STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL047-170	B. WING		07/2	2/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
			TLE CREEKS			
SHARON	SHARON LEAK AFL RAEFORD, NC 28376					
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION	(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETE DATE
V 000	INITIAL COMMENT	rs	V 000			
	An annual survey w 2021. Deficiencies	as completed on July 22, were cited.				
	category: 10A NCA	sed for the following service C 27G .5600F Supervised Family Living in a Private				
V 118	27G .0209 (C) Med	ication Requirements	V 118			
	only be administered order of a person and drugs. (2) Medications shat clients only when and client's physician. (3) Medications, included and individual drugs administered only bunlicensed persons pharmacist or other privileged to prepare (4) A Medication Adall drugs administer current. Medication recorded immediated MAR is to include the (A) client's name; (B) name, strength, (C) instructions for a (D) date and time the (E) name or initials drug. (5) Client requests to the characteristic order or constructions for a construction of the constructions for a construction of the constructions for a construction of the construction of t	inistration: 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 by licensed persons, or by trained by a registered nurse, legally qualified person and e and administer medications. Iministration Record (MAR) of red to each client must be kept administered shall