	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
		MHL060-381	B. WING		R 06/14/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
\/!!! A OF	OF HODE HAVEN	3815 NOR	TH TRYON STE	REET	
VILLAGES	S OF HOPE HAVEN	CHARLOT	TE, NC 28206		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 000	INITIAL COMMENTS		V 000		
	on 6/14/18. Deficienc This facility is license	up survey was completed ies were cited. d for the following service C 27G .4100 Residential			
	Recovery Programs f	or Individuals with corders and Their Children			
V 108	27G .0202 (F-I) Perso	onnel Requirements	V 108		
	(g) Employee training provided and, at a mi following: (1) general organiza (2) training on client delineated in 10A NC 10A NCAC 26B; (3) training to meet to client as specified in the plan; and (4) training in infection bloodborne pathogen (h) Except as permitted. 5602(b) of this Subclamember shall be avaitimes when a client is member shall be trainincluding seizure mar to provide cardiopulm trained in the Heimlic techniques such as the American Heart A.	tion shall be documented. g programs shall be nimum, shall consist of the ditional orientation; rights and confidentiality as AC 27C, 27D, 27E, 27F and the mh/dd/sa needs of the the treatment/habilitation bus diseases and s. ed under 10a NCAC 27G hapter, at least one staff filable in the facility at all s present. That staff fined in basic first aid hagement, currently trained honary resuscitation and h maneuver or other first aid hose provided by Red Cross,			

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:			
			A. Boilbirto.			В
		MHL060-381	B. WING		00	R 5/ 14/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	. ZIP CODE	·	
			RTH TRYON STRE			
VILLAGES	S OF HOPE HAVEN	CHARLO	OTTE, NC 28206			
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 108	Continued From page	e 1	V 108			
	reporting, investigating	nd procedures for identifying, ag and controlling infectious seases of personnel and				
	facility failed to ensur trained in basic first a management, current cardiopulmonary resu in the Heimlich mane techniques such as the the American Heart A equivalence for reliev	riew and interviews, the e at least one staff member id including seizure tly trained to provide uscitation (CPR) and trained uver or other first aid nose provided by Red Cross, uscociation or their ring airway obstruction was for 3 of 6 staff (#1, #3 and				
	revealed: -hired on 5/10/17 with Abuse Counselor; -documentation of ce completed on 4/1/16 4/30/18;	r staff #1's personnel record In the job title of Substance In the job title of Substance				
	revealed: -hired on 7/27/12 with Abuse Counselor; -documentation of ce completed on 4/22/16 4/30/18;	staff #3's personnel record the job title of Substance rtification of CPR/First Aid with expiration date of current certification in				

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STATE FORM 6899 7J3C11 If continuation sheet 2 of 13

DIVISION	i Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
						ь
		MUL 000 204	B. WING	/ING R 06/14/2018		
		MHL060-381			06/	14/2018
NAME OF PR	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		3815 NOI	RTH TRYON STI	REET		
VILLAGES	OF HOPE HAVEN		TTE, NC 28206			
2411.15	CLIMMADV CT	ATEMENT OF DEFICIENCIES		DROVIDEDIS DI ANI CE COD	DECTION	0.70
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S		(X5) COMPLETE
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE A	PPROPRIATE	DATE
				DEFICIENCY)		
V 108	Continued From page	. 2	V 108			
V 100	Continued From page	. 2	1 100			
	CPR/First Aid.					
		staff #5's personnel record				
	revealed:					
	-hired on 6/1/16 with t	-				
	Support/Weekend As					
		rtification of CPR/First Aid				
	•	with expiration date of				
	4/30/18;					
		current certification in				
	CPR/First Aid.					
	Intensions on 6/12/19	with staff #1 revealed:				
		with staff #1 revealed:				
	-worked at the facility					
		portation of clients to off site				
	appointments/meeting					
	-had training in CPR/I	FIISLAIU.				
	Interview on 6/12/18 v	with staff #3 revealed:				
	-worked at the facility					
	-	portation of clients to off site				
	recovery meetings;	portation of cherits to on site				
	-had training in CPR/I	Firet Aid				
	naa talliing in Oi TVI	i ii Striid.				
	Interview on 6/12/18 v	with staff #5 revealed:				
	-worked at the facility					
		portation of clients to off site				
	appointments/meeting					
	-had training in CPR/I					
	Interview on 6/14/18	with the Vice President of				
	Clinical Services and	the Chief Executive Officer				
	revealed:					
		site currently trained in				
	CPR/First Aid;	· · · · · · · · · · · · · · · · · · ·				
	•	rainings several times a				
	year;	3				
	-	vere transporting clients off				
	site with expired CPR					

Division of Health Service Regulation

-will address issue.

