STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED	
	MHL060-586		B. WING		R 11/20/2019	
NAME OF PF	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
DLEWILD	HOME	6807 IDI	EWILD BROOK LA	NE		
	TIOME	CHARLO	DTTE, NC 28212			
(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 T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMENTS	3	V 000			
	completed on 11/20/ unsubstantiated (Inta #NC151183). A defici This facility is license	An annual, complaint and follow up survey was completed on 11/20/19. The complaints were insubstantiated (Intakes #NC147423, 4NC151183). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential				
V 118	27G .0209 (C) Medic	ation Requirements	V 118			
	<ul> <li>only be administered order of a person aut drugs.</li> <li>(2) Medications shall clients only when aut client's physician.</li> <li>(3) Medications, inclu administered only by unlicensed persons to pharmacist or other le privileged to prepare</li> <li>(4) A Medication Adm all drugs administere current. Medications recorded immediately MAR is to include the (A) client's name;</li> </ul>	istration: n-prescription drugs shall to a client on the written horized by law to prescribe be self-administered by horized in writing by the uding injections, shall be licensed persons, or by rained by a registered nurse, egally qualified person and and administer medications. hinistration Record (MAR) of d to each client must be kept administered shall be y after administration. The				
	<ul> <li>(C) instructions for ac</li> <li>(D) date and time the</li> <li>(E) name or initials of drug.</li> <li>(5) Client requests for</li> </ul>					

ZXQ911

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			(X3) DATE SURVEY COMPLETED	
	MUL 000 590					R	
		MHL060-586	B. WING		11/20/2019		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
IDLEWILD	HOME	6807 IDL	EWILD BROOK LA	NE			
		CHARLC	OTTE, NC 28212				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE COMF D THE APPROPRIATE DA		
V 118	Continued From page 1		V 118				
	file followed up by ap with a physician.	ppointment or consultation					
	administered to a clie person authorized by Medication Administr drugs administered to current and medication	view, interviews and sility failed to ensure rescription drugs were ent on the written order of a / law to prescribe drugs, a ration Record (MAR) of all o each client was kept ons administered were y after administration					
	record revealed: -admission date of 10 Major Depressive Dis and Stressor Related Seasonal Allergies; -physician's orders d following medications three times daily and daily. -a printed form from a regarding a medical 11/7/19 listed the foll medications: oxcarba 300mg one tablet da	azepine(generic for Trileptal) ily, Lexapro 10mg one tablet ng one tablet daily and Abilify					

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If continuation sheet 2 of 5

	of Health Service Regu							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
	MHL060-586		B. WING	11	R 11/20/2019			
	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE		11/20/2019			
IDLEWILD	HOME		OTTE, NC 28212					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
V 118	Continued From page	e 2	V 118					
	oxcarbazepine(generic for Trileptal) 300mg one tablet daily, Lexapro 10mg one tablet daily, Trazadone 50mg one tablet daily and Abilify 5mg one half tablet a bed.							
	Observation on 11/20/19 at 3:50pm revealed the following medications present on site for client #1: -oxcarbazepine 300mg one tablet daily; -Lexapro 10mg one tablet daily; -Trazadone 50mg one tablet daily; -Abilify 5mg one half tablet a bed.							
	10/15/19-11/20/19 re dates left blank with r -11/1 and 11/8 for Tri three times daily;	of client #1's MARS from vealed the following dosing no explanation on the form: leptal 150mg one tablet pine 300mg one tablet daily; Omg one tablet daily.						
	from 10/15/19-11/20/ medications administ orders present in the -Ciprex OTIC suspen twice daily for 7 days	sion 4 drops in the left ear						
	Interview on 11/20/19 -got her medications -not missed any med							
	record revealed: -admission date of 9/ Attention Deficit Hype Post Traumatic Stres -physician's order dat	and 11/20/19 of client #2's 20/19 with diagnoses of eractivity Disorder(ADHD), s Disorder and Epilepsy; ted 8/29/19 for the following 50mg one tablet two times						

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If continuation sheet 3 of 5

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL060-586	B. WING		11	R I/ <b>20/2019</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
DLEWILD	HOME		LEWILD BROOK LA OTTE, NC 28212	NE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From page	e 3	V 118			
	D HOME CHARLO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)					
	Finding #3 Review on 11/14/19 a record revealed:	and 11/20/19 of client #3's				

STATE FORM

ZXQ911

		1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
	MHL060-586		B. WING		11	R 11/20/2019	
AME OF PROVIDER OR S	JPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE			
DLEWILD HOME			LEWILD BROOK LA DTTE, NC 28212	NE			
PREFIX (EAC	H DEFICIENCY M	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
-admission ADHD and -physician' medication -a printed fi regarding a 10/22/19 li medication Flonase 50 -no signed record for fi Observation following n -Claritin 10 -Flonase 5 -Monteluka Review on 10/15/19-1 dates left fi -11/1 for Fl -11/1 for Fl -11/1 for Fl -11/7 for M Interview of was admin Interview of revealed: -all clients prescribed -will ensure -will obtain clients' me	Child Negled s orders date : Montelukas orm from a lo a medical visi sted the follow s: Claritin 100 mcg daily; physicians' o he above list n on 11/20/19 medications pr mg one table Omcg daily; ist 4mg one table 0mcg daily; ist 4mg one table 11/20/19 of c 1/20/19 revea lank with no aritin 10mg o onase 50mcg ontelukast 4m n 11/20/19 w istered her m n 11/20/19 w get their med e no blanks le the physiciar dications.	ablet at bed. lient #3's MARS from aled the following dosing explanation on the form: ne tablet daily; daily; ng one tablet at bed. ith client #3 revealed she edications everyday. ith the Program Manager ications daily as	V 118	DEFICIEN			

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