	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMP	SURVEY LETED
		MHL098-169	B. WING			२) 3/202 5
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
WILSON	COUNTY GROUP HC)MF #1	AGG ST NE I, NC 27893			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X COMP DA
	on 4/3/25. Deficence This facility is licens category: 10A NCA Living for Adults wit This facility is licens census of 4. The su audits of 3 current of 27G .0207 Emerge 10A NCAC 27G .02 AND SUPPLIES (a) Each facility sha and a disaster plan these plans availab to the county emerge request. The plans procedures and rou (b) The plans shall and evacuation pro posted in the facility. (c) Fire and disaster	w up survey was completed cies were cited. Sed for the following service C 27G .5600C Supervised h Developmental Disability. Sed for 5 and has a current urvey sample consisted of clients. Incy Plans and Supplies 207 EMERGENCY PLANS all develop a written fire plan and shall make a copy of ole gency services agencies upon shall include evacuation utes. be made available to all staff ocedures and routes shall be r drills in a 24-hour facility st quarterly and shall be	V 000 V 114		IVED BY IL & C	
	Drills shall be condu simulate the facility emergencies.	ucted under conditions that 's response to fire Ill have a first aid kit			4/2025	
Vision of H	ealth Service Regulation	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S IDENTIFICAT	UPPLIER/CLIA			(X3) DATE COMP	SURVEY LETED
				A. BUILDING	B:	F	
		MHL098-	169	B. WING			3/2025
AME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
/ILSON	COUNTY GROUP HO	OME #1		GG ST NE NC 27893			
(X4) ID	SUMMARY STA	TEMENT OF DEFIC	-	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	MUST BE PRECED	ED BY FULL	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLET DATE
V 114	Continued From pa	age 1		V 114	V 114		
	This Rule is not me Based on record re failed to ensure that facility were held a repeated for each s Review on 4/3/25 o	view and interv at disaster drills t least quarterly shift. The findin of the facility's d	iew, the facility in a 24-hour and shall be gs are:		Drill Schedule indicating the ro drills to include Emergency Dri the Operations Manager with th home staff responsible for com identified.	ills will be posted by ne assigned group	4/25/25
	schedule revealed completed monthly Review on 4/3/25 o book revealed:	r. If the facility's d	isaster drill log				
	 No disaster dril January 2024- Apr No disaster dril (10pm-6am) 	il 2024	ted from ted for 3rd shift				
	Interview on 4/3/25 Manager/Qualified - The shifts were 2pm-10pm, and 3re - Disaster drills v - The House Ma disaster drills	Professional s e: 1st shift 6am- d shift 10pm-6a were completed	tated: 2pm, 2nd shift am I on all 3 shifts				
	 There had not be June of 2024 There was a set supposed to follow 	chedule that sta to complete dis	aff were aster drills				
	 The Quality Ma reminders to her th completed "I would have b they were done" 		eded to be				
	- "I may have be drills than tornado	drills" as to why disa	ed more on fire ster drills would				
	This defiency const must be corrected	titutes a re-cited					

Division	of Health Service Re	egulation				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MHL098-169	B. WING			२ 3/2025
NAME OF F	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY,	STATE, ZIP CODE		
WILSON	COUNTY GROUP HO	DMF #1	RAGG ST NE ON, NC 27893			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 118	10A NCAC 27G .02 REQUIREMENTS (c) Medication adm (1) Prescription or r only be administered order of a person a drugs. (2) Medications sha clients only when a client's physician. (3) Medications, ind administered only b unlicensed persons pharmacist or othe privileged to prepar (4) A Medication Ad all drugs administe current. Medication recorded immediat MAR is to include t (A) client's name; (B) name, strength (C) instructions for (D) date and time tt (E) name or initials drug. (5) Client requests checks shall be rec file followed up by a with a physician.	inistration: non-prescription drugs shall ed to a client on the written uthorized by law to prescribe all be self-administered by puthorized in writing by the cluding injections, shall be by licensed persons, or by a trained by a registered nurs r legally qualified person an re and administer medication dministration Record (MAR) red to each client must be k a administered shall be ely after administration. The he following: , and quantity of the drug; administering the drug; he drug is administering the for medication changes or corded and kept with the MA appointment or consultation	e se, d ns. of ept e			
Division of H	This Rule is not me ealth Service Regulation	et as evidenced by:				
STATE FOR	_		6899	UY4L11	If continuatio	on sheet 3 of 11

