Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED	
		MHL060-402	B. WING		R-C 09/15/202	!5
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
COMMON	WEALTH GROUP HOME	3601 COM	MONWEALTH	AVENUE		
COMMON	WEALTH GROOF HOME	CHARLOT	ΓE, NC 28205			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		BE CON	(X5) MPLETE DATE
V 000	A complaint and follow up survey was completed on 9/15/25. The complaint was unsubstantiated (intake #NC00233017). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.		V 000			
		d for 6 and has a current rey sample consisted of ents.				
V 108	27G .0202 (F-I) Perso	onnel Requirements	V 108			
	V 108 27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross,					

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

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL060-402	B. WING		R- 09/1	C 5/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
COMMON	WEALTH GROUP HOME		MONWEALTH A	AVENUE		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 108	(i) The governing bod implement policies and reporting, investigating and communicable disclients. This Rule is not metabased on record reviet failed to provide training needs of the clients at (#1). The findings are Review on 9/11/25 of revealed: -Hire date of 8/30/22Job title of Lead Resenvo documentation of needs training. Interview on 9/2/25 well-review on 9/15/25 well-review o	ing airway obstruction. Ity shall develop and d procedures for identifying, g and controlling infectious seases of personnel and as evidenced by: ew and interview, the facility ing to meet the MH/DD/SA ffecting 1 of 3 audited staff : Staff #1's personnel file Idential Service Provider. I client specific MH/DD/SA Ith Staff #1 revealed: I det training. With the Group Home ofessional revealed: I facility on 7/1/25. I had not received client eeds training. I facilier through the cracks'' I fired after previously working	V 108			
	This deficiency consti	tutes a re-cited deficiency				

Division of Health Service Regulation

STATE FORM 6899 F0T211 If continuation sheet 2 of 16

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		MHL060-402	B. WING		09/15/2025
		141112000-402	1		03/13/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
COMMON	WEALTH GROUP HOME		MONWEALTH	AVENUE	
		CHARLOT	TE, NC 28205		
(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 APPROPF DEFICIENCY)	BE COMPLETE
V 108	Continued From page	2	V 108		
	and must be correcte	d within 30 days.			
V 118	27G .0209 (C) Medica	ation Requirements	V 118		
	10A NCAC 27G .0209	9 MEDICATION			
	REQUIREMENTS (c) Medication admini	istration:			
	• ,	n-prescription drugs shall			
		to a client on the written			
		horized by law to prescribe			
	drugs.				
		be self-administered by			
	-	horized in writing by the			
	client's physician.	ding injections, shall be			
		licensed persons, or by			
		rained by a registered nurse,			
		egally qualified person and			
		and administer medications.			
		inistration Record (MAR) of			
	current. Medications	d to each client must be kept			
		administered shall be after administration. The			
	MAR is to include the				
	(A) client's name;	•			
		nd quantity of the drug;			
	(C) instructions for ad	O O ,			
		drug is administered; and			
	(E) name or initials of drug.	person administering the			
	•	r medication changes or			
		ded and kept with the MAR			
		pointment or consultation			
	with a physician.				

Division of Health Service Regulation

STATE FORM 6899 F0T211 If continuation sheet 3 of 16

Division of Health Service Regulation

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: _		COMPLETE	.0
			B. WING		R-C	
		MHL060-402	B. WING		09/15/2	2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
COMMON	WEALTH GROUP HOME		MONWEALTH .	AVENUE		
		CHARLOT	TE, NC 28205	-		
(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 APPROPF DEFICIENCY)	BE 0	(X5) COMPLETE DATE
V 118	18 Continued From page 3		V 118			
	Continued From page 3					
	interviews, the facility Medication Administra drugs administered to current and medicatio ordered affecting 2 of findings are:	iew, observations and failed to ensure a ation Record (MAR) of all				
	-Admission date of 8/Diagnoses of Mild Info Disability, Generalized Intermittent Explosive Hyperactive Disorder, Obstructive Pulmonar -Physician's orders for -9/18/24 Azelasti one spray into each in 8pm9/18/24 Budeson Suspension Inhale on daily at 8am and 8pm -9/18/25 Bupropidisabilities)150mg Talevery morning at 8am -9/18/25 Fluvoxa 1000mg Take one tab 8pm9/18/24 Hydroxy	tellectual Developmental d Anxiety Disorder, Disorder, Attention Deficit Cerebral Palsy, Chronic Disease (COPD). In the following medications: The following medications: The (allergies) 0.1% Spray Costril twice daily at 8am and Chide (COPD) 0.5mg/2ml Dise vial via nebulizer twice Discontinuity.				
	8pm9/18/24 Loratadi tablet by mouth every -12/18/24 Methin Take one tablet by mo -1/29/25 Metopro	ine (allergies)10mg Take one				

