PRINTED: 09/13/2018 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '		(X3) DATE SURVEY COMPLETED			
AND LEW OF CONCESSION			A. BUILDING:					
MHL0601343		B. WING		09/12/2018				
NAME OF PRO	OVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STAT	E, ZIP CODE				
HUDSON H	HUDSON HOME 4734 PALUSTRIS COURT							
HODOGITTI		CHARLO	TTE, NC 28269					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (XECTION (XECTION SHOULD BE COMPICE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
V 000 I	INITIAL COMMENTS		V 000					
	An annual survey was 12, 2018. A deficienc	s completed on September y was cited.						
1	This facility is licensed for the following service category: 10A NCAC 27G .5600F Alternative Family Living for Individuals with Developmental Disabilities.							
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 administered; and (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							

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

TITLE (X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPLE	ובט
MHL0601343		B. WING		09/12/2018		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
HUDSON	HOME	4734 PALI	JSTRIS COURT	ī		
ПОВООК	TIOME	CHARLO1	TE, NC 28269			
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
V 118	Continued From page 1		V 118			
	with a physician.					
	with a physician.					
	This Rule is not met	as evidenced by:				
	This Rule is not met as evidenced by: Based on interview, record review, and					
		y failed to keep MARs				
	current affecting 1 of 2 clients (Client #2). The					
	findings are:					
	Davisor at 0/40/40 and 0/40/40 at 0/5-44 #0/-					
	Review on 9/10/18 and 9/12/18 of Client #2's record revealed:					
	-Admission date of 7/	(12/18:				
	-Diagnoses of Moder					
	_	oility, Psychotic Disorder with				
	· · · · · · · · · · · · · · · · · · ·	nt Explosive Disorder,				
	Autism Disorder, Alle	rgic Rhinitis, Morbid Obesity,				
	Pre-Diabetes;					
	-Physician's order da					
	hydrochlorothiazide 12.5mg 1 tab daily (blood					
	pressure);					
	-September, 2018 MAR did not list hydrochlorothiazide 12.5mg 1 tab daily.					
	nydrochiorothiazide i	2.5mg T tab daily.				
	Interview on 9/12/18 revealed:	with the AFL Provider				
		Client #2's September, 2018				
		ochlorothiazide 12.5mg 1 tab				
	daily;	- J				
	-Client #2 had been a	administered				
	hydrochlorothiazide 1	2.5 mg 1 tab daily as				
	ordered by the physic					
	-Will immediately contact the pharmacy to ensure					
	an accurate MAR is o	delivered to the facility.				
Observation on 9/12/18 at approximately 2:25pm of Client #2's medications revealed:						
	-Blister pack of hydro	chlorothiazide 12.5mg				

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MANUS OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 473 FALUSTRIS COURT CHARLOTTE, NC 28289 ORIGIN SUMMARY STATEMENT OF DEPTICENCESS TAG ORIGIN FIG. CHARLOTTE, NC 28289 ORIGINATE CHARLOTTE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMF	(X3) DATE SURVEY COMPLETED			
HUDSON HOME 4734 PALUSTRIS COURT CHARLOTTE, NC 28269 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 118 Continued From page 2 dispensed on 8/29/18 with administration 4734 PALUSTRIS COURT CHARLOTTE, NC 28269 ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE V 118			MHL0601343	B. WING		09	/12/2018			
HUDSON HOME CHARLOTTE, NC 28269 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 118 Continued From page 2 dispensed on 8/29/18 with administration CHARLOTTE, NC 28269 ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE) V 118	NAME OF PI	·								
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	V 118	dispensed on 8/29/18	with administration	V 118						

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