STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-023	A. BUILDING: _____ B. WING _____	R 04/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOGWOOD ACRES	211 NELLIE JOHN DRIVE CLYDE, NC 28721

(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 and follow up survey was completed on 4/27/18. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Individuals of all Disability Groups.	V 000		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interview the facility failed to conduct fire and disaster drills quarterly on each shift. The findings are: Review on 4/25/18 of the facility disaster drills revealed: -No documentation of a 3rd shift fire drill for 7/2017-9/2017. -No documentation of a 1st or 2nd shift fire drill for 10/2017-12/2017. -No documentation of a 2nd shift disaster drill for	V 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-023	A. BUILDING: _____ B. WING _____	R 04/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOGWOOD ACRES	211 NELLIE JOHN DRIVE CLYDE, NC 28721

(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 114	Continued From page 1 4/2017-6/2017. -No documentation of a 3rd shift disaster drill for 10/2017-12/2017. -No documentation of a 3rd shift disaster drill for 1/2018-3/2018. Interview on 4/27/18 with the Qualified Professional revealed: -The facility had 3 shifts 7am-3pm, 3pm-11pm and 11p-7am. -The Qualified Professional Assistant would schedule the fire drills. -She was aware of the rule requirement and this would be addressed as an area of improvement.	V 114		
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;	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-023	A. BUILDING: _____ B. WING _____	R 04/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOGWOOD ACRES	211 NELLIE JOHN DRIVE CLYDE, NC 28721

(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 118	Continued From page 2 (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (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 review, interview and observation the facility failed to ensure prescription drugs were available to be administered as ordered by the physician for 2 of 3 sampled clients (#2, #3). The findings are: Observation on 4/25/18 at 10:30am of the medications for Client #2 revealed: -No Guaifenesin, Haloperidol, Hyoscyamine, Morphine, Prochlorperazine, Acetaminophen or Famotadine were present with his medications. Observation on 4/25/18 at 11:15am of the medications for Client #3 revealed: -Glucagen 1 mg Hypo kit expired 12/7/17. -No Ketoconazole 2% cream present with Client #3's medications. Review on 4/25/18 and 4/26/18 of the record for Client #2 revealed: -Admission date of 12/2/13 with diagnoses of Moderate Intellectual Disability, Mood Disorder, Chronic Obstructive Pulmonary Disease, Dementia, Hypertension, Peripheral Vascular Disease, Aortic Valve Disorder, Seizure Disorder and Enuresis.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-023	A. BUILDING: _____ B. WING _____	R 04/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOGWOOD ACRES	211 NELLIE JOHN DRIVE CLYDE, NC 28721

(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 118	Continued From page 3 Review on 4/25/18 and 4/26/18 of the physician orders dated 8/10/17 for Client #2 included: -Guaifenesin DM Syrup 10ml every 4 hours as needed. -Haloperidol 20mg/ml .05 every 6 hours as needed. -Hyoscyamine 0.125 1 tablet under tongue every 4 hours as needed. -Morphine 20mg take .025 (5mg) every 3 hours as needed. -Prochlorperazine 10mg 1 tablet every 6hours as needed. -Acetaminophen 650mg suppository every 6 hours for mild fever. -Famotadine 20mg 1 tablet 2 times daily as needed for indigestion. Review on 4/25/18 and 4/26/18 of the record for Client #3 revealed: -Admission date of 5/1/15 with diagnoses of Schizoaffective Disorder, Bipolar, Moderate Intellectual Disability, Diabetes, Traumatic Brain Injury, Sick Sinus Syndrome, Gastroesophageal Reflux Disease and Decreased Visual Acuity. Review on 4/25/18 and /26/18 of the physician orders dated 8/21/17 for Client #3 revealed: -Ketoconazole 2% cream apply daily as needed. -Glucagen 1 mg Hypo kit as needed for severe hypoglycemia. Interview on 4/25/18 with Staff #1 revealed: -Client #2 was currently under hospice care. -Client #2's medications were expired and his nurse picked them up last week to replace. -Client #2's famotidine was not a medication provided by hospice and she was not sure why he did not have any in the facility. -Staff #1 would follow up on the replacement of	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-023	A. BUILDING: _____ B. WING _____	R 04/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOGWOOD ACRES	211 NELLIE JOHN DRIVE CLYDE, NC 28721

(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 118	Continued From page 4 the hospice medications which included the Guaifenesin, Haloperidol, Hyoscyamine, Morphine, Prochlorperazine and Acetaminophen. -She was not aware the Glucagen Hypo kit for Client #3 was expired and would order a replacement. -She could not recall Client #3 using the Ketoconazole Cream. Interview on 4/27/18 with the Qualified Professional revealed: -The medications were the primary responsibility of the Qualifed Professional Assistant (QPA). -She was aware that the QPA had a difficult time getting follow up from some of the local medical providers for orders or changes. -The medications provided by hospice were replaced on 4/25/18 and 4/26/18 and now available in the facility for Client #2.	V 118		