STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
	or connection	IDENTIFICATION NOMBER.	A. BUILDING:			
		MHL026-960	B. WING			R 08/2021
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
омми	NITY ALTERNATIVE H	IOUSING INC	ABISCUIT DRIV N, NC 28371	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
V 000	INITIAL COMMENTS		V 000			
		w up survey was completed 021. A deficiency was cited.				
	category: 10A NCA	sed for the following service C 27G .5600F Supervised amily Living in a Private				
V 118	27G .0209 (C) Med	lication Requirements	V 118			
	 only be administered order of a person a drugs. (2) Medications shat clients only when a client's physician. (3) Medications, include the administered only builteensed persons pharmacist or other privileged to prepare (4) A Medication Act all drugs administered unnediate MAR is to include the theorem of the administere of the theorem of theorem of the theorem of theo	non-prescription drugs shall ed to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be by licensed persons, or by a trained by a registered nurse, r legally qualified person and re and administer medications. Iministration Record (MAR) of red to each client must be kep s administered shall be ely after administration. The				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		egulation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL026-960	B. WING			R 09/08/2021	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
сомми	NITY ALTERNATIVE H	IOUSING INC	ABISCUIT DRIV DN, NC 28371	VE			
(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 ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
V 118	Continued From pa	age 1	V 118				
	with a physician.						
	This Rule is not met as evidenced by: Based on record review, observation and interviews the facility failed to ensure medications were administered as ordered by a physician and MARs kept current affecting 1 of 1 clients (#1). The findings are:						
	-	of client #1's record revealed:					
	-Diagnoses of Autis Intellectual Disabili Hyperactivity Disor	sm Spectrum Disorder, ty, Mild and Attention Deficit der (ADHD), Combined					
	discontinued order Gabapentin 100 m Clonidine 2 mg, Tri	ned physician orders or s for Zoloft 50 mg (milligrams), g, Trazadone 100 mg, amcinolone Acetonide Fluticasone 50 mcg	,				
		of client #1's "Risk Support					
	7/16/21 revealed: -Zoloft 50mg 3 time -Gabapentin 100 m -Trazadone 100 mg	ng nightly for restlessness. g nightly for sleep.					
	-Clonidine 2 mg tw and ADHD.	ice daily for blood pressure					
	Review on 9/8/21 c orders dated 7/27/2	of client #1's signed physician					

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	of Health Service Re			CONSTRUCTION		
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL026-960	B. WING			R 08/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
сомми	NITY ALTERNATIVE H	INC 1410 SE	ABISCUIT DRI	VE		
		PARKTC	N, NC 28371			
(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 ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From pa	age 2	V 118			
	-Amlodipine Besylate 5 mg, twice daily at 8am and 2pm. (high blood pressure) -Escitalopram Oxalate Sol 5 mg, 7.5 mg daily at 8am. (depression/anxiety) -Cholecalciferol 25 mg, 2 twice daily at 8am and 7pm. (vitamin D supplement) -Albuterol Sulfate HFA 90 mcg, 2 puffs every 4 hours as needed for coughing/wheezing/SOB (shortness of breath) or 15 minutes prior to exercise.					
	28, 2021 - Septemi -Escitalopram Oxal as 5mg once daily -Triamcinolone Ace transcribed as need -Fluticasone 50 mc on August MAR an -Cholecalciferol 25 September MAR. -Amlodipine Besyla	of client #1's MARs from July ber 8, 2021 revealed: late Sol 5 mg was transcribed on July and August MAR. etonide ointment 0.1% was ded on July and August MAR. og nasal spray was transcribed d administered daily. mg was not transcribed on the 5 mg dosing times were and 7pm for September.				
	on 9/8/21 between -Albuterol Sulfate H	nt #1's medication locked box 1:00pm - 1:30pm revealed: IFA 90 mcg, Triamcinolone t 0.1% and Cholecalciferol 25 ble at facility for				
	Interview on 9/8/21 received his medic	client #1 stated he had ations daily.				
	stated: -The Alternative Fa responsible for ens available for admin	the Qualified Professional mily Living (AFL) provider was uring medications were istration. uardian had medications filled				

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6899

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If continuation sheet 3 of 5

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Division	of Health Service Re	egulation			FORM	APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL026-960			R 08/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
		1410 SEA	ABISCUIT DRI			
COMMU	NITY ALTERNATIVE H	IOUSING INC	N, NC 28371			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETE DATE
V 118	Continued From pa	ge 3	V 118			
	-The pharmacy use would not release a -She did not know i for Zoloft, Gabapen were current or disc -She spoke with cliv requested current p -She understood it to ensure medicatio administered as ord Interview on 9/8/21 -Client #1's physicia Licensee office. -All medications for AFL by client #1's g -Client #1's guardia Gabapentin, Trazao -Client #1's Escitato administered as ord -She did not have or Triamcinolone ointr administration. -Client #1's guardia and Triamcinolone did not have prescr -Client #1's Fluticas not provided to her #1's legal guardian. -Client #1's Choleca provided for Septer -She had not chang #1's day time media AFL at the school.	ent #1's legal guardian and ohysician orders. was the facility's responsibility ons were available and dered by physician. with AFL provider stated: an orders were kept at the r client #1 were delivered to juardian. In had not provided any Zoloft, done or Clonidine to her. opram Oxalate Sol 5 mg was dered. client #1's Albuterol inhaler or ment at the facility for an had the Albuterol inhaler ointment but the medications iption labels. sone 50 mcg nasal spray was in July or September by client				
	for 10/7/21 and AFL	s appointment was scheduled _ provider would have all client led as ordered by physician.				

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6899

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If continuation sheet 4 of 5

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND FLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
		MHL026-960	B. WING			R)/08/2021	
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
	NITY ALTERNATIVE H		ABISCUIT DRIV	VE			
		PARKTO	N, NC 28371			-	
(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 ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
V 118	Continued From pa	age 4	V 118				
	to ensure medication	was the facility's responsibility ons were available and dered by physician.					

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