Division	of Health Service Regu	ılation			1 01(1	VIAPPROVI
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE : COMPL	
		MHL001-232	B. WING		1	R 15/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATI	E ZIP CODE	1 00/	10/2022
CHANGIN	0 11/50 54441 / 0 4 55	207 AAI	RONS WAY	C, ZII 000E		
CHANGIN	G LIVES FAMILY CARE I	HOME, LLC BURLIN	IGTON, NC 27217			
(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 APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	completed on August (intake #NC00190950 were deficiencies cited					
	category: 10A NCAC 2 Supervised Living for A	Adults with Mental Illness				
	has a census of 5. The survey sample co- current clients.	for 5 beds and currently nsisted of audits of 3				
V 114	27G .0207 Emergency	Plans and Supplies	V 114			
	10A NCAC 27G .0207 AND SUPPLIES (a) A written fire plan for area-wide disaster plan shall be approved by the authority. (b) The plan shall be mand evacuation proced posted in the facility. (c) Fire and disaster drishall be held at least quite repeated for each shift.	EMERGENCY PLANS or each facility and on shall be developed and one appropriate local orade available to all staff ours and routes shall be only the staff of the staff ours and routes shall be		RECEIVED AUG 2 6 2022		
fa s		and interview the facility disaster drills on each		DHSR-WHH Licenstone Sect		

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

DUNER

(X6) DATE

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A COMPANIES CONTRACTOR	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						3
		MHL001-232	B. WING		1	15/2022
NAME OF P	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE		
CHANGIN	IG LIVES FAMILY CARE I	HOME, LLC 207 AARG	ONS WAY TON, NC 272	17		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 114	Continued From page	1	V 114			
V 118	Review on 8/11/22 of disaster drills record in There were 2nd shift 2/1/22, 3/16/22, 4/11/2 7/12/22 and 8/4/22. There was one 2nd s 1/11/22. There were no fire an on 1st and 3rd shift. Interview on 8/15/22 wrevealed: -Staff was aware fire a conducted on each shift. Clients would leave exprogramHe would have the we shift fire and disaster designs.	the facility's fire and evealed: disaster drills conducted on 22, 5/23/22, 6/13/22, hift fire drill conducted on disaster drills conducted with the Executive Director and disaster drills should be lift. early on 1st shift for the day exekend staff conduct 1st brills on the weekends. Lutes a re-cited deficiency within 30 days.	V 118	The weekend staff will conduct fire/disaster drills or in March, June, September, and December. They conduct 3rd shift drills in January and July. The weekday staff will conduct fire/disaster drills or in February, May, August, and November. They will 3rd shift drills in April and October.	will also	
	only be administered to order of a person authordrugs. (2) Medications shall be clients only when authordient's physician. (3) Medications, including administered only by licunlicensed persons trainered only by the order of the persons trainered only the per	tration: prescription drugs shall of a client on the written prized by law to prescribe e self-administered by prized in writing by the ang injections, shall be				

Division of Health Service Regulation

STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MULTI	IDLE CONCEDUCATION		
	OF CORRECTION	IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X	3) DATE SURVEY
			A. BUILDIN	G:		COMPLETED
		MHL001-232	B. WING _			R 08/15/2022
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS CITY	STATE, ZIP CODE		00/10/2022
		007.4.4		STATE, ZIP CODE		
CHANGI	NG LIVES FAMILY CARE I	TOME, LLC	ONS WAY	047		
(VA) ID	CUMMADVOT		GTON, NC 27	21/		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
V 118	privileged to prepare a (4) A Medication Admi all drugs administered current. Medications a recorded immediately MAR is to include the (A) client's name; (B) name, strength, an (C) instructions for adm (D) date and time the o (E) name or initials of p drug. (5) Client requests for a checks shall be recorded	and administer medications. nistration Record (MAR) of to each client must be kept dministered shall be after administration. The following: d quantity of the drug; ninistering the drug; drug is administered; and person administering the medication changes or ed and kept with the MAR pointment or consultation	V 118			
	physician for one of threare:	ee clients (#1). The finding				
	-Admission date of 12/10 -Diagnoses of Schizoph Disorder, Mild, Cannabis Hallucinogen Use Disord RemissionPhysicians orders included -4.14.22 - "Staff is to every morning and recorderssure is systolic is over	renia, Tobacco Use s Use Disorder, Mild and der, In Sustained				

Division of Health Service Regulation

08/15/2022

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: _ COMPLETED R B. WING_ MHL001-232