STATE FORM 6899 7J3C11 If continuation sheet 3 of 13

DIVISION	or riealth Service Negu	iation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	:IED
		MIII 000 004	B. WING		R	
		MHL060-381	B. WINO		06/14	4/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		3815 NO	RTH TRYON STR	REFT		
VILLAGES	S OF HOPE HAVEN		OTTE, NC 28206	\		
			711E, NC 20200			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
		,		DEFICIENCY)		
V 114	27G .0207 Emergend	cy Plans and Supplies	V 114			
		7 EMERGENCY PLANS				
	AND SUPPLIES					
	(a) A written fire plan					
		an shall be developed and				
	shall be approved by	the appropriate local				
	authority.					
		made available to all staff				
		edures and routes shall be				
	posted in the facility.					
	(c) Fire and disaster (drills in a 24-hour facility				
		quarterly and shall be				
	repeated for each shi	ft. Drills shall be conducted				
	under conditions that	simulate fire emergencies.				
	(d) Each facility shall	have basic first aid supplies				
	accessible for use.					
	This Rule is not met					
	Based on records rev	view and interviews, the				
	facility failed to ensur	e fire and disaster drills were				
	held at least quarterly	and repeated for each shift.				
	The findings are:					
	Review on 6/12/18 of					
	disaster drill documer	ntation from 5/1/17 until				
	6/12/18 revealed: -no documentation of fire drills conducted from					
	11/13/17 until 3/9/18;					
	-no documentation of	disaster drills conducted				
	from 11/13/17 until 3/	9/18.				
	Interview on 6/12/18	with the Vice President of				
	Maintenance revealed	d:				
	-missing drills already	cited by DHSR construction				
	a few months ago;	,				
		plan of correction to DHSR				
	construction.					

Division of Health Service Regulation

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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	
		MHL060-381	B. WING		06	R 5/ 14/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
VILLAGES	OF HOPE HAVEN		ORTH TRYON STRE OTTE, NC 28206	ET		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 114	Continued From page	e 4	V 114			
	revealed: -participated in rando -drills happen differer	m fire and disaster drills; at times of day and night.				
V 118	only be administered order of a person aut drugs. (2) Medications shall clients only when aut client's physician. (3) Medications, incluadministered only by unlicensed persons trepharmacist or other leprivileged to prepare (4) A Medication Admall drugs administered current. Medications recorded immediately MAR is to include the (A) client's name; (B) name, strength, a (C) instructions for acc (D) date and time the (E) name or initials of drug. (5) Client requests for checks shall be record autoright autoright and the context of the cont	istration: n-prescription drugs shall to a client on the written horized by law to prescribe be self-administered by horized in writing by the ding injections, shall be licensed persons, or by rained by a registered nurse, egally qualified person and and administer medications. hinistration Record (MAR) of d to each client must be kept administered shall be or after administration. The following:	V 118			

Division of Health Service Regulation

STATE FORM 6899 7J3C11 If continuation sheet 5 of 13

	or periorenoiro		(VO) MULTIPLE	CONCEDUCTION	TOWN DATE OUR VEV
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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					R
		MHL060-381	B. WING		06/14/2018
	DOLUBER OF CLUBRUER	0.70557.4	200000000000000000000000000000000000000	TE 710 000E	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA		
VILLAGES	S OF HOPE HAVEN		RTH TRYON STE	REET	
		CHARLO	TTE, NC 28206		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF	
IAG	TREGOLATION ON E	iso is a rate in the craw there,	TAG	DEFICIENCY)	TW/12
V 118	Continued From page	e 5	V 118		
	This Rule is not met	as evidenced by:			
		riew, observations and			
	interviews, the facility				
		ation Record (MAR) of all			
	drugs administered to	• •			
		administered were recorded			
	1	ninistration and prescription			
	I -	rugs were administered to a			
		rder of a person authorized			
		rugs affecting 5 of 9 clients			
	(#1, #4, #6, #7 and #8	_			
		o, manigo are.			
	Finding #1:				
	Review on 6/12/18 of	client #1 revealed:			
		25/17 with diagnoses of			
	Opiate Use Disorder,				
		Disorder, Bipolar Disorder,			
	Insomnia and Anxiety				
		ed 1/11/18 for Amitriptyline			
	' '	I with a discontinue order			
	dated 5/1/18;				
	-new physician's orde	er dated 5/1/18 for			
	Amitriptyline 25mg 2-	3 tablets at bed as needed;			
		ed 1/11/18 for Gabapentin			
	300mg 2 tablets three	e times a day with a			
	discontinue order date	ed 5/1/18;			
	-new physician's orde	er dated 5/1/18 for			
		tablets three times a day.			
		Ţ			
	Observation on 6/14/	18 at 11:58am of client #1's			
	medications on site re				
	-Amitriptyline 25mg 6	tablets at bed dispensed			
	4/30/18;	•			
	· ·	3 tablets three times a day			
	dispensed 5/30/18;	,			
	-Aleve 220mg two tab	olets as needed.			

