Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE SURVEY COMPLETED	
		MHL011-403	B. WING		10/2	8/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
DIERING	HOME	2 VILLAG BLACK N	E WAY IOUNTAIN, N	C 28711			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	NC	(X5)	
PRÉFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE	
V 000	INITIAL COMMENT	rs	V 000				
	An annual survey w Deficiencies were c	as completed on 10/28/22. ited.					
	This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Individuals of all Disability Groups/Alternative Family Living.						
		sed for 2 and currently has a urvey sample consisted of clients.					
V 118	27G .0209 (C) Med	ication Requirements	V 118				
	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	administering the drug; ne drug is administered; and of person administering the					

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

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	MULTIPLE CONSTRUCTION UILDING:		(X3) DATE SURVEY COMPLETED	
		MHL011-403	B. WING		10/	28/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
DIERING HOME 2 VILLAG BLACK N			E WAY IOUNTAIN, N	C 28711			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 118	drug. (5) Client requests checks shall be rec file followed up by a with a physician. This Rule is not me Based on record re facility failed to kee	for medication changes or orded and kept with the MAR appointment or consultation et as evidenced by: view and interviews, the p the MAR current and failed	V 118				
	clients (Clients #1, ii Finding 1 Review on 10/27/22 revealed: -Date of Admission: -Diagnoses: Moders Autism Spectrum D Hypothyroidism and DisorderPhysician ordered included: -Levothyroxine 50 (hypothyroidism)- o -Loratadine 10mg/ tablet dailyVitamin D 2000iu (supplement)- one o -Physician ordered included: -Invega 3mg (antip -Guanfacine 1mg one tablet twice dai	ate Intellectual Disability, bisorder, Schizophrenia, di Post Traumatic Stress medications dated 2/28/22 mcg (micrograms) ne capsule daily. (milligrams) (allergies)- one (international units) capsule daily. medications dated 1/19/22 psychotic) one tablet daily. (attention deficit disorder)-					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/S		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		MHL011-403	B. WING		10/2	8/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DIERING	HOME	2 VILLAG		0.00744		
			OUNTAIN, N			
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 2	V 118			
	twice daily.					
	Review on 10/27/22 MARs revealed: -Levothyroxine wa on 10/27/22Loratadine was not 10/27/22Vitamin D was not 10/27/22Invega was not in 10/27/22Guanfacine was no 10/27/22 am dos -Lithium Carbonat administered on 10/27/22 revealed: -Date of Admission: -Diagnoses: Attentic Disorder (ADHD), N Spectrum Disorder -Physician ordered included: -Yaz 3-0.02mg (mVitamin D 2000iu -Fluoxetine 40mg ordered 5/3/22Propranolol 20mg 6/6/22. Review on 10/27/22 MARs revealed: -Yaz was not initia 10/27/22.	e was not initialed as /27/22 am dose. 2 of Client #2's record				
	10/27/22. -Fluoxetine was no 10/27/22.	ot initialed as administered on				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) DATE SURVEY COMPLETED	
			A. BUILDING:	A. BUILDING:			
		MHL011-403	B. WING		10/2	8/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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	-Propranolol was a on 10/27/22 am dos on 10/27/22 am dos Finding 2 Review on 10/27/23/3/30/22 for Client # -Ibuprofen 400mg PRN (as needed). revealed give Ibuprofer dated 10/25/2 times a day PRNTylenol 500mg (porder dated 10/13/2 MARs for Client #2-Instructions on back MAR revealed "PRI should be noted on -Ibuprofen was ini 8/1/22-8/31/22 oncoidentified. Nothing August MAR. Ibuptwice a day from 9/identified. Nothing September MAR. Clbuprofen was initia 10/1-10/26/22, 12p10/1-10/23/22 and was noted on the b-Tylenol was not work of the doctors transition on the dualified Profession on the Qualified Profession.	not initialed as administered se. 2 of physician's orders dated 2 revealed: (pain) give every 4 hours Order dated 10/13/22 ofen 3 times a day PRN. 22 revealed give Ibuprofen 4 vain) give 3 times a day PRN 22.	V 118				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL011-403	B. WING		10/2	8/2022
		DRESS, CITY, S	STATE, ZIP CODE	1		
DIERING HOME 2 VILLAG			E WAY OUNTAIN, N	IC 28711		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	-She administered due to Client #2 bei think about writing i trying to help Client Interview on 10/28/2 -Staff #1 should have givenShe only recently be learning all the bit a	Tylenol at 3am on 10/27/22 ng in such pain. She didn't t on the MAR, she was just	V 118			

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