NAME OF PROVIDER OF SUPPLIER

	IG LIVES FAMILY CARE HOME, LLC 207 AAF	ADDRESS, CITY, STA RONS WAY GTON, NC 27217		
(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
	Continued From page 3 -6/9/22 - "Staff to assist patient with taking Blood Pressure daily." -7/11/22 - "Propranolol HCL 10mg oral tablet Take one tablet (10mg) by mouth daily. Monitor heart rate. Notify provider if rate is less than 70." -7/28/22 Start Propranolol 20mg take daily in a.m. Monitor heart rate and blood pressure daily. Notify provider for heart rate less than 70 and systolic BP less than 100." Review on 8/11/22 of Client #1's Medication Administration Record from April 2022 - July 2022 revealed: -There was no evidence client #1's blood pressure and heart rate was checked. -There was no recording of client #1s blood pressure and heart rate. Interview on 8/11/22 with Client #1 revealed: -Presented limited understanding of blood pressure and heart rate checkHe did respond when asked about blood pressure checks and heart rate. Interview on 8/11/22 with Staff #2 revealed: -He worked three days a week/24hr shiftClient #1 self-administered blood pressureThe Nurse Practitioner ordered client #1 an electronic machine. Client #1 was to check blood pressure daily in he a.m. He told client #1 to check blood pressure and heart rate every morning. Client #1 was supposed to check blood pressure and heart rate every morning. Client #1 was supposed to check blood pressure heart rate until the NP discontinued it. He said client #1's monitoring of heart rate and blood pressure started around May or June. He would assist and show client #1 how to use it.	V 118	A new order was received from the the primary care provider on 8/15/2022 to clarify time of which blood pressure was to be taken as well as the protocol of maintaining a record in the client record/MAR of the results. QP will maintain consistent contact with the primary care provider as well as review the orders on a weekly, bi-weekly or monthly basis after all visits to determine that orders are being followed as written and to obtain clarification of orders if there are questions on administration, etc of any orders. QP will also monitor the information provider from additional providers for medication or orders such as psychiatrist, optometrist, therapist, etc.	

Division of Health Service Regulation

STATE FORM

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	E SURVEY
		IDENTIFICATION NUMBER:	A. BUILDING:		CON	PLETED
		MHL001-232	B. WING		0.0	R 8/15/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATI	E, ZIP CODE	1 00	0/10/2022
CHANGIN	IG LIVES FAMILY CARE I		RONS WAY			
		BURLIN	GTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From page	4	V 118			
r	Interview on 8/12/22 w -He worked the weeke -He was told client #1 blood pressure and he -Confirmed he did not machineHe said he would need Interview on 8/12/22 wirevealed: -She was an independed she worked on the weduring the weekShe provided nursing of trainings, contribute to the communicating with propadministrationShe denied when asked doctor ordersShe reported it was the	with Staff #3 revealed: ends. had to self-administer the art rate. know how to use the d training. ith the Registered Nurse ent contractor. ekends and sometimes duties, assessed clients, the treatment plan.	VIII			
s s -% -% -% -S -S In re -T cli	T would do it sporadical The machine was in clie ed. She thought the order w She would ensure the R	evealed order was for him to eveekend staff that client lly. ent #1's room and by his east discharged. N trained all staff. the Executive Director ponsible for reviewing and new doctor orders				

Division of Health Service Regulation

STATE FORM

Division of Health Service Regulation

(X1) PROVIDER

	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL001-232	B. WING			R / 15/2022
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE	1 00	115/2022
CHANG	ING LIVES FAMILY CARE F	IOIVIE, LLC	RONS WAY			
(X4) ID		BURLIN	IGTON, NC 27217			
PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 118	Continued From page	5	V 118			
	responsibilities.					
V 29	1 27G .5603 Supervised		V 291			
	six clients when the cliedevelopmental disabilition June 15, 2001, and than six clients at that the provide services at nonlicensed capacity. (b) Service Coordination maintained between the qualified professionals with treatment/habilitation of (c) Participation of the Responsible Person. Exprovided the opportunity relationship with her or the means as visits to the father facility. Reports shathan annually to the parent of legally responsible person Reports may be in writing conference and shall for progress toward meeting (d) Program Activities. It activity opportunities baseneeds and the treatment Activities shall be design inclusion. Choices may loor legal system is involves affety issues become a provided than the clients of the provided that the control of the legal system is involved as a provided than the clients of the provided that the control of the legal system is involved as a provided that the clients of the provided that the provided th	y shall serve no more than ents have mental illness or ies. Any facility licensed providing services to more ime, may continue to more than the facility's on. Coordination shall be a facility operator and the who are responsible for case management. Family or Legally ach client shall be to to maintain an ongoing his family through such icility and visits outside all be submitted at least of a minor resident, or the on of an adult resident. If yo reach the form of a sus on the client's individual goals. Each client shall have seed on her/his choices, whabilitation plan. It is a submitted when the court is dor when health or orimary concern.				
E	This Rule is not met as e Based on record review a	videnced by: and interviews the facility				

