Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) I

STATEMENT OF DEFICIENCIES (X1) PR		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					D.O.	
		MIII 000 400	B. WING		R-C	
		MHL060-402			09/15/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
COMMON	WEALTH GROUP HOME	3601 COM	MONWEALTH	AVENUE		
COMMON	WEALTH GROUP HOWE	CHARLOT	TE, NC 28205			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)N (X5)	
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	D BE COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE DATE	
				BEI IOIEI(OT)		
V 000	INITIAL COMMENTS		V 000			
	A complaint and follow	w up survey was completed				
		plaint was unsubstantiated				
	-	7). Deficiencies were cited.				
	(.,				
	This facility is license	d for the following service				
	-	27G .5600C Supervised				
	Living for Adults with	Developmental Disability.				
	This facility is license	d for 6 and has a current				
	census of 3. The surv	ey sample consisted of				
	audits of 3 current clie	ents.				
V 108	27G .0202 (F-I) Perso	onnel Requirements	V 108			
	404 NO40 070 000	PEDOONNE				
	10A NCAC 27G .0202	2 PERSONNEL				
	REQUIREMENTS	tion about he decumented				
	· ·	tion shall be documented.				
	(g) Employee training	nimum, shall consist of the				
	following:	minum, shall consist of the				
	(1) general organiza	tional orientation:				
		rights and confidentiality as				
	` '	AC 27C, 27D, 27E, 27F and				
	10A NCAC 26B;	7.0 270, 270, 271, 271 and				
		he mh/dd/sa needs of the				
	• •	the treatment/habilitation				
	plan; and					
	(4) training in infection	ous diseases and				
	bloodborne pathogen					
	(h) Except as permitte	ed under 10a NCAC 27G				
		hapter, at least one staff				
	member shall be avail	ilable in the facility at all				
	times when a client is	present. That staff				
	member shall be train	ned in basic first aid				
	including seizure mar	nagement, currently trained				
	to provide cardiopulm	nonary resuscitation and				
	trained in the Heimlic	h maneuver or other first aid				
	techniques such as th	nose provided by Red Cross,				
	the American Heart A	Association or their				
			•			

