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CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure all medications were given without error. This affected one audit client (#2). The finding is: compliance with physicians orders for client # 2, and all individuals. Monitoring will occur through weekly medication and a boost. He also had his blood pressure checked. However, he did not have any creams applied. After the medication pass, the medication technician was asked if this was all of client #2's 8:00am and 7:00am orders and she stated yes. Interview with the other third shift staff revealed she was responsible for client #2's beth and had not put his cream on him. Review on 1/9/19 of the record revealed doctors orders signed 10/14/18 which indicated he should receive Lamisil AF AER 1% "apply topically to bilateral feet between toes twice daily." This was ordered to be done at 6:00am.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI	JLD BE	(X5) COMPLETION DATE	
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ordered to be done at 6:00am.		orders signed 10/1	4/18 which indicated he should					
DUCE MALL iconquero Soci			-		MAR 0 4 2019			
Review on 1/9/19 of the medication administration record (MAR) after all third shift was gone for the day revealed the Lamisil was		administration reco	ord (MAR) after all third shift		DHSR-MH Licensure	Sect		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 01/11/2019

Facility ID: 922167

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING COMPLET 34G211 B. WING O1/09/ NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 928 MAGNOLIA DRIVE ABERDEEN, NC 28315 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION			ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 01/11/2019 FORM APPROVED OMB NO. 0938-0391		
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