ND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _			R
		MHL098-169	B. WING			03/2025
AME OF F	PROVIDER OR SUPPLIER	STREET	TADDRESS, CITY, ST	ATE, ZIP CODE		
/ILSON	COUNTY GROUP HO	OMF #1	RAGG ST NE			
		WILSO	ON, NC 27893			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN(TION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE
V 118	Continued From pa	ige 3	V 118			
	interview, the facilit medications were a	eview, observation, and ty failed to ensure that administered on the written n affecting 3 of 3 clients (# 2, gs are:				
	revealed: - Admitted: 8/11/ - Diagnoses: Mil Disability (IDD), (G Disease (GERD), H Weight Loss, Cons bleeding, Mixed Hy Vitamin D Deficient Leukopenia, Cardia - Doctor's Order - Acetamino (MG) Tablet (Tab), (pain/elevated tem - Hemorrhoi Suppository 25mg,	d Intellectual Developmenta astroesophageal Reflux Heart Disease, Abnormal tipation, Gastritis with perlipidemia, Abnormal Gait cy, Allergic Rhinitis, ac Murmur dated 3/3/25 revealed: phen (APAP) 325 milligram as needed (PRN)				
	- APAP was adm	of Client # 2's MAR revealed: ninistered on 3/28/25				
	of Client # 2's med - APAP had an e - No other APAP	/25 at approximately 11:30al ication box revealed: expiration date on 8/27/24 9 was in the facility dal HC or Milk of Magnesia the facility	m			
	revealed: - Admitted: 10/25 - Diagnoses: Mo	5 of Client #3's record 5/22 derate IDD, Chromosomal ecified, Schizoaffective				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION		E SURVEY PLETED
		MUI 009 460	B. WING			R 03/2025
		MHL098-169			04/	03/2025
	PROVIDER OR SUPPLIER	308 BR	DDRESS, CITY, STA AGG ST NE	ATE, ZIP CODE		
VILSON	COUNTY GROUP HO	OMF #1	I, NC 27893			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pa	age 4	V 118			
V 118	Disorder, Bipolar ty Explosive Disorder Diabetes Mellitus w Hypertension, Othe Obstructive Sleep unspecified, GERE Persistent Asthma - Doctor's order - APAP 325 - Ibuprofen (- IPRAT (Ipra 3M, PRN (asthma)) Review on 4/3/25 (2025 MARs reveal - IPRAT was add Observation on 4/3 of Client #3's medi - APAP and Ibug - IPRAT-Albut et C. Review on 4/3/2 revealed: - Admitted: 8/20 - Diagnoses: IDI Disorder, Hepatitis Essential Hyperter Prostate Hypertrop - Doctor's order - APAP 3250 - Benzonata - Ondansetr	ype, Epilepsy, Intermittent r, Bipolar Disorder, Type 2 vithout complications, Essentia er Seasonal Allergic Rhinitis, Apnea, Hyperlipidemia,) without Esophagitis, and Mile , uncomplicated dated 11/6/24 revealed: mg tab, PRN (pain) 600mg tab, PRN (pain) atropium)-Albut (Albuterol) 0.5 Client #3's March 2025 & April ed: ministered on 3/13/25 3/25 at approximately 11:40am cation box revealed: orofen not in the med box xpired 9/13/24 25 of Client #4's record 11 D, Unspecified Circulatory B, Disorder of Tooth Eruption, nsion, Hyperlipidemia, and ohy dated 10/1/24 revealed: mg tab, PRN (pain) ate 100mg cap, PRN (cough) on 4mg, PRN (nausea)				
	of Client #4's med - APAP and Ben - Ondansetron e	zonatate not in the med box expired 7/14/24				
	Interview on 4/2/25	5 with Staff # 2 stated:				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING	3:		
		MHL098-169	B. WING			R 03/2025
IAME OF I	PROVIDER OR SUPPLIER	STREE	ET ADDRESS, CITY,	STATE, ZIP CODE		
	COUNTY GROUP HO	OMF #1 308 E	BRAGG ST NE			
		WILS	ON, NC 27893			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLE ⁻ DATE
V 118	Continued From pa	nued From page 5		V118 Designed DN second state the result of the	1	4/05/05
		ecked medications (meds)		Regional RN complete the medication of 4/25/25. These will continue to be completerely.		4/25/25
	 Unaware of wh the facility She did not real expired The Operational 	by the PRN meds were not in alize that the medication had al Manager (OM)/Qualified double checked the meds		Monthly Med Closet review to be o assigned GH Manager covering wh without a manager. These will be s Regional RN for compliance.	en a home is	4/25/25
	 Not sure who we meds "I know they she should do an extra set of eye Interview on 4/3/25 Staff normally be should be shou	with the QP stated: was responsible for checking ould be checked monthly" o it, but not sure if there was s over it "to my knowledge" with the OM/QP stated: looked over the meds ng a House Manager would e	5			
	June 2024 - She should hav	ad a House Manager since ve checked the meds				
V 119	10A NCAC 27G .02 REQUIREMENTS (d) Medication disp (1) All prescription medication shall be guards against dive (2) Non-controlled of by incineration, f system, or by trans destruction. A reco shall be maintained Documentation sha	osal: and non-prescription disposed of in a manner the ersion or accidental ingestic substances shall be dispose flushing into septic or sewe afer to a local pharmacy for rd of the medication dispos	on. ed r al			