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			URVEY ETED	
	A. BUILDING.		A. BUILDING:			0
		MHL060-402	B. WING		R- 09/1	5/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	ATE, ZIP CODE		
COMMON	WEALTH GROUP HOME	3601 COM	MONWEALTH	AVENUE		
COMMISSION	WEAETH GROOT HOME	CHARLOT	TE, NC 28205			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / 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 108	Continued From page	: 1	V 108	V108-		10/15/25
, 130	equivalence for relievi (i) The governing bod implement policies an reporting, investigatin	ing airway obstruction.	, 186	GH Manager will complete an Individual Spec Training with all staff. GH Manager will complete Individual Specific with staff at hire, as needed and yearly, this will documented in the EHR.	Training	
	failed to provide trainineeds of the clients at (#1). The findings are Review on 9/11/25 of revealed: -Hire date of 8/30/22Job title of Lead Resi	ew and interview, the facility ng to meet the MH/DD/SA ffecting 1 of 3 audited staff				
	specific MH/DD/SA ne-Staff #1 must have "f because she was rehi in a sister facilityPlanned to retrain all September 2025.	ed training. with the Group Home ofessional revealed: facility on 7/1/25. #1 had not received client eeds training. fallen through the cracks" red after previously working staff by the end of				
	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 AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MUI 000 402	B. WING			R-C
		MHL060-402			0:	9/15/2025
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	•		
COMMON	IWEALTH GROUP HOME		MMONWEALTH A	VENUE		
			OTTE, NC 28205			
(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 ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 108	Continued From page	2	V 108			
	and must be corrected	d within 30 days.				
V 118	27G .0209 (C) Medica	ation Requirements	V 118			
	only be administered order of a person authoriugs. (2) Medications shall clients only when authorient's physician. (3) Medications, incluadministered only by unlicensed persons transmistered persons transmistered to the privileged to prepare a current. Medication Admall drugs administered current. Medications a recorded immediately MAR is to include the (A) client's name; (B) name, strength, and (C) instructions for add (D) date and time the (E) name or initials of drug. (5) Client requests for checks shall be recorded.	stration: n-prescription drugs shall to a client on the written norized by law to prescribe be self-administered by norized in writing by the ding injections, shall be licensed persons, or by ained by a registered nurse, egally qualified person and and administer medications. inistration Record (MAR) of d to each client must be kept administered shall be after administration. The following:				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DAT			SURVEY .ETED	
7.1.2 7 27.11 01 001.11.201.10			A. BUILDING:			
		MHL060-402	B. WING		R: 09/ 1	-C 1 5/2025
NAME OF PROVIDER OR S	I IDDI IED	STREET AD	DRESS, CITY, ST	ATE ZID CODE		
NAME OF TROVIDER OR 3	OI I LILIX		IMONWEALTH			
COMMONWEALTH GR	OUP HOME		TTE, NC 2820			
0/4) ID	CLIMMA DV CT	ATEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CORRECTIO	NI .	0(5)
PREFIX (EAC	H DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118 Continued	From page		V 118	V118-		10/13/25
This Rule	is not met	as evidenced by: iew, observations and	V 110	Regional RN will complete a Medication Adn Training with staff and GH Manager to include documentation protocols.		
interviews Medication drugs adm current an	the facility Administr Sinistered to d medication fecting 2 of	of failed to ensure a ation Record (MAR) of all of each client was kept ons were administered as 3 clients (#1 and #2). The				
-Admission -Diagnose Disability, Intermitter Hyperactiv Obstructiv -Physician -9/18/ one spray 8pm9/18/ Suspension daily at 8a -9/18/ disabilities every more -9/18/ 1000mg To 8pm9/18/ disabilities 8pm9/18/ tablet by m -12/18 Take one	n date of 8/s s of Mild In Generalize at Explosive ve Disorder e Pulmona 's orders for 24 Azelasti into each no 24 Budeso on Inhale or m and 8pm 25 Bupropi 150mg Taning at 8am 25 Fluvoxa ake one table 24 Loratad nouth every 3/24 Mething ablet by metalized for the solution of the soluti	tellectual Developmental d Anxiety Disorder, e Disorder, Attention Deficit, Cerebral Palsy, Chronic ry Disease (COPD). The following medications: the (allergies) 0.1% Spray ostril twice daily at 8am and mide (COPD) 0.5mg/2ml the vial via nebulizer twice the vial via nebulizer twice the cone (intellectual ke one tablet by mouth				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION			
, , , , , , , , , , , , , , , , , , , ,		A. BUILDING:			00	PLETED
		MHL060-402	B. WING			R-C 9/15/2025
			<u> </u>			71072020
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
COMMON	WEALTH GROUP HOME		MMONWEALTH A	/ENUE		
		CHARLO	OTTE, NC 28205			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From page	÷ 4	V 118			
	8am.					
		kast (COPD) 10mg Take				
	one tablet by mouth a	· · · · · · · · · · · · · · · · · · ·				
	-	imin (nutritional supplement)				
		outh every morning at 7am.				
		azepine (mood stabilizer)				
	300mg Take one table	et by mouth every morning				
	at 8am. Take two tabl	ets every evening at 8pm.				
		n (intellectual disability) 2mg				
		outh at bedtime at 8pm.				
		one (intellectual disability)				
	-	et by mouth at bedtime at				
	8pm.					
		one (anxiety) 600mg Take				
		n twice daily at 8am and				
	5pm with food.	ral) 1 25: no order propert				
	-Zovia (birtii cont	rol) 1-35: no order present.				
	Review on 9/11/25 of	Client #1's MARs from				
	7/1/25 to 9/9/25 revea					
	-There were no staff in dates:	nitials for the following				
		(137 MCG) Spray on 7/1/25				
		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				
	8am and 8pm, 9/2/25	•				
		mg/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,				
	9/1/25 at 8am, 9/7/25					
		150mg on 7/4/25 at 8am,				
		at 8am, 8/9/25 at 8am,				
		25 at 8am, 8/15/25 at 8am,				
	9/1/25 8am.					
		aleate 1000mg on 7/4/25 at				
		8/30/25 at 8pm, 8/31/25 at				