Division of Health Service Regulation

STATE FORM 6899 F0T211 If continuation sheet 4 of 16

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		MHL060-402	B. WING	B. WING		R-C / /15/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	•	
		3601 COM	MONWEALTH A	AVENUE		
COMMON	WEALTH GROUP HOME	CHARLO	TTE, NC 28205			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From page	e 4	V 118			
	8am. -9/18/24 Montelu one tablet by mouth a -9/18/24 Multivita Take one tablet by m -9/18/24 Oxcarba 300mg Take one table at 8am. Take two table at 8am. Take two table -9/18/24 Prazosi Take one tablet by m -9/18/24 Trazodo 500mg Take one table 8pm9/18/24 Ziprasic one capsule by moute 5pm with foodZovia (birth contents) Review on 9/11/25 of 7/1/25 to 9/9/25 revea	akast (COPD) 10mg Take at bedtime at 8pm. amin (nutritional supplement) buth every morning at 7am. azepine (mood stabilizer) et by mouth every morning ets every evening at 8pm. In (intellectual disability) 2mg buth at bedtime at 8pm. In en (intellectual disability) et by mouth at bedtime at 8pm. In en (intellectual disability) et by mouth at bedtime at 8pm. In (intellectual disability) et by mouth at bedtime at 8pm. In (intellectual disability) et by mouth at bedtime at 8pm. In (intellectual disability) et by mouth at bedtime at 8pm. In (intellectual disability) et by mouth at bedtime at 8pm. In (intellectual disability) et by mouth at bedtime at 8pm. In (intellectual disability) et by mouth at bedtime at 8pm. In (intellectual disability) et by mouth at bedtime at 8pm. In (intellectual disability) et by mouth at bedtime at 8pm. In (intellectual disability) et by mouth at bedtime at 8pm. In (intellectual disability) et by mouth at bedtime at 8pm. In (intellectual disability) et by mouth at bedtime at 8pm. In (intellectual disability) et by mouth at bedtime at 8pm. In (intellectual disability) et by mouth at bedtime at 8pm. In (intellectual disability) et by mouth at bedtime at 8pm. In (intellectual disability) et by mouth at bedtime at 8pm. In (intellectual disability) et by mouth at bedtime at 8pm. In (intellectual disability) et by mouth at 8pm.				
	dates:	(137 MCG) Spray on 7/1/25 in and 8pm, 7/5/25 at 8am am, 8/9/25 at 8am, 8/10/25 im, 8/15/25 at 8am, 8/29/25 im, 8/31/25 at 8pm, 9/1/25 at at 8am and 8pm. img/2ml Suspension on at 8am and 8pm, 7/5/25 at at 8am, 8/9/25 at 8am, 25 at 8am, 8/15/25 at 8am, 25 at 8pm, 8/31/25 at 8pm,				

