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		
		MHL078-276	B. WING		02/1	2/2020		
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE				
TANGLEWOOD ARBOR 207 WEST 29TH STREET								
IANOLL	TOOD ANDON	LUMBER	TON, NC 28:	358				
(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)	LD BE	(X5) COMPLETE DATE		
V 000	V 000 INITIAL COMMENTS		V 000					
	An annual survey w 2020. A deficiency v	ras completed on February 12, was cited.						
	categories: 10A NC Medical Detoxificati	sed for the following service AC 27G .3100 Non-Hospital on and 10A NCAC 27G .5000 ces for all Disability Groups.						
V 118	27G .0209 (C) Med	ication Requirements	V 118					
	only be administered order of a person and drugs.  (2) Medications shad clients only when a client's physician.  (3) Medications, included and individual of the privileged to prepare (4) A Medication Ad all drugs administer current. Medications recorded immediated MAR is to include the (A) client's name;  (B) name, strength, (C) instructions for a (D) date and time the (E) name or initials drug.  (5) Client requests the corrections of the privileged to prepare (4) and the privileged to prepare (4) and the privileged to prepare (4) and the privileged to prepare (5) client requests the privileged to prepare (6) client requests the privileged to prepare (7) cli	inistration: non-prescription drugs shall d to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be y licensed persons, or by trained by a registered nurse, legally qualified person and e and administer medications. Iministration Record (MAR) of red to each client must be kept administered shall be ely after administration. The ne following: and quantity of the drug; administering the drug; he drug is administering the for medication changes or						
		orded and kept with the MAR appointment or consultation						

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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	Of Fleatill Service IN	guiation			1	
STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		MIII 070 070	B. WING		00/4	0/0000
		MHL078-276	J. WINO		02/1	2/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		207 WES	C 29TH STRE	ET		
TANGLE	WOOD ARBOR		ΓΟN, NC 28			
	OLIMA AA DV OTA		· ·		DNI .	41.5
(X4) ID PREFIX		TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL)		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
		,		DEFICIENCY)		
V 118	Continued From pa	ge 1	V 118			
	with a physician.					
	with a physician.					
	This Rule is not met as evidenced by: Based on record review, observation and					
		y failed to administer				
	medications on the written order of a physician					
		ee clients (#1 and #6). The				
	findings are:					
	A. Review on 02/12/20 of client #1's record revealed: - 46 year old male.					
	- Date of admission: 2/10/20.					
	- Diagnoses of Alcohol Use Disorder-Severe and					
	Substance-Induced Depressive Disorder.					
	Review on 02/12/20 of client #1's medication					
		y signed by the physician on				
	02/11/20 revealed:	y eighted by the physician en				
		id-prevents ulcers in stomach				
		ke one tablet at bedtime.				
	and intodiffico) tak	constant at bodinio.				
	Review on 02/12/20	of client #1's February 2020				
		ocumentation famotidine was				
	administered as ord					
	aumminstereu as ord	iereu.				
	Interview on 00/40/	20 aliant #1 atatad ha had				
		20 client #1 stated he had				
		dications at the facility. He was				
	unable to recall the	names of his medications.				
	D D! 20/15	100 of all and 1101				
		1/20 of client #6's record				
	revealed:					
	- 46 year old male.					
	- Date of admission					
	- Diagnoses of Sevi	ere Stimulant I lee Disorder				

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Severe Major Depressive Disorder and

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	E SURVEY IPLETED	
		MHL078-276	B. WING		02/1	2/2020	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
TANGLE	WOOD ARBOR		T 29TH STRE TON, NC 28:				
(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 APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
V 118	Continued From pa	ge 2	V 118				
	Generalized Anxiety	y Disorder.					
	Review on 02/12/20 orders electronically 02/10/20 revealed: - Famotidine - take  Review on 02/12/20 MAR revealed no dadministered as order of the facility.  Observation on 02/12/20 received an anti-defacility.  Observation on 02/2:30pm of the facility famotidine available Interview on 02/12/20 stated: - The facility did not stock today. She wow was obtained for use the facility had swelectronic based syen the admitting phy medication orders of the famotidine was a stated.	of client #6's medication y signed by the physician on one tablet at bedtime.  of client #1's February 2020 ocumentation famotidine was dered.  client #6 stated he had pressant medication at the stated he had pressant medication at the reducations revealed note for administration.  the Program Manager thave famotidine currently in ould ensure the medication security in the pull of the program					
		. She would address the h the medical director.					

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