Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
					R				
		MHL026-913	B. WING		10/13/2021				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE									
5975 SPINNER ROAD									
UNITY HO	UNITY HOME CARE RESIDENTIAL FACILITY HOPE MILLS, NC 28348								
(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 000	INITIAL COMMENTS		V 000						
	on October 13, 2021. This facility is licensed category: 10A NCAC	up survey was completed Deficiencies were cited. d for the following service 27G .5600C Supervised Developmental Disabilities.							
V 118	27G .0209 (C) Medica	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 administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR								

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

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
				71. BOILBING: _			_
		MHL026-913		B. WING		10	R / 13/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•	
					,		
UNITY HO	UNITY HOME CARE RESIDENTIAL FACILITY 5975 SPINNER ROAD HOPE MILLS, NC 28348						
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	_	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FUL LSC IDENTIFYING INFORMATIO		PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
V 118	Continued From page	e 1		V 118			
	This Rule is not met	-					
		ews and interviews the					
		the MARs current affecti	ng				
	one of three clients (#	f3). The findings are:					
	Daview en 40/00/04	of aliant #Ola nasand					
	Review on 10/08/21 or revealed:	or client #3 s record					
	-69 year old male.						
	-og year old maleAdmission date of 06/16/21.						
	-Diagnoses of Modera						
	Developmental Disab						
		Disorder, Hypertension	,				
	High Cholesterol, Ecz						
	Obstructive Pulmonal	ry Disease.					
	Review on 10/07/21 o	of client #3's physician					
	orders revealed:						
	06/17/21						
	-Atorvastatin 40mg (u	ised to treat high					
	cholesterol) Take 1 ta	ablet by mouth daily.					
	-Benztropine MES 1n						
	-	mptoms of Parkinson's					
		t by mouth daily at bedti	me.				
		I to treat symptoms of					
	depression and/or an	-	.				
		pression, or other menta le by mouth daily at bedt					
	-Escitalopram 20mg (-	.IIIIC.				
		n adults and adolescents	.)				
	Take 1 tablet by mout		"				
	-Ferrous Sulfate 325r	-					
		ake 1 tablet orally daily.					
		used to treat fluid retention	n)				

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Division of Health Service Regulation

DIVISION	n nealth Service Negu	lation						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED				
		-						
					R			
		MHL026-913	B. WING		10/13/2021			
NAME OF PI	ROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, STA	TE, ZIP CODE				
LINITY HOME CARE RESIDENTIAL FACILITY 5975 SPINNER ROAD								
UNITY HOME CARE RESIDENTIAL FACILITY HOPE MILLS, NC 28348								
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD				
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE			
				DEFICIENCY)				
		_	1/ 440					
V 118	Continued From page	2	V 118					
	Take 1 tablet by mout	th daily						
	-Meloxicam 7.5mg (us	-						
	• (•						
	inflammation) Take 1							
		50mg (used to treat angina						
	(chest pain) and hype	ertension) Take 1 tablet by						
	mouth daily.							
	-Montelukast SOD 10	mg (used to treat allergies)						
	Take 1 tablet by mout	th daily.						
	-Trelegy Ellipta 200-6	2.5-25 (used to improve						
		nt bronchospasm in adults						
	• .	ne puff orally every day.						
	09/16/21	to pair orany every day.						
		(used to treat cortain soizure						
	-Clonazepam 0.5mg (used to treat certain seizure disorders) Take 1 tablet by mouth 2 times per							
	day.							
	-Olanzapine 20mg (used to treat psychotic							
	conditions such as schizophrenia and bipolar							
	disorder) Take 1 table	et by mouth daily.						
	Review on 10/07/21 of	of the September and						
	October 2021 MAR revealed the following blanks:							
	-Atorvastatin 40mg- 0	9/29/21, 9/30/21.						
	-Benztropine MES 1m	ng- 09/29/21, 09/30/21.						
	-Clonazepam 0.5mg-	•						
	09/28/21-09/30/21 at							
	-Clopidogrel 75mg- 09	-						
	-Doxepin 25mg- 09/02							
	-Escitalopram 20mg-							
		mg- 09/29/21-09/30/21.						
	-Furosemide 20mg- 0							
	-Meloxicam 7.5mg- 09							
		50mg- 09/28/21-09/30/21.						
		mg- 09/28/21-09/30/21.						
	-Olanzapine 20mg- 09	9/28/21-09/30/21.						
		2.5-25- 10/01/21-10/07/21,						
	09/14/21-09/30/21.	,						
	During interview on 1	0/07/21 client #3 revealed:						
	-He received his med							
	i lo roccived filo filed	loadon dany.	I					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
				B WING		R		
		MHL026-913		B. WING		10/1	3/2021	
NAME OF PE	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
UNITY HO	UNITY HOME CARE RESIDENTIAL FACILITY 5975 SPINNER ROAD							
I			IOPE MILL	S, NC 28348				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 118	Continued From page	: 3		V 118				
		ofessional revealed: the medication issues. trained in the refresher						
V 736	27G .0303(c) Facility	and Grounds Maintenanc	e	V 736				
		EMENTS	rly					
	was not maintained in and orderly manner. To Observation on 10/07 12:15pm of the facility -The bottom of the storage -The cabinets next to was worn. -The light switch in the -The area next to the area that needed to book -The ceiling in client # and bugs were in the -Client #3's bedroom of the storage -The storage	and interviews, the facility a safe, clean, attractive The findings are: //21 at approximately a revealed: by e in the kitchen was berethe refrigerator the paint the hall bathroom was broke staff desk had a patched to painted. 83's room had brown stain floor vent. wall next to the window he of painted and the carpet	nt. en. ns					
		had a patched area on the	e					

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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		
		MHL026-913	B. WING			R 10/13/2021		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
UNITY HOME CARE RESIDENTIAL FACILITY 5975 SPINNER ROAD HOPE MILLS, NC 28348								
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE		
V 736	During interview on 1 Licensee/Qualified Pr revealed: -He was in the proces a bedroom and the do not been removed.	had debris and trash. 0/07/21 the rofessional's husband as of turning the garage into ebris on the back porch had e other issues in the home	V 736					

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