Division of Health Service Regulation

STATE FORM 6899 If continuation sheet 5 of 16 F0T211

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R-C	
		MHL060-402	B. WING		09/15/2025	5
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		3601 COM	IMONWEALTH	AVENUE		
COMMON	WEALTH GROUP HOME		TTE, NC 28205			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTION	ON (V	(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE COMF	PLETE TE
V 118	Continued From page	e 5	V 118			
	0nm					
	8pm.	moate 25mg on 7/4/25 at				
	• •	8/30/25 at 8pm, 8/31/25 at				
	8pm.	0/30/23 at opin, 0/3 1/23 at				
	•	g on 7/4/25 at 7am and				
		at 7am, 8/9/25 at 7am,				
		25 at 7am, 8/15/25 at 7am,				
	9/1/25 7am.	, _, .,,				
	-Methimazole 5m	ng on 7/4/25 at 8am and				
	7/5/25 at 8am, 8/8/25 at 8am, 8/9/25 at 8am,					
	8/10/25 at 8am, 8/13/	/25 at 8am, 8/15/25 at 8am,				
	9/1/25 8am.					
	-Metoprolol 25mg	g on 7/4/25 at 8am and				
		at 8am, 8/9/25 at 8am,				
		25 at 8am, 8/15/25 at 8am,				
	9/1/25 8am.					
		ng on 7/4/25 at 8pm, 8/29/25				
	at 8pm, 8/30/25 at 8p	•				
		7/4/25 at 7am and 7/5/25 at				
		8/9/25 at 7am, 8/10/25 at 8/15/25 at 7am, 9/1/25 at				
	7am.	0/13/23 at 7am, 9/1/23 at				
		300mg on 7/1/25 at 8am,				
	•	m, 7/5/25 at 8am, 8/8/25 at				
		8/10/25 at 8am, 8/13/25 at				
		8/29/25 at 8pm, 8/30/25 at				
	8pm, 8/31/25 at 8pm,	•				
	-Prazosin 2mg o	n 7/4/25 at 8pm, 8/29/25 at				
	8pm, 8/30/25 at 8pm,	8/31/25 at 8pm.				
		ng on 7/4/25 at 8pm, 8/29/25				
	at 8pm, 8/30/25 at 8p					
		7/4/25 at 7am, 7/5/25 at 7am,				
		at 7am, 8/10/25 at 7am,				
		25 at 7am, 9/1/25 7am.				
	•	7/3/25 at 5pm, 7/4/25 at 8am				
	•	am and 5pm, 8/8/25 at 8am,				
	·	5 at 8am, 8/13/25 at 8am				
	and 5pm, 8/15/25 at 8					
		at 7am, 8/9/25 at 7am,				
	o/ 10/25 at /am, 8/13/	25 at 7am, 8/15/25 at 7am,				

Division of Health Service Regulation

STATE FORM 6899 F0T211 If continuation sheet 6 of 16

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			, 551EBII10		R-C	
		MHL060-402	B. WING		09/15/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
COMMON	WEALTH GROUP HOME		MMONWEALTH A	AVENUE		
(V4) ID	OUR MADY STATEMENT OF REFIGIENCES			PROVIDER'S PLAN OF CORRECTION	M (VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 118	Continued From page	e 6	V 118			
	9/1/25 at 7am.					
	Review on 9/5/25 of 0	Client #2's record revealed:				
	-Admission date of 5/					
	 Diagnoses of Modera Developmental Disab 					
	Epilepsy.	ility, Gerebrai Paisy,				
	-Physician's order for the following medications:					
		ycin (dermatitis) 1-5% Apply				
	to the affected areas topically every day9/19/24 Eucerin Advanced Repair Cream					
	(xerosis) Apply to the					
	morning at 8am.	ortisone (dermatitis) 2.5%				
		ffected areas twice daily at				
	8am and 8pm.	•				
		nazole (dermatitis) 2%				
	at 8am.	ffected areas every morning				
		nide (epilepsy) 100mg Take				
	•	wice daily at 8am and 8pm.				
		nin HCL (diabetes) 500mg outh every day at 7pm.				
	-12/30/24 Pravas	statin Sodium (cholesterol)				
	-	by mouth every day at				
	8am. -9/19/24 Vitamin	D3 (nutritional supplement)				
		apsule by mouth every day				
	at 8am.					
		Client #2's MARs from				
	7/1/25 to 9/9/25 reveal- -There were no staff i	aled: nitials for the following				
	dates:					
	_	% 7/1/25-7/31/25 at 8pm,				
	8/1/25-8/10/25 at 8am at 8pm.	n , 8/19/25 at 8pm, 8/31/25				

