Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
			A. BUILDING.				
		MHL0601572	B. WING		03/1	9/2025	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
MONAR	CH DBA UMAR-HALL		RMAL ROAI ITE, NC 282				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
V 000	INITIAL COMMEN	rs	V 000				
	An annual survey w 2025. Deficiencies	vas completed on March 19, were cited.					
	category: 10A NCA	sed for the following service C 27G .5600C Supervised h Developmental Disability.					
		sed for 6 and has a current urvey sample consisted of clients.					
V 118	27G .0209 (C) Med	ication Requirements	V 118				
	only be administered order of a person a drugs. (2) Medications shat clients only when a client's physician. (3) Medications, included administered only bunlicensed persons pharmacist or other privileged to prepare (4) A Medication Acall drugs administer current. Medication recorded immediate MAR is to include the (A) client's name; (B) name, strength, (C) instructions for (D) date and time the	inistration: non-prescription drugs shall ad to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be by licensed persons, or by trained by a registered nurse, legally qualified person and le and administer medications. Iministration Record (MAR) of red to each client must be kept s administered shall be lely after administration. The					

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL0601572	B. WING		03/	19/2025
MONARCH DBA UMAR-HALI			DRESS, CITY, S RMAL ROAD ITE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 118	(5) Client requests to checks shall be rec	for medication changes or orded and kept with the MAR appointment or consultation	V 118			
	Based on record reobservations, the famedications were a order of a physician current MAR of clie (#1 and #2). The fin Review on 3/19/25	views, interviews, and icility failed to ensure that dministered on the written and failed to maintain a ints prescribed medications idings are: of client #1's record revealed:				
	Depressive Disorder Disorder, and Inteller Disability, Severe well-Physician order da 10 milligrams (mg)(mouth once daily. Figland), take 1 tableter Physician order da (supplement), take daily; -Physician order da Multivitamin (supplement) once daily; -Physician order da 500mg (supplement) daily; -Physician order da 500mg (supplement)	al Anxiety Disorder, Major er, Obsessive Compulsive ectual Developmental ith exacerbation side effects; ted 8/14/24 for Alfuzosin ER prostate), take 1 tablet by inasteride 5mg (prostate to by mouth once daily; ted 9/4/24 for Reguloid 400mg 1 capsule by mouth once ted 7/21/23 for Centrum Silver ement), take 1 tablet by mouth ted 7/22/23 for Vitamin C to the tablet by mouth once ted 2/19/25 for Escitaloprame 1 tablet by mouth every				

Division of Health Service Regulation

STATE FORM 6899 Y99R11 If continuation sheet 2 of 7

DIVISION	of Health Service Re	guiation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILDING:		JOWIF LE I ED		
MHL0601572		B. WING		03/19/2025		
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MONARO	CH DBA UMAR-HALL	6426 THE	RMAL ROAD			
WONARG	CH DBA UMAK-HALL	CHARLO1	TE, NC 282	11		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 2	V 118			
	,	1 tablet by mouth once daily.				
	of client #1's medic	8/25 at approximately 1:16pm ations revealed: g was dispensed on 2/20/25				
	-Finasteride 5mg was dispensed on 2/20/25 for prostate gland; -Reguloid 400mg was dispensed on 2/20/25 for fiber supplement; -Centrum Silver Multivitamin was dispensed on 2/20/25 for supplement; -Vitamin C 500mg was dispensed on 2/20/25 for supplement;					
	for anxiety;	g was dispensed on 2/20/25 ium 7.5mg was dispensed on				
	2/20/25 for supplem					
	February 2025, and -Alfuzosin ER 10mg having been admini -Finasteride 5mg wheen administered	as not documented as having				
	been administered -Centrum Silver Mu as having been adm	on 1/5/25; Itivitamin was not documented ninistered on 1/5/25; vas not documented as having				
	-Escitalopram 20mç having been admini -L-Methyfolate Calc	g was not documented as stered on 1/5/25;				
	Review on 3/19/25	of client #2's record revealed:				

Division of Health Service Regulation

-Date of Admission: 7/16/22;

