STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING:		J COIVII L	LILD	
		MHL0601020	B. WING		05/14/2018		
NAME OF P	ROVIDER OR SUPPLIER	TE, ZIP CODE					
JOYCE R	JOYCE ROBINSON HOME 3306 HENDRICK CHAPEL LANE						
		CHARLOT	TE, NC 28216				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 000	INITIAL COMMENTS	;	V 000				
	An annual survey was Deficiencies were cite	s completed on 5/14/18. ed.					
	This facility is licensed for the following service category: 10A NCAC 27G .5600F Alternative Family Living.						
V 118	V 118 27G .0209 (C) Medication Requirements		V 118				
	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 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.						

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

(X6) DATE TITLE

	of Health Service Regu				(X3) DATE SURVEY	
		(X1) PROVIDER/SUPPLIER/CLIA	' '	(X2) MULTIPLE CONSTRUCTION		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED	
MHL0601020		MHL0601020	B. WING		05/14/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATI	E ZIP CODE		
TO THE OT THE	to vibert of tool i eleft		ENDRICK CHAPEL			
JOYCE RO	DBINSON HOME		OTTE, NC 28216	LANE		
	CLIMMADY CT			DDOWDEDIC DLAN OF CODDECTIO	NI	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE DATE	
				DEFICIENCY)		
V 118	Continued From page	e 1	V 118			
	1 0					
	This Rule is not met	as evidenced by:				
	Based on records rev	•				
		ility failed to ensure the				
	MARS were kept curi					
	administered were recorded immediately after administration. for 2 of 2 clients (#1, #2). The					
	findings are:					
	E: 1: //4					
	Finding #1 Review on 5/10/18 of client #1's record revealed:					
		1/02 with diagnoses of nental Disability-Moderate				
	and Allergic Rhinitis;	ieritai Disability-ivioderate				
		ted 3/23/18 for the following				
		ne Besylate 5mg one tablet				
	daily.	3				
	•					
	Observation on 5/14/	18 at 2:50pm of client #1's				
		vealed amlodipine besylate				
		5mg one tablet daily				
	dispensed 4/30/18.					
	Daviou on 5/10/10	nd 5/14/18 of client #1's				
		14/18 revealed no May 2018				
	MAR.	1-7 10 revealed no may 2010				
	u u					
	Interview on 5/14/18	with client #1 revealed she				
	got her pill daily.					
	,					
		with staff #1 revealed:				
		sional (QP) was supposed to				
		R forms as they were out;				
		ny additional forms so May				
	2018 medication not	documented:				

Division of Health Service Regulation

-client #1 has been on the same medication for

STATE FORM 6899 DI8N11 If continuation sheet 2 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL0601020	B. WING		05/1	05/14/2018	
	ROVIDER OR SUPPLIER	3306 HEN	DDRESS, CITY, STA	,	•		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
V 118	years and gets one palways gives client #Finding #2: Review on 5/10/18 of admission date of 12 Dysthymic Disorder, Intellectual Disability-Moderate, Eand Seasonal Allergie-physicians' orders damedications: Flonase nostril daily, atorvasta 20mg one tablet daily tablet at bed.  Observation on 5/14/client #2's medication-Flonase 50mcg one dispensed 4/27/18; atorvastatin 20mg or 4/25/18; -Amitriptyline 10mg or 4/23/18.  Review on 5/10/18 ar MARs from 3/1/18-5/5-Flonase 50mcg one not documented as a atorvastatin 20mg or administered from 5/5-Amitriptyline 10mg or documented as administered as administered as administered as administered as administeries on 5/14/18 of the medications of the same strains of the same same same same same same same sam	client #2's record revealed: 2/31/09 with diagnoses of Disruptive Behavior Developmental Enuresis, High Cholesterol es; ated 5/23/17 for the following 50mcg one spray in each atin (generic for Lipitor) and Amitriptyline 10mg one  18 at 2:55pm revealed the s on site revealed: spray in each nostril daily the tablet daily dispensed  and 5/14/18 of client #2's 14/18 revealed: spray in each nostril daily dministered from 5/1-5/14; the tablet not documented as 1-5/14; the tablet at bed not anistered from 5/1-5/14.  With client #2 revealed she	V 118				

Division of Health Service Regulation

for client #2;

STATE FORM 6899 DI8N11 If continuation sheet 3 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL0601020	B. WING		05	5/14/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STATE	, ZIP CODE		
JOYCE R	OBINSON HOME		NDRICK CHAPEL I TTE, NC 28216	_ANE		
(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 ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 118	-have administered of prescribed; -usually document as month.  Additional observation	iient #2's medication daily as administer but not this n on 5/14/18 at 2:58pm umenting on May 2018 MAR	V 118			
V 752	EQUIPMENT (b) Safety: Each facil constructed and equipensures the physical visitors. (4) In areas of exposed to hot water.	4 FACILITY DESIGN AND	V 752			
	the facility where clief water, the temperatur maintained between affecting 2 of 2 clients  Observation on 5/14/ water in the client bat water temperature reaffecting.	n, record review and railed to ensure in areas of the were exposed to hot the of the water was 100-116 degrees Fahrenheit is (#1, #2). The findings are:  18 at 3:50pm of the hot hot hroom sink revealed a hot adding of 122 degrees				
		the facility's incident reports evealed no incidents of				

Division of Health Service Regulation

STATE FORM 6899 DI8N11 If continuation sheet 4 of 5

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
MHL0601020		B. WING		05/	05/14/2018			
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
JOYCE R	JOYCE ROBINSON HOME 3306 HENDRICK CHAPEL LANE CHARLOTTE, NC 28216							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
V 752	injuries related to the  Interview on 5/14/18 v -clients #1 and #2 had -clients #1 and #2 use	hot water temperature.  with staff #1 revealed: d no injuries this year; e the upstairs bathroom; hot water temperature ed degrees;	V 752					

Division of Health Service Regulation

STATE FORM 6899 DI8N11 If continuation sheet 5 of 5