Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDILAN	A. BUILDING:						
		MHL060-802	B. WING		R 10/22/2019		
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
WATED M	III HOME	6801 WA	TER MILL COURT	•			
WAIERIN	ILL HOME	CHARLO	TTE, NC 28215				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
V 000	INITIAL COMMENTS		V 000				
	completed on 10-22-′ unsubstantiated (#NC were cited. This facility is licensed	and follow up survey was 19. The complaint was c00155680). Deficiencies d for the following service 27G 1700 Residential re for Children or					
V 118	27G .0209 (C) Medica	ation 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						

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

TITLE (X6) DATE

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N	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
MHL060-802		B. WING		R 10/22/2019
UPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
	CHARLOT	TE, NC 28215		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
From page	: 1	V 118		
checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.				
observatior e facility fai nistered on ccurate MA ns were adr order, effe	n, interviews and record led to ensure medications ly with a physicians order, R was maintained and minister according to the cting two of two clients			
Finding 1:				
Observation 10 10-22-19 of client #1's medications revealed; Montelukast SOD 5 mg, Pro air inhaler.				
al revealed t #1's medi	l: cations were brought over by			
	From page all be record up by application. From page all be record up by application. is not met a beservation of a facility fair inistered on a curate MA as were address were address revealed aller. 10-22-19 of Montelukas inistered. 10-22-19 of Montelukas inistered. 10-22-19 of Montelukas inistered. 10-22-19 of Montelukas inistered. 10-21-19 of Montelukas inistered. 10-22-19 of Montelukas inistered.	SUMMARY STATEMENT OF DEFICIENCIES TH DEFICIENCY MUST BE PRECEDED BY FULL JULATORY OR LSC IDENTIFYING INFORMATION) From page 1 all be recorded and kept with the MAR d up by appointment or consultation sician. is not met as evidenced by: observation, interviews and record a facility failed to ensure medications nistered only with a physicians order, occurate MAR was maintained and as were administer according to the order, effecting two of two clients and client #2). The findings are: on 10 10-22-19 of client #1's are revealed; Montelukast SOD 5 mg, Pro air inhaler inistered. 10-22-19 of physicians order revealed: nysicians orders for Montelukast SOD air inhaler. on 10-22-19 with the Associate al revealed: t #1's medications were brought over by	SUMMARY STATEMENT OF DEFICIENCIES H DEFICIENCY MUST BE PRECEDED BY FULL JLATORY OR LSC IDENTIFYING INFORMATION) From page 1 all be recorded and kept with the MAR d up by appointment or consultation sician. Is not met as evidenced by: observation, interviews and record a facility failed to ensure medications nistered only with a physicians order, courate MAR was maintained and as were administer according to the order, effecting two of two clients and client #2). The findings are: 10-22-19 of client #1's October MAR Montelukast SOD 5 mg, Pro air inhaler inistered. 10-22-19 of physicians order revealed: nysicians orders for Montelukast SOD air inhaler. 10-22-19 with the Associate al revealed: t #1's medications were brought over by 1.	6801 WATER MILL COURT CHARLOTTE, NC 28215 SUMMARY STATEMENT OF DEFICIENCIES H DEFICIENCY MUST BE PRECEDED BY FULL JULATORY OR LSC IDENTIFYING INFORMATION) From page 1 all be recorded and kept with the MAR d up by appointment or consultation sician. Is not met as evidenced by: observation, interviews and record e facility failed to ensure medications nistered only with a physicians order, occurate MAR was maintained and is were administer according to the order, effecting two of two clients and client #2). The findings are: In 10 -22-19 of client #1's is revealed; Montelukast SOD 5 mg, Pro air inhaler inistered. 10-22-19 with the Associate al revealed: t #1's medications were brought over by 10. PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD (EACH CORRECTIVE ACT

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STATE FORM 6899 JNO211 If continuation sheet 2 of 6

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
				R			
MHL060-802		B. WING		10/22/2019			
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
WATER M	ILL HOME		TER MILL COURT				
WAI EIV III	ILE TIOME	CHARLO	TTE, NC 28215				
(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	Continued From page	2	V 118				
	revealed: -Concerta 27 mg 40 mg once daily, Gu tab daily, Quetiapine Melatonin 10 MG 1 ta listed. -Concerta 27 mg October 1-6 indicating -No documentation medications. -No Gueanfacine Quetiapine 100 mg do administer on Octobe	had a line drawn through g it was not given. on for October 22 am HCL ER 4 mg 1 tab daily, ocumented as being r 21.					
	-Didn't get his Qu pm, or the 27 am.	uetiapine on the 11th, the 18					
	orders revealed: -No physician ord	of client #2's physicians ders for the Fluoxetine HCL eanfacine HCL ER 4 mg 1					
	the pharmacy and sor them up. -A line drawn thro						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICA		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
				R		
MHL060-802		B. WING		10/22/2019		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WATED M	II L LIOME	6801 WATE	R MILL COUR	т		
WAIERM	ILL HOME	CHARLOT	TE, NC 28215			
(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 118	Continued From page	: 3	V 118			
	-He didn't know why a line would be through some medications but not them all if the client was on therapeutic leave. Interview on 10-22-19 with the Qualified Professional revealed: -he thought the information sheet that comes with the prescriptions were as good as a physicians orderThe other medications were at the					
pharmacy. -He didn't know why there were blanks and spaces with aline through them on the MAR's.						
V 736	27G .0303(c) Facility	and Grounds Maintenance	V 736			
	10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.					
	This Rule is not met Based on observatior failed to be maintaine attractive manner. Th	and interviews the facility d in a clean, safe and				
	pm revealed: -Beeping smoke -Empty bedroom broken door jamHall bathroom li	detector in back bedroom. had a broken doorknob and ghts were all burned out in a, wall next to the first toilet . In the second area				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL060-802		B. WING		R 10/22/2019	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	JE. ZIP CODE	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
			R MILL COUR		
WATER M	ILL HOME	CHARLOT	TE, NC 28215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / 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
V 736	second area had full to was broken, door jampeeling around the too burned out. -Carpet was stair—Kitchen had the peeling. -Outside, old soft of the house, mattress against the back of the was broken, garbage garbage cans with a fisiding was peeling are house. Interview on 10-21-19—She had called a furniture last week bu—They were trying shape and were making linterview on 10-22-19 professional revealed—He would make	with two toilets and sinks, ub/shower), the toilet seat was loose, paint was let, 2 of 3 lights were ned throughout the house. panel in front of the sink was a and love seat on the side and box springs leaning the house, Front storm door was laying around the oul odor surrounding it, bound the bottom of the with staff #1 revealed: someone to remove the they never came. If to get the facility in better ing improvements.	V 736		
	had been done.	ely and then later reported it ing and doing improvements it look better.			
	facility. -They had called furniture away, but the -They would take as possible.	: ng improvements to the someone to take the old			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
					R		
		MHL060-802	B. WING		10/22/2019		
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA				
WATER M	WATER MILL HOME 6801 WATER MILL COURT CHARLOTTE, NC 28215						
(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 APPROPRIEM DEFICIENCY)	D BE COMPLETE		
V 736	Continued From page	e 5	V 736				
1	and must be corrected						
		a 00 aa,o.					

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