Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		MHL077-071	B. WING		06/11/2019			
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
DILIGENT CARE GROUP HOME #1  161 BOWEN STREET  HOFFMAN, NC 28347								
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	N SHOULD BE COMPLETE			
V 000	INITIAL COMMENTS		V 000					
	An annual survey w 2019. Deficiencies	ras completed on June 11, were cited.						
	category: 10A NCA	sed for the following service C 27G .5600C Supervised h Developmental Disabilities.						
V 121	27G .0209 (F) Medi	ication Requirements	V 121					
	governing body or of for obtaining a review regimen at least even shall be to be performant physician. The on-stree client's physician the review when medical the findings of the street of the stree	w: ives psychotropic drugs, the operator shall be responsible ew of each client's drug ery six months. The review rmed by a pharmacist or ite manager shall assure that n is informed of the results of edical intervention is indicated. the drug regimen review shall client record along with						
		views and interview the facility reviews every six months for (#2) who received						
	-Admission date of -Diagnoses of ADH Cerebral Palsy; Mo	D; Autism; Seizure Disorder; derate Intellectual Disability. lated 11/28/18 for Lamotrigine						

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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL077-071		B. WING		06/1	06/11/2019	
NAME OF PROVIDER OR SUPPLIER  DILIGENT CARE GROUP HOME #1  STREET ADDRESS, CITY, STATE, ZIP CODE  161 BOWEN STREET  HOFFMAN, NC 28347						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 121	-The 2019 MAR for June revealed clien above medicationsThere was no evid psychotropic drug r  Interview with the M-She was unaware psychotropic medications review physician every six recordsShe thought that creviewed by his phy-She confirmed the	the months of April, May and at #2 was administered the ence of a six months eview for client #2.  Manager on 6/11/19 revealed: that clients that received eations had to have their ed by a pharmacist or months and placed in their lient#2 had his medications visicians recently. The entry is the month of the entry is the month of the entry. The entry is the month of the entry is the entry is the month of the entry is th	V 121			
V 736	10A NCAC 27G .03 EXTERIOR REQUI (c) Each facility and maintained in a safe manner and shall b odor.  This Rule is not me Based on observatifailed to ensure facin a clean, safe and findings are:  Observation on 6/1 kitchen area reveal.	d its grounds shall be e, clean, attractive and orderly e kept free from offensive et as evidenced by: on and interview, the facility ility grounds were maintained attractive manner. The	V 736			

Division of Health Service Regulation

STATE FORM 6899 IJFN11 If continuation sheet 2 of 3

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		MHL077-071	B. WING		06/1	1/2019	
NAME OF PROVIDER OR SUPPLIER  DILIGENT CARE GROUP HOME #1  STREET ADDRESS, CITY, STATE, ZIP CODE  161 BOWEN STREET HOFFMAN, NC 28347							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
V 736	curved downward ir -Vertical blinds cove to the back porch h some were misaligr  Observation on 6/11 hallway bathroom re-Ceiling had a large mildew/moldWallpaper and pair wall underneath the  Observation on 6/11 porch revealed: -Entrance door had had been scratched  Interview on 6/11/19 -There had been a ago. Roof was pato -Plan was to paint a bathroomShe was aware tha porch were not in ge -Agency was respon for the home -She confirmed the	In the middle.  In the middle.	V 736				

6899

Division of Health Service Regulation STATE FORM