		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
74101244	or contraction	BENTI TO THOM NO MBERT.	A. BUILDING: _	A. BUILDING:		
		MHL074-158	B. WING		R 08/16/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
WIMBLED	ON SUPERVISED LIVING	ì	BLEDON DRIVI			
			.LE, NC 27858			
(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 COMPLE	
V 000	INITIAL COMMENTS		V 000			
	completed August 16 unsubstantiated (Intal deficiency was cited. This facility is licensed	and follow up survey was , 2019. The complaint was see #NC00154616). A d for the following service 27G .5600C Supervised				
		Developmental Disabilities.				
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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
						R
		MHL074-158	B. WING		08.	/16/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
WIMBLER	ON SUBERVISER LIVING	1650 WIN	MBLEDON DRIVE #	101		
VVIIVIBLEL	OON SUPERVISED LIVING	GREENV	ILLE, NC 27858			
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 118	Continued From page	: 1	V 118			
		pointment or consultation				
	facility failed to admin	as evidenced by: ews and interviews, the ister medications on the sician and failed to keep the g two of two clients (#1 and				
	Palsy, Dysmenorrhea					
	bedtimeBenazepril 20mg (tre Take 1 tablet by mout -Fluticasone 50 mcg is sprays by nasal route -Levetiracetam 500m tablet by mouth twice -Levothyroxine 75 mc Take 1 tablet by mout -Metoprolol ER 50 mc pressure) Take 1 table	d 03/25/19 revealed: prams(mg) (treats ablets (10mg) by mouth at pats high blood pressure) h daily. hasal (treats allergies) Use 2 daily. g (anticonvulsant) Take 1 daily. g (treats hypothyroidism) h every day.				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL074-158	B. WING		0.5	R 3/16/2019		
					00	3/10/2019		
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE					
WIMBLED	WIMBLEDON SUPERVISED LIVING							
	T	GREENV	/ILLE, NC 27858					
(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 ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE		
V 118	tablet by mouth every-Omeprazole DR 40 1 capsule by mouth trepotassium ER 10 M tablet by mouth every-Sertraline 100 mg (a by mouth daily for ge a. Review on 08/14/1 incident report reveal "-Description of Error (discontinued) in Quir-Strategies Develope with staff how to redowhen meds come in. make sure orders we in QuickMar." Review on 08/14/19 2019 MAR's revealed "Dc'd" was indicated the following medicat Levetiracetam, Levot Montelukast.	y evening. mg (treats acid reflux) Take wice daily. EQ (supplement) Take 1 y day. Intidepressant) Take 1 tablet neralized anxiety disorder. 9 of the facility's Level 1 led: s: Medication showing DC'd ckMar. Ind/Actions Taken: Discussed of med (medication) checks Spoke with pharmacy to are up to date and corrected of client #1's July and August of the following: I on the July 2019 MAR after tions: Benazepril, hyroxine, Metoprolol,	V 118					
	grayed out and no ini indicate the medication	ectronic MAR(EMAR) was itials were on August 1-6 to on had been administered iracetam, Levothyroxine, ast.						
	Client #1 was unable due to her Mutism.	to effectively communicate						
	-She had worked at t -The pharmacy made several medications. -She did not work du have known it was ar	08/15/19 staff #2 revealed: he facility over a year. e an error and discontinued ring that time and she would he error because client #1 had or for the medication to be						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R
		MHL074-158	B. WING		08/16/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
WIMBLED	OON SUPERVISED LIVING	1650 WIMB	LEDON DRIVE	E #101	
VVIIVIDEED	ON SOF ERVISED EIVING	GREENVIL	LE, NC 27858		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 118	Continued From page	3	V 118		
	normal staff at the fact administer the medical During interview on 08 Manager/Qualified Pre-Client #1 did not get days because the phase medication on the EM-She should be check other day for errors.	ation as ordered. B/15/19 the Group Home ofessional (QP) revealed: several medications for 6 armacy had discontinued the AR. ing the EMAR daily or every evel 1 incident report once			
	at the end of July 201 because the medication discontinued. -The staff saw the meand did not administeThe expectation was Manager/QP to check for medication adminite. The medication disconshould have been caumany daysThe Group Home Mathe EMAR system at the employment of the system withThe staff working in the staff and if an old they would have known	iscontinued the medication 9 and it was a mistake on had not been dication as discontinued or the medication. for the Group Home sing the EMAR system daily stration and errors. ontinued by the pharmacy oright before being missed so anager/QP had access to all times because she had oright had been working orn and recognized the error fied the supervisor because in to the doctor for the			

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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	
		A. BOILDING.		_		
		MHL074-158	B. WING		R 08/16/2019	
NAME OF PROVID	DER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WIMBI EDON S	SUPERVISED LIVING	1650 WIME	BLEDON DRIVE	E #101		
WINDLEDON 3	SOPERVISED LIVING	GREENVIL	LE, NC 27858			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
MAI -Bis -Flu -On -Po -Se Find Rev reve - 43	R revealed the foll sacodyl EC 5mg- 0 uticasone 50mcg- (meprazole DR 40m stassium ER 10ME ertraline 100mg- 08 ding #2:	08/01/19, 08/02/19. 08/01/19. ng- 08/01/19. Q- 08/01/19 s/01/19				
- Dia Spa Dea Revords 03/7-Do cap -Fai tabl -Flo Inha -Lor tabl -Phi tabl -Vita Tak -Hyg of s day -Ke Sha	iagnoses of Profou astic Quadriplegia, af Mutism, Asthma view on 07/10/19 of ers revealed: 16/19 ocusate 100mg (tre osule by mouth twice imotidine 20mg (tre let by mouth every ovent HFA 110 mog ale 2 puffs by mou motrigine 25mg (a lets by mouth every enobarbital 32.4 m lets by mouth twice amin B-12 1000 m are 1 tablet by mout drocortisone 2.5% skin) Apply topically	and Mental Retardation, Seizure Disorder, Blind, , Constipation. If client #2's physician Pats constipation) Take 1 Ce daily. Pats acid in stomach) Take 1 day. G (prevent asthma attacks) th every twelve hours. Inticonvulsant) Take 2 y day. Ing (anticonvulsant) Take 2 e daily. Ing (used as supplement)				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
