

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G303	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/10/2025
NAME OF PROVIDER OR SUPPLIER MONROE ROAD			STREET ADDRESS, CITY, STATE, ZIP CODE 7621 MONROE ROAD CHARLOTTE, NC 28212		
(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) COMPLETION DATE	
W 000	INITIAL COMMENTS	W 000			
{W 369}	<p>DRUG ADMINISTRATION CFR(s): 483.460(k)(2)</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure medications were administered in accordance with physician's orders. This affected 2 client (#2 and #4) observed during medication administration. The finding is:</p> <p>A. The facility failed to ensure that client #4's medications were administered at the correct time. For example:</p> <p>During observations in the home on 9/24/25, client #4 was observed to enter the medication room at 7:56 AM. Further observation revealed client #4 to exhibit behaviors including screaming and throwing items in the medications room. Staff responded by escorting client #4 to her bedroom at which time she calmed down. Continued observation revealed staff A to prepare and administer the following medications to client #4 Buspirone, CA CIT/Vit D, Senna-Time, Benzotropine, Divalproex, Ferusol, Vit B3, Omega 3 Fish Oil, Levothyroxine, Meloxicam, Alendronate, Clonidine, Ingrezza, Lactulose. Continued observation revealed staff A to take the</p>	{W 369}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{W 369}	<p>Continued From page 1</p> <p>medications to client #4 in her bedroom and client #4 to take all medications at 8:05 AM.</p> <p>Review on 9/24/25 of client #4's physician's orders dated 9/24/25 revealed that the Levothyroxine is to be administered at 6:00 AM and the Lactulose is to be administered at 5:00 PM.</p> <p>Interview on 9/27/25 with the nursing supervisor confirmed that client #4's Levothyroxine and Lactulose were administered outside of the time prescribed for each and that all medications should be administered according to the physicians' orders.</p> <p>B. The facility failed to ensure that client #2's medications were administered at the correct time. For example:</p> <p>During observations in the home on 9/24/25, client #2 was observed to enter the medication room at 8:15 AM. Further observation revealed staff A to prepare and administer the following medications to client #2: Lorazepam, Omega 3 Fish Oil, Cetirizine, Duloxetine, Vit D3, Lo Loestrine, Ciclopirox. Continued observation revealed client #2 to take all medications at 8:20 AM.</p> <p>Review on 9/24/25 of client #2's physician's orders dated 7/15/25 revealed that all medications are to be administered at 7:00 AM.</p> <p>Interview on 9/27/25 with the nursing supervisor confirmed that all of client #2's medications should have been administered between 6:00 AM and 8:00 AM and that all medications should be administered according to the physicians' orders.</p>	{W 369}			

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{W 382}	<p>DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2)</p> <p>The facility must keep all drugs and biologicals locked except when being prepared for administration.</p> <p>This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all medications and biologicals remained locked except when being prepared for administration. The finding is:</p> <p>Morning observations in the home on 9/24/25 at 8:03 AM revealed staff A to leave the medication area and leave 14 medications, including 1 controlled medication, on a desk. Further observations revealed that there is no door on the medication room, just a privacy screen which is pulled across the door when clients are in the room. Continued observations revealed all staff to be away from the medication room for 5 minutes with the medications out on the desk.</p> <p>Interview on 9/24/25 with the nursing supervisor revealed that all medications should be locked inside the medication cart when staff are not directly supervising the medications.</p>	{W 382}			