		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
ANDILAN	A. BUILDING:			JOSINII LETED				
		MHL068-128	B. WING		R 01/14/2022			
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
SUNRISE	AT UNC HORIZONS		& 211 CONNOR D HILL, NC 27599	PRIVE				
	CLIMMA DV CT			DROWIDEDIC DI ANI OF CORDECTIO	N			
(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 APPROPI DEFICIENCY)	BE COMPLETE			
V 000	INITIAL COMMENTS		V 000					
	An annual and follow- on January 14, 2022.	-up survey was completed Deficiencies cited.						
	category: 10A NCAC							
	Therapeutic Homes for Substance Abuse Dis	or individuals with corders and their Children.						
The survey sample consisted of 3 current clients, 0 former clients and 0 deceased clients.								
V 118 27G .0209 (C) Medication Requirements		V 118						
	10A NCAC 27G .0209 MEDICATION REQUIREMENTS							
	(c) Medication administration:							
	` '	n-prescription drugs shall						
		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.							
		ding injections, shall be						
administered only by licensed persons, or by unlicensed persons trained by a registered nurse,								
		egally qualified person and						
		and administer medications.						
	` '	inistration Record (MAR) of						
	current. Medications	d to each client must be kept						
	recorded immediately after administration. The MAR is to include the following:  (A) client's name;							
		nd quantity of the drug;						
	(C) instructions for ac							
		drug is administered; and						
	· ·	person administering the						
	drug.							

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		A. BUILDING.			D	
		MHL068-128	B. WING		01	R / <b>14/2022</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	•	
OUNDIOE	AT LING LIGBITONS		& 211 CONNOR DI			
SUNRISE	AT UNC HORIZONS	CHAPEL	. HILL, NC 27599			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO I DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From page	e 1	V 118			
	checks shall be recor	r medication changes or ded and kept with the MAR pointment or consultation				
		n, record review and failed to assure the ation Record (MAR) were of three audited clients (#1,				
	Sedative, Hypnotic, A Severe and Tobacco -Physician order date medications: -Prenatal Vitamir daily. -Bupropion XR 3	/21. Use Disorder, Severe, unxiolytic Use Disorder, Use Disorder, Severe. d 11/12/21 for the following n - Take one tablet by mouth				
	mouth every morning -Buspirone 10mg twice daily	g - Take one tablet by mouth				
	Review on 1-13-22 of December 2021 throu revealed blanks on th -Prenatal Vitamin - 1/ staff. -Bupropion XR - 1/10 -Buspirone - 12/7/21	ugh January 13, 2022 le following dates: 14/22 staff/client; 1/10/22				

Division of Health Service Regulation

STATE FORM 6899 QXWQ11 If continuation sheet 2 of 6

DIVISION	n nealth Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
					_	_
			D WING		F	
		MHL068-128	B. WING		01/1	14/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE ZIP CODE		
			211 CONNOR			
SUNRISE	AT UNC HORIZONS	·				
		CHAPEL	HILL, NC 27599	<del>9</del>		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI		(X5) COMPLETE
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		DATE
IAG			IAG	DEFICIENCY)		
V 118	Continued From page	e 2	V 118			
	staff/client; 12/11/21 o	client; 12/12/21 client;				
	12/16/21 staff/client;	12/18/21 staff/client;				
		2/23/21 staff/client 12/24/21				
	staff/client 12/27/21 s					
		taff; 1/13/21 staff/client.				
	Stanfonont, 1/10/22 St	ian, 1/10/21 stan/onent.				
	B. Review on 1/13/22	of Client #2 record				
	revealed:					
	-Admission Date: 10/	12/21.				
	-Diagnoses of Opiate	Use Disorder, Severe,				
	-	er, Severe and Tobacco Use				
	Disorder, Severe	· · · · · · · · · · · · · · · · · · ·				
-Physician order dated 1/10/22 for the following medications:		d 1/10/22 for the following				
	medications: -Bupropion XL 150 mg - Take one tablet by					
	mouth every day in th	-				
		I'e morning. Img - Take one tablet by				
	•	ing - Take one tablet by				
	mouth every day.					
	Review on 1-13-22 of	f Client #2's MAR for				
	December 2021 throu	ıgh January 13, 2022				
	revealed blanks on th	e following dates:				
		1/21 staff; 1/22/21 client;				
	12/27/21 staff/client;					
		/21 staff; 1/2/22 staff/client.				
		,_, _, _, _, _, _, _, _, _, _, _, _, _,				
	C. Review on 1/13/22	of Client #3 record				
	revealed:					
	-Admission Date:9/13	3/21.				
		ant Use Disorder - Cocaine,				
	Severe.					
		the following medication				
	included:	and removing medication				
		Take one tablet by mouth				
		n - Take one tablet by mouth				
	daily - order dated 9/					
	· ·	50mg - Take one tablet by				
	mouth each morning	- order dated 10/21/21.				
	Daview er 4 40 00 1	Cliant #Ola MAD far				
	Review on 1-13-22 of	Ullent #3's MAR for	1			

