STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL081-106	A. BUILDING: _____ B. WING _____	08/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY MOUNTAIN HOME	503 SOUTH MOUNTAIN ROAD BOSTIC, NC 28018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and follow-up survey was completed on August 18, 2022. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living. The facility is licensed for 3 and currently has a census of 3. The survey sample consisted of audits of 3 current clients.	V 000		
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.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL081-106	A. BUILDING: _____ B. WING _____	08/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY MOUNTAIN HOME	503 SOUTH MOUNTAIN ROAD BOSTIC, NC 28018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 1 (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure MARs were kept current for each client affecting 3 of 3 audited clients (Clients #1, #2 and #3). The findings are: Review on 8/17/22 of Client #1's record revealed: -Date of admission - 10/10/11. -Diagnoses of Spina Bifida with hydrocephalus, Seizure Disorder, Moderate Intellectual Developmental Disability (IDD), Urinary Incontinence, Suprapubic Catheter, Colostomy, Allergic Rhinitis, Neurogenic Bladder, Dysmenorrhea, and Generalized Anxiety Disorder. Observation on 8/16/22 at approximately 4:00 p.m. of Client #1's medications revealed: -Lamotrigine (Lamictal) (anticonvulsant) ER 300 mg - 1 tablet daily. -Claritin (allergy) 10 mg - 1 tablet daily. -Omeprazole DR (proton-pump inhibitor) 20 mg - 1 capsule daily. -Methenamine MD (Mandelate) (anti-infective) 500 mg - 1 tablet 2 times a day. -Levetiracetam (Keppra) (anticonvulsant) 250 mg - 1 tablet 2 times daily. -Sertraline HCL (Zoloft) (selective serotonin	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL081-106	A. BUILDING: _____ B. WING _____	08/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY MOUNTAIN HOME	503 SOUTH MOUNTAIN ROAD BOSTIC, NC 28018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 2	V 118		

reuptake inhibitor) 100 mg - 1 tablet 2 times daily.
-Flonase (allergy) 50 mcg (micrograms) - 2 sprays each nostril daily.

Review on 8/16/22 of Client #1's MARs from June 2022 to present revealed:
-The above medications were listed as observed.
-Medications were last initialed by the AFL provider, to indicate they were administered as ordered, on 8/11/22.

Review on 8/17/22 of Client #1's physician orders revealed:
-7/27/21 - Omeprazole DR 20 mg - 1 capsule daily; Sertraline HCL 100 mg - 1 tablet 2 times daily.
-11/19/21 - Lamotrigine ER 300 mg - 1 tablet daily; Claritin 10 mg - 1 tablet daily; Levetiracetam 250 mg - 1 tablet 2 times daily; Flonase 50 mcg - 2 sprays each nostril daily.
-2/10/22 - Methenamine MD 500 mg - 1 tablet 2 times a day.

Interview on 8/16/22 with Client #1 revealed:
-The AFL provider administered her medications every day.
-She had no concerns and received her medications as ordered.

Review on 8/17/22 of Client #2's record revealed:
-Date of admission - 3/1/19.
-Diagnoses of Severe IDD, Cerebral Palsy, Vitamin D Deficiency, Anxiety, Insomnia, Seizure Disorder, Gastroesophageal Reflux Disease, Fatigue, and Constipation.

