Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_ COMPLETED B. WING MHL024-104 03/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 411 WEST BURKHEAD STREET **BURKHEAD GROUP HOME** WHITEVILLE, NC 28472 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) V 000 INITIAL COMMENTS V 000 RECEIVED An annual survey was completed on March 13, By DHSR - Mental Health Lic. & Cert. Section at 10:45 am, Apr 01, 2019 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 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 administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRÉSENTATIVE'S SIGNATURE TITLE (X6) DATE

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PRINTED: 03/15/2019 FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL024-104 03/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **411 WEST BURKHEAD STREET BURKHEAD GROUP HOME** WHITEVILLE, NC 28472 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 118 V 118 Continued From page 1 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: Finding #1 Review on 03/12/19 of client #1's record revealed: -24 year old male. -Admission date of 10/05/16. -Diagnoses of Moderate Intellectual Developmental Disability, Attention Deficit Hyperactivity Disorder-Combined Type and Disruptive Behavior Disorder. Review on 03/12/19 and 03/13/19 of client #1's medication orders revealed: 08/20/18 -Benztropine (treats Parkinson's symptoms) 0.5 milligrams (mg) - take one tablet twice daily. -Trileptal (treats seizures) 300mg/5milliters (ml) take 12.5mls twice daily. -Chlorpromazine (antipsychotic) 100mg - take one tablet twice daily. -Depakote (treats seizures) 500mg - take one tablet every morning and two tablets at bedtime.

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-Colace (stool softener) 100mg - take one daily

-Keppra (treats seizures) 500mg - take one tablet

in the morning and two at bedtime.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE	(X3) DATE SURVEY COMPLETED					
					COME						
		MHL024-104	B. WING		03/13/2019						
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STATE, ZIP CODE								
BURKH	EAD GROUP HOME		BURKHEA								
	WHITEVILLE, NC 28472										
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRIOR DEFICIENCY)	JLD BE	D BE COMPLETE					
V 118	Continued From page 2		V 118								
	12/28/18 -Flonase (treats alle 2 sprays per nostril	ergies) 50 micrograms (mcg) - 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.			,							
	8am.	, 03/04/19 and 03/06/19 at 3/01/19 at 8pm, 03/02/19 at									
	8am and 03/04/19 a										
	8amColace - 03/01/19 at 8pm, 03/02/19 at 8am and 03/04/19 at 8am.			,							
	-Keppra 03/01/19 at 8am, 03/04/19 thru (at 8am.	8am and 8pm, 03/02/19 at 03/06/19 at 8am and 03/09/19 and 03/04/19 at 8am.									
	Interview on 03/12/1 his medications daily	9 client #1 stated he received y as ordered.									
	Finding #2 Review on 03/12/19 revealed:	of client #5's record									
	<ul><li>-20 year old male.</li><li>-Admission date of 1</li><li>-Diagnoses of Traun Retardation, Season</li></ul>	12/29/15. natic Brain Injury, Mild Mental nal Allergies, and Asthma.									
	Review on 03/12/19 dated 02/06/19 rever medications:	of client #5's signed FL2 aled the following									
	-Claritin 10mg (Treat everyday. -Polyethylene Glycol	ts Allergies) 1 tab by mouth  3350 (Treats Constipation) 1				*					
	cap full with 8 ounce	s of fluid.									

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PEAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
X 5							
MHL024-104		B. WING		03/13/2019			
NAME OF	PROVIDER OR SUPPLIER			, STATE, ZIP CODE			
BURKH	EAD GROUP HOME		BURKHEAD STREET				
(X4) ID	SUMMARY STA		LE, NC 28				
PRÉFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETE		
V 118	8 Continued From page 3		V 118				
	-Vitamin D 2000 uni 1 cap by mouth ever -Seroquel 200mg (tr mouth every mornin -MonteluKast SOD 1 tablet by mouth ever -Clonidine HCL 0.1m hyperactivity disorde -Seroquel 400mg 1 t -Tricor 145mg (treat triglycerides levels) 1 -Propranolol 40mg (thypertension) Take 1 day.	ts (For Vitamin D deficiency) ryday. eat schizophrenia) 1 tablet by g. 10mg (treats allergies) 1					
	January-March 2019 following blanksClaritin 10mg-03/01/ -Polyethylene Glycol -Vitamin D 2000 units -Seroquel 200mg-03/ -Montelukast SOD 10/ -Clonidine HCL 0.1ms/ -Seroquel 400mg-03/ -Tricor 145mg-03/01/ -Propranolol 40mg-03/ 8am, 03/01/19 at 8pm/ -Flonase 50mcg's-03/ 8pm, 02/01/19 at 8pm/ 01/04/19 at 8pm.  During interview on 03/ received his medication.	119-3/12/19. 3350-03/01/19-03/12/19. 3-03/01/19-03/12/19. 02/19 at 8am. 0mg-03/02/19 at 8am. g-03/01/19 at 8pm. 19 at 8pm. 19 at 8pm. 3/01/19 at 8am, 03/02/19 at n. 01/19 at 8pm, 02/19/19 at n. 01/19 at 8pm, 02/19/19 at n.					

**FORM APPROVED** Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ B. WING MHL024-104 03/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 411 WEST BURKHEAD STREET **BURKHEAD GROUP HOME** WHITEVILLE, NC 28472 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **TAG** DATE DEFICIENCY) V 118 Continued From page 4 V 118 - 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.

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