		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7.110 1 27.11	or correction.	BENTH TO THOMBER	A. BUILDING:		D	
		MHL024-104	B. WING		07/1	₹ 6/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BURKHE	AD GROUP HOME		BURKHEAI LE, NC 284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	rs	V 000			
	on July 16, 2021. D The facility is licens category: 10A NCA	w up survey was completed eficiencies were cited. ed for the following service C 27G .5600C Supervised h Developmental Disability.				
V 114	27G .0207 Emerge	ncy Plans and Supplies	V 114			
	10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use.					
	failed to have fire a quarterly and repea are:	et as evidenced by: view and interview, the facility nd disaster drills held at least ted on each shift. The findings and 7/16/21 of the facility's				
	drill logs records from revealed: -3rd Quarter 7/1/20	om July 2020 to June 2021 -9/30/20: No disaster drill end 8pm - 8am shift.				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		MHL024-104	B. WING	<u></u>		6/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BURKHE	AD GROUP HOME		BURKHEA			
(V4) ID	SLIMMA DV STA	TEMENT OF DEFICIENCIES	LE, NC 284	PROVIDER'S PLAN OF CORRECTI	ON	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 114	Continued From pa	ge 1	V 114			
	completed on 1st si completed on 1st, 3 8pm-8am shifts. -2nd Quarter 4/1/21 completed on 3rd s completed on 2nd s Interview on 7/15/2 Home Manager sta	1 and 7/16/21 the Group ted:				
	-The facility has 5 shifts3 shifts on Monday thru Friday, 1st shift 8am-3pm, 2nd shift 3pm-12am, and 3rd shift 12am-8amThe 1st shift is a dual shift with 3rd shift to assist in getting clients ready for the day treatment programWeekends shifts are from 8am to 8pm and 8pm to 8amThe fire/disaster drill logs for January 2021 to current were kept at the facilityThe fire/disaster drill logs for July 2020 to December 2020 were kept at the officeHe had some additional disaster drills from July 2020 to December 2020 at the facility that were not kept in the fire/disaster logs.					
V 118	10A NCAC 27G .02 REQUIREMENTS (c) Medication adm (1) Prescription or r only be administered order of a person a drugs. (2) Medications shall		V 118			

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STATE FORM 545C11 If continuation sheet 2 of 7

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(V2) MULTIPL	E CONSTRUCTION	(V2) DATE	CLID\/EV	
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
	*****		B WING		F	
		MHL024-104	D. WING		07/1	6/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DIIDKUE	AD COOLD HOME	411 WEST	BURKHEA	D STREET		
DUKKHE	AD GROUP HOME	WHITEVIL	LE, NC 284	72		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
IAG	THE GOLD TO THE OTHER		IAG	DEFICIENCY)	140.41	
V 440	0 - 6 - 1 -	0	\/.440			
V 118	Continued From pa	ge 2	V 118			
		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				
	MAR is to include the					
	(A) client's name;	le following.				
		and quantity of the drug;				
		administering the drug;				
		ne drug is administered; and				
		of person administering the				
	drug.	1 3				
		for medication changes or				
	checks shall be rec	orded and kept with the MAR				
	file followed up by a	appointment or consultation				
	with a physician.					
	This Rule is not me	at as evidenced by:				
		views and interviews, the				
		· · · · · · · · · · · · · · · · · · ·				
	facility failed to assure medications were administered on the written authorization of a physician and failed to keep the MARs current					
		nts (#1, #2, #6). The findings				
	are:	(,, ,, <u>,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, </u>				
	Finding #1					
		7/16/21 of client #1's record				
	revealed:					
-28 year old male						