Observation on 8/16/22 at approximately 3:32 p.m. of Client #2's medications revealed:
-Linzess (irritable bowel syndrome agent) 290 mcg - 1 capsule in a.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL081-106	A. BUILDING: _____ B. WING _____	08/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY MOUNTAIN HOME	503 SOUTH MOUNTAIN ROAD BOSTIC, NC 28018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 3 -Omeprazole 40 mg - 1 capsule in a.m. -Paroxetine HCL (selective serotonin reuptake inhibitor) 40 mg - 1 capsule in a.m. -Phenytoin Infatabs (anticonvulsant) 50 mg - 2 1/2 tablets in a.m. and p.m. -Vitamin D3 (fat-soluble secosteroids) 1,000 - 1 tablet in a.m. -Gabapentin (anticonvulsant) 300 mg - 1 capsule in p.m. -Melatonin (biogenic amine) 10 mg - 1 tablet in p.m. -Zolpidem Tartrate (sedative-hypnotics) 10 mg - 1 tablet in p.m. -Risperidone (antipsychotic) 1 mg - 1 tablet 2 times a day. -Ketoconzaole 2% shampoo (imidazoles) - apply to skin twice weekly at least 3 days between shampooing. Review on 8/16/22 of Client #2's MARs from June 2022 to present revealed: -The above medications were listed as observed. -Medications were last initialed by the AFL provider, to indicate they were administered as ordered, on 8/11/22. -Ketoconzaole 2% shampoo was last initialed 8/9/22; was to be applied 8/12/22 but was blank. Review on 8/17/22 of Client #2's physician orders revealed: -2/8/22 - Linzess 290 mcg - 1 capsule in a.m.; Omeprazole 40 mg - 1 capsule in a.m.; Paroxetine HCL 40 mg - 1 capsule in a.m.; Vitamin D3 1,000 - 1 tablet in a.m.; Melatonin 10 mg - 1 tablet in p.m.; Ketoconzaole 2% shampoo - apply to skin twice weekly at least 3 days between shampooing; Risperidone 1 mg - 1 tablet 2 times a day. -6/7/22 - Zolpidem Tartrate 10 mg - 1 tablet in p.m.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL081-106	A. BUILDING: _____ B. WING _____	08/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY MOUNTAIN HOME	503 SOUTH MOUNTAIN ROAD BOSTIC, NC 28018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 4	V 118		

-7/1/22 - Phenytoin Infatabs 50 mg - 2 1/2 tablets in a.m. and p.m.
-7/21/22 - Gabapentin 300 mg - 1 capsule in p.m.

Review on 8/17/22 of Client #3's record revealed:
-Date of admission - 12/23/20.
-Diagnoses of Severe IDD, Herpes, Cochlear Implant and Hard of Hearing.

Observation on 8/16/22 at approximately 3:42 p.m. of Client #3's medications revealed:
-Clonidine HCL (antihypertensive) 0.1 mg - 2 tablets in p.m.
-Famotidine (H2-blocker) 20 mg - 1 tablet in p.m.
-Melatonin 5 mg - 1 tablet in p.m.
-Pantoprazole Sodium (proton-pump inhibitor) 40 mg - 1 in a.m. and 1 in p.m.
-Aripiprazole (antipsychotic) 5 mg - 1 at bedtime.
-Ketoconazole 2% cream (imidazoles) - apply to affected areas topically 2 times a day.

Review on 8/16/22 of Client #3's MARs from June 2022 to present revealed:
-The above medications were listed as observed.
-Medications were last initialed by the AFL provider, to indicate they were administered as ordered, on 8/11/22.

Review on 8/17/22 of Client #3's physician orders revealed:
-11/19/21 - Clonidine HCL 0.1 mg - 2 tablets in p.m.; Aripiprazole 5 mg - 1 at bedtime; Ketoconazole 2% cream - apply to affected areas topically 2 times a day.
-2/2/22 - Melatonin 5 mg - 1 tablet in p.m.
-7/21/22 - Famotidine 20 mg - 1 tablet in p.m.; Pantoprazole Sodium 40 mg - 1 in a.m. and 1 in p.m.

Client's #2 and #3 were non-interviewable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL081-106	A. BUILDING: _____ B. WING _____	08/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY MOUNTAIN HOME	503 SOUTH MOUNTAIN ROAD BOSTIC, NC 28018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 5 Interview on 8/16/22 with the AFL provider revealed: -There was "no excuse" for not having the MARs up-to-date; this was "my mistake." -She gave the clients their medications as ordered. Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician.	V 118		