			A. BUILDING:	A. BOILDING.			
		MHL074-158	B. WING		08	R 3/ 16/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE			
		_ 1650 WI	MBLEDON DRIVE :	#101			
WIMBLED	ON SUPERVISED LIVING	G GREEN	VILLE, NC 27858				
(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	Continued From page	e 5	V 118				
	Ear Way Drope 6 5%	(cleans ears) Place 3					
	drops in each ear twice						
	 Review on 08/14/19 o	of client #2's August 2019					
	MAR revealed the fol						
	-Docusate 100mg- 08						
	-Ear Wax Drops- 08/0						
	-Famotidine- 085/01/ -Flovent- 08/01/19 at						
	-Lamotrigine- 08/01/1						
	-Phenobarbital- 08/01						
	-Vitamin B-12-08/01/						
	_	1/19 at 7am, 8pm, 08/02/19					
	at 8pm.	poo- 08/01/19 at 3:30pm.					
	-Netoconazole Sham	poo- 06/0 1/ 19 at 3.30pm.					
	Client #2 was unable due to her Mutism.	to effectively communicate					
	During interview on 0	8/14/19 and 08/15/19 Staff					
	_	medication was always					
	available to administe never missed any me	er to client #2 and she had edication.					
	During interview on 0	8/14/19 the Program					
	Manager revealed cli	ent #1 received the					
		aff did not go into the EMAR					
	system to put their ini	tials.					
	Due to the failure to a	accurately document					
	medication administra						
		received their medications					
	as ordered by the phy	ysician.					
	 Review on 08/15/19 c	of the Plan of Protection					
		ompleted by the Group					
	Home Manager/QP re						
	"-What immediate act	tion will the facility take to					
		he consumers in your care? tion correction was made.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:	
					R
		MHL074-158	B. WING		08/16/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
14/114D1 ED	ON OURER 4055 1 17/11/1	1650 WIN	IBLEDON DRIVI	E #101	
MIMBLED	ON SUPERVISED LIVING	GREENV	ILLE, NC 27858	1	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION (X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETE
V 118	Continued From page	e 6	V 118		
	Croup Home Manage	or will abook modication			
		er will check medication facility to make sure all			
		tch. Group Home Manager			
		rs do not match, that the			
		's office are contacted			
	T	Home Manager will meet			
		s importance of contacting			
		ely with any medication			
		Home Manager will check			
	QuickMar daily to ins	·			
	correctly and on time				
	-Describe your plans	to make sure the above			
	happens.				
		er will hold a staff meeting			
		e employees have a clear			
		ectations when dealing with			
		ager will check QuickMar			
	daily for med errors a	ind blank spots on MAR."			
	Client medications we	ere supplied by a pharmacy			
	contracted by the fac	ility to fill and deliver			
	medications to the fac	cility and the MARs were			
	ı ·	electronic system. The			
		mistakenly discontinued 5			
	medications for client				
		oid medication and high			
	· · · · · · · · · · · · · · · · · · ·	cations. Client #1 did not			
		itions for six days and the			
	facility did not recogn	-			
	those medications an	ent #1, the abrupt ending of			
	withdrawal like sympt	ys put her at risk of suffering			
		ne inaccurate documentation			
	•	nt #2's medication made it			
		or certain if the client's			
	received medications				
		providing medications and			
		tion documentation placed			
		hat was detrimental to their			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE		
ANDILAN	or contribution	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:			
		MHL074-158	B. WING		R 08/16	6/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
WIMBLED	ON SUPERVISED LIVING	G	BLEDON DRIVI				
		GREENVIL	LE, NC 27858				
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 118	Continued From page	e 7	V 118				
V 118	health, safety, and we constitutes a Type B is not corrected within penalty of \$200.00 pe	elfare. This deficiency rule violation. If the violation in 30 days, an administrative er day will be imposed for is out of compliance beyond	V 118				

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