STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _		
		MHL060-402	B. WING		05/29/2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
COMMON	WEALTH GROUP HOME		IMONWEALTH A	AVENUE	
0(4) ID	SLIMMADV ST.	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECT	TION (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETE
V 000	INITIAL COMMENTS		V 000		
	The complaint was su #NC00150820). Defice This facility is licensed category: 10A NCAC	d for the following service 27G 5600C Supervised se primary Diagnoses is a			
V 118	27G .0209 (C) Medica	ation Requirements	V 118		
	V 118 27G .0209 (C) Medication Requirements 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				

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

TITLE (X6) DATE

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			_				
		MHL060-402	B. WING		05	/29/2019	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA				
COMMON	WEALTH GROUP HOME		IMONWEALTH A FTE, NC 28205	AVENUE			
(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 CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
V 118	Continued From page	e 1	V 118				
		pointment or consultation					
		ew, observation and failed to ensure that ministered according to fecting 1 of 1 audited clients					
	-Admitted 1-1-11 -Diagnoses of Ma Generalized Anxiety I Explosive Disorder, A Disorder, Pervasive I Mental Retardation, F	ttention Deficit/Hyperactivity Disorder, Non Specified, Mild					
	Feb, march, and April -Jan, Feb, and M Pamoate 25 mg docu AM.	larch 2019 Hydroxyzine mented as been given at 7 oxyzine Pamoate 25 mg					
	dated 2-27-19 reveale -Hydroxyzine Pa night at bedtime. Review on 5-29-19 of and electronically sign	Client #1's physician order ed: moate 25 mg one tablet each final report from hospital ned by physician revealed: medicationsHydroxyzine					

Division of Health Service Regulation

STATE FORM 6899 QG1011 If continuation sheet 2 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		MHL060-402	B. WING		0:	5/29/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
COMMON	WEALTH CROUR HOME	3601 CO	MMONWEALTH AV	'ENUE		
COMINION	WEALTH GROUP HOME	CHARLO	OTTE, NC 28205			
(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 ACT CROSS-REFERENCED TO DEFICIENCED	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	Pamoate 25 mg per night at bedtime)." -"Patient summa department on 2/23 a agitated at her group multiple hospitalization the past year. per reppatient has become rexpressing suicidal in Observation on 5-29-am revealed: -Client #1 screar around outside the fareal cout!" (No cursing from Interview on 5-29-19 guardian revealed: -Client #1 had be changed her Hydroxy the AM to the PM on The facility content Hydroxyzine Pamoat month of march 2019. -The mother/legate facility manager but walready filled the presedesignated.	arypresents the emergency after being found to be more home. Patient has required ons for similar issues over port, group home states more agitated and deation." 19 at approximately 11:00 ming at staff and running acility. Creaming at staff "I can't take of you!", "You cussed me in staff noted). with client #1's mother/legal leen in the hospital and they yzine Pamoate 25 mg from 2-27-19. Inued to give client #1 the e 25 mg in the AM for the	V 118			
	-When client #1 morning, "it makes yo all the time." -Client #1 was sl and then complained she never did before.	ation could be changed. took the medicine in the bu sleepy, she was sleeping leeping 19 1/2 hours a day about hallucinations, which upposed to be discharged				
		, but she thought it was the				

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STATE FORM G899 QG1011 If continuation sheet 3 of 5

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					B) DATE SURVEY COMPLETED	
			A. BUILDING:				
		MHL060-402	B. WING		0:	5/29/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE			
COMMON	WEALTH CROUD HOME	3601 CO	MMONWEALTH AV	'ENUE			
COMMON	WEALTH GROUP HOME	CHARLO	TTE, NC 28205				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 118	Continued From page	2 3	V 118				
V 118	medications causing a "The psychiatris disorder." -"The medication discharge." -The facility had a she was getting it cor Interview on 5-29-19 -She does remer wanting the medication follow the medication Interview on 5-29-19 -As far as she kn administered correctly medication book regulation book regulation book regulation was a shear of the shad not been shear of the pharmacy change and was told filled and insurance wagain. -She sent a staff and she was told the she was told the she was told the she know now to to the pharmacist and medication. Interview on 5-29-19 she couldn't remedication.	the behaviors. It says she has a personality It says she has a personality It error played a part in her Ichanged the medication and rectly now. With staff #1 revealed: Inber client #1's mother Ion changed, but they have to orders. With the shift lead revealed: Iew the medications were and she checks the elarly. With the facility ofessional revealed: Ion at the facility very long. Ion at the facility very long. Ion at the medication the medication had been rouldn't pay to get it filled member to the pharmacy	V 118				
	-Client #1 had be	with the supervisor revealed: een taking the Hydroxyzine e AM for approximately 1					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED			
		MHL060-402	B. WING		05/29/2019	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3601 COMMONWEALTH AVENUE CHARLOTTE, NC 28205						
(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 CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE	
V 118	yearThe medication her behaviorsThe medication	was not what was increasing should have been changed came out of the hospital.	V 118			

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