STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
				A. BUILDING:			
		MHL067-091	B. WING			R 10/18/2019	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
IANTUC	KET		SEY DRIVE	8540			
(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				
		w up survey was completed 9. Deficiencies were cited.					
	category: 10A NCA	sed for the following service AC 27G .5600C, Supervised h Developmental Disabilities.					
V 114	27G .0207 Emerge	ncy Plans and Supplies	V 114				
	AND SUPPLIES (a) A written fire pla area-wide disaster shall be approved b authority. (b) The plan shall b and evacuation pro posted in the facility (c) Fire and disaste shall be held at lease repeated for each s under conditions th	207 EMERGENCY PLANS in for each facility and plan shall be developed and by the appropriate local we made available to all staff cedures and routes shall be y. if drills in a 24-hour facility st quarterly and shall be shift. Drills shall be conducted at simulate fire emergencies. all have basic first aid supplies					
	failed to have fire a quarterly and repea findings are:	view and interviews the facility nd disaster drills held at least ated on each shift. The	,				
	10/1/18 - 9/30/19 re - 1st quarter (10/01 documented on the	/18- 12/31/18): No fire drills					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL067-091	B. WING		R 10/18/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
NANTUC	KET		DSEY DRIVE NVILLE, NC 2	8540		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLI THE APPROPRIATE DATE	
V 114	Continued From pa	ige 1	V 114			
	drills documented of - 2nd quarter (1/01/ documented on the	(19- 3/30/19): No fire drills				
	Interview on 10/18/19 the Group Home Manager stated: - 1st shift was 7:00am- 3pm. - 2nd shift was 3pm- 11pm. - 3rd shift was 11pm- 7am.					
V 118	27G .0209 (C) Med	lication Requirements	V 118			
	 only be administered order of a person a drugs. (2) Medications shat clients only when a client's physician. (3) Medications, inclient's physician. (4) A Medication Action and the privileged to prepare (4) A Medication Action all drugs administered current. Medication recorded immediate MAR is to include the (A) client's name; (B) name, strength, (C) instructions for (D) date and time the (E) name or initials 	inistration: non-prescription drugs shall ed 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 by licensed persons, or by a trained by a registered nurse r legally qualified person and re and administer medications liministration Record (MAR) of red to each client must be kep s administered shall be ely after administration. The				
	drug. (5) Client requests	for medication changes or				

STATE FORM

TGPQ11

If continuation sheet 2 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE		(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NOMBER.	A. BUILDING:			
		MHL067-091	B. WING			R 18/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
NANTUC	KET	109 LIND	SEY DRIVE			
		JACKSO	NVILLE, NC 2	28540		
(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	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
V 118	Continued From pa	ge 2	V 118			
		orded and kept with the MAR appointment or consultation				
	facility failed to kee	et as evidenced by: view and interviews, the p the MARs current affecting t clients (#1 and #2). The				
	revealed: - 47-year old female - Admission date of					
	form dated 6/17/19 medication orders: - Zyrtec (treats aller tablet daily. - Monodox (treats b tablet daily.	9 of client #1's signed FL-2 revealed the following rgies) 10 milligrams (mg) - 1 pacterial infections) 100mg - 1 ndder blockages) 0.4mg - 1				
	capsule daily. - Jolessa (prevents (mcg) - 0.15mg - 1 - Onfi (treats seizur - Carnitor (treats ca tablet twice daily. - Keppra (treats sei twice daily.	pregnancy) 30 micrograms				

STATE FORM

TGPQ11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL067-091		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		D D	
		MHL067-091	B. WING			R 18/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S ⁻	TATE, ZIP CODE		
NANTUC	KET		SEY DRIVE NVILLE, NC 2	8540		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
V 118	Continued From pa	ige 3	V 118			
	 Ivermectin Cream (treats rosacea) 1% - Apply to affected area on face daily. Calcium D 600-400 (treats calcium D deficiency) 1 tablet twice daily. 					
	 Review on 10/17/19 of client #1's July 2019 - October 2019 MARs revealed the following blanks: Zyrtec 10mg - 8/18/19 and 8/19/19 at 8am. Monodox 100mg - 8/19/19 - 8/20/19 and 9/22/19 at 8am. Flomax 0.4mg - 8/19/19 at 8am. Jolessa 30mcg / 0.15mg - 7/19/19, 8/17/19 - 8/20/19 at 8am. Onfi 10mg - 7/30/19-7/31/19 at 8am. Onfi 10mg - 7/09/19 and 7/28/19 at 8pm. Carnitor 330mg - 9/01/19 and 9/02/19 at 8pm. Carnitor 330mg - 7/26/19 (no specified time). Keppra 1000mg - 7/09/19 at 8pm. Phenobarbital 60mg - 9/15/19, 9/18/19, and 9/26/19 at 8pm. Ivermectin Cream 1% - 9/05/19, 9/08/19, 9/09/19, and 9/20/19 at 8am. Calcium D 600-400 - 9/01/19 and 9/02/19 at 8pm. 					
	Unable to interview verbal ability.	client #1 due to limitations in				
	revealed: - 51-year old female - Admission date of	f 7/03/08. llectual Disability (Profound)				
	#2 dated 10/03/19 i	9 of physician orders for client revealed: ats irritable bowel syndrome)				

STATE FORM

TGPQ11

If continuation sheet 4 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL067-091			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		B. WING			R 10/18/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
NANTUC	KET		DSEY DRIVE DNVILLE, NC 2	8540		
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pa	ige 4	V 118			
	24mcg - 1 capsule twice daily. - Desyrel (treats depression) 300mg - 1 tablet in the evening.					
	Review on 10/17/19 of client #1's July 2019 - October 2019 MARs revealed the following blanks:					
	- Lubiprostone 24mcg - 8/07/19 at 8am. - Desyrel 300mg - 8/31/19 at 8pm.					
	verbal ability.	client #2 due to limitations in				
	medication adminis determined if client	o accurately document stration it could not be #1 and client #2 received thei ered by the physician.	r			
		nstitutes a re-cited deficiency sted within 30 days.]				

TGPQ11