ZLRY11

MHL001-232 B WING ROS/15/2022 STREET ADDRESS, CITY, STATE, ZIP CODE 207 AARONS WAY BURLINGTON, NC 27217 SUMMARY STATEMENT OF DEFICIENCIES BURLINGTON, NC 27217 CACH DEFICIENCY MUST BE PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION) V 291 Continued From page 6 failed to coordinate medical services with other professionals responsible for treatment/habilitation of client (#1). The findings are: Review on 8/11/22 of Client #1's record revealed: -Admission date of 12/16/19Diagnoses of Schizophrenia, Tobacco Use Disorder, Mild, Cannabis Use Disorder, Mild and Hallucinogen Use Disorder, in Sustained RemissionPhysicians orders included the following dates: -4.14.22 "Staff is to take blood pressure every morning and record, Notify provider if blood pressure is systolic is over 150 or less than 100." -6/9/22 "Staff to assist patient with taking Blood Pressure daily." -7/11/22 - "Propranolol HCL 10mg oral tablet Take one tablet (10mg) by mouth daily. Monitor heart rate. Notify provider for heart rate less than 70 and systolic BP less than 100." -7/28/22 Start Propranolol 20mg take daily in a.m. Monitor heart rate and blood pressure daily. Notify provider for heart rate less than 70 and systolic BP less than 100."	AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
CHANGING LIVES FAMILY CARE HOME, LLC 207 AARONS WAY BURLINGTON, NC 27217 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG COMPLIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 291 Continued From page 6 failed to coordinate medical services with other professionals responsible for treatment/habilitation of client (#1). The findings are: Review on 8/11/22 of Client #1's record revealed: -Admission date of 12/16/19Diagnoses of Schizophrenia, Tobacco Use Disorder, Mild, Cannabis Use Disorder, Mild and Hallucinogen Use Disorder, In Sustained RemissionPhysicians orders included the following dates: -4.14.22 - "Staff is to take blood pressure every morning and record. Notify provider if blood pressure is systolic is over 150 or less than 100." -6/9/22 - "Staff to assist patient with taking Blood Pressure daily." -7/11/22 - "Propranolol HCL 10mg oral tablet Take one tablet (10mg) by mouth daily. Monitor heart rate. Notify provider if rate is less than 70." -7/28/22 Start Propranolol 20mg take daily in a.m. Monitor heart rate and blood pressure daily. Notify provider for heart rate less than 70 and			MHL001-232	B. WING		08	
SUMMARY STATEMENT OF DEFICIENCIES DEPRETED	NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		10/2022
CAM ID PREPIX SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE APPROPRIATE	CHANGIN	IG LIVES FAMILY CARE	HOME, LLC 207 AA	RONS WAY			
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) V 291 Continued From page 6 failed to coordinate medical services with other professionals responsible for treatment/habilitation of client (#1). The findings are: Review on 8/11/22 of Client #1's record revealed: -Admission date of 12/16/19Diagnoses of Schizophrenia, Tobacco Use Disorder, Mild, Cannabis Use Disorder, Mild and Hallucinogen Use Disorder, In Sustained RemissionPhysicians orders included the following dates: -4.14.22 - "Staff is to take blood pressure every morning and record. Notify provider if blood pressure is systolic is over 150 or less than 100." -6/9/22 - "Staff to assist patient with taking Blood Pressure daily." -7/11/122 - "Propranolol HCL 10mg oral tablet Take one tablet (10mg) by mouth daily. Monitor heart rate. Notify provider if rate is less than 70." -7/28/22 Start Propranolol 20mg take daily in a.m. Monitor heart rate and blood pressure adily. Notify provider for heart rate less than 70 and			BURLIN	IGTON, NC 27217			
failed to coordinate medical services with other professionals responsible for treatment/habilitation of client (#1). The findings are: Review on 8/11/22 of Client #1's record revealed: -Admission date of 12/16/19Diagnoses of Schizophrenia, Tobacco Use Disorder, Mild, Cannabis Use Disorder, Mild and Hallucinogen Use Disorder, In Sustained RemissionPhysicians orders included the following dates: -4.14.22 - "Staff is to take blood pressure every morning and record. Notify provider if blood pressure is systolic is over 150 or less than 100." -6/9/22 - "Staff to assist patient with taking Blood Pressure daily." -7/11/22 - "Propranolol HCL 10mg oral tablet Take one tablet (10mg) by mouth daily. Monitor heart rate. Notify provider if rate is less than 70." -7/28/22 Start Propranolol 20mg take daily in a.m. Monitor heart rate and blood pressure daily. Notify provider for heart rate less than 70 and	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP) RE	COMPLET
failed to coordinate medical services with other professionals responsible for treatment/habilitation of client (#1). The findings are: Review on 8/11/22 of Client #1's record revealed: -Admission date of 12/16/19Diagnoses of Schizophrenia, Tobacco Use Disorder, Mild, Cannabis Use Disorder, Mild and Hallucinogen Use Disorder, In Sustained RemissionPhysicians orders included the following dates: -4.14.22 - "Staff is to take blood pressure every morning and record. Notify provider if blood pressure is systolic is over 150 or less than 100." -6/9/22 - "Staff to assist patient with taking Blood Pressure daily." -7/11/22 - "Propranolol HCL 10mg oral tablet Take one tablet (10mg) by mouth daily. Monitor heart rate. Notify provider if rate is less than 70." -7/28/22 Start Propranolol 20mg take daily in a.m. Monitor heart rate and blood pressure daily. Notify provider for heart rate less than 70 and	V 291	Continued From page	6	V 291			
really provider for heart rate less than 70 and	I F	professionals respons treatment/habilitation are: Review on 8/11/22 of -Admission date of 12 -Diagnoses of Schizop Disorder, Mild, Cannal Hallucinogen Use Disorder Staff is every morning and recopressure is systolic is of -6/9/22 - "Staff to a Blood Pressure daily." -7/11/22 - "Proprar Take one tablet (10mg) neart rate. Notify provident area. Notify provident. Monitor heart rate	Client #1's record revealed: /16/19. chrenia, Tobacco Use bis Use Disorder, Mild and order, In Sustained luded the following dates: to take blood pressure ord. Notify provider if blood over 150 or less than 100." assist patient with taking molol HCL 10mg oral tablet by mouth daily. Monitor ler if rate is less than 70." branolol 20mg take daily in and blood pressure daily				
	In -H -C ch -T ele	ressure checks and he aterview on 8/11/22 with the worked three days a client #1 self-administeneck. The Nurse Practitioner dectronic machine. Elient #1 was to check be a.m.	n Staff #2 revealed: a week/24hr shift. red blood pressure ordered client #1 an				

