Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
					R	
		MHL009-040 B. WING		10/07/2022		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BLADEN	I COUNTY #1 MILLBR	ANCH	FBLADEN ST BORO, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	E
V 000	INITIAL COMMENT	-S	V 000			
V 440	on October 7, 2022 This facility is licens category: 10A NCA Living for Adults wit This facility is licens census of 6. The su audits of 3 current of		V.440			
V 118	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 administering the drug.		V 118			

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BUILDING:				
		MHL009-040	B. WING		10/0	7/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BLADEN	COUNTY #1 MILLBR	PANCH	BLADEN STORO, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y 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 118	(5) Client requests checks shall be rec	age 1 for medication changes or corded and kept with the MAR appointment or consultation	V 118			
	Based on record re interviews the facili current and adminis	et as evidenced by: eviews, observations and ty failed to keep the MARs ster medications as ordered by 3 audited clients (#4, #5). The				
	revealed: -67 year old maleAdmitted on 7/1/11 -Diagnoses of Psyc Disability Moderate	chotic Disorder, Intellectual				
	for client #4 dated 2 -Clonazepam 0.5 m day. (Seizures)	nilligram (mg) 1 tablet twice a				
	from 7/1/22 - 10/4/2 -Clonazepam 0.5 m administered for 8p	- 10/5/22 of client #4's MARs 22 revealed: ng was not documented as om dose 10/1/22 - 10/3/22. ckings documented as worn				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER			` '	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		A. BUILDING:				₹	
		MHL009-04	0	B. WING			7/2022
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BLADEN	COUNTY #1 MILLBR	RANCH		BLADEN ST BORO, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIE! Y MUST BE PRECEDE! SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 118	Continued From pa	ige 2		V 118			
	daily from 7/1/22 -	10/4/22.					
	Observation on 10/ 4:00pm of client #4 -Client #4 was not stockings.	's revealed:					
	Interview on 10/4/22 client #4 responded he took his medications.						
	Finding #2 Review on 10/4/22 - 10/5/22 of client #5's record revealed: -47 year old femaleAdmitted on 6/12/19Diagnoses of Schizoaffective Disorder, Bipolar Type History; Mild Intellectual Disability; Neurocognitive Disorder due to general medical conditions (Seizure Disorder).						
	Review on 10/5/22 for client #5 reveals -Order dated 2/8/22 tablet 3 times daily spasms. - II daily as needed for -Order dated 4/20/2 stockings wear dail (Circulation/Swellin	ed: 2 - Methocarbamo as needed for mo buprofen 800 mg pain. 22 Knee High Cor ly remove at bedt	ol 750 mg 1 uscle 1 tab 3 times mpression				
	Review on 10/4/22 from 7/1/22 - 10/4/2 -Knee High Compras worn daily from	22 revealed: ession Stocking o					
	Observation on 10/ 2:30pm of client #5 -Methocarbamol 75 were not available	's medications re 50 mg and Ibupro	vealed:				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			X3) DATE SURVEY COMPLETED	
MHL009-040				R 10/07/2022			
NAME 05.					10/0	112022	
NAME OF F	PROVIDER OR SUPPLIER		BLADEN S	STATE, ZIP CODE			
BLADEN	COUNTY #1 MILLBR	ANCH	BORO, NC 2				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 118	Continued From pa	ge 3	V 118				
	Interview on 10/4/22 -Client #4 received as ordered she forg administeredClient #4 had not v stockings on 10/4/2 them on before his -She had document compression stocki	nedication daily. high compression stockings. 2 staff #1 stated: his Clonazepam medications to to document it was worn his compression 2 because she forgot to put community outing. ted client #4 wore his ngs on 10/4/22. t #5 had worn her knee high					
	Interview on 10/5/22 and 10/7/22 the Nurse stated: -She reviewed medications and checked MARs monthlyShe was informed client #5 lost her compression stockingsShe was unsure when client #5 lost her compression stockingsThe staff searched her room on 10/4/22 and could not locate the compression stockingsThe MARs should not be documented if client #4 and client #5 had not worn their compression stockingsClient #5's Methocarbamol 750 mg and lbuprofen 800 mg were ordered.						
	stated: -The nurse was responsible for reviewing medications and MARsClient #5 threw stuff away often and may have thrown her compression stockings awayThe clients received their medications as						

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
MHL009-040		B. WING		R 10/07/2022		
NAME OF PROVIDER OR SUPPLIER STREET ADI 715 EAST			DRESS, CITY, S BLADEN S BORO, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
V 118	Continued From particle ordered. This deficiency contand must be corrected.	stitutes a re-cited deficiency	V 118			
V 752	10A NCAC 27G .03 EQUIPMENT (b) Safety: Each fa constructed and eq ensures the physica visitors. (4) In areas cexposed to hot water	t Water Temperatures 04 FACILITY DESIGN AND cility shall be designed, uipped in a manner that al safety of clients, staff and of the facility where clients are er, the temperature of the tained between 100-116	V 752			
	failed to maintain the 100-116 degrees Failed: Observation on 10/4 pm revealed: -The bathroom sink degrees Fahrenheit -The bathroom sink degrees Fahrenheit Interview on 10/4/2/2	ons and interview the facility e water temperature between ahrenheit. The findings are: 4/22 at approximately 12:15 on the first hall was 80 on the second hall was 80 classification.				
	-The water at the fa Interview on 10/4/22 -The water tempera second shift.	cility "really did not get warm." 2 staff #1 stated: tures were checked daily on temperature was between 100				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				B) DATE SURVEY COMPLETED	
			A. BUILDING.			,	
		MHL009-040	B. WING		10/0	7/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
BLADEN	COUNTY #1 MILLBR	ΔΝΩΗ	BLADEN ST BORO, NC 2				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
V 752	Continued From pa	ge 5	V 752				
	Interview on 10/5/2 stated: -The water temperal-If the water temperal-	2 the Qualified Professional atures were checked daily. ratures were off staff kept a and turn it in to the office.					

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Division of Health Service Regulation STATE FORM

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