STATE FORM 6899 Y99R11 If continuation sheet 3 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		MHL0601572	B. WING		03/1	9/2025
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MONAR	CH DBA UMAR-HALL		RMAL ROAD TE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 118	-Diagnoses: Down Hyperactivity Disord Developmental Dis-Physician order da micrograms (mg)(a nostril daily. Pantop tablet by mouth dai-Physician order da (supplement), take-Physician order da (supplement), take-Physician order da Observation on 3/1 of client #2's medic-Fluticasone 50mcg for allergies; -Pantoprazole 40m for reflux; -Multivitamin was d supplement. Review on 3/18/25 February 2025, and -Fluticasone 50mcg having been admin-Pantoprazole 40m having been admin-Multivitamin was n been administered Interview on 3/18/2 -Staff gave him his day. I don't need ar Interview on 3/19/2 -Staff gave him his Interview on 3/19/2	Syndrome, Attention-Deficit, der, and Intellectual ability, Severe; ted 9/30/25 for Fluticasone 50 llergies), instill 1 spray in each prazole 40mg (reflux), take 1 ly; ted 3/22/24 for Multivitamin 1 tablet by mouth daily.; ted 8/25 @ approximately 1:45pm ations revealed: g was dispensed on 12/2024 g was dispensed on 3/20/25 ispensed on 3/20/25 for of MARs for January 2025, March 2025 revealed: g was not documented as istered on 2/17/25; g was not documented as istered on 2/17/25; ot documented as having on 2/17/25. 5 with client #1 revealed: medication, "ironically every my medication." 5 with client #2 revealed: medicine every day. 5 with Staff #2 revealed: g any medication errors within	V 118			

Division of Health Service Regulation STATE FORM

Y99R11 If continuation sheet 4 of 7

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER.		A. BUILDING:		COMP	LETED	
		MHL0601572	B. WING		03/1	9/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		6426 THE	RMAL ROAD			
MONAR	CH DBA UMAR-HALL		ΓΤΕ, NC 282			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
V 118	Continued From pa	ige 4	V 118			
	Interview on 3/19/2 Services revealed: -"Residential Mana Professional (QP), responsible for che -The RM, QP, and cross checking MA medications once r would also be responsible to get the -There was not a nearly in the responsible to the service of the service	ger (RM), Qualified and Team Leader (TL) were cking MARs;" TL would be responsible for Rs, physician orders, and monthly. RM, QP, and TL onsible for contacting the information corrected; urse assigned to the Hall taff and was available to The nursing staff did not visit				
V 736	-"I review the MAR: -"Some of her duties medications are ad MARs, medication, -She was aware of administration and time on site at the f -"I met with the pharm talk to the pharmac -The Licensee has position, "hopefully change in the admi	es aremaking sure ministered appropriately, and pharmacy;" some issues with medication she began spending more facility; armacy Director on 3/18/25. I hacy manager last month, and I	V 736			
v /30	10A NCAC 27G .03 EXTERIOR REQU (c) Each facility and	303 LOCATION AND	V 730			

Division of Health Service Regulation

STATE FORM 6899 Y99R11 If continuation sheet 5 of 7

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	MHL0601572		B. WING		03/19/2025	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MONAR	CH DBA UMAR-HALL		RMAL ROAD			
(V4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
V 736	Continued From pa	ge 5	V 736			
	manner and shall b odor.	e kept free from offensive				
	This Rule is not met as evidenced by: Based on observations and interviews, the facility was not maintained in a clean, attractive, and orderly manner affecting clients (#1, #2, #3, #4, #5, and #6). The findings are:					
	Observation on 3/14/25 and 3/18/25 at approximately 1:10pm and 2:28pm revealed: Hallway (right) Bathroom: -The countertop surface had discolored and had two different textures; -The tub basin was stained black.					
	Hallway (left) Bathroom: -The walls had black growth at the top surrounding the shower and above the mirror; -The paint was peeling to the right of the door frame.					
	Hallway (left): Bedroom #1 -The mattress was the bed.	sunken in, on the left side of				
	Bedroom #3 -The blinds had 3 to bottom.	o 4 broken blades at the				
		e in the back yard, had a hole approximately 10 x 5				
	Interview on 3/18/25 with client's #1, #2, and #3 revealed:					

6899

Division of Health Service Regulation STATE FORM

Y99R11 If continuation sheet 6 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			SURVEY PLETED	
		MHL0601572	B. WING		03/	19/2025
MONARCH DRA LIMAR-HALL 6426 THEI			ORESS, CITY, S RMAL ROAL TE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
V 736	-They were unawar the facility; Interview on 3/14/2! -The mattress in be sunken in because playing video game -The blind in bedroc couple of months; -He was unsure of I been that way; -The bridge had bed Interview on 3/19/2! revealed: -"I was unaware of facility;" -"I recently noticed thonestly could not a	e of the maintenance needs in 5 with staff #2 revealed: droom #1 was that was the client sat on the bed while s; om #3 had been that way for a now long the bathrooms had en that way, at least a month. 5 with the Residential Director any maintenance needs in the the bridge that way and I answer the question;" submitted on 3/17/25 for	V 736			

6899

Division of Health Service Regulation STATE FORM

Y99R11 If continuation sheet 7 of 7