PRINTED: 09/16/2019 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDILAN	or contribution	IDENTIFICATION NOMBER.	A. BUILDING:		J COMIT EL		
		MHL045-086	B. WING		09/11/2019		
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE			
WATERMULDER HOME 8 BANNERWOOD DRIVE							
			HOE, NC 28742				
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 000	INITIAL COMMENTS		V 000				
	An annual survey was Deficiencies were cite	s completed on 9/11/19. ed.					
	This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Individuals of all Disability						
	Groups/Alternative Fa	amily Living.					
V 118	V 118 27G .0209 (C) Medication Requirements		V 118				
	only be administered order of a person authorized drugs. (2) Medications shall clients only when authorized client's physician.						
	administered only by unlicensed persons tr pharmacist or other le privileged to prepare (4) A Medication Adm all drugs administered current. Medications	licensed persons, or by rained by a registered nurse, egally qualified person and and administer medications. inistration Record (MAR) of d to each client must be kept administered shall be a after administration. The					
	(B) name, strength, a (C) instructions for ac (D) date and time the (E) name or initials of drug. (5) Client requests for checks shall be record	nd quantity of the drug; Iministering the drug; drug is administered; and person administering the r medication changes or ded and kept with the MAR pointment or consultation					

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

TITLE (X6) DATE Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND LAN OF CONNECTION			A. BUILDING: _	A. BUILDING:			
		MHL045-086	B. WING	B. WING		09/11/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
WATERMI	JLDER HOME	8 BANNE	RWOOD DRIVE				
VVAIERIVI	JEDEK HOME	HORSE S	HOE, NC 28742	2			
(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 ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 118	Continued From page 1		V 118				
	Continuos i ioni page i						
	with a physician.						
	This Rule is not met	-					
		n, interview, and record					
		ed to ensure prescription					
		red only on the written order					
of a person authorized by		, ,					
	for 1 of 2 sampled clie	for 1 of 2 sampled clients (Client #2). The					
	findings are:						
	Di	Ol: #0					
	Review on 9/10/19 of Client #2's record revealed: -an admission date of 6/5/19diagnoses of Intellectual Developmental Disability- mild, Autism Disorder, Obesity, and						
	Attention-Deficit Hype	eractivity Disorder.					
	Observation on 9/10/ p.m. of Client #2's me	19 at approximately 1:30					
	· ·	3 ml at bedtime - dispensed					
	7/10/19.	at bodding disponded					
		nent - 2-3 times daily for 5-7					
	days when skin flares	•					
	-Vistaril 25 mg - was						
	-						
		Client #2's Medication					
		d from June 2019 through					
	9/10/19 revealed:						
	<u>.</u>	3 ml at bedtime, was initialed					
	to indicate it was give						
		nent - 2-3 times daily for 5-7					
	_	up was not listed for the					
	month of August.						
	-Vistaril - 25 mg - one	three times a day as					
needed - was not initialed by the AFL provider to indicate any was given.							
	-Vistaril - 25 mg - the	client's guardian initialed it					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			X3) DATE SURVEY COMPLETED	
MHL045-086		B. WING	B. WING		09/11/2019		
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
WATERMULDER HOME 8 BANNERWOOD DRIVE HORSE SHOE, NC 28742							
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 118	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		V 118				

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