PRINTED: 08/16/2022 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: __ COMPLETED R MHL001-232 B. WING 08/15/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 207 AARONS WAY CHANGING LIVES FAMILY CARE HOME, LLC **BURLINGTON, NC 27217** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 291 Continued From page 7 V 291 heart rate every morning. -Client #1 did not want to do it. -Client #1 was supposed to check blood pressure/heart rate until the NP discontinued it. Interview on 8/12/22 with Staff #3 revealed: -He worked on the weekends. -He was told client #1 had to self-administer the blood pressure and heart rate. -Confirmed he did not know how to use the machine. -He said he would need training. -The Registered Nurse would check client #1's blood pressure and heart rate if she came on the weekends. Interview on 8/12/22 with the Registered Nurse revealed: -She was an independent contractor. -She worked on the weekends and sometimes during the week. -She provided nursing duties, assessed clients, trainings, contribute to the treatment plan, communicating with providers and medication administration. -She denied when asked if she reviewed clients doctor orders. -She reported it was the Qualified Professional responsibility to review clients records and doctor -She would train staff to check and monitor client #1's blood pressure and heart rate with the machine.

revealed:

3-6 weeks.

Interview on 8/12/22 with the Nurse Practitioner

-She provided primary care services about every

-The issue was that client #1's blood pressure

and heart rate was extremely high.

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY	
	TO SOUNCE HOW	IDENTIFICATION NUMBER:	A. BUILDING: _			PLETED	
		MHL001-232	B. WING			R	
NAME OF F	PROVIDER OR SUPPLIER				30	3/15/2022	
			DDRESS, CITY, STAT	TE, ZIP CODE			
CHANGIN	NG LIVES FAMILY CARE I	IOIVIE, LLC	ONS WAY				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	GTON, NC 27217				
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 291	Continued From page	8	V 291				
	-She left a blood press pressure and heart rat -The nurse that worked to take blood pressure weekends. -She did not write a set -She did not discontinu -Client #1had on and o issues. -The remote patient mo cuffs had cellular chips website. -On the 4/14/22 she left -Staff was to take blood and record. -Order also indicated to pressure was systolic of -Pulse had been over 13	d for the company refused and pulse on the defeatment of the order. If had blood pressure to where it download to a defeat every morning the pressure every	V 231				
In click the contract of the c	Interview on 8/11/22 and Qualified Professional reships was told client #1's self-administered. She thought the order was would contact the Naew order. Confirmed she was responsiblents' record and currer She would ensure the Rae heart rate and blood patterview on 8/15/22 with evealed:	evealed: order was for him to ras discharged. Jurse Practitioner for a consible for reviewing at and new doctor orders. N trained all staff to use coressure machine. the Executive Director ponsible for reviewing and new doctor orders					

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Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A. BUILDING: ___ R MHL001-232 B. WING 08/15/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CHANGING LIVES FAMILY CARE HOME, LLC 207 AARONS WAY BURLINGTON, NC 27217 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY)

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