Lorazepam 1mg (Anxiety) Take 1 tablet by mouth twice daily. -Risperidone 1mg (Schizophrenia) Take 1 tablet by mouth twice daily.</p> <p>Review on 10/29/24 of client #4's October 2024 MAR revealed no initials on the MAR to indicate the medication had been administered for the following dates: -Lorazepam 1mg-10/28/24. -Risperidone 1mg-10/28/24.</p> <p>During interview on 10/29/24 client #4 revealed: -He received his medication daily.</p> <p>During interview on 10/29/24 Qualified Professional/Licensee revealed: -Client #1's ointment and mouthwash was no longer being used. -The doctor did not give a discontinue date and he did not give any refills. -The wounds healed and client #1 did not use the medication any longer. -The staff were putting initial's on the MAR when they should not have for the medications. -She would talk with the staff. -She was not aware the staff were not initialing the MAR when the medication was administered.</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL040-026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 10/31/2024
NAME OF PROVIDER OR SUPPLIER EDWARDS GROUP HOME #3		STREET ADDRESS, CITY, STATE, ZIP CODE 1233 APPLE TREE ROAD STANTONSBURG, NC 27883		
(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) COMPLETE DATE
V 736	<p>27G .0303(c) Facility and Grounds Maintenance</p> <p>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS</p> <p>(c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.</p> <p>This Rule is not met as evidenced by: Based on observation and interviews, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are:</p> <p>Observation on 10/29/24 at approximately 10:30am revealed:</p> <ul style="list-style-type: none"> - Mattresses and furniture stored under storage shelter. - A satellite cable dish was laying outside to the left of the back door. The dish had cable wires attached to the house. - The metal bench outside the back door wobbled and was unstable. - The air return vent in the dining room was pulled away from the ceiling. - The floor vent register in the dining room was rusty. - The paneling in the living room area had various damage approximately top of furniture height. - The light fixture above the dining room had cob webs. - A cabinet in the living room had a missing handle. - An approximately 2 foot by 2 foot patched area painted gray on a brown wall. - Client #1's bedroom had a window pane pushed out. - The bedroom to the front right of the facility had bent curtain rods. A broken electrical cover and a telephone line cover removed. 	V 736		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL040-026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 10/31/2024
NAME OF PROVIDER OR SUPPLIER EDWARDS GROUP HOME #3		STREET ADDRESS, CITY, STATE, ZIP CODE 1233 APPLE TREE ROAD STANTONSBURG, NC 27883		
(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) COMPLETE DATE
V 736	Continued From page 5 The window sills had paint rubbed of the corners Interview on 10/29/24 the House Manager stated: - The facility had recently had new floors installed. - New kitchen counters were being installed today. Interview on 10/29/24 and 10/31/24 the Qualified Professional/Licensee stated she understood facility and grounds issues discussed. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		
V 738	27G .0303(d) Pest Control 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (d) Buildings shall be kept free from insects and rodents. This Rule is not met as evidenced by: Based on observation and interview, the facility was not free from insects. The findings are: Observation on 10/29/24 at approximately 10:30am revealed: - Numerous flies throughout the facility to include the kitchen and dining room area. - Multiple flies were on the dining room table. Interview on 10/29/24 the House Manager stated the facility had new floors put in and the flies came in the house.	V 738		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL040-026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 10/31/2024
NAME OF PROVIDER OR SUPPLIER EDWARDS GROUP HOME #3		STREET ADDRESS, CITY, STATE, ZIP CODE 1233 APPLE TREE ROAD STANTONSBURG, NC 27883		
(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) COMPLETE DATE
V 738	Continued From page 6 Interview on 10/29/24 the Qualified Professional/Licensee stated the facility had been spayed for flies.	V 738		