Division of Health Service Regulation

-Eucerin Advanced Repair Cream on 7/1/25

STATE FORM 6899 F0T211 If continuation sheet 7 of 16

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: _		COMPLE	IED
			D WING		R-0	
		MHL060-402	B. WING		09/1	5/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
COMMON	WEALTH GROUP HOME		MONWEALTH A	AVENUE		
			TE, NC 28205			
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	Continued From page	e 7	V 118			
V 118	at 8am, 8/5/25 at 8am, 8am, 8/10/25 at 8am, 8/3/25 at 8am, 8/3/25 at 8am, 8/9/25 at 8am, 8/9/25 at 8am, 8/9/25 at 8am, 8/9/25 at 8am, 8/15/25 at 8am, 8/10/2 8/9/25 at 8am, 8/10/2 8/15/25 at 8am, 8/10/2 8/15/25 at 8am, 8/13/3 -Lacosamide 100/8/10/25 at 8am, 8/13/8/19/25 at 8pm and 8/31/25 at 7pm. -Pravastatin Sod 8/10/25 at 8am, 8/13/3 -Vitamin D3 2000/at 8am, 8/13/25 at 8am Observation on 9/11/2 medications in the factory of the system of 11/2 which is the factory of 11/2 w	n, 8/8/25 at 8am, 8/9/25 at 8/13/25 at 8am, 8/15/25 at 8/24/25 at 8am. 2.5% Cream on 7/1/25 at 8/10/25 at 8/10/25 at 8am, 8/13/25 at 8/19/25 at 8pm, 8/31/25 at 8/19/25 at 8am, 8/13/25 at 8am, 8/13/25 at 8am, 25 at 8am. 25 at 8am. 25 at 8am. 25 at 8am, 8/15/25 at 8am, 25 at 8am, 8/15/25 at 8am, 8/15/25 at 8am, 25 at 8am, 8/15/25 at 8am, 20 unit 8/9/25 at 8am, 8/15/25 at 8am. 20 unit 8/9/25 at 8am. 25 at 8am, 8/15/25 at 8am. 20 unit 8/9/25 at 8am. 25 at 8am, 8/15/25 at 8am.	V 118			
	take it home."	,				
	Interview on 9/2/25 with Client #2 revealed: -Denied missing any medications.					
	staff were signing off.	ns and made sure that all				
		with Staff #3 revealed: given, staff forgot to sign				

Division of Health Service Regulation

STATE FORM 6899 F0T211 If continuation sheet 8 of 16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' ·	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		MHL060-402	B. WING	B. WING		
	ROVIDER OR SUPPLIER WEALTH GROUP HOME	3601 CO	DDRESS, CITY, STATE MMONWEALTH AV			
(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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 118	client was "out of faci-On 9/11/25 Client #2 Cream, so applied European,	not put on the MAR that the lity" when on a home visit. was out of Ketoconazole ocerin Cream instead. with Staff #6 revealed: nister medications. y missed medications. with the Qualified literating on the MAR anks when clients went on ling "med unavailable" when medication. In August 2025 and had MARs. rained to complete the MAR ms for Client #2 with his ccurately document ation, it could not be eccived their medications visician. tutes a re-cited deficiency	V 118			
V 123		•	V 123			

Division of Health Service Regulation

STATE FORM 6899 F0T211 If continuation sheet 9 of 16

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			_
		MHL060-402	B. WING		I	R-C / 15/2025
NAME OF D			DDDEGG OITY OTA	TE 7/D 000F	1 00.	10.2020
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	,		
COMMON	WEALTH GROUP HOME		MMONWEALTH A OTTE, NC 28205	AVENUE		
0/0.15	STIMMADA ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRI	ECTION	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SECROSS-REFERENCED TO THE API	IOULD BE	(X5) COMPLETE DATE
V 123	Continued From page	9	V 123			
	and the drug reaction	to a physician or of the drug administered shall be properly recorded client's refusal of a drug				
	This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure all medication administration errors were immediately reported to a pharmacist or physician affecting 2 of 3 audited clients (#1 and #2). The findings are:					
	-Admission date of 8/ -Diagnoses of Mild In Disability, Generalize Intermittent Explosive Hyperactive Disorder Obstructive Pulmonal -Physician's orders for -9/18/24 Azelasti one spray into each in 8pm9/18/24 Budeso Suspension Inhale or daily at 8am and 8pm -9/18/25 Bupropi disabilities)150mg Ta every morning at 8am -9/18/25 Fluvoxa	tellectual Developmental d Anxiety Disorder, e Disorder, Attention Deficit , Cerebral Palsy, Chronic ry Disease (COPD). or the following medications: ne (allergies) 0.1% Spray nostril twice daily at 8am and nide (COPD) 0.5mg/2ml ne vial via nebulizer twice on (intellectual ke one tablet by mouth				
	8pm.	zine Pamoate (intellectual				

