

RECEIVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 02/27/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G233	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/26/2025
NAME OF PROVIDER OR SUPPLIER WEBSTER GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 103 LITTLE SAVANNAH RD WEBSTER, NC 28788		
(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 368	<p>DRUG ADMINISTRATION CFR(s): 483.460(k)(1)</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure medications were administered in accordance with physician's orders. This affected 1 client (Client #4) observed during medication administration. The finding is:</p> <p>Observations in the home on 2/26/25 revealed client #4 to enter the medication administration area at 8:02 AM and staff to dispense the following medications: Lamotrigine 25 mg - 2 tablets, Olanzapine 10 mg - 1 tablet, Clonazepam 1 mg - 1 tablet, Topiramate 100 mg - 1.5 tablets. Continued observation revealed client #4 to swallow all medications with water and to receive no further medications for the duration of the observation.</p> <p>Review on 2/26/25 of client #4's physician's orders revealed an order dated 11/25/24 to add Pepcid, 1 tablet 2 times per day for 180 days to client #4's standing prescription order.</p> <p>Interview on 2/26/25 with the Director of Nursing (DON) for the home confirmed the physician's order was current and that Client #4 should have received the prescribed dose of Pepcid during medication administration. The DON further verified that the order for Pepcid had never been placed with the pharmacy, so client #4 has not received any doses of this medication to date.</p>	W 368	<p>Following the survey exit interview, the MCH RN contacted the pharmacy to request a label for Pepcid according to the physician's order. The RN verified with the group home manager the medication was received and properly labeled at the group home. The RN approved the addition of Pepcid to the medication administration record in client #4's electronic health record. Client #4 received the first dose of Pepcid on the evening of 2/26/2025. Please see attachment #1 as evidence of correction.</p> <p>The RN will use a new checklist to ensure all physician orders received are properly implemented. Please see attachment #2 as a sample of the checklist.</p> <p>The group home manager, QP and/or RN will perform periodic checks of each resident's medications against orders in Therap to ensure they match. These checks will occur at least once a week for 60 days. Evidence of this will be found on the monitoring tool (see attachment #3).</p>	2/26/2025	
W 440	<p>EVACUATION DRILLS CFR(s): 483.470(i)(1)</p>	W 440			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Christi Huff

Executive Director

3.12.2025

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 440 Continued From page 1
at least quarterly for each shift of personnel.
This STANDARD is not met as evidenced by:
Based on record review and interview, the facility
failed to ensure evacuation drills were held at
least quarterly for each shift of personnel. The
finding is:

A review of the facility fire drill reports on 2/25/25
revealed that between 3/30/24 and 2/25/25, the
facility conducted 9 fire drills, and that of those,
five occurred on first shift, two on second shift
and two on third shift. Continued review revealed
that there were no second or third shift fire drills
for the third or fourth quarters of the review year.

Interview with the facility administrator on 2/26/25
confirmed fire drills should have been conducted
quarterly for each shift of personnel.

W 440 The QP reviewed the evacuation drill
schedule with the group home manager.
In an effort to ensure drills are
conducted properly, the QP will review
and sign off on the annual drill schedule
(see attachment #4). Additionally, the
QP will review and sign the drill report in
addition to the group home manager
(see attachment #5).

3/14/2025

Individual Name: Client #4
Medicaid Number:
Date of Birth:

Attachment #1

Macon Citizens Abilities, Inc.



Medication Administration Record - February, 2025

Individual Name: Client #4

Birth Date:

Created By: Health Care Assistant on 01/27/2025 11:33 AM

Approved By: Health Care Assistant on 02/26/2025 11:35 AM

Form ID: MAR MCHNC-P3V4NSCYLENN5 Time Zone : US/Eastern

Legends: ☒ MR Missed/ Refused ☐ LOA LOA ☐ OH On hold ☐ Deleted ☐ User with no Initial



Client #4

Scheduled Medication(s)

BENZOYL PEROXIDE 10% GEL - gel, topical, Scheduled (Medication)

Strength: 10%

Indication/Purpose Acne

Give Amount / Quantity: Pea Size Ointment Frequency: QID

Begin Date & Time: 03/01/2019 7:30 pm

Schedule Repeat: Every Day 1 time(s) a day Schedule Time Slot(s): 8:00 pm

Instruction: Apply to acne prone areas after bath

Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI
8:00 pm	CMS	CMS	mjl	DH	CBT	DH	CMS	CMS	CBT	DH	DH	DH	DH	DH	mjl	mjl	MAC	DH	CBT	DH	DH	CMS	CMS	CBT	DH	DH	DH	DH

Individual Name: Client #4
 Medicaid Number:
 Date of Birth:

Macon Citizens Abilities, Inc.



CICLOPIROX 8% SOLUTION - Solution, Non-Oral, topical, Scheduled (Medication)

Strength: 8% Attachment: Ciclopirox Solution.pdf(83.16 KB)

Indication/Purpose Toenail Fungus

Give Amount / Quantity: APPLY TO TOENAILSSolution Frequency: ONCE DAILY

Begin Date & Time: 07/09/2022 7:30 pm

Schedule Repeat: Every Day 1 time(s) a day Schedule Time Slot(s): 8:00 pm

Instruction: APPLY TOPICALLY ONCE DAILY AS DIRECTED

Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI
8:00 pm	CMS	CMS	mjl	DH	CBT	DH	CMS	CMS	CBT	DH	DH	DH	DH	DH	mjl	mjl	MAC	DH	CBT	DH	DH	CMS	CMS	CBT	DH	DH	DH	DH

