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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or dortheorion	IDENTIFICATION NOWIBER.	A. BUILDING:		OOMII EETEB	
		MHL0601396	B. WING		07/11/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATI	E, ZIP CODE		
VIOLET H	VIOLET HAMEED-NELSON HOME 8046 HEREFORD STREET					
		CHARLO	TTE, NC 28213		,	
(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 COMPLETE	
V 000	INITIAL COMMENTS		V 000			
	An annual survey was deficiency was cited.	s completed on 7/11/19. A				
	category: 10A NCAC	d for the following service 27G .5600F Alternative riduals with Developmental				
V 118	27G .0209 (C) Medica	ation Requirements	V 118			
	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 file followed up by appointment or consultation					

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

TITLE (X6) DATE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
		MHL0601396	B. WING		07/1	1/2019	
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
VIOLET H	AMEED-NELSON HOME		REFORD STREE TTE, NC 28213	Т			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)	
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)		COMPLETE DATE	
V 118	Continued From page	1	V 118				
	with a physician.						
	This Rule is not met	-					
	Based on record reviews, the facility	•					
	Medication Administra	ation Record (MAR) of all					
	drugs administered to current, medications	each client was kept administered were recorded					
	immediately after adn	ninistration and all					
		ninistered per a written clients (#1, #2). The findings					
	are:	(, , ,					
	Finding #1:						
	Review on 7/9/19 of c	client #1's record revealed:					
		tellectual Developmental Cerebral Palsy, Anxiety					
	Disorder, Bipolar Diso	order, GERD, Blindness Left					
	Eye, Arthritis, Cervica Toxoplasmosis Left E						
	-physician's orders da	ated 2/20/19 for Vitamin D3					
	daily.	and Multivitamin one tablet					
		19 at 3:41pm of client #1's					
	medications on site re- -Vitamin D3 1000 unit	evealed: ts one tablet daily over the					
	counter medication;	·					
	-Multivitamin one tabl medication.	et daily over the counter					
		1 7/11/19 of client #1's					
		11/19 revealed Vitamin D3 daily over the counter					
		vitamin one tablet daily over					
		n not listed on the MARs.					

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DIVISION	or riealth Service Negu	ialion				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	A. BUILDING:		.ETED	
			55.25.110.			
		MHL0601396	B. WING		07/1	11/2019
NAME OF D		OTDEETAL	DDEGG OITY OTA	ATE 710 000E		
NAME OF P	ROVIDER OR SUPPLIER	STREETAL	DDRESS, CITY, STA	ATE, ZIP CODE		
VIOLET H	AMEED-NELSON HOME	8046 HEF	REFORD STREE	ET .		
VIOLETTI	AMELD-NELGON HOME	CHARLO	TTE, NC 28213			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
				DEFICIENCY)		
\/ 110	O	- 0	V 118			
V 118	Continued From page	2	V 110			
	Interview on 7/11/19 v	with staff #1 revealed:				
		counter(OTC) Vitamin D3				
	and Multivitamins for					
		m the pharmacy who does				
	the other medications	,				
	_ ·	t any medications on the				
	MARs that they do no					
		C medications in on the				
	MARS;					
	-forgot to write the O	ΓC medications on the				
	MARS;					
	-administered the OT	C medications to client #1				
	as ordered.					
	Finding #2:					
	_	client #2's record revealed:				
		21/18 with diagnoses of				
		<u> </u>				
	IDD-Mild, Schizophre	•				
	Dysregulation Disorde					
	Depressive Disorder	and Mood Affective				
	Disorder;					
		ated 3/6/19 for the following				
	medications: sertralin	e(generic for Zoloft) 100mg				
	one table daily, sertra	iline 25mg one tablet daily,				
	mellaril (generic for T	hioridazine) 25mg two				
	tablets twice daily, ato	orvastation (generic for				
	_	let daily, desyrel (generic for				
		e tablet at bed, Travatan eye				
	drops one drop each					
		oyo at mgm.				
	Interview on 7/11/10 v	with client #1 revealed she				
						[
	gets her medicines da	ally.				
	Observation 7/44/	10 at 1:00 and at all and 401				[
		19 at 4:03pm of client #2's				
	medications on site re]
	-sertraline 100mg one					
	-sertraline 25mg one					
	-mellaril 25mg two tal					
	-atorvastation 40mg of	one tablet daily;				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
BULL 0004000		B. WING		07/44/0040	
		MHL0601396	B. WIIVO		07/11/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	E, ZIP CODE	
		8046 HE	REFORD STREET	-	
VIOLET H	AMEED-NELSON HOME		TTE, NC 28213		
	OUR MAR DV OT			DD0/4DEDI0 D/ AN 05 00DD507/0	
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	()
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP	l l
			,,,,,	DEFICIENCY)	
V 118	Continued From page	e 3	V 118		
	-desyrel 50mg one ta	hlet at hed:			
	, ,	one drop each eye at night.			
	Travatari eye drope t	one drop edon eye at might.			
	Review on 7/0/10 and	d 7/11/19 of client #2's			
		11/19 revealed the following:			
		e table daily dosing dates left			
		m) with no explanation on			
	,	ii) with no explanation on			
	the form;	tablet daily dosing dates left			
		n) with no explanation on			
	,	ii) with no explanation on			
	the form;	alata turias dailu dasina			
	_	olets twice daily dosing			
		24-5/31(am/pm) with no			
	explanation on the for				
	_	one tablet daily dosing dates			
		1(pm) with no explanation			
	on the form;				
		blet at bed dosing dates left			
		ກ) with no explanation on			
	the form;				
		one drop each eye at night			
	_	k for 5/24-5/31(pm) with no			
	explanation on the for	rm.			
	7/44/40				
		with client #2 revealed she			
	got her medications e	every day.			
		7/44/40 : 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
	Further interview on 7	7/11/19 with stan #1			
	revealed:	I I P C			
	-she gave client #2 al	i ner medications as			
	prescribed;				
	-no missed medicatio				
		te the documentation on the			
	MARs for those dates	S.			
	Interview on 7/11/19				
	Professional revealed				
		osing dates on MARs;			
	I -not aware OTC medi	ications not listed on MARs:			

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-will make an OTC MAR for staff #1 to complete;

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STATEMENT OF DEFICIENCIES (X1) I AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATI COM	(X3) DATE SURVEY COMPLETED	
		MHL0601396	B. WING		07	7/11/2019	
	ROVIDER OR SUPPLIER AMEED-NELSON HOME	8046 HE	DDRESS, CITY, STATE REFORD STREET DTTE, NC 28213	E, ZIP CODE			
(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 ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 118		cumentation issues with	V 118				

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