Division of Health Service Regulation

STATE FORM 6899 F0T211 If continuation sheet 10 of 16

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		1 ' '	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		MHL060-402	B. WING			R-C / 15/2025
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	, 50	. 10,2020
			MONWEALTH A	,		
COMMON	WEALTH GROUP HOME		TE, NC 28205	AVENOE		
	0.11.11.12.77.07				200000000000000000000000000000000000000	
(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 ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 123	Continued From page	e 10	V 123			
	8pm9/18/24 Loratad tablet by mouth every -12/18/24 Methin Take one tablet by mo -1/29/25 Metopro Take one-half tablet b	te one capsule every day at ine (allergies)10mg Take one day at 7am. nazole (hypothyroidism) 5mg buth every morning at 8am blol (sinus tachycardia) 25mg by mouth every morning at				
	8am. -9/18/24 Montelukast (COPD) 10mg Take one tablet by mouth at bedtime at 8pm. -9/18/24 Multivitamin (nutritional supplement) Take one tablet by mouth every morning at 7am. -9/18/24 Oxcarbazepine (mood stabilizer) 300mg Take one tablet by mouth every morning at 8am. Take two tablets every evening at 8pm. -9/18/24 Prazosin (intellectual disability) 2mg Take one tablet by mouth at bedtime at 8pm. -9/18/24 Trazodone (intellectual disability) 500mg Take one tablet by mouth at bedtime at					
	one capsule by moutl 5pm with food.	lone (anxiety) 600 mg Take n twice daily at 8am and trol) 1-35: no order present.				
	Review on 9/11/25 of 7/1/25 to 9/9/25 revealunce -There were no staff i dates:	Client #1's MARs from				
	at 8am, 7/4/25 at 8an and 8pm, 8/8/25 at 8a at 8am, 8/13/25 at 8a at 8pm, 8/30/25 at 8p 8am and 8pm, 9/2/25 -Budesonide 0.5 7/1/25 at 8am, 7/4/25 8am and 8pm, 8/8/25	n and 8pm, 7/5/25 at 8am am, 8/9/25 at 8am, 8/10/25 m, 8/15/25 at 8am, 8/29/25 m, 8/31/25 at 8pm, 9/1/25 at				

Division of Health Service Regulation

STATE FORM 6899 If continuation sheet 11 of 16 F0T211

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					X3) DATE SURVEY COMPLETED	
ANDILAN	OF CONNECTION	IDENTIFICATION NOWBER.	A. BUILDING:		COM	LETED
						R-C
		MHL060-402	B. WING		09	/15/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE	E. ZIP CODE		
			MONWEALTH A			
COMMON	WEALTH GROUP HOME		TTE, NC 28205	VENUE		
()(1) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CO	APPECTION .	(V5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 123	Continued From page	÷ 11	V 123			
V 123	8/29/25 at 8pm, 8/30/9/1/25 at 8am, 9/7/25 -Bupropion HCL 7/5/25 at 8am, 8/8/25 8/10/25 at 8am, 8/13/9/1/25 8amFluvoxamine Ma 8pm, 8/29/25 at 8pm, 8pmHydroxyzine Pal 8am, 8/29/25 at 8pm, 8pmLoratadine 10m, 7/5/25 at 7am, 8/8/25 8/10/25 at 7am, 8/13/9/1/25 7amMethimazole 5m 7/5/25 at 8am, 8/8/25 8/10/25 at 8am, 8/3/9/1/25 8amMontelukast 10r at 8pm, 8/30/25 at 8p -Multivitamin on 7am, 8/8/25 at 7am, 8/8/25	25 at 8pm, 8/31/25 at 8pm, at 8am. 150mg on 7/4/25 at 8am, at 8am, 8/9/25 at 8am, 25 at 8am, 8/15/25 at 8am, 26 at 8am, 8/15/25 at 8am, 27 at 8am, 8/15/25 at 8am, 28 at 8/30/25 at 8pm, 8/31/25 at 8/30/25 at 7am and at 7am, 8/9/25 at 7am, 25 at 7am, 8/15/25 at 7am, 25 at 8am, 8/15/25 at 8am, 25 at 8am, 8/15/25 at 8am, 25 at 8am, 8/9/25 at 8am, 25 at 8am, 8/15/25 at 8	V 123			
	-Oxcarbazepine 7/4/25 at 8am and 8p 8am, 8/9/25 at 8am, 8 8am, 8/15/25 at 8am, 8pm, 8/31/25 at 8pm,					
	8pm, 8/30/25 at 8pm, -Trazodone 500n at 8pm, 8/30/25 at 8p	ng on 7/4/25 at 8pm, 8/29/25				