Division of Health Service Regulation

STATE FORM 6899 F0T211 If continuation sheet 5 of 16

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		
		MHL060-402	B. WING		R-C 09/15/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	TE ZIP CODE	•
INAME OF T	KOVIDER OR OOF FEER		MMONWEALTH A		
COMMON	WEALTH GROUP HOME		OTTE, NC 28205	TVLITOL .	
()(1) ID	CLIMMADV CT	ATEMENT OF DEFICIENCIES	-	DROVIDER'S DI ANI CE CORRECTIO	N OVE
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	DBE COMPLETE
V 118	Continued From page	5	V 118		
	8pm.				
	-Hydroxyzine Pa 8am, 8/29/25 at 8pm, 8pm.	moate 25mg on 7/4/25 at 8/30/25 at 8pm, 8/31/25 at			
	7/5/25 at 7am, 8/8/25	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.	ng 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.	g on 7/4/25 at 9am and			
		g on 7/4/25 at 8am and 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 8amMontelukast 10r	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.	200ma on 7/1/25 of 20m			
		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,				
	·	n 7/4/25 at 8pm, 8/29/25 at			
	8pm, 8/30/25 at 8pm,	•			
	-Trazodone 500r	ng on 7/4/25 at 8pm, 8/29/25			
	at 8pm, 8/30/25 at 8p	m, 8/31/25 at 8pm.			
		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, 25 at 7am, 8/15/25 at 7am,			

Division of Health Service Regulation

STATE FORM 6899 F0T211 If continuation sheet 6 of 16

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
					R-	c l
		MHL060-402	B. WING			5/2025
	20,425, 22, 21, 22, 45		DE00 0171/ 074	TE 710 0005		
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA			
COMMON	WEALTH GROUP HOME		MONWEALTH A	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	Continued From page	6	V 118			
	9/1/25 at 7am.					
	-Admission date of 5/2 -Diagnoses of Modera Developmental Disab EpilepsyPhysician's order for -0/26/24 Clindam to the affected areas -9/19/24 Eucerin (xerosis) Apply to the morning at 8am9/14/24 Hydroco Cream Apply to the af 8am and 8pm9/19/24 Ketocom Cream Apply to the af at 8am9/19/24 Lacosam one tablet by mouth tr -9/19/24 Metform Take one tablet by mouth tr -12/30/24 Pravas 40mg Take one table 8am9/19/24 Vitamin 2000 unit Take one ca at 8am.	ate Intellectual idity, Cerebral Palsy, the following medications: hycin (dermatitis) 1-5% Apply topically every day. Advanced Repair Cream affected areas every ortisone (dermatitis) 2.5% ffected areas twice daily at mazole (dermatitis) 2% ffected areas every morning mide (epilepsy) 100mg Take wice daily at 8am and 8pm. hin HCL (diabetes) 500mg outh every day at 7pm. statin Sodium (cholesterol) t by mouth every day at D3 (nutritional supplement) apsule by mouth every day				
		Client #2's MARs from				
	7/1/25 to 9/9/25 revea					
	dates:	nitials for the following				
		5% 7/1/25-7/31/25 at 8pm,				
		n , 8/19/25 at 8pm, 8/31/25				
	at 8pm.					
	-Eucerin Advance	ed Repair Cream on 7/1/25				