Division of Health Service Regulation

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING		D	
		MHL060-381	B. WING		R 06/14	4/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
VILLAGES	OF HOPE HAVEN		H TRYON STE	REET		
			TE, NC 28206			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	Continued From page	e 6	V 118			
	from 4/1-6/14 revealer-Amitriptyline 25mg 6 as administered 4/1-6-Amitriptyline 25mg 2 not listed on May 201-Gabapentin 300mg 2 documented as admin 6/1-6/12; -Gabapentin 300mg 3 not listed on June 201-Aleve 220mg two tables as administered on 4 such date exists), 5/1 Further review on 6/1 revealed no physician two tablets as needed.	tablets at bed documented 6/12; -3 tablets at bed as needed 8 MAR or June 2018 MAR; 2 tablets three times a day nistered 4/1-4/30 and 3 tablets three times a day 18 MAR; blets as needed documented 1/24-4/30, also on 4/31 (no -5/6 and 6/7. 4/18 of client #1's record n's order for Aleve 220mg d present in the record. with client #1 revealed:				
	 -gets her medications -Nurse Practitioner has psychotropic medicat 	andles the prescribing of her				
	-admission date of 2/3 Crack/Cocaine Use D Disorder and Schizoa -physician's order dat Buspirone 5mg 2 tabl	uffective Disorder; red 2/5/18 and 2/14/18 for				
	medications on site re	ite 1mg daily as needed				

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7. BOILDING.		R	
		MHL060-381	B. WING		06/14/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
VILLAGES	S OF HOPE HAVEN		TH TRYON STE	REET		
			TE, NC 28206			
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 118	Continued From page	2 7	V 118			
V 118	5/24/18; -Buspirone 10mg one 5/24/18; -Lisinopril 5mg one ta -Naproxen 500mg on needed not on site. Further review on 6/1 revealed no physiciar -Naproxen 500mg on needed; -benzotropine mesyla -Losartan 50mg one ta -no initial order and n Lisinopril 5mg one tal -no initial order and n Lisinopril 5mg one ta	ablet twice daily dispensed ablet daily not on site; e tablet twice daily as 4/18 of client #4's record as' orders for the following: e tablet twice daily as ate 1mg daily as needed; ablet daily; o discontinue order for olet daily. 14/18 of client #4's MARs evealed the following: the 1mg daily as needed anistered 4/1-6/14; e tablet twice daily as as administered 4/26-4/29, c; ablet daily documented as as administered 4/1-6/14; ablet daily not listed on May MAR, listed in April 2018 ions only with no dosing mentation of administration; atablet twice daily dosing ank with no explanation on	V 118			
		with client #4 revealed: dications every morning and any medications.				
	Finding #3 Review on 6/13/18 of	client #6's record revealed:				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
74101 2741	or dorate of the transfer of t	IDENTIFICATION NO.	A. BUILDING: _			
		MHL060-381	B. WING		R 06/14/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
VILLAGES	OF HOPE HAVEN		TH TRYON STE	REET		
0/0.15			·	PROVIDER'S PLAN OF CORRECTION	OVE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
V 118	Continued From page	e 8	V 118			
	Alcohol Use Disorder Disorder; -physicians' orders da 10mg one tablet daily and quetiapine 25mg	·				
	medications on site re- amlodipine 10mg one 5/30/18; -HCTZ 25mg on table	/18 at 11:36am of client #6's evealed the following: e tablet daily dispensed et daily dispensed 5/30/18; ablets at 9pm dispensed				
	Review on 6/12/16-6/14/18 of client #6's MARs from 4/1/18-6/14/18 revealed dosing dates left blank for 6/1 for amlodipine 10mg one tablet daily, HCTZ 25mg on tablet daily and quetiapine 25mg 5 tablets at 9pm.					
	-staff administer his n	with client #6 revealed: nedications every night; has missed the 9pm med				
	-admission date of 5/ Alcohol Use Disorder Heroin Use Disorder	client #7's record revealed: 17/18 with diagnoses of , Cocaine Use Disorder, and Cannabis Use Disorder; ed 6/6/18 for Trinellix 5mg				
	from 4/1/18-6/14/18 rd-venlafexine (generic MARs as two tablets administered 5/17-6/1	for Effexor) 75mg listed on twice daily documented as				

