PRINTED: 07/23/2025 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
		A. BOILDING			
		MHL036-400	B. WING		R 07/18/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE	·
		1482 HO	FFMAN ROAD	12, 211 3332	
MONARC	H DBA UMAR-HOFFMAN		IIA, NC 28054		
(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 CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODERICIENCY)	JLD BE COMPLETE
V 000	INITIAL COMMENTS		V 000		
	on 7-18-25. Deficient This facility is license category: 10A NCAC Living For Adults With This facility is license census of 6. The sur audits of 4 current clic A sister facility is iden sister facility will be identification.	d for the following service 27G .5600C Supervised n Developmental Disability. d for 6 and has a current vey sample consisted of			
V 118	facility and a numeric 27G .0209 (C) Medica	al identifier.	V 118		
	only be administered order of a person autidrugs. (2) Medications shall clients only when auticlient's physician. (3) Medications, incluadministered only by unlicensed persons transfer or other learning privileged to prepare (4) A Medication Admall drugs administered current. Medications	istration: n-prescription drugs shall to a client on the written horized by law to prescribe be self-administered by horized in writing by the ding injections, shall be licensed persons, or by rained by a registered nurse, egally qualified person and and administer medications. hinistration Record (MAR) of d to each client must be kept administered shall be y after administration. The			

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED	
AND FLAN OF CORRECTION IDENTIFICATION NUMBER.		A. BUILDING: _		COMPLETED	
		MHL036-400	B. WING		R 07/18/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MONARC	H DBA UMAR-HOFFMAN		MAN ROAD		
		GASTONIA	NC 28054		T
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 118	(C) instructions for ac (D) date and time the (E) name or initials of drug. (5) Client requests for checks shall be recor	nd quantity of the drug;	V 118		
	This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure medications were administered on the written order of a physian affecting 2 of 4 audited clients (client #1 and #4). The findings are: Review on 7-8-25 and 7-10-25 of client #1's record revealed: -Date of admission: 2-19-16Diagnoses: Mild Intellectual Developmental Disability (IDD); Manic Episodes with psychotic symptoms, unspecified; Cerebral PalsyPhysicians' order dated 9-6-24 and updated 7-10-25 for Alclometasone (corticosteroid for skin conditions) 0.05% cream: apply to affected areas on face, ears and neck twice a day three days a week. Review on 7-8-25 of client #1's MARs for April 1, 2025 to July 8, 2025 revealed Alclometasone				
	_	day from June 1, 2025 to			

Division of Health Service Regulation

STATE FORM 6899 M19O11 If continuation sheet 2 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL036-400	B. WING		0	R 7/18/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
MONARC	H DBA UMAR-HOFFMAN		FFMAN ROAD			
(VA) ID	SLIMMADY ST	ATEMENT OF DEFICIENCIES	IIA, NC 28054	PROVIDER'S PLAN OF CO	OPPECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From page	2	V 118			
	-Date of admission: 7 -Diagnoses: Mild IDD Bi-Polar Type. -Physicians' order da (fungal infection) 100	f client #4's record revealed: -24-24. ; Schizoaffective Disorder, ted 9-4-24 for Nystatin ,00 unit/gram topical cream: a(s) by topical route two				
	July 10, 2025 reveale	MARs for April 1, 2025 to d no documentation of statin from June 1, 2025 to				
	for April 1, 2025 to Ju reports for June 1, 20 documenting missed	the facility incident reports ly 8, 2025 revealed incident 25 through June 9, 2025 administration of client #4's 2025 to June 9, 2025 due at of the medication.				
	-"Yeah I take a lot of I of different creams ar and back for my skin. (medications) on diffe	with client #1 revealed: medicines. I take a couple nd ointments for my face I take different ones erent days. I'm not sure ave to ask staff what I get."				
		on 7-14-25 with client #4 was t #4 was quarantined due to				
	-"I don't know why sh (Alclometasone) ever been a new order cha record]. I can't find a					

Division of Health Service Regulation

STATE FORM 6899 M19O11 If continuation sheet 3 of 7

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-400	B. WING	B. WING		
					1 07	//18/2025
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
MONARC	H DBA UMAR-HOFFMAN		FFMAN ROAD			
	T		IA, NC 28054			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From page	e 3	V 118			
	-"I don't know why it o order. I have no idea. -The HM is responsib	with staff #4 revealed: changed. I don't see a new " le for making sure the updated and that MARs are				
	-The HM or staff #3 a physicians' orders an MARsConducts medication med closet for expiremeds administered a -"If I don't do it (obtain update the MARs) mydoes it (obtain orders -"Usually one of the sin the monthly batch assigned to a specific time third shift will do do it if they (staff) has shift duty but she will particular shift is respitime to do it." -"No, she does not go accuracy of the medichecking now."	ns physicians' orders and y first shift staff (staff #3) and update MARs)." taff on third or first will sign meds (medications). It's not e shift you know, most of the it, sometimes first shift will be time to do it. It's not a first do it if she has time. So no onsible, just whoever has behind staff to check cations. "But I guess I'll start				
	Alclometasone twice wasn't aware of that. happened, I'll have to her doctor changed tl -Staff notified the HM out of medication (Ny pharmacy for a refill the H4 did not have any results.)	check her record to see if				