CLONAZEPAM 1 MG TABLET - tablet, oral, Scheduled (Medication)

Strength: 1mg

Indication/Purpose Anxiety Disorder

Give Amount / Quantity: 1 Tablet Frequency: BID

Begin Date & Time: 03/01/2019 7:30 am

Schedule Repeat: Every Day 2 time(s) a day Schedule Time Slot(s): 8:00 am, 4:00 pm

Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI
8:00 am	mjl	mjl	MNH	CBT	MNH	CMS	MNH	mjl	mjl	RPC	MNH	MAC	MNH	MNH	mjl	MAC	MNH	CBT	MNH	CMS	MAC	mjl	mjl	MNH	mjl	MNH	MNH	MNH
4:00 pm	mjl	mjl	TIE	LOA	TIE	TIE	TIE	mjl	mjl	TIE	TIE	TIE	TIE	TIE	mjl	mjl	TIE	TIE	RPC	RPC	RPC	mjl	mjl	RPC	LOA	TIE	TIE	TIE

Individual Name: Client #4
 Medicaid Number:
 Date of Birth:

Macon Citizens Abilities, Inc.



FT ACID REDUCER 10 MG TABLET - tablet, oral, Scheduled (Medication)

Strength: 10mg Controlled Substance: No Prescriber: [REDACTED] Dr. (Macon County Public Health Department)

Instruction/Comments 1 tab PO BID

Give Amount / Quantity: 1 Tablet Frequency: PO BID

Begin Date & Time: 02/26/2025 7:30 pm End Date & Time: 05/24/2025 11:45 pm

Schedule Repeat: Every Day 2 time(s) a day Schedule Time Slot(s): 8:00 am, 8:00 pm

Instruction: 1 tab PO BID

Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI
8:00 am																												
8:00 pm																											MNH	MNH
																										DH	DH	DH

LAMOTRIGINE 25 MG TABLET - tablet, oral, Scheduled (Medication)

Strength: 25mg

Indication/Purpose Psychotic Disorder, NOS

Give Amount / Quantity: 2 Tablet Frequency: BID

Begin Date & Time: 03/01/2019 7:30 am

Schedule Repeat: Every Day 2 time(s) a day Schedule Time Slot(s): 8:00 am, 8:00 pm

Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI
8:00 am	mjl	mjl	MNH	CBT	MNH	CMS	MNH	mjl	mjl	RPC	MNH	MAC	MNH	MNH	mjl	MAC	MNH	CBT	MNH	CMS	MAC	mjl	mjl	MNH	mjl	MNH	MNH	MNH
8:00 pm	CMS	CMS	mjl	DH	CBT	DH	CMS	CMS	CBT	DH	DH	DH	DH	DH	mjl	mjl	MAC	DH	CBT	DH	DH	CMS	CMS	CBT	DH	DH	DH	DH

CHECKING IN NEW MEDICATION ORDERS

For new, **regularly scheduled** medications, please enter information in columns as requested. For columns with an asterisk, please enter a checkmark when completed. Do no initial until all steps have been completed.

[illegible]

[illegible]

Attachment #3

1998

[illegible]

ANNUAL FIRE DRILL AND SAFETY TRAINING SCHEDULE

MONTH	SHIFT	SAFETY TRAINING	QP SIGNATURE
JANUARY	FIRST SHIFT WEEKEND	WINTER STORM	
FEBRUARY	SECOND SHIFT WEEKDAY	BATHROOM SAFETY	
MARCH	THIRD SHIFT WEEKEND	FOLLOWING HOUSE RULES	
APRIL	FIRST SHIFT WEEKDAY	FIRST AID	
MAY	SECOND SHIFT WEEKEND	VEHICLE SAFETY	
JUNE	THIRD SHIFT WEEKDAY	HOT WEATHER SAFETY	
JULY	FIRST SHIFT WEEKEND	HEAT STROKE	
AUGUST	SECOND SHIFT WEEKDAY	PARKING LOT SAFETY	
SEPTEMBER	THIRD SHIFT WEEKEND	POWER OUTAGE	
OCTOBER	FIRST SHIFT WEEKDAY	KITCHEN SAFETY	
NOVEMBER	SECOND SHIFT WEEKEND	STRANGER DANGER	
DECEMBER	THIRD SHIFT WEEKDAY	COLD WEATHER SAFETY	

FIRST SHIFT (7a-3p)

SECOND SHIFT (3p-11p)

THIRD SHIFT (11p-7a)

SAFETY TRAINING MAY OCCUR EITHER AFTER A DRILL OR DURING THE MONTHLY HOUSE MEETING AND MUST BE DOCUMENTED. QP WILL REVIEW DRILL FORMS AND SIGN SHEET TO ENSURE DRILLS ARE COMPLETED ON CORRECT SHIFT.

Attachment #5

MACON CITIZENS HABILITIES, INC. FIRE DRILL AND SAFETY TRAINING

Date of drill: _____ *Shift: _____ Time: _____

Staff Conducting Drill: _____

Observers (if any): _____

Location of residents in the house or on the grounds:

Name	Location	Special Procedure
Name	Location	Special Procedure
Name	Location	Special Procedure
Name	Location	Special Procedure
Name	Location	Special Procedure
Name	Location	Special Procedure

Procedures used to evacuate:

Total time taken to evacuate house: _____

Assessment of evacuation and recommendations for future drills:

Other safety training conducted (describe in detail): _____

Projected date for next drill: _____

Staff completing form: _____ Date: _____

Manager review: _____ Date: _____

QP review: _____ Date: _____