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MHL060-381 Mill Mi		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER WILLAGES OF HOPE HAVEN STREET ADDRESS, CITY, STATE, 2IP CODE 3815 NORTH TRYONS STREET CHARLOTTE, NC 20206 PROVIDERS PLAN OF CORRECTION (PA) ID RECULATORY OR LISC DENTIFYING INFORMATION) V118 Continued From page 9 documented as administered 5/17-6/14; -AZO Yeast Plus on etablet daily documented as administered 5/25, 5/30, 5/31, 6/1-6/5, 6/7-6/12 with dosing dates left blank for 5/25-5/29, 6/8; -Probiotics two tablets daily documented as administered 5/25, 5/30, 5/31, 6/1-6/5, 6/7-6/12 with dosing dates left blank for 5/25-5/29, 6/8; -Probiotics two tablets daily documented as administered 5/25, 5/30, 5/31, 6/1-6/5, 6/7-6/12 with dosing dates left blank for 5/25-5/29, 6/8; -Probiotics two tablets daily documented as administered 5/25, 5/30, 5/31, 6/1-6/5, 6/7-6/12 with dosing dates left blank for 5/25-5/29, 6/8; -Probiotics two tablets daily documented as administered 5/25, 5/30, 5/31, 6/1-6/5, 6/7-6/12 with dosing dates left blank for 5/25-5/29, 6/8; -Probiotics two tablets daily venifiexine 7/5mg and benztropine mesylate 0.5mg one tablet at bed. Observations on 6/14/18 at 11:36am of client #7's medications on site revealed the following: -Venifiexine 7/5mg no dosing instructions and no dispensed date, sample with expiration date 7/2018: -benztropine mesylate 0.5mg one tablet at bed dispensed 5/11/18; -AZO Yeast Plus one tablet daily not on site; -Trintellix 5mg one tablet daily not on site; -Interview on 6/13/18 with client #7's record revealed: -staff administer her medications; -missed her med call 1 or 2 times. Finding #5 Review on 6/13/18 of client #8's record revealed: -admission date of 5/2/16 with diagnoses of Cocaine Use Disorder, Heroin Use Disorder and Cannabis Use Disorder;				71. BOILBING.		_D	
CASHID CHARLOTTE, NO. 28206 CHARLOTTE,			MHL060-381	B. WING			18
(XA) ID SUMMARY STATEMENT OF DEPICIENCIES (PRETEX TAG) (PACH DEPICIENCY MUST BE PRECEDED BY FULL REQUILATORY OR LSC IDEMTIFTING INFORMATION) V118 Continued From page 9 documented as administered 5/17-6/14; -AZO Yeast Plus one tablet daily documented as administered 5/25, 5/30, 5/31, 6/1-6/5, 6/7-6/12 with dosing dates left blank for 5/26-5/29, 6/6; -Probiotics two tablets daily documented as administered 5/25, 5/30, 5/31, 6/1-6/5, 6/7-6/12 with dosing dates left blank for 5/26-5/29, 6/6; -Probiotics two tablets daily dosing date of 6/11 left blank. Further review on 6/14/18 of client #7's record revealed no physicians' orders present in the record for AZO Yeast Plus one tablet daily. Probiotics two tablets daily Venlafexine 75mg and benztropine mesylate 0.5mg one tablet at bed. Observations on 8/14/18 at 11:36am of client #7's medications on site revealed the following: -Venlafexine 75mg no dosing instructions and no dispensed date, sample with expiration date 7/2018; -benztropine mesylate 0.5mg one tablet at bed dispensed 5/11/18; -AZO Yeast Plus one tablet daily not on site; -Probiotics two tablets daily not on site; -Probiotics two tablets daily not on site; -Interview on 6/13/18 with client #7 revealed: -staff administer her medications; -missed her med call 1 or 2 times. Finding #5 Review on 6/13/18 of client #8's record revealed: -admission date of 5/2/18 with diagnoses of Cocane Use Disorder, Heroin Use Disorder and Cannabis Use Disorder;	NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CHARLOTTE, NC 28206 SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V118 Continued From page 9 documented as administered 5/17-6/14; -AZO Yeast Plus one tablet daily documented as administered 5/25, 5/30, 5/31, 6/1-6/5, 6/7-6/12 with dosing dates left blank for 5/26-5/29, 6/6; -Probiotics two tablets daily documented as administered 5/25, 5/30, 5/31, 6/1-6/5, 6/7-6/12 with dosing dates left blank for 5/26-5/29, 6/6; -Probiotics two tablets daily dosing date of 6/11 left blank. Further review on 6/14/18 of client #7's record revealed on physicians' orders present in the record for AZO Yeast Plus one tablet daily, Probiotics two tablets daily ventalexine 75mg and benztropine mesylate 0.5mg one tablet at bed. Observations on 6/14/18 at 11:36am of client #7's medications on site revealed the following: -Ventalexine 75mg no dosing instructions and no dispensed date, sample with expiration date 7/2018; -benztropine mesylate 0.5mg one tablet at bed dispensed 5/11/18; -PZO Yeast Plus one tablet daily not on site; -Trintellix 5mg one tablet daily not on site; -Interview on 6/13/18 with client #7 revealed: -staff administer her medications; -missed h	VII I AGES	S OF HOPE HAVEN	3815 NOR	TH TRYON STE	REET		
PREFIX TAG CACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE COMMETTE MAYE			CHARLOT	TE, NC 28206			
documented as administered 5/17-6/14; -AZO Yeast Plus one tablet daily documented as administered 5/25, 5/30, 5/31, 6/1-6/5, 6/7-6/12 with dosing dates left blank for 5/26-6/29, 6/6; -Probiotics two tablets daily documented as administered 5/25, 5/30, 5/31, 6/1-6/5, 6/7-6/12 with dosing dates left blank for 5/26-5/29, 6/6; -Trinellix 5mg one tablet daily dosing date of 6/11 left blank. Further review on 6/14/18 of client #7's record revealed no physicians' orders present in the record for AZO Yeast Plus one tablet daily, Probiotics two tablets daily Venlafexine 75mg and benztropine mesylate 0.5mg one tablet at bed. Observations on 6/14/18 at 11:36am of client #7's medications on site revealed the following: -Venlafexine 75mg no dosing instructions and no dispensed date, sample with expiration date 7/2018; -benztropine mesylate 0.5mg one tablet at bed dispensed 5/11/18; -AZO Yeast Plus one tablet daily not on site; -Probiotics two tablets daily not on site; -Trintellix 5mg one tablet daily not on site. Interview on 6/13/18 with client #7 revealed: -staff administer her medications; -missed her med call 1 or 2 times. Finding #5 Review on 6/13/18 of client #8's record revealed: -admission date of 5/2/18 with diagnoses of Cocaine Use Disorder, Heroin Use Disorder and Cannabis Use Disorder, Feroin Use Disorder and Cannabis Use Disorder.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE CO	OMPLETE
-physicians' orders dated 5/10/18 for Naltrexone 50mg one half tablet for 2 days then one tablet daily thereafter;	V 118	documented as admin-AZO Yeast Plus one administered 5/25, 5/3 with dosing dates left -Probiotics two tablets administered 5/25, 5/3 with dosing dates left -Trinellix 5mg one tableft blank. Further review on 6/1 revealed no physiciar record for AZO Yeast Probiotics two tablets benztropine mesylate Observations on 6/14 medications on site re-Venlafexine 75mg no dispensed date, samp 7/2018; -benztropine mesylate dispensed 5/11/18; -AZO Yeast Plus one -Probiotics two tablets -Trintellix 5mg one tall Interview on 6/13/18 vestaff administer her remissed her med call Finding #5 Review on 6/13/18 of -admission date of 5/2 Cocaine Use Disorde Cannabis Use Disorde Cannabis Use Disorder of 50mg one half tablet in the same interview of the same int	nistered 5/17-6/14; tablet daily documented as 30, 5/31, 6/1-6/5, 6/7-6/12 blank for 5/26-5/29, 6/6; daily documented as 30, 5/31, 6/1-6/5, 6/7-6/12 blank for 5/26-5/29, 6/6; det daily dosing date of 6/11 4/18 of client #7's record as orders present in the Plus one tablet daily, daily Venlafexine 75mg and 0.5mg one tablet at bed. /18 at 11:36am of client #7's evealed the following: orders present in the endosing instructions and no one with expiration date as 0.5mg one tablet at bed. /18 at 11:36am of client #7's evealed the following: or dosing instructions and no one with expiration date as 0.5mg one tablet at bed. with client #7 revealed: a daily not on site; or 2 times. client #8's record revealed: 2/18 with diagnoses of record revealed: 2/18 with	V 118			