Division of Health Service Regulation

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 A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			-		R-C
		MHL060-402	B. WING		09/15/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		3601 CO	MMONWEALTH A	AVENUE	
COMMON	IWEALTH GROUP HOME	CHARLO	OTTE, NC 28205		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
V 118	Continued From page	7	V 118		
V 116	at 8am, 8/5/25 at 8am, 8am, 8/10/25 at 8am, 8/10/25 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, 8/10/2 8/9/25 at 8am, 8/10/2 8/15/25 at 8am, 8/10/2 8/15/25 at 8am, 8/13/3 8/19/25 at 8am, 8/13/3 8/19/25 at 8pm and 8 -Metformin HCL 8 and 8/31/25 at 7pmPravastatin 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 factorial states of the second of the	1, 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 8/19/25 at 8/19	VIIO		
	Interview on 9/11/25 v -All medications were the MAR.	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 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
					R-C		
		MHL060-402	B. WING		09/15/2025		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
COMMON	COMMONWEALTH GROUP HOME 3601 COMMONWEALTH AVENUE						
			OTTE, NC 28205				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / 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 COMPLETE		
V 118	Continued From page	8	V 118				
	client was "out of facil	vith Staff #6 revealed:					
	-Was not aware of any	y missed medications.					
	rather than leaving bla home visitsStaff were document the client refused the -A new nurse began in noted "issues" on the -All staff would be retr correctly.	l: nenting on the MAR we of absence" on the MAR anks when clients went on ing "med unavailable" when medication. n August 2025 and had					
	Due to the failure to a medication administrate determined if clients reas ordered by the phy	ation, it could not be eceived their medications					
	This deficiency consti- and must be corrected	tutes a re-cited deficiency d within 30 days.					
V 123	27G .0209 (H) Medica	ation Requirements	V 123				
		MEDICATION Drug administration errors se drug reactions shall be					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER: A. BUILDING:		COMPL	ETED
					R-	-C
		MHL060-402	B. WING			5/2025
NAME OF D	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE ZIR CODE		
INAME OF T	NOVIDEN ON 3011 LIEN		MONWEALTH			
COMMON	IWEALTH GROUP HOME		TE, NC 28205			
	CUMMADVCT		-		1	
(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	, Q	V 123	V 123-		10/13/25
V 123	reported immediately pharmacist. An entry and the drug reaction		V 123	Regional RN will complete a Medication Admi Training with staff and GH Manager to include p documentation protocols.		
	failed to ensure all me errors were immediat or physician affecting and #2). The findings Review on 9/5/25 of C-Admission date of 8/4-Diagnoses of Mild In Disability, Generalize Intermittent Explosive Hyperactive Disorder Obstructive Pulmona-Physician's orders for 9/18/24 Azelasti one spray into each in 8pm. -9/18/24 Budeso Suspension Inhale or daily at 8am and 8pm -9/18/25 Bupropi disabilities)150mg Ta every morning at 8am -9/18/25 Fluvoxa 1000mg Take one tab 8pm.	ew and interview, the facility edication administration ely reported to a pharmacist 2 of 3 audited clients (#1 are: Client #1's record revealed: 5/11. tellectual Developmental d Anxiety Disorder, et Disorder, Attention Deficit cry Disease (COPD). or the following medications: ine (allergies) 0.1% Spray costril twice daily at 8am and anide (COPD) 0.5mg/2ml the vial via nebulizer twice in the following medications: ine (allergies) 0.1% spray costril twice daily at 8am and anide (COPD) 0.5mg/2ml the vial via nebulizer twice in the following medications: ion (intellectual ke one tablet by mouth				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED		
			A. BOILDING		5.0
		MHL060-402	B. WING		R-C 09/15/2025
NAME OF D	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE ZIR CODE	•
NAME OF T	KOVIDEK OK 301 1 EIEK		MMONWEALTH A		
COMMON	WEALTH GROUP HOME		TTE, NC 28205	TVENOL	
0/0/15	CHMMADV CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	N are
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 123	Continued From page	: 10	V 123		
