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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	IED
		MHL0601423	B. WING		06/02/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
FOREST	POND HOME	6019 FORE	ST POND DRI	VE		
	0.12 1.02	CHARLOT	TE, NC 28262			
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	An annual survey was deficiency was cited.	s completed on 6/2/22. A				
This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living.						
V 118	V 118  27G .0209 (C) Medication Requirements  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 file followed up by appointment or consultation		V 118			

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

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
		IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
	MHL0601423		B. WING		06/02/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
			EST POND DRI			
FOREST I	POND HOME		TE, NC 28262			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	Ξ.
V 118	Continued From page	2.1	V 118			
V 118	Continued From page	<del>2</del> 1	V 118			
	This Rule is not met	as evidenced by:				
	This Rule is not met as evidenced by: Based on records review, observations and					
	interviews, the facility failed to ensure MARs of all					
	drugs administered to each client was kept					
	current affecting 1 of 1 client(#1). The findings					
	are:					
	Review on 5/24/22 of	client #1's record revealed:				
	-admission date of 6/11/18;					
		tellectual Developmental				
	,	•				
	,	e, ADHD(Attention Deficit				
	Hyperactivity Disorder) and DMDD(Disruptive					
	Mood Dysregulation [	•				
	-physicians' orders dated 11/18/21 for the					
	following medications	s: Focalin XL 15mg two				
	tablets daily and Foca	alin XL 25mg one tablet in				
	the am(for ADHD);	· ·				
		ated 3/3/22 and 4/14/22 for				
	Focalin XL 15mg one					
		ted 3/10/22 for client to take				
	Focalin XL 15mg one					
	1	ted 4/14/22 for citalopram(for				
	, -	let daily quantity of 14				
	tablets;					
	-no discontinue physi	cian's order for				
	citalopram(for mood)	10mg one tablet daily				
	present in the record;					
	-physician's order dat					
		te birth control one tablet in				
		e birtir control one tablet in				
	the am.					
	□ Observations on 5/25	5/22 at 5:01pm of client #1's	1			

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medications revealed:

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
			-				
			D WING				
		MHL0601423	B. WING		06/0	2/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DRESS, CITY, STA	TE ZIP CODE			
TO WILL OF TH	TO VIDER OR GOLF EIER						
FOREST F	OND HOME		REST POND DRI	VE			
		CHARLO	TTE, NC 28262				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)	
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	KIATE	DATE	
				DEI IOIENOT)			
V 118	Continued From page	e 2	V 118				
	Communa Trom page	-					
	-Focalin XL 15mg two	tablets daily dispensed					
	4/14/22 with the "two"	" marked out and "one"					
	handwritten on medic	ation bottle label;					
		e tablet in the am dispensed					
	4/14/22;						
	•	) 10mg one tablet daily not					
	on site;	, roning one tablet daily not					
	•	te birth control one tablet in					
	the am dispensed 4/3						
	ille alli disperised 4/3	00/22.					
	Daview en 5/04/00 en	- 4 E/0E/00 of allow #41-					
	Review on 5/24/22 and 5/25/22 of client #1's						
	MARs from 3/1/22-5/25/22 revealed:						
	•	tablets daily with "two"					
	marked out and handwritten "discon.(discontinue)						
	2 take 1" on 5/2022 N						
	-Focalin XL 15mg two	•					
	doc(documented) as	adms(administered) 6am					
	3/1-3/11, doc as adm	s at 12:00noon 3/12, 3/13,					
	3/19, 3/20, 3/21, 3/26	and 3/27. other dates at					
	12:00noon have line drawn thru;						
	-Focalin XL 25mg one	e tablet in the am doc as					
	adms at 12:00noon o						
		22 MAR "citalopram started					
	5/1/2022 14 day supp	•					
		c as adms 5/1-5/12 with					
	1	5/2022 MAR "discon. spoke					
		•					
		phone picking skin pulling					
		as well" and blanks for the					
	dosing dates of 5/13						
		te birth control handwritten					
		ith no dosing instructions					
	and doc as adms fror	n 4/1-4/30.					
		with staff #1 revealed:					
	-client #1 started pick	ing her skin and pulling her					
	hair while on the cital	opram;					
	-teachers called also	and client #1 was having					
	issues at school:	3					

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-noticed client #1 was snappy and moody;

-was so unlike client #1;

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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	
		MHL0601423	B. WING		06	6/02/2022	
	ROVIDER OR SUPPLIER	6019 FO	DTTE, NC 28262				
(X4) ID PREFIX TAG	(4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROV REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH C				F CORRECTION (X5) TION SHOULD BE COMPLETE THE APPROPRIATE DATE CY)		
V 118	-staff #1 called the ph -the physician said it v -discontinued the cital -did not make it to the -was only for a 14 day -did not refill the cital -now client #1 is ok;	ysician; was one of the side effects, lopram; full 14 days; r trial;	V 118				

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