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DIVISION	n nealth Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					_	
			D MANAGE		R	
		MHL060-381	B. WING		06/14/2018	ś
NAME OF D	ROVIDER OR SUPPLIER	STREET AN	ORESS, CITY, STA	TE ZIR CODE		
NAME OF T	NOVIDEN ON 3011 LIEN					
VILLAGES	OF HOPE HAVEN		TH TRYON ST	REET		
		CHARLOT	TE, NC 28206			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X	.5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DAT	IE
				DETICIENCY)		
V 118	Continued From page	e 10	V 118			
	. •					
		ekly and Fluconazole				
	150mg one tablet dail					
		ed 6/5/18 for Amox-Clav				
	875-125mg one table	t twice daily for 14 days.				
		14/18 of client #8's MARs				
	from 4/1/18-6/14/18 re					
	-Amox-Clav 875-125r	ng one tablet twice daily for				
	14 days dosing date of	of 6/7 (am) and 6/8 (am) left				
	blank with no explana	ition on the form;				
	-Vitamin D2 1.25mg of	one tablet weekly not listed				
	on 6/2018 MAR;					
	-Fluconazole 150mg	one tablet daily one dose not				
	listed on 6/2018 MAR					
	-Naltrexone 50mg one	e half tablet for 2 days then				
	one tablet daily therea	after not listed on 6/2018				
	MAR, dosing dates le	ft blank for 5/21, 5/25-5/31				
	with no explanation or	n the form;				
	-Tinidazole 500mg tw	o tablets for 5 days				
	documented as admir	<u> </u>				
	Further review on 6/1	4/18 of client #8's record				
	revealed:					
	-no physicians' orders	s present in the record for				
	Tinidazole 500mg two	•				
	•	for Naltrexone 50mg one				
	half tablet for 2 days t					
	thereafter.	and one tablet daily				
	tricicaltor.					
	Observations on 6/14	/18 at 12:15pm of client #8's				
	medications on site re					
		e half tablet for 2 days then				
	_	_				
	one tablet daily therea					
	_	one tablet weekly dispensed				
	5/25/18;					
	_	one tablet daily one dose not				
	on site.					
	Interview on 6/12/18 v	with client #8 revealed:				

