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Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
ANDILAN	or contribution	IDENTIFICATION NOMBER.	A. BUILDING:					
		MHL036-296	B. WING		R 11/07/2023			
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE				
DOROTHY	DOROTHY'S PLACE 1961 BROWNSTONE COURT							
		GASTONI	A, NC 28054					
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE			
V 000	INITIAL COMMENTS		V 000					
	An annual and follow on 11-7-23. Deficience	up survey was completed cies were cited.						
		d for the following service 27G . 1700 Residential re For Children or						
		d for 4 and currently has a vey sample consisted of ents.						
V 118	V 118 27G .0209 (C) Medication Requirements		V 118					
	only be administered order of a person autidrugs. (2) Medications shall clients only when auticlient's physician. (3) Medications, incluadministered only by unlicensed persons transmistered to other leprivileged to prepare (4) A Medication Admall drugs administered current. Medications are corded immediately MAR is to include the (A) client's name; (B) name, strength, a (C) instructions for additional control of the co	stration: n-prescription drugs shall to a client on the written norized by law to prescribe be self-administered by norized in writing by the ding injections, shall be licensed persons, or by rained by a registered nurse, regally qualified person and and administer medications. inistration Record (MAR) of d to each client must be kept administered shall be refer administration. The following:						

Division of Health Service Regulation 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:	(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED	
74101 2741	or dorate of the transfer of t	IDENTIFICATION NO.	A. BUILDING: _		
		MHL036-296	B. WING		R 11/07/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
DOROTHY	('S PLACE		WNSTONE CO	URT	
			A, NC 28054		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE COMPLETE
V 118	Continued From page	e 1	V 118		
	drug. (5) Client requests for checks shall be recor	r medication changes or ded and kept with the MAR pointment or consultation			
	This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure medications were administered on the written order of a physician affecting 2 of 3 clients (#2 and #3). The findings are:				
	record revealed: -Date of admission: 5 -Age: 12Diagnoses: Post-Tra Attention Deficit Hype Combined Type, Uns Related Disorder, Op (ODD)Physician's order dat Hydroxyzine HCL (Hy	umatic Stress Disorder, eractivity Disorder (ADHD) pecified Trauma or Stress positional Defiant Disorder			
	MAR revealed: -Only had 7am and 7 documented on the N of 3 times a day as or	pm administration times lovember 2023 MAR instead rdered by the physician.			

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STATE FORM PEWG11 If continuation sheet 2 of 4

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Division of	of Health Service Regu	lation			FURIV	IAPPROVED
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED R 11/07/2023	
	MHL036-296		B. WING			
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STAT	E, ZIP CODE		
DOROTHY	Y'S PLACE		OWNSTONE COL	JRT		
		GASTON	IIA, NC 28054			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE OSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
V 118	Continued From page	e 2	V 118			
	REGULATORY OR LSC IDENTIFYING INFORMATION)					

Division of Health Service Regulation

oversight."

the MAR."

orders.

-"I'll add it right now. I'll make the correction on

-"We could not get him (client #3) an appointment

Interview with the Executive Director on 11-3-23

-Client #3 was admitted without physician's

with the doctor until today (11-3-23)."

STATE FORM PEWG11 If continuation sheet 3 of 4

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
						R		
		MHL036-296	B. WING		11	/07/2023		
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STAT	E, ZIP CODE				
DOROTH	Y'S PLACE		OWNSTONE COU	IRT				
	GASTONIA, NC 28054							
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE		
V 118	revealed: -He was aware that c physician's orders wh -"We usually make su come with them at ad came from a private f foster mom stated she the orders before she emergency admission fast. Once he got he admitted him and imn get him seen but the get was for this morni	lient #3 did not have sen he was admitted. ure that all of our paperwork limission but [Client #3] soster care home and the se did not have time to get se brought him. It was an an and everything happened are we went ahead and mediately called the doctor to first appointment we could ing."	V 118					

Division of Health Service Regulation

STATE FORM PEWG11 If continuation sheet 4 of 4