If continuation sheet 6 of 11

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
						R
		MHL098-169	B. WING		04/	03/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE		
WILSON	COUNTY GROUP H	OMF #1	AGG ST NE N, NC 27893			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OL (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLE DATE
V 119	Continued From pa	age 6	V 119			
	disposing of media witnessing destruct (3) Controlled subs accordance with the Substances Act, G subsequent amend (4) Upon discharger remainder of his of disposed of promp expected that the p to the facility and in drug supply shall r	stances shall be disposed of ir ne North Carolina Controlled .S. 90, Article 5, including any				
	Based on record re interview, the facilit medication in a ma diversion or accide audited clients (#2 A. Review on 4/2/2 revealed: - Admitted: 8/11 - Diagnoses: Mi Disability, Gastroe (GERD), Heart Dis	et as evidenced by: eview, observation, and sy failed to dispose of inner that guards against intal ingestion affecting 3 or 3 2, #3, #4). The findings are: 5 of Client #2's record /2011 Id Intellectual Developmental sophageal Reflux Disease iease, Abnormal Weight Loss iritis with bleeding, Mixed				
	Hyperlipidemia, At Deficiency, Allergio Murmur - Doctor's Order	ritis with bleeding, Mixed phormal Gait, Vitamin D c Rhinitis, Leukopenia, Cardia dated 3/3/25 revealed: phen (APAP) 325 milligram	c			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _			R
		MHL098-169	B. WING			03/2025
AME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE		
VILSON	COUNTY GROUP HO	OMF #1	AGG ST NE N, NC 27893			
(X4) ID		TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN O		(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLE [®] DATE
V 119	Continued From pa	age 7	V 119			
	 (MG) Tablet (Tab), as needed (PRN) (pain/elevated temperature) Observation on 4/2/25 at approximately 11:30am of Client # 2's medication box revealed: APAP had an expiration date of 8/27/24 					
			ו			
	 B. Review on 4/3/2 revealed: Admitted: 10/23 Diagnoses: Mod Abnormality, unspec Disorder, Bipolar ty Explosive Disorder Diabetes Mellitus w Hypertension, Othe Obstructive Sleep J unspecified, GERD Persistent Asthma, Doctor's order - IPRAT(Ipra 3M, PRN (asthma) 	5 of Client #3's record 5/22 oderate IDD, Chromosomal ecified, Schizoaffective /pe, Epilepsy, Intermittent r, Bipolar Disorder, Type 2 /ithout complications, Essentia er Seasonal Allergic Rhinitis, Apnea, Hyperlipidemia,) without Esophagitis, and Mil , uncomplicated dated 11/6/24 revealed: atropium)-Albut (Albuterol) 0.5	d ;-			
	revealed: - Admitted: 8/20 - Diagnoses: IDI Disorder, Hepatitis Essential Hyperten Prostate Hypertrop - Doctor's order - Ondansetr	D, Unspecified Circulatory B, Disorder of Tooth Eruption, ision, Hyperlipidemia, and hy dated 10/1/24 revealed: ron 4mg, PRN (nausea)				
	of Client #4's med - Ondansetron e					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G:		SURVEY PLETED
		MUI 009 460	B. WING			R 03/2025
		MHL098-169			04/	03/2025
NAME OF F	PROVIDER OR SUPPLIER		AGG ST NE	STATE, ZIP CODE		
WILSON	COUNTY GROUP HC)MF #1	N, NC 27893			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLET DATE
V 119	Continued From pa	ge 8	V 119	V119		
	- She usually che	with Staff # 2 stated: ecked medications (meds)		Regional RN complete the medication closet revie 4/25/25. These will continue to be completed by t quarterly.		
	- The Operationa	ork lize that the APAP was expire al Manager (OM)/Qualified double checked the meds	d	Monthly Med Closet review to be complete assigned GH Manager covering when a ho without a manager. These will be submitted Regional RN for compliance	me is	4/25/25
	meds - "I know they sh - Staff should do	with the QP stated: vas responsible for checking ould be checked monthly" it, but not sure if there was ar ver it "to my knowledge"	1			
		with the OM/QP stated: t expired meds back to the				
V 736	27G .0303(c) Facili	ty and Grounds Maintenance	V 736			
	EXTERIOR REQUI (c) Each facility and maintained in a safe	03 LOCATION AND IREMENTS d its grounds shall be e, clean, attractive and orderly e kept free from offensive	,			
		on and interview, the facility safe, clean, attractive, and				
	Observation on 4/3/ revealed:	/25 at approximately 2:50pm				
	Client #4's bedroom - dresser drawer top right drawer	n: was missing one knob on the				

