Division of Health Service Regulation

` · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
			A. BOILDING					
		MHL060-974	B. WING		R 02/11/2020			
NAME OF PF	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE				
		2430 UM	AR COURT					
ANGEL	ANGEL 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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE			
V 000	INITIAL COMMENTS		V 000					
	on 2-11-20. Deficience This facility is licensed	d for the following service 27G 5600 Supervised Living						
	Developmental Disord	der.						
V 118	27G .0209 (C) Medica	ation Requirements	V 118					
	only be administered order of a person autidrugs.  (2) Medications shall clients only when auticlient's physician.  (3) Medications, incluadministered only by unlicensed persons transmistered or other leading of the privileged to prepare (4) A Medication Admall drugs administered current. Medications are corded immediately MAR is to include the (A) client's name;  (B) name, strength, a (C) instructions for addictions of the control of th	stration: n-prescription drugs shall to a client on the written norized by law to prescribe be self-administered by norized in writing by the ding injections, shall be licensed persons, or by rained by a registered nurse, regally qualified person and and administer medications. inistration Record (MAR) of d to each client must be kept administered shall be rafter administration. The following: and quantity of the drug; liministering the drug; drug is administered; and reson administering the remedication changes or						
	checks shall be recor	r medication changes or ded and kept with the MAR pointment or consultation						

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

(X6) DATE TITLE

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, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		MHL060-974	B. WING		02/11/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
ANGEL		2430 UMA				
		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 APPROPE DEFICIENCY)	BE COMPLETE	
V 118	Continued From page	: 1	V 118			
	with a physician.					
	facility failed to mainta	iews and interviews the ain an accurate MAR d clients (Clients #1, #2,				
	Review on 2-7-20 of client #1's MAR's from December 2019 through February 2020 revealed: -January MAR documented; Escitalopram 5 mg one tablet once daily, Vitamin D 1,000 one tablet once daily, Flovent 44 mcg inhale 2 puffs twice daily, Topamax 100 mg one tablet in am, Topamax 100 mg 1 and 1/2 tablet at bedtime, Methscopolam tablet 2.5 mg 1 tablet at bedtime, albuterol HFA inhale 2 puffs 4 times daily					
	PRN,Fluticasone 50 r nostril every day as no topically twice daily as Mupirocin 2% ointmet	ncg administer 1 spray each eeded, Mederma gel apply s needed for dry skin, nt apply topically to affected				
	5 mg one tablet once tablet once daily, Flow	documented: Escitalopram daily, Vitamin D 1,000 one rent 44 mcg inhale 2 puffs 100 mg one tablet in am,				
	Topamax 100 mg 1 at Methscopolam tablet albuterol HFA inhale 2	nd 1/2 tablet at bedtime, 2.5 mg 1 tablet at bedtime,				
	nostril every day as not topically twice daily as Mupirocin 2% ointment area every 12 hours a	eeded, Mederma gel apply s needed for dry skin, nt apply topically to affected				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:		COMPLETED	
			D MING		F	
		MHL060-974	B. WING		02/1	1/2020
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
ANGEL			AR COURT			
		CHARLO	TTE, NC 28215			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	Continued From page	e 2	V 118			
	Review on 2-7-20 of December 2019 throu-January 2020 M 20mg Cap i cap every 750 mg three capsule Risperidone .5 mg talbedtime, Amoxicillin 8 times daily.  -February MAR 0 20mg Cap i cap every 750 mg three capsule Risperidone .5 mg talbedtime, Amoxicillin 8 times daily.	client #2's MAR's from ugh February 2020 revealed: IAR Documented: Fluoxetine y morning, Balsalazide cap es three times a day, b 1 tablet by mouth at 500 mg capsules 1 tablet 4  documented: Fluoxetine y morning, Balsalazide cap				
	December 2019 throus January MAR do units tab 1 tablet once mcg tab 1 tab once described and tablet on the second	client #3's MAR's from ugh February 2020 revealed: coumented:Vitamin D3 2,000 e daily, Levothyroxine 75 aily except Sunday, g 1 and 1/2 tablets once rythromycin 5mg/gm opth n both eyes at bedtime, to whole body every evening ble), Mometasone .1% apply effected areas once daily, ply once daily to hands. MAR revealed: Vitamin D3 et once daily, Levothyroxine e daily except Sunday, g 1 and 1/2 tablets once rythromycin 5mg/gm opth n both eyes at bedtime, to whole body every evening ble), Mometasone .1% apply effected areas once daily, ply once daily to hands. 019 MAR available to review.				

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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
			A. BUILDING:			
		MHL060-974	B. WING		02	R 2/ <b>11/2020</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATI	E, ZIP CODE		
ANGEL		2430 UM.	AR COURT			
ANGLL		CHARLO	TTE, NC 28215			
(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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 118	Continued From page	e 3	V 118			
		vith client #1 revealed: er medications daily and staff nem to her.				
	-She listed her m	vith client #2 revealed: nedications and said that she and that staff never forgot to				
Interview on 2-7-20 with client #3 revealed:  -She got her medications in the morning and the evening.  -Staff never forgot to give her medications to						
	her.	C				
	revealed:  -The December   facility because she h of the month.  -The Local Mana at the facility in Janua	MAR's had been in the had checked them at the end had seen them.  If all over the office and the lid not find them.				
		vith staff #1 revealed: and what happened. I know d." (Giving medications)				
	evening and she know	vith staff #2 revealed; I December 31 in the ws she documented giving the December MAR's in the				
	Professional reveale	regular Qualified				

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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  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
						R		
		MHL060-974	B. WING			/11/2020		
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	TE, ZIP CODE				
ANGEL 2430 UMAR 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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE		
V 118	Continued From page	÷ 4	V 118					
	Entity had been out in of the MAR's.	at the Local Management  I January and had seen all  tutes a recited deficiency						
	and must be corrected							

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