

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL040-007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/20/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>DOGWOOD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>212 DOGWOOD LANE</b> <b>SNOW HILL, NC 28580</b>
--	--

(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	<p>INITIAL COMMENTS</p> <p>An annual and follow up survey was completed on March 20, 2019. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p>	V 000		
V 114	<p>27G .0207 Emergency Plans and Supplies</p> <p>10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES</p> <p>(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.</p> <p>(b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.</p> <p>(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.</p> <p>(d) Each facility shall have basic first aid supplies accessible for use.</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to have fire and disaster drills held at least quarterly and repeated on each shift. The findings are:</p> <p>Review on 03/20/19 of facility records from April 2018 thru present revealed: -April 2018-June 2018 no 1st or 2nd shift fire drill and no 1st or 3rd shift disaster drill documented. -July 2018-September 2018 no 3rd shift fire drill</p>	V 114		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL040-007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/20/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>DOGWOOD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>212 DOGWOOD LANE</b> <b>SNOW HILL, NC 28580</b>
--	--

(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  and no 2nd or 3rd shift disaster drill documented. -October 2018-December 2018 no 2nd or 3rd shift fire drill documented and no 1st or 3rd shift disaster drill documented.  During interview on 03/20/19 client #2 and #3 stated they participated in fire and disaster drills.  Interview on 03/21/19 the Qualified Professional stated safety drills would be discussed with staff in the facility.	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; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL040-007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/20/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>DOGWOOD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>212 DOGWOOD LANE</b> <b>SNOW HILL, NC 28580</b>
--	--

(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	<p>Continued From page 2</p> <p>drug.</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to keep the MARs current affecting two of three clients (#2 and #3). The findings are:</p> <p>Finding #1: Review on 03/19/19 of client #2's record revealed: -45 year old male. -Admission date of 03/03/15. -Diagnoses of Schizophrenia, Moderate Mental Retardation, Seizure Disorder, Insomnia, Hypertension, Hyponatremia, Anemia, and Vitamin D Deficiency.</p> <p>Review on 03/19/19 of client #2's Physician orders revealed: 10/04/18 -Chlorpromazine 100mg Take 2 tablets by mouth 3 times daily. -Lorazepam 1mg Take 1 tablet by mouth every night at bedtime. -Ferrous Sulfate 325mg Take 1 tablet by mouth twice daily.</p> <p>Review on 03/19/19 of client #2's February 2019 MAR revealed the following blanks: -Chlorpromazine 100mg-02/12/19 at 2:00pm. -Ferrous Sulfate 325mg-2/26/19 at 8:00pm. -Lorazepam 1mg 02/06/19, 02/07/19.</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL040-007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/20/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>DOGWOOD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>212 DOGWOOD LANE</b> <b>SNOW HILL, NC 28580</b>
--	--

(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	<p>Continued From page 3</p> <p>During interview on 03/20/19 client #2 stated he received his medication daily.</p> <p>Finding #2 Review on 03/19/19 of client #3's record revealed: -78 year old male. -Admission date of 06/08/93. -Diagnoses of Schizophrenia Disorder, Obesity, Moderate Mental Retardation, Hearing Loss, Allergic Rhinitis, Hypokalemia, Cardiomyopathy, Hypercholesterolemia.</p> <p>Review on 03/19/19 of client #3's Physician orders revealed: 04/02/18 -Lorazepam 1mg Take 1 tablet by mouth at bedtime. 07/02/18 -Risperidone 1mg Take 1 tablet by mouth at bedtime. 10/25/17 -Rosumastatin 10mg Take 1 tablet by mouth at bedtime.</p> <p>Review on 03/19/19 of client #3's February 2019 MAR revealed the following blanks: -Lorazepam 1mg-02/04/19, 02/06/19, 02/07/19, 02/12/19, 02/26/19. -Risperidone 1mg-02/04/19, 02/06/19, 02/07/19, 02/12/19, 02/26/19. -Rosumastatin 10mg-02/04/19, 02/06/19, 02/07/19, 02/12/19, 02/26/19.</p> <p>During interview on 03/20/19 client #2 stated he received his medication daily.</p> <p>During interview on 03/20/19 the Certified Medical Assistant stated:</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL040-007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/20/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>DOGWOOD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>212 DOGWOOD LANE</b> <b>SNOW HILL, NC 28580</b>
--	--

(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	<p>Continued From page 4</p> <ul style="list-style-type: none"> <li>-All the facilities are using the electronic MAR.</li> <li>-The computer system does not always record the initials.</li> <li>-She was going to contact the pharmacy to get the issues corrected.</li> </ul> <p>Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician.</p>	V 118		