PRINTED: 03/13/2020 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			
AND PLAN OF CORRECTION		IDENTIFICATION NOMBER.	A. BUILDING:		COMPLETED			
MHI 060		MHL0601014	B. WING		R 03/11/2020			
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
	1206 BERSHIRE LANE							
MILLER F	AMILY HOME	CHARLOT	TE, NC 28262					
(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	(X5) COMPLETE DATE		
V 000	INITIAL COMMENTS		V 000					
		up survey was completed A deficiency was cited.						
		d for the following service 27G .5600F Supervised Family Living.						
V 118 27G .0209 (C) Medication Requirements		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 checks shall be recorded and kept with the MAR							

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

TITLE (X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
MHL0601014 B. WING _		B. WING		R 03/11/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
MILLER F	AMILY HOME	1206 BER	SHIRE LANE		
WIILLER	AMILITIOML	CHARLO	TTE, NC 28262		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETE
V 118	Continued From page 1		V 118		
	were kept current affe #1 and #2). The find #1 and #2). The find Review on 3/10/20 of -Admitted 10/1/17; -Diagnosed with Autis Disorder, Attention D Phonological Disorder da 10mg 1 tab twice dail tabs at hour of sleep; -January, February, a revealed no documer Propranolol (used to and anger outbursts) -January, February, a revealed Trazodone (hour of sleep. Review on 3/10/20 of -Admitted 11/15/04; -Diagnosed with Seve Developmental Disab Disease, lleostomy, E Urinary System Disease Aspasia;	record review, and fity failed to ensure MARs recting 2 of 3 clients (Clients ings are: If Client #1's record revealed: Is m, Unspecified Mood reficit Hyperactivity Disorder, er; ted 7/25/19 for Propranolol by and Trazodone 150mg 2 In many terms of the second dose of treat high blood pressure; and March, 2020 MARs (sleep aid) 150mg 1 tab at If Client #2's record revealed: If Client #3 in The Propriet			
	(seizure control) 25m -Physician's order da (treatment of stomach twice daily;	ted 2/18/20 for Lamotrigine g take 4 tabs twice daily; ted 2/12/20 for Pantoprazole h ulcers) 40mg take 1 tab			

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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			
						R			
MHL0601014			B. WING			/11/2020			
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
MILLER FAMILY HOME 1206 BERSHIRE LANE CHARLOTTE, NC 28262									
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(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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