

Division of Health Service Regulation

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-296 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED R 06/10/2019 |
|--|---|---|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER DOROTHY'S PLACE | STREET ADDRESS, CITY, STATE, ZIP CODE 1024 JUNIUS STREET GASTONIA, NC 28052 |
|--|---|

| (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 6/10/19. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Level III</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 ensure fire and disaster drills were held at least quarterly and were repeated for each shift. The findings are:</p> <p>Review on 6/10/19 of the facility's fire and disaster drills log from 8/2018 to 5/2019 revealed: - only one fire and disaster drill had been conducted on 1st shift from 8/15/18 - 5/31/19.</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: MHL036-296 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED R 06/10/2019 |
|--|---|---|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER DOROTHY'S PLACE | STREET ADDRESS, CITY, STATE, ZIP CODE 1024 JUNIUS STREET GASTONIA, NC 28052 |
|--|---|

| (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 Interview on 6/10/19 with direct care staff revealed: - staff shifts were 1st, 2nd and 3rd; - missing fire and disaster drills had been "pulled" and not placed back in the notebook. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days. | 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 drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR | V 118 | | |

Division of Health Service Regulation

| | | | | |
|--|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-296 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED R 06/10/2019 |
| NAME OF PROVIDER OR SUPPLIER DOROTHY'S PLACE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1024 JUNIUS STREET GASTONIA, NC 28052 | | |
| (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 file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure prescribed medications were administered on the written order of a person authorized by law to prescribe drugs affecting 1 of 3 audited clients (#3). The findings are: Review on 6/10/19 of client #3's medications and April, May and June 2019 MAR's revealed: - Client #3 was administered Melatonin 5mg, 2 tabs by mouth daily; - No physician's order for the Melatonin. Interview on 6/10/19 with the direct care staff and Qualified Professional (QP) revealed: - The physicians order for client #3's Melatonin would be obtained by the psychiatrist. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days. | V 118 | | |

Division of Health Service Regulation

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-296 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED R 06/10/2019 |
|--|---|---|--|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER DOROTHY'S PLACE | STREET ADDRESS, CITY, STATE, ZIP CODE 1024 JUNIUS STREET GASTONIA, NC 28052 |
|--|---|

| (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 This deficiency constitutes a re-cited deficiency. | V 118 | | |