STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL040-026	A. BUILDING: _____ B. WING _____	R-C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDS GROUP HOME #3	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 A complaint and follow up survey was completed on January 31, 2025. The complaint was unsubstantiated (intake #NC00226413). Deficencies were 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 4. The survey sample consisted of audits of 3 current clients and 1 former client.	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	V 118		

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V 118	Continued From page 1 (E) name or initials of person administering the drug. (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. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to administer medications on the written order of a physician and failed to keep the MARs current for 3 of 3 audited clients (#1, #3, #4). The findings are: Finding #1 Review on 1/24/25 of client #1's record revealed: -Date of Admission: 1/8/21. -Diagnoses: Schizophrenia, Intellectual Developmental Disability, Bipolar Disorder, Depression, Seizures and Hypertension. Review on 1/24/25 of client #1's signed physician orders dated 10/1/24 revealed: -Divalproex (Seizures) 500 milligrams (mg) - take one tablet in the morning and one tablet at night. -Keppra (Seizures) 1000 mg - take one tablet twice daily. -Vitamin D1 (Supplement) 1250 microgram (mcg) - take one capsule once a week. Review on 1/24/25 of client #1's MAR from 1/1/25-1/24/25 revealed the following medications had no staff initials to indicate the medications were administered as ordered:	V 118		

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V 118	Continued From page 2	V 118		

-Divalproex 500 mg - 1/14/25-1/23/25.
-Keppra 1000 mg - 1/13/25 (8pm) and 1/16/25 (8pm).
-Vitamin D1 1250 mcg - 1/17/25.

Interview on 1/24/25 client #1 stated:
-He took medications.
-He received his medications everyday.

Finding #2
Review on 1/27/25 of client #3's record revealed:
Date of Admission: 12/22/21.
Diagnoses: Schizoaffective Disorder, Bipolar Disorder.

Review on 1/24/25 of client #3's signed physician orders dated 5/6/24 revealed:
-Chlorpromazine (Schizoaffective Disorder) 100 mg - take one tablet three times a day.
-Vitamin D (Supplement) 1250 mcg - take one capsule once a week.

Review on 1/24/25 of client #3's MAR from 1/1/25-1/24/25 revealed the following medications were not documented as administered:
-Vitamin D 1250 mcg - 1/15/25.
-Chlorpromazine 100 mg - 1-16-25 (2pm).

Interview on 1/24/25 client #3 stated:
-He took his medications everyday.

Finding #3
Review on 1/27/25 of client #4's record revealed:
Date of Admission: 6/15/22.
Diagnoses: Schizoaffective Disorder, Bipolar Disorder.

Review on 1/24/25 of client #4's signed physician orders dated 11/1/24 revealed:
-Klonopin (Schizoaffective Disorder) 1 mg - take

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V 118	Continued From page 3 one tablet twice daily. Review on 1/24/25 of client #4's MAR from 1/1/25-1/24/25 revealed the following medications were not documented as administered: -Klonopin 1mg - 1/10/25 (8pm), 1/13/25 (8pm), 1/19/25 (8pm), 1/20/25 (8pm) and 1/22/25 (8pm). Interview on 1/24/25 client #4 stated: -He took his medications everyday. Interview on 1/24/25 the House Manager stated: -The clients received their medications as prescribed. -There was an issue with how the pharmacy printed the MARs for January 2025. -He was not sure why there were blanks on the MARs. Interview on 1/31/25 the Qualified Professional/Registered Nurse/Licensee stated: -She had addressed the issue with the way the MARs were printed with the pharmacy. -She would ensure the MARs would be "correct going forward." Due to failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS	V 367		

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V 367	Continued From page 4 (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential	V 367		

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information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).
(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:
(1) medication errors that do not meet the definition of a level II or level III incident;
(2) restrictive interventions that do not meet the definition of a level II or level III incident;
(3) searches of a client or his living area;
(4) seizures of client property or property in the possession of a client;
(5) the total number of level II and level III incidents that occurred; and
(6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.

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V 367	Continued From page 6 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report a level II incident to the Local Management Entity/Managed Care Organization (LME/MCO) within 72 hours of becoming aware of the incident. The findings are: Review on 1/31/25 of the North Carolina Incident Response Improvement System (IRIS) revealed no level II report for incident between Former Client (FC) #5 and the House Manager revealed: -Date Submitted: 1/30/25 -Date of incident: 1/16/25 -Incident Comments: "According to the staff, [FC #5] walked into the kitchen and told staff to call the police because he was going to 'f**k him up.' Staff was opening a can of vegetables with a pocket knife and [FC #5] grabbed the knife. Staff tried to take the knife from him and slipped on the floor. [FC #5] started kicking him repeatedly. Staff called the office while he was being kicked and requested police and medical assistance. [FC #5] left the house before police arrived." -Incident prevention note dated 1/30/25: "According to the staff and [FC #5] housemates, he had shown no aggression or anger prior to the incident. There were no triggers or warning signs. He watched television (TV) and socialized appropriately with both staff and his housemates." Review on 1/24/25 of facility internal incident report revealed: -Date: 1/16/25 -Member: "[FC #5]	V 367		

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V 367	Continued From page 7 -Description of the Incident: Assaulted House Manager. Police and Emergency Medical Services (EMS) notified. [FC #5] and the House Manager transported to the Emergency Department (ED) for evaluation of potential injuries. Diagnostic evaluations were negative. Office Manager will submit IRIS report within 72hrs (hours)." Interview on 1/24/25 and 1/27/25 the Qualified Professional/Registered Nurse/Licensee stated: -"The Officer Manager was expected to submit the IRIS report within the 72 hours." -She would ensure that the IRIS report was submitted. -She was aware the IRIS report was submitted late. -She had been in contact with the Local Management Entity/Managed Care Organization regarding the specifics in the IRIS report.	V 367		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (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. This Rule is not met as evidenced by: Based on observation and interviews, the facility and its grounds were not maintained in a safe, clean, attractive and orderly manner. The findings are: Observation on 1/24/25 from approximately 10:50 am to 11:23 am revealed: -The curtain rod was bent in Client #1 and Client	V 736		

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V 736	Continued From page 8 #4 shared bedroom and paint was chipped around the entire frame of the bedroom door. -Client #1's entire pillow was covered in brown stains, in the closet their were unfolded clothes piled approximately two feet high and the bar in the closet was missing. -Client #3's bedroom had paint chipped on the baseboard around the entire room, the dresser was missing 1 of 9 drawers and 2 of 13 handles, approximately 5 feet by 3 feet area on ceiling near window was unpainted. -Client #3 private bathroom had a gray shower curtain that was covered all over with dark stains and the faucet was covered in white residue and the half of the tip of the faucet was broken off. -Bathroom with shower had approximately 4 inches in diameter of paint chipped in ceiling near light above the sink and had paint chipped around the entire door frame. -Vacant bedroom had an electrical receptacle cover that was missing, approximately 2 inch hole in the wall, several areas on the walls had were unpainted. -The living room had couches with various sized rips in the top layer of the fabric. -The dining room had a floor vent covered in rust. -In the kitchen the stove was missing two of four burners. -On the ground outside there was a satellite cable dish to the right of the back door that did not appear operable which pointed towards the ground. The dish had cable wires attached to the house. Interview on 1/24/25 with the House Manager stated: -Maintenance issues were reported to the Qualified Professional (QP)/Registered Nurse (RN)/Licensee.	V 736		

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V 736	Continued From page 9 Interview on 1/31/25 with the QP/RN/Licensee stated: -The facility had requested the satellite company to come pick up the equipment from outside of the facility. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		