Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | | |
|---|---|---|--|--|-------------|--|--|
| | | | - I MANAGE | | | | |
| | | MHL060-198 | B. WING | | 10/12/2021 | | |
| NAME OF P | NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | | |
| NEVIN #1 | | | VIN ROAD OTTE, NC 28269 | | | | |
| (X4) ID | SUMMARY STA | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | N (X5) | | |
| PREFIX TAG | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETE | | |
| V 000 | INITIAL COMMENTS | | V 000 | | | | |
| | An annual survey was Deficiencies were cite | s completed on 10/12/21. ed. | | | | | |
| | category: 10A NCAC | d for the following service 27G .5600C Supervised Developmental Disabilities. | | | | | |
| V 120 | 27G .0209 (E) Medica | ation Requirements | V 120 | | | | |
| | 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; | | | | | | |
| | (E) in a secure manner for a client to self-med (2) Each facility that n controlled substances registered under the N | ernal and internal use; er if approved by a physician dicate. naintains stocks of s shall be currently North Carolina Controlled 90, Article 5, including any | | | | | |
| | interviews, the facility | iew, observations and | | | | | |

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|---------------------|--|-------------------------------|--------------------------|--|
| ANDILAN | OF CONNECTION | IDENTIFICATION NOMBER. | A. BUILDING: | | COM | LLILD | |
| | | MHL060-198 | B. WING | | 10 | 12/2021 | |
| NAME OF F | ROVIDER OR SUPPLIER | STREET AI | DDRESS, CITY, STAT | E, ZIP CODE | | | |
| NEVIN #1 | NEVIN #1 3827 NEVIN ROAD CHARLOTTE, NC 28269 | | | | | | |
| (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 CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE | |
| V 120 | affecting 3 of 3 clients findings are: Finding #1: Review on 10/11/21 arecord revealed: -admission date of 11-Diagnoses of IDD(In Disability)-Moderate, Depressive Type and Disorder; -physician's order dat one tablet prn(as need in 60 minutes if ineffer maximum 2 doses in Observation on 10/11 medications revealed: -Chlorhexidine 0.12% oral health dispensed plastic tray in the third cart with another clied dispensed 9/16/21; -Ativan 0.5mg one tal anxiety may repeat in times 1 dose, maximudispensed 9/29/21 stems 1 dose, m | and 10/12/21 of client #1's 1/14/18; tellectual Developmental Schizoaffective Disorder Generalized Anxiety ted 2/24/21 for Chlorhexidine ce daily for oral health; ted 9/29/21 for Ativan 0.5mg tedd) for anxiety may repeat rective times 1 dose, 24 hours. 1/21 at 3:09pm of client #1's 1: 10 rinse 15ml twice daily for 13 9/1/21 stored in a blue 14 drawer of the medication 15 Invega injection 16 minutes if ineffective 17 mum 2 doses in 24 hours 18 ored with client #2 and client 18 ations in the locked metal 18 and 10/12/21 of client #2's 18 16/01; 18 oderate, Convulsion 18 and Attention Deficit | V 120 | DE. KALNOT) | | | |

Division of Health Service Regulation

STATE FORM 6899 7CP411 If continuation sheet 2 of 5

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (I | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|------------------------------|--|--|--------------------------|---|----------|-------------------------------|--|
| | | | A. BUILDING: | | | | |
| | | MHL060-198 | B. WING | | 10 | /12/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | TE, ZIP CODE | | | |
| NEVIN #1 | | 3827 NEV | IN ROAD TTE, NC 28269 | | | | |
| | QUILLA DV QT | | | 220/425210 21 44 05 0022 | | | |
| (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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETE DATE | |
| V 120 | Continued From page 2 | | V 120 | | | | |
| | -physician's order dated 7/28/21 for clonazepam 1mg one tablet twice daily for anxiety; -physician's order dated 7/28/21 for Ritalin 30mg one tablet twice daily for ADHD. | | | | | | |
| | medications revealed -clonazepam 1mg on anxiety dispensed 9/1 and client #2's controlocked container in the medication cart; -Ritalin 30mg one tab dispensed 10/1/21 std #3 controlled medicat container in the in the medication cart. Finding #3: Review on 10/11/21 arecord revealed: -admission date of 12 diagnoses of IDD-Mi Depressive Disorder; | e tablet twice daily for 19/21 stored with client #1 lled medications in the metal e in the second drawer of let twice daily for ADHD ored with client #1 and client ions in the metal locked e second drawer of the and 10/12/21 of client #3's 1/30/15; ld, ADHD and Unspecified | | | | | |
| | for ADHD. Observation on 10/11 medications revealed 54mg one tablet daily 9/30/21 stored with cl controlled medication | idate 54mg one tablet daily /21 at 3:21pm of client #3's Concerta/methylphenidate for ADHD dispensed ient #1 and client #2's | | | | | |
| | revealed: | with the Home Manager | | | | | |

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Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|--|---|-------------------------------|--|
| | MHL060-198 | | B. WING | | 10/12/2021 | |
| | | | DRESS, CITY, STA | TE, ZIP CODE | | |
| NEVIN #1 3827 NEVIN ROAD CHARLOTTE, NC 28269 | | | | | | |
| (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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLETE | |
| V 120 | -had dividers in the lo separate the controlle -staff must have removed interview on 10/12/21 Professional revealed -Medication technicia the medications in the -only have two nurses nurses to get to all tw -nurses used to audit -there were dividers in box for the controlled -somebody must have | cked metal container to ed medications; oved the dividers. with the Qualified d: ns/staff are responsible for e cart; so now and it is hard for enty four sites; the medication carts; in the controlled medication | V 120 | | | |
| | REGISTRY (d2) Before hiring health care facility or health care facility shapersonnel Registry at of access in the approximate of access in the proximate of access in the approximate of access in the access the Health of ac | as evidenced by: ew and interview, the facility ICPR prior to hire for 1 of 2 | | | | |

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STATE FORM 6899 7CP411 If continuation sheet 4 of 5

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | COM | | (X3) DATE S COMPLI | URVEY ETED | | |
|---|--|--|------------------|---|-----------------------|------------------|--|--|
| | | | A. BUILDING: | | | | | |
| | | MHL060-198 | B. WING 10/12/20 | | 2/2021 | | | |
| NAME OF P | NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | | | |
| NEVIN #1 | NEVIN #1 3827 NEVIN ROAD CHARLOTTE, NC 28269 | | | | | | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID ID | PROVIDER'S PLAN OF CORRECTION |)N | (X5) | | |
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| V 131 | Continued From page | e 4 | V 131 | | | | | |
| | -rehire date of 6/28/2 | | | | | | | |
| | -job title of Direct Sup | pport Specialist; | | | | | | |
| | -documentation of HO present in the file. | CPR check dated 7/1/21 | | | | | | |
| | | with staff #1 revealed: | | | | | | |
| | -worked for RHA 7 ye -came back to work 2 | | | | | | | |
| | -work 7 days on, 7 da | | | | | | | |
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