STATE FORM

UY4L11

If continuation sheet 9 of 11

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED		
		MHL098-169	B. WING		04	R 04/03/2025	
AME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
ILSON	COUNTY GROUP HO	OMF #1	RAGG ST NE DN, NC 27893				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE	
V 736	Continued From pa - 4th dresser dra	age 9 wer had one of the handles	V 736	V736 ESPH Facilities will obtain a quo plumbing concern.	ote regarding the	6/1/25	
	the 2nd draw on th - nightstand bott handle - TV stand was r door Bathroom #1 and E	om drawer had a zip-tie as the nissing the right knob on the	ne	Handles and Knobs will be repla	ced.	6/1/25	
	/Qualified Professio - She was not av #4's bedroom furni - Was unaware i furniture if it was th - She would disc updating his bedro	ware they were cited for clien ture in the past if they were able to repair the ie client's personal stuff cuss with Client #4 about					
V 774	EQUIPMENT (d) Indoor space reprior to October 1, square footage req time. Unless otherwork residential facilities 1988 shall meet the requirements: (7) Minimum furnis include a separate	inimum Furnishings 304 FACILITY DESIGN AND equirements: Facilities license 1988 shall satisfy the minimu juirements in effect at that wise provided in these Rules a licensed after October 1, e following indoor space hings for client bedrooms sha bed, bedding, pillow, bedsid for personal belongings for	ed um s, all				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G:		E SURVEY PLETED
			A. BUILDING	j		R
		MHL098-169	B. WING		04/	03/2025
IAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
VILSON	COUNTY GROUP HO)MF #1	GG ST NE , NC 27893			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLET DATE
V 774	Continued From pa	ge 10	V 774	V774		
				QM will communicate with all ESPH Group hon requirement for vacant rooms to have a bed, nigh dresser, bedding, and pillow.		6/1/25
	failed to ensure mir bedrooms that inclu- pillow, bedside tabl belongings for each Review on 4/2/25 of Service Regulation Capacity 5 Observation on 4/2/ of the vacant bedro - No bed, beddin - Cleaning Suppl dresser and floors Interview on 4/3/25 Qualified Professio - The room had b - The room had b - The room had b - The previous of they moved out - The facility did p put in the room whe - Was unaware t furniture available i - She would need	ion and interview, the facility nimum furnishings for client ude a separate bed, bedding, le, and storage for personal in client. The findings are: of The Division of Health 's Facility License revealed: /25 at approximately 10:40am bom revealed: ig, or pillow lies and extra food were on the with the Operational Manager/ nal stated: been vacant since June 2024 been a "swinging door" brought their own furniture lient took their furniture when not keep bedroom furniture to en a client moved out hat the facility needed to have		Vacant room will be cleared out with the minim furnishings provided.	um	6/1/25