STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUP AND PLAN OF CORRECTION IDENTIFICATION		IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		MHL024-104	B. WING		03/13/2019	
AME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, SI	TATE. ZIP CODE	03/	13/2013
	AD GROUP HOME	411 WEST	BURKHEAD	STREET		
			LE, NC 2847			
(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 ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
V 000	INITIAL COMMENTS		V 000			
	An annual survey was completed on March 13, 2019. A deficiency was cited.					
	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.					
V 118	27G .0209 (C) Medication Requirements		V 118			
	 only be administered order of a person a drugs. (2) Medications shat clients only when an client's physician. (3) Medications, include the dimensional order of the privileged to prepare of the privileged to prepare of the dimensional drugs administered on the privileged to prepare of the dimensional drugs administered order of the dimensional drug of the dimensional drug of the dimensional drug. (5) Client requests checks shall be recorded drug or dimensional drug or dimensional drug. 	non-prescription drugs shall ad 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. ministration Record (MAR) of red to each client must be kept s administered shall be ely after administration. The				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
	MHL024-104 B. WING			03/13		
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
BURKHE	AD GROUP HOME		ST BURKHEAD ILLE, NC 2847			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
V 118	Continued From pa	ige 1	V 118			
	This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to administer medications on the written order of a physician and failed to keep the MARs current affecting two of three clients (#1 and #5). The findings are:					
	revealed: -24 year old male. -Admission date of -Diagnoses of Mode Developmental Disa	erate Intellectual ability, Attention Deficit der-Combined Type and				
	Review on 03/12/19 medication orders r 08/20/18	9 and 03/13/19 of client #1's evealed:				
	-Benztropine (treats milligrams (mg) - ta -Trileptal (treats sei take 12.5mls twice	s Parkinson's symptoms) 0.5 ike one tablet twice daily. izures) 300mg/5milliters (ml) - daily. intipsychotic) 100mg - take				
		ly. eizures) 500mg - take one g and two tablets at bedtime.				
	11/16/18 -Colace (stool softe	ener) 100mg - take one daily				
	12/10/18 -Keppra (treats seiz in the morning and ealth Service Regulation	zures) 500mg - take one tablet two at bedtime.	t			

STATE FORM

BUW611

		2gulation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
	MHL024-104		B. WING		03/	03/13/2019	
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		03/	13/2019	
			T BURKHEAD				
	AD GROUP HOME	WHITEVI	LLE, NC 2847	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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
V 118	Continued From pa	ge 2	V 118				
	12/28/18 -Flonase (treats allergies) 50 micrograms (mcg) - 2 sprays per nostril daily.						
	Review on 03/12/19 of client #1's March 2019 MAR revealed the following blanks: -Benztropine - 03/01/19 at 8pm, 03/02/19 at 8am and 03/04/19 at 8am. -Trileptal - 03/02/19, 03/04/19 and 03/06/19 at 8am.						
	-Chlorpromazine - C 8am and 03/04/19 a -Depakote - 03/01/1 8am. -Colace - 03/01/19	03/01/19 at 8pm, 03/02/19 at at 8am. 19 at 8pm and 03/04/19 at at 8pm, 03/02/19 at 8am and					
	8am, 03/04/19 thru at 8am.	t 8am and 8pm, 03/02/19 at 03/06/19 at 8am and 03/09/19 and 03/04/19 at 8am.					
	Interview on 03/12/ his medications dai	19 client #1 stated he received ly as ordered.					
	revealed: -20 year old male. -Admission date of	9 of client #5's record 12/29/15. matic Brain Injury, Mild Mental					
	Retardation, Seaso	of client #5's signed FL2					
	dated 02/06/19 reve medications:						
	everyday.	ol 3350 (Treats Constipation) 1					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL024-104	B. WING		03/	13/2019
IAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
	EAD GROUP HOME	411 WES	T BURKHEAD	STREET		
		WHITEVI	LLE, NC 2847	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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pa	ge 3	V 118			
	1 cap by mouth ever -Seroquel 200mg (t mouth every mornir -MonteluKast SOD tablet by mouth ever -Clonidine HCL 0.1t hyperactivity disord -Seroquel 400mg 1 -Tricor 145mg (trea triglycerides levels) -Propranolol 40mg hypertension) Take day.	reat schizophrenia) 1 tablet by ng. 10mg (treats allergies) 1				
	January-March 201 following blanks. -Claritin 10mg-03/0 -Polyethylene Glycc -Vitamin D 2000 un -Seroquel 200mg-0 -Montelukast SOD -Clonidine HCL 0.11 -Seroquel 400mg-0 -Tricor 145mg-03/0 -Propranolol 40mg- 8am, 03/01/19 at 8 -Flonase 50mcg's-0	bl 3350-03/01/19-03/12/19. its-03/01/19-03/12/19. 3/02/19 at 8am. 10mg-03/02/19 at 8am. mg-03/01/19 at 8pm. 3/01/19 at 8pm. 1/19 at 8pm. 03/01/19 at 8am, 03/02/19 at				
	During interview on received his medica	03/12/19 client #5 stated he ation daily.				
	- The House Manag	19 the Licensee stated: ger had been out for a few eview the MARs for March				

BUW611

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			
		MHL024-104	B. WING		03/	13/2019
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
BURKHE	AD GROUP HOME					
	SUMMARY STA	TEMENT OF DEFICIENCIES	ILLE, NC 2847	Z PROVIDER'S PLAN OF	CORRECTION	(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pa	ge 4	V 118			
	2019. - The completion of MARs would be addressed with staff					
	Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician.					

BUW611