Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL059-079	B. WING		01/17/2020	
	ROVIDER OR SUPPLIER	1225 MA	DDRESS, CITY, STA CKEY CREEK RO RT, NC 28762			
(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 APPROF DEFICIENCY)	D BE COMPLETE	
V 000	INITIAL COMMENTS		V 000			
	2020. A deficiency wa	d for the following service 27G .5600F Supervised				
V 118	27G .0209 (C) Medica	ation Requirements	V 118			
	V 118 27G .0209 (C) Medication Requirements 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.					

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
		MHL059-079	B. WING		01	//17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
MACKEY	CDEEK HOME	1225 M	ACKEY CREEK ROA	AD		
MACKEY	CREEK HOME	OLD FO	ORT, NC 28762			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From page	1	V 118			
	MAR for 2 of 2 audite #2). The findings are:	ew, observation and failed to keep current the d clients (Clients #1 and of Client #1's record /21/18;				
	Obsessive Compulsiv Post-Traumatic Stres -12/21/19, a written a	ve Disorder (OCD), s Disorder (PTSD); and signed physician order xib (Celebrex) 50 milligram				
	#1's medication reveal -His medication dose pharmacy-dispensed according to dosage PM);	s were in , single-dose blister cards times (i.e., 8 AM, 3 PM, 8 s observed removing a				
	2019 and January 20 -His celecoxib 50 mg 12/20/19 which indica medication; -1/12/20 to 1/14/20, to staff-initialed after the					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL059-079		B. WING		01/17/2020		
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	,	
			CKEY CREEK R			
WACKEY	CREEK HOME	OLD FOR	RT, NC 28762			
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 118	Continued From page 2		V 118			
	Interview on 1/16/202 -His AFL providers ga daily.	0 revealed: eve him his medications				
	Interview on 1/16/2020 with AFL Provider #2 revealed: -She removed Client #1's celecoxib from his					
	blister pack due to his doctor having discontinued this medication last month; -She mistakenly initialed his January MAR on the celecoxib from 1/12/20 to 1/14/20;					
	-She always removed	I and disposed of the administering Client #1's				
	Review on 1/16/2020 of Client #2's record revealed:					
	-Date of admission: 7/12/19; -Diagnoses: Autism, Moderate Intellectual Developmental Disability (IDD), Peters Anomaly, Legal Blindness;					
	-7/9/19, a written and sertraline (Zoloft) Hyo mg/ml., concentrate,	signed physician's order for Irochloric acid (HCL) 20 take 5 milliliters (ml) (100				
	anxiety disorders; -1/7/20 a written and	o treat depression and/or signed physician's order to				
	increase sertraline fro dose.	om 100 mg dose to 150 mg				
	MARs revealed:	of Client #2's January 2020				
	100 mg dose was sta	1/16/20, her sertraline HCL ff-initialed as administered and not at the prescribed 150				
	_	50 mg was not identified on				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL059-079	B. WING		01	/17/2020
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1225 MACKEY CREEK ROAD OLD FORT, NC 28762					
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	Interview with AFL Pro-A local pharmacy using when there was a charmedication dosage; -She would follow up Qualified Professional QP #2 for Client #2) are ensure the correct med MARs. Interview on 1/17/202 revealed: -She confirmed Client QPs; -She and QP #2 would pharmacy and the AF	ovider #2 revealed: ually printed a new MAR ange in medication and/or Clients #1 and #2's Is (QP #1 for Client #1 and and the local pharmacy and edications are listed on the O with Client #1's QP ts #1 and #2 had separate Id follow up with the	V 118			

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