STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL055-134	A. BUILDING: _____ B. WING _____	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-PITZER	200 WELLINGTON DRIVE LINCOLNTON, NC 28092

(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 survey was completed on 5/21/25. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. The facility is licensed for 6 and has a current census of 6. The survey sample consisted of an audit 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		

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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 record reviews, interviews and observation, the facility failed to ensure medications were administered on the written order of a physician and failed to keep the MAR current affecting 2 of 3 clients (#1,#3). Review on 5/21/25 of Client #1's record revealed: -Date of admission: 3/12/04. -Diagnoses: Impulse Control Disorder, Moderate Intellectual Developmental Disability (IDD), Speech Disturbance, Dyslipidemia. -Physician's order dated 8/30/24 included: -Ocusoft lid scrub pad- use on both eye lids once daily. Review on 5/21/25 of MARs 3/1/25-5/21/25 for Client #1 revealed: -Ocusoft was not documented as administered 4/1/25-5/21/25. (51 doses) Review on 5/21/25 of Client #3's record revealed: -Date of admission: 12/29/15. -Diagnoses: Delusional Disorder, Severe IDD, Type II diabetes, Hypertension, Anemia, Essential Tremor, Gastroesophageal Reflux, Vitamin D Deficiency. -Physician's orders included: -Lisinopril 10milligram (mg) (hypertension) - 1	V 118		

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V 118	Continued From page 2	V 118		

tablet (tab) daily ordered 9/23/24; order on 3/31/25 increased to 20mg tab daily.
-Haloperidol 1mg (anti-psychotic) - 1 tab daily at bedtime ordered 9/6/24; order on 3/31/25 decreased to ½ tab daily at bedtime.
-There was no physician's order for multivitamin.

Review on 5/21/25 of MARs 3/1/25-5/21/25 for Client #3 revealed:
-Lisinopril 10mg was documented as administered 4/1/25-4/30/25. (30 doses)
-Haloperidol "take 1 tab" was printed on the April MAR however "(0.5mg) Dr changed" and "1/2" was handwritten in the haloperidol section. Haloperidol was documented as administered 4/2-4/30/25 although there was no additional documentation to indicated if 1 tab or ½ tab was administered.
-Multivitamin was documented at administered on 4/16/25, 4/17/25, 4/29/25, 4/30/25, 5/1-5/21/25. (25 doses)

Observation on 5/21/25 at approximately 10am of Client #1's medication revealed 1 box of Ocusoft lid scrub (box of 30 individually wrapped pads) with the top of the box removed and was about ¾ full. The pharmacy label revealed this medication was dispensed on 5/7/25.
Additional observation of Client #3's medication revealed 1 blister pack card for Lisinopril 20mg, Haloperidol 1mg blister pack card with ½ tabs in each bubble and 1 blister pack card of multivitamin, all dispensed on 5/15/25.

Interview on 5/21/25 with Client #1 revealed:
-Responded "yes" when asked if staff wiped his eyes with a pad every morning.

Interview on 5/21/25 with Client #3 revealed:
-He was administered medications but didn't

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V 118	Continued From page 3 know the names. Interview on 5/21/25 with the licensee's contracted pharmacy revealed: -Client #3's Lisinopril 20mg was received on 3/31/25 and a 17-day supply was dispensed on 3/31/25. -Client #3's Haloperidol ½ tab of 1mg order was received on 3/31/25. A 17-day supply was dispensed on 4/1/25. It was dispensed again with cycle medications on 4/12/25 and 5/8/25. -Initial order for Client #3's multivitamin was received on 4/11/25. On 4/12/24, a 5-day supply was dispensed which was the remainder of a previous prescription. On 4/25/25, a 20-day supply was dispensed to get the medication caught up with the cycle refills. Interview on 5/21/25 with the Residential Manager revealed: -"Our nurse was just here to review ..." -"Staff should have called me to say they have meds (medications) but no script (prescription) for it." -"A new section on the MAR should have been created to show the change in dosages." -Staff had been in facility longer than she had been manager and there were still some communication issues. She would be addressing this. Interview on 4/24/25 with the Residential Director/Qualified Professional (QP) revealed: -Had been acting QP since November 2024. -He was in the houses weekly but always available. -The facility did not have direct nursing oversight but "nurse could come at my request." -The residential manager was responsible for medications, orders and MARs.	V 118		

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V 118	Continued From page 4 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		
V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to obtain a pharmacist's or physician's review of medications every 6 months for 1 of 3 audited clients (#3). The findings are: Review on 5/21/25 of Client #3's record revealed: -Date of admission: 12/29/15. -Diagnoses: Delusional Disorder, Severe IDD, Type II diabetes, Hypertension, Anemia, Essential Tremor, Gastroesophageal Reflux, Vitamin D Deficiency.	V 121		

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V 121	Continued From page 5 -Physician ordered medications: -Sertraline 100milligram (mg) (depression) - 1 tablet (tab) daily at bedtime ordered 3/20/24. -Haloperidol 1mg (anti-psychotic) - 1 tab daily at bedtime ordered 9/6/24; order on 3/31/25 decreased to ½ tab daily at bedtime. -The last drug review was completed on 2/3/23. There was no documentation to indicate a pharmacist or physician had provided a 6 month review of medications for Client #3. Interview on 5/21/25 with the Residential Director/Qualified Professional revealed: -Their pharmacy "looked at the medications either virtually or come out" (to the facility). -Not sure when this facility last had a review ..."probably had one but don't have the copy (of the review)."	V 121		