Division of Health Service Regulation

December 2021 through January 13, 2022

STATE FORM 6899 QXWQ11 If continuation sheet 3 of 6

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL068-128		B. WING		R 01/14/2022		
					1 01/1	4/2022
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA 211 CONNOR	•		
SUNRISE	AT UNC HORIZONS		HILL, NC 27599			
(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 118	Continued From page	2 3	V 118			
	revealed blanks on the -Prenatal Vitamin - 12 client; 12/10/21 staff/c1/7/22 staff/client 1/12 -Bupropion XL - 12/1/12/13/21 client; 12/18/21 - 12/2 client; 12/18/21 - 12/2 client; 12/22/21-12/24 12/26/21-12/27/21 staff/client; 1/1/22-1/3/22 staff/client; 1/1/22-1/3/22 staff/client.  Interview on 1/13/22 revealed: -Staff and clients were when medication was -If clients refused medication was -If clients refused medication was last three months.  Interview on 1/14/22 officer revealed: -Confirmed there was last three months.  Interview on 1/14/22 officer revealed: -Confirmed if clients reduced to document on an ineshe had a meeting we regarding medication documentationShe implemented a recomplianceShe reported 3rd shi ensure client and staff-Any blanks on the M follow-up with that staff	e following dates: 2/1/21 staff/client; 12/7/21 client; 12/23/21 staff/client; 2/22 staff/client. 2/21-12/10/21 staff/client; 2/21 staff/client; 12/17/21 2/21 staff/client; 12/21/21 2/21 staff/client; 12/21/21 2/21 staff/client; 2/21/21  with the Office Manager  e supposed to initial MAR administered. dication staff was supposed cident report. an o incidents reports in the  with the Clinical Compliance  efused medication staff was cident report. with staff on 1/11/22 administration and  new policy to ensure MAR  ft staff would review MAR to aff initialed. AR 3rd shift staff would aff person. ail reminding staff to sign				

Division of Health Service Regulation

STATE FORM 6899 QXWQ11 If continuation sheet 4 of 6

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED				
AND I EAR OF CONNECTION		A. BUILDING: _					
		MHL068-128	B. WING		R 01/14/2022		
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
SUNRISE	AT UNC HORIZONS		211 CONNOR ILL, NC 27599				
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE		
V 736	Continued From page	÷ 4	V 736				
V 736	27G .0303(c) Facility	and Grounds Maintenance	V 736				
		EMENTS					
	This Rule is not met Based on observation failed to ensure the fa maintained in a safe, manner. The findings	n and interview, the facility acility grounds were clean and attractive					
	revealed: -Apartments 211-7, 2 missing vertical blinds -Apartment 211-7 had wall vent in the living -Apartment 207-9 hal	21 at 11:30 - 12:15 p.m.  211-8, 211-10, 211-15 were s for the living room window. d black tape holding up the room.  Ilway carpet tac strip was esident tripping on the					
	revealed: -A residential advisor apartment inspections	with the Office Manager was responsible for weekly s. of the issues mentioned.					
	Officer revealed: -Confirmed a resident for weekly apartment	with the Clinical Compliance tial advisor was responsible inspections. erns would be addressed and					

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Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  207, 209 & 211 CONNOR DRIVE CHAPEL HILL, NC 27599  (MA) ID PRETTY TAG  (PACH DEPICIENCY MUST BE PRECEDED BY FILL. RECOLLATORY OR LOC IDENTIFYING INFORMATION)  V 736  Continued From page 5  reported to the community maintenance staff.		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  207, 209 & 211 CONNOR DRIVE  CHAPEL HILL, NC 27599   (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 736  Continued From page 5  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  207, 209 & 211 CONNOR DRIVE  CHAPEL HILL, NC 27599  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE DATE)  OMPLETE DATE  V 736				-		R
SUNRISE AT UNC HORIZONS  207, 209 & 211 CONNOR DRIVE CHAPEL HILL, NC 27599  (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 736  Continued From page 5  207, 209 & 211 CONNOR DRIVE CHAPTER (CHAPTER)  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE)			MHL068-128	B. WING		
CHAPEL HILL, NC 27599  (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  V 736 Continued From page 5  CHAPEL HILL, NC 27599  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMPLETE DATE)  (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE)  V 736 Continued From page 5	NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 736 Continued From page 5  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE)  V 736 Continued From page 5  V 736	SUNRISE	AT UNC HORIZONS				
	PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE COMPLETE
	V 736			V 736	DEFICIENCY)	

Division of Health Service Regulation

STATE FORM 6899 QXWQ11 If continuation sheet 6 of 6