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-Admission date 9/13/20.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			7 t. BOILBING.		R	
	MHL024-104		B. WING			6/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BURKHE	AD GROUP HOME		T BURKHEAI	_		
BOKKIIL	LAD GROOF HOWL	WHITEVIL	LE, NC 284	72		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 3	V 118			
	Mild Intellectual Dis Control Disorder an Review on 7/15/21- physician orders rev -6/29/21: Ibuprofen	500mg (milligrams) every 8				
	hours as needed. (I -No physician order medications.	Pain) is for over-the-counter (OTC)				
	Non-Routine Over-t client #1 revealed: -Coriciden HBP(Hig administered for co 10am, 2pm, 7pm ar	of a "MAR As-Needed and the-Counter Medications" for the Blood Pressure) ugh/congestion on 6/28/21 at and 6/29/21 at 8am and 4pm. flu administered for coughing				
	for May - July 2021	7/16/21 of client #1's MARs revealed: nad not been transcribed on				
		5/21 between 1:45pm - 3pm of n 500mg revealed a full blister 9/21.				
	Interview on 7/16/2 received his medica	1 client #1 stated he had ations daily.				
	revealed: -60 year old maleAdmission date of	Paranoid Schizophrenia, Mild y, hypertension and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL024-104	B. WING		07/1	R 6/2021
BURKHEAD GROUP HOME 411 WEST			DRESS, CITY, S BURKHEAI LE, NC 284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 4	V 118			
	physician orders rev 2/5/21 -Albuterol Sulfate H 90mcg (microgram) needed. (Wheezing 4/21/21 FL-2 -Chlorpromazine 50 (Mood/mental disor 4/28/21 -Eliquis 5mg tab 2 t clots) Review on 7/15/21-for May - July 2021 -Chlorpromazine 50 administered on 5/7 -Eliquis 5mg was not administered on 5/7 -Ventolin HFA 90mc 4 hours as needed, Observation on 7/15/21-revealed. Interview on 7/16/2 received his medical revealed: -27 year old maleAdmission date of -Diagnoses include	FA (hydrofluoroalkane) 1 puff every 4 hours, as hyshortness of breath) 2 mg tab at bedtime. 3 ders) 3 wice daily. (Prevent blood 4 7/16/21 of client #2's MARs revealed: 3 mg was not documented as 7/21. 3 to documented as 8 1/21 at 8 am. 3 transcribed as 2 puffs every not administered. 5 1/21 between 1:45pm - 3pm of HFA 90mcg inhaler evealed 1 puff every 4 hours as 1 client #2 stated he had ations daily. 5 1/16/21 of client #6's record 5 1/1/18. 5 1/1/18. 5 1/1/18. 5 1/1/18. 5 1/1/1/18. 5 1/1/1/18. 5 1/1/1/18. 5 1/1/1/18. 5 1/1/1/18. 5 1/1/1/18. 5 1/1/1/18. 5 1/1/1/18.				

Division of Health Service Regulation

STATE FORM 6899 545C11 If continuation sheet 5 of 7

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE	SURVEY PLETED	
			A. BUILDING:			_
		MHL024-104	B. WING			⋜ 16/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BURKHE	EAD GROUP HOME		BURKHEAI LE, NC 284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 118	Continued From pa	ige 5	V 118			
V 118	Review on 7/15/21-physician orders re -1/5/21: Fluticasone neededNo physician order Review on 7/16/21 Non-Routine Over-client #6 revealed: -"Mucus Relief "war on 5/10/21 at 6am"Tussin" was admi 5/10/21 at 6pm"Nite time Cold and sore throat on 5/1/2 Review on 7/15/21-for May - July 2021 -Fluticasone 50mcg nostril twice daily at administered daily for the cold of the cold and the cold	-7/16/21 of client #6's signed vealed: e 50mcg 1 spray twice daily as rs for OTC medications. of a "MAR As-Needed and the-Counter Medications" for s administered for sore throat nistered for sore throat on d Flu" was administered for 21 at 6pm. -7/16/21 of client #6's MARs revealed: g transcribed as 1 spray per	V 118			
	Interview on 7/16/2 received his medical	1 client #6 stated he had ations daily.				
	Manager stated: -All clients received: -Client #1 was received he had not taken itAs needed medicaroutine medications: -He had not realize client #3's Ventolin -He had verified with	ations were kept separate from				

Division of Health Service Regulation

STATE FORM 6899 545C11 If continuation sheet 6 of 7

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMF	SURVEY	
		MHL024-104	B. WING			R 16/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 077	10/2021
BURKHE	EAD GROUP HOME		BURKHEAI LE, NC 284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 6	V 118			
	needed.					
	-There were no phy medications given t -The facility never h medications.	nad physician orders for OTC stitutes a re-cited deficiency				

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