Division of Health Service Regulation

STATE FORM 6899 F0T211 If continuation sheet 12 of 16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			D. MINIC		R-	
		MHL060-402	B. WING		09/1	5/2025
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
COMMON	WEALTH GROUP HOME		MONWEALTH	AVENUE		
		CHARLOT	TE, NC 28205			
(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 123	Continued From page	: 12	V 123			
	8/13/25 at 7am, 8/15/ -Ziprasidone on 7 and 5pm, 7/5/25 at 8a 8/9/25 at 8am, 8/10/2 and 5pm, 8/15/25 at 8 -Zovia on 8/8/25 8/10/25 at 7am, 8/13/ 9/1/25 at 7am.	at 7am, 8/9/25 at 7am, 25 at 7am, 8/15/25 at 7am, Client #2's record revealed: 2/24. ate Intellectual				
	EpilepsyPhysician's order for -0/26/24 Clindam to the affected areas is -9/19/24 Eucerin (xerosis) Apply to the morning at 8am9/14/24 Hydroco Cream Apply to the at 8am and 8pm9/19/24 Ketocom Cream Apply to the at at 8am9/19/24 Lacosar one tablet by mouth to -9/19/24 Metform Take one tablet by mouth -12/30/24 Pravas	the following medications: lycin (dermatitis) 1-5% Apply topically every day. Advanced Repair Cream				
	-9/19/24 Vitamin	D3 (nutritional supplement) apsule by mouth every day				

Division of Health Service Regulation

STATE FORM 6899 F0T211 If continuation sheet 13 of 16

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SI	
			A. BUILDING: _			
		MHL060-402	B. WING		R-0 09/1	C 5/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
COMMON	WEALTH ODOLD HOME	3601 COM	IMONWEALTH .	AVENUE		
COMMON	WEALTH GROUP HOME	CHARLO	TTE, NC 28205			
(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 123	Continued From page	e 13	V 123			
	Review on 9/11/25 of 7/1/25 to 9/9/25 reveal -There were no staff in dates: -Clindamycin 1-5 8/1/25-8/10/25 at 8am at 8pm. -Eucerin Advance at 8am, 8/5/25 at 8am, 8/10/25 at 8am, 8/3/25 at 8am, 8/3/25 at 8am, -Hydrocortisone 8am, 8/9/25 at 8am, 8/15/25 at 8am, 8/15/25 at 8am, 8/15/25 at 8am, 8/15/25 at 8am, 8/13/25 at	Client #2's MARs from aled: nitials for the following % 7/1/25-7/31/25 at 8pm, n, 8/19/25 at 8pm, 8/31/25 ed Repair Cream on 7/1/25 n, 8/8/25 at 8am, 8/9/25 at 8/13/25 at 8am, 8/15/25 at 8/24/25 at 8am. 2.5% Cream on 7/1/25 at 8/10/25 at 8am, 8/13/25 at 8/19/25 at 8pm, 8/31/25 at 8/19/25 at 8am, 25 at 8am, 25 at 8am, 25 at 8am, 25 at 8am, 8/15/25 at 8am, 26 at 1:15pm of Client #2's cility revealed: ream was not present. ith Client #1 revealed: ication was missed was visit, because "I forgot to				
	Interview on 9/2/25 w -Denied missing any	ith Client #2 revealed: medications.				

Division of Health Service Regulation

STATE FORM 6899 F0T211 If continuation sheet 14 of 16

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING			_
		MHL060-402	B. WING		R- 09/1	5/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
COMMON	WEALTH GROUP HOME	3601 COM	MONWEALTH A	AVENUE		
COMMON	WEALTH GROOF HOME	CHARLOT	TE, NC 28205			
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 123	Continued From page	e 14	V 123			
	Interview on 9/2/25 w	rith Staff #1 revealed: ns and made sure that all y medication errors. with Staff #6 revealed:				
	-Was not aware of an	y missed medications.				
	-All medications were the MAR. -Sometimes staff did client was "out of faci -On 9/11/25 Client #2 Cream, so applied Eu	sional was responsible for				
	rather than leaving black home visitsStaff were document the client refused the -A new nurse began inoted "issues" on the -All staff would be retrorrectly.	Il revealed: nenting on the MAR ve of absence" on the MAR anks when clients went on ting "med unavailable" when medication. n August 2025 and had				
	dermatologist"If a medication error reach out to the pharr -Had not documented pharmacy.	r is brought to my attention, I macy." I contacts with the and been completed for				

Division of Health Service Regulation

STATE FORM 6899 If continuation sheet 15 of 16 F0T211

PRINTED: 09/29/2025

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ R-C B. WING _ MHL060-402 09/15/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **3601 COMMONWEALTH AVENUE** COMMONWEALTH GROUP HOME

		OTTE, NC 28205		
(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) COMPLET DATE

Division of Health Service Regulation