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-staff administer her medications;

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILBING.		R	
		MHL060-381	B. WING			/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE		
VILLAGES	S OF HOPE HAVEN	3815 NOI	RTH TRYON STR	EET		
VILLAGE	OF HOTE HAVEN	CHARLO	TTE, NC 28206			
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 118	Continued From page	e 11	V 118			
	get medications daily	<i>I</i> .				
	Clinical Services and revealed: -train staff to do medi-have a Nurse Practit medications; -not sure why continumedications. This deficiency consti	ed problems with tutes a re-cited deficiency				
V 131	and must be correcte G.S. 131E-256 (D2) H	d within 30 days. HCPR - Prior Employment	V 131			
	Verification	To The Employment				
	REGISTRY (d2) Before hiring hea health care facility or health care facility sha	alth CARE PERSONNEL alth care personnel into a service, every employer at a all access the Health Care and shall note each incident opriate business files.				
	facility failed to acces Registry(HCPR) befo The findings are:	iew and interviews, the s the Health Care Personnel re hiring for 1 of 6 staff (#6).				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
			B. WING			R
		MHL060-381	B. W. TO		06	/14/2018
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
VILLAGES	S OF HOPE HAVEN		RTH TRYON STR	REET		
			TTE, NC 28206			
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 131	Continued From page 12		V 131			
	Substance Abuse Co -the HCPR check cor					
	Interview on 6/12/18 with Human Resources Staff revealed: -the original HCPR check was completed; -the original HCPR check could not be located; -completed a current one.					
		with staff #6 revealed he had the facility for almost a year.				

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