	disabilities) 25mg Tak	ce one capsule every day at			
	8pm.				
		ne (allergies)10mg Take one			
	tablet by mouth every				
		nazole (hypothyroidism) 5mg			
	_	outh every morning at 8am			
		olol (sinus tachycardia) 25mg by mouth every morning at			
	8am.	by modificevery morning at			
		kast (COPD) 10mg Take			
	one tablet by mouth a	, ,			
	-9/18/24 Multivita	ımin (nutritional supplement)			
	Take one tablet by me	outh every morning at 7am.			
		azepine (mood stabilizer)			
		et by mouth every morning			
		ets every evening at 8pm.			
		n (intellectual disability) 2mg			
		outh at bedtime at 8pm. one (intellectual disability)			
		et by mouth at bedtime at			
	8pm.	o. 2, a. 200 a.			
	-	one (anxiety) 600mg Take			
		n twice daily at 8am and			
	5pm with food.				
	-Zovia (birth cont	rol) 1-35: no order present.			
	Review on 9/11/25 of 7/1/25 to 9/9/25 revea	Client #1's MARs from			
		nitials for the following			
	dates:	illiais for the following			
		(137 MCG) Spray on 7/1/25			
		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			
	8am and 8pm, 9/2/25	-			
		mg/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,			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R-C
		MHL060-402	B. WING		09/15/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
			MMONWEALTH		
COMMON	IWEALTH GROUP HOME		TTE, NC 28205		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX TAG	,	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 123	Continued From page	: 11	V 123		
	8/29/25 at 8pm, 8/30/2	25 at 8pm, 8/31/25 at 8pm,			
	9/1/25 at 8am, 9/7/25				
	-Bupropion HCL	150mg on 7/4/25 at 8am,			
	-	at 8am, 8/9/25 at 8am,			
	-	25 at 8am, 8/15/25 at 8am,			
	9/1/25 8am.				
		aleate 1000mg on 7/4/25 at			
	• • •	8/30/25 at 8pm, 8/31/25 at			
	8pm.	7/4/05			
		moate 25mg on 7/4/25 at			
	•	8/30/25 at 8pm, 8/31/25 at			
	8pm.	g on 7/4/25 at 7am and			
		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.				
		ng 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.				
		g on 7/4/25 at 8am and			
	· ·	at 8am, 8/9/25 at 8am,			
	9/1/25 8am.	25 at 8am, 8/15/25 at 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			
		3/9/25 at 7am, 8/10/25 at			
		8/15/25 at 7am, 9/1/25 at			
	7am.	,			
	-Oxcarbazepine	300mg on 7/1/25 at 8am,			
	7/4/25 at 8am and 8pi	m, 7/5/25 at 8am, 8/8/25 at			
	8am, 8/9/25 at 8am, 8	8/10/25 at 8am, 8/13/25 at			
	· ·	8/29/25 at 8pm, 8/30/25 at			
	8pm, 8/31/25 at 8pm,	9/1/25 8am.			
		n 7/4/25 at 8pm, 8/29/25 at			
	8pm, 8/30/25 at 8pm,				
		ng on 7/4/25 at 8pm, 8/29/25			
	at 8pm, 8/30/25 at 8p				
	-Venlafaxine on 7	7/4/25 at 7am, 7/5/25 at 7am,			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED				
		, <u> </u>		R-C				
MHL060-402	B. WING	B. WING		09/15/2025				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3601 COMMONWEALTH AVENUE								
COMMONWEALTH GROUP HOME CHAR	OTTE, NC 28205							
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE				
V 123 Continued From page 12 8/8/25 at 7am, 8/9/25 at 7am, 8/10/25 at 7am, 8/13/25 at 7am, 8/15/25 at 7am, 9/1/25 7am. - Ziprasidone on 7/3/25 at 5pm, 7/4/25 at 8am and 5pm, 7/5/25 at 8am and 5pm, 8/8/25 at 8am, 8/9/25 at 8am, 8/10/25 at 8am, 8/13/25 at 8am and 5pm, 8/15/25 at 8am, 8/13/25 at 7am, 8/15/25 at 7am, 8/10/25 at 7am, 8/13/25 at 7am, 8/15/25 at 7am, 9/1/25 at 7am. Review on 9/5/25 of Client #2's record revealed: -Admission date of 5/2/24Diagnoses of Moderate Intellectual Developmental Disability, Cerebral Palsy, EpilepsyPhysician's order for the following medications: -0/26/24 Clindamycin (dermatitis) 1-5% Apply to the affected areas topically every day9/19/24 Eucerin Advanced Repair Cream (xerosis) Apply to the affected areas every morning at 8am9/14/24 Hydrocortisone (dermatitis) 2.5% Cream Apply to the affected areas twice daily at 8am and 8pm9/19/24 Ketoconazole (dermatitis) 2% Cream Apply to the affected areas every morning at 8am9/19/24 Lacosamide (epilepsy) 100mg Take one tablet by mouth twice daily at 8am and 8pm9/19/24 Metformin HCL (diabetes) 500mg Take one tablet by mouth every day at 7pm12/30/24 Pravastatin Sodium (cholesterol) 40mg Take one tablet by mouth every day at 8am9/19/24 Vitamin D3 (nutritional supplement) 2000 unit Take one capsule by mouth every day at 8am.	V 123	DEFICIENCY						