Division of Health Service Regulation

STATE FORM 6899 M19O11 If continuation sheet 4 of 7

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL036-400	B. WING		R 07/18/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
MONARC	LI DDA IIMAD LICEMANI	1482 HOFF	MAN ROAD			
WIONARC	H DBA UMAR-HOFFMAN	GASTONIA	A, NC 28054			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 118	Continued From page	· 4	V 118			
	-"When I was notified I, immediately called the pharmacy, then the doctor to try to get the refill. Her (client #4) doctor was out of the office and we couldn't get her in to see the on call doctor." -"Yeah staff should have caught it before she ran out."					
	Interview o 7-10-25 and 7-17-25 with the Residential Director revealed: -It is the HM's responsibility to monitor the medications administration process"She (HM) is suppose to be doing medication audits weekly. There is a check off form that she is suppose to use and check off that the audits are happening." -"[Client #4's] Nystatin, that should have been ordered before the medication ran out. That should have been caught (discrepancy in administration of client #1's Alclometasone cream), that should not have happened."					
V 291	six clients when the c developmental disabil on June 15, 2001, and than six clients at that provide services at no licensed capacity. (b) Service Coordinal maintained between t qualified professionals treatment/habilitation (c) Participation of the Responsible Person. provided the opporture	B OPERATIONS ty shall serve no more than lients have mental illness or lities. Any facility licensed d providing services to more time, may continue to more than the facility's lion. Coordination shall be the facility operator and the swho are responsible for or case management. e Family or Legally	V 291			

Division of Health Service Regulation

STATE FORM 6899 M19O11 If continuation sheet 5 of 7

PRINTED: 07/23/2025 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		A. BOILDING.			_		
		MHL036-400	B. WING			R 18/2025	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE ZIP CODE	, ,,,		
TVAIVIL OF T	NOVIDEN ON GOIT EIEN		FFMAN ROAD	IL, ZII OODL			
MONARC	H DBA UMAR-HOFFMAN		IIA, NC 28054				
0(1) 15	QUIMMADV QT		·	PROVIDER'S PLAN	I OE COPPECTION	0/5)	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE	
V 291	291 Continued From page 5		V 291				
	means as visits to the	e facility and visits outside					
		shall be submitted at least					
	annually to the paren	t of a minor resident, or the					
		erson of an adult resident.					
	1 .	riting or take the form of a					
	conference and shall						
	progress toward mee	s. Each client shall have					
	, ,						
	activity opportunities based on her/his choices, needs and the treatment/habilitation plan.						
		signed to foster community					
		nay be limited when the court					
	or legal system is inv	olved or when health or					
	safety issues become a primary concern.						
	This Rule is not met	as evidenced by:					
		ew and interviews, the					
	facility failed to ensur	e that no more than 6 clients					
	were being served at	the facility. The findings					
	are:						
	Poviow on 7.9.25 of	facility records revealed:					
	-The facility was licer						
	- The lacinty was need	isca for o chefits.					
	Interview on 7-14-25	with staff #3 revealed:					
	-Client A #11 from sis	ter facility A came to the					
		gh Friday from approximately					
8:30am to 3pm because sister facility A did not have enough staff after 10am to be in ratio.							
	-"One of [sister facility A's)] staff leaves (shift						
	-	nat puts them out of ratio					
		So [A #1] comes over here					
	(facility) during the da						
	-	om sister facility A) at [day					
		ning transport and I pick her					
(A #1) up from the day program then she rides with 2nd shift (staff) in the afternoon when they do							

Division of Health Service Regulation

STATE FORM 6899 M19O11 If continuation sheet 6 of 7

PRINTED: 07/23/2025 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MUU 020 400	B. WING		R
		MHL036-400	B. WIII 0		07/18/2025
NAME OF P	ROVIDER OR SUPPLIER		ORESS, CITY, STA	TE, ZIP CODE	
MONARC	H DBA UMAR-HOFFMAN		MAN ROAD A, NC 28054		
(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 SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
V 291	Continued From page	÷ 6	V 291		
	A]"We come back here watch her make sure sometimes we go out	nd she goes back to [facility (Hoffman), I supervise her, she is safe. Give her lunch, in the community, she with [client #2] and [client			
	revealed: -"She's (A #1) has be (facility) for a couple of the exact day she sta	with the Home Manager en coming over here of months. I'm not sure of rted coming. I think it has to acility A) being out of ratio."			
	revealed: -"Ratio is only part of comes over. She (A in (Hoffman)). We asked (Hoffman during the coguardian and her care with her coming to Hoguardian wanted to mactive and the resider	her and she agreed to it			

Division of Health Service Regulation

STATE FORM 6899 M19O11 If continuation sheet 7 of 7