Division of Health Service Regulation

STATE FORM 6899 F0T211 If continuation sheet 13 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	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
			MONWEALTH	AVENUE		
COMMON	WEALTH GROUP HOME		TE, NC 28205			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETE DATE
V 123	Continued From page	e 13	V 123			
V 123	Review on 9/11/25 of 7/1/25 to 9/9/25 reveal -There were no staff indates: -Clindamycin 1-58/1/25-8/10/25 at 8am at 8pm. -Eucerin Advance at 8am, 8/5/25 at 8am, 8/10/25 at 8am, 8/10/25 at 8am, 8/23/25 at 8am, -Hydrocortisone 8am, 8/9/25 at 8am, 8/9/25 at 8am, 8/9/25 at 8am, 8/15/25 at 8am, 8/10/25 at 8am, 8/13/8/15/25 at 8am, 8/13/8/19/25 at 8pm and 8 -Metformin HCL and 8/31/25 at 7pmPravastatin Sod 8/10/25 at 8am, 8/13/-Vitamin D3 2000 at 8am, 8/13/25 at 8am Observation on 9/11/25 medications in the factoric review on 9/2/25 we-The only time a medications at 8 am and 10/2/25 we-The only time a medications at 8 am and 10/2/25 we-The only time a medications at 8 am and 10/2/25 we-The only time a medications at 8 am and 10/2/25 we-The only time a medications at 8 am and 10/2/25 we-The only time a medications at 8 am and 10/2/2/25 we-The only time a medications at 8 am and 10/2/2/25 we-The only time a medications at 8 am and 10/2/2/25 we-The only time a medications at 8 am and 10/2/2/25 we-The only time a medications at 8 am and 10/2/2/25 we-The only time a medications at 8 am and 10/2/2/25 we-The only time a medications at 8 am and 10/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2	Client #2's MARs from aled: nitials for the following 5% 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 8/13/25 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 8pm, 8/31/25 at 9% Cream on 7/1/25 at 8am, 25 at 8am, 8/13/25 at 8am, 25 at 8am, 8/13/25 at 8am, 25 at 8am, 8/15/25 at 8am, 25 at 8am, 8/15/25 at 8am, 25 at 8am, 8/15/25 at 8am, 3/31/25 at 8pm. 500mg on 8/9/25 at 8am, 25 at 8am, 8/15/25 at 8am, 20 unit 8/9/25 at 8am. 21 at 1:15pm of Client #2's cility revealed: 22 at 1:15pm of Client #2's cility revealed: 23 at 1:15pm of Client #2's 25 at 1:15pm of Client #2's 26 at 1:15pm of Client #2's 27 at 1:15pm of Client #1 revealed: 28 at 1:15pm was not present.	V 123			
	take it home."	visit, because "I forgot to rith Client #2 revealed:				
	-Denied missing any					

Division of Health Service Regulation

STATE FORM 6899 F0T211 If continuation sheet 14 of 16

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			720.250.			2.0
		MHL060-402	B. WING	B. WING		R-C /15/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	F ZIP CODE	•	
TVAINE OF T	NOVIDER OR OUT LIER		MMONWEALTH A			
COMMON	WEALTH GROUP HOME		OTTE, NC 28205			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORI	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	COMPLETE DATE
V 123	Continued From page	e 14	V 123			
	Interview on 9/2/25 with Staff #1 revealed:					
		ns and made sure that all				
	staff were signing off.					
	-Was not aware of an					
	Interview on 9//2/25 w	vith Staff #6 revealed:				
	-Usually did not admir					
		y missed medications.				
	Interview on 9/11/25 v	with Staff #3 revealed:				
	-All medications were	given, staff forgot to sign				
	the MAR.					
		not put on the MAR that the				
		lity" when on a home visit.				
		was out of Ketoconazole				
	Cream, so applied Eu					
		sional was responsible for				
	reporting errors to the	ерпаппасу.				
	Interview on 9/11/25 a	and 9/15/25 with the				
	Qualified Professional revealed:					
	-Staff were not docum	nenting on the MAR				
	correctly.					
		ve of absence" on the MAR				
		anks when clients went on				
	home visits.	ing "mod upovoilable" when				
	the client refused the	ing "med unavailable" when				
		n August 2025 and had				
	noted "issues" on the					
		rained to complete the MAR				
	correctly.					
	•	ms for Client #2 with his				
	dermatologist.					
		is brought to my attention, I				
	reach out to the pharr					
	-Had not documented	i contacts with the				
	pharmacy.	ad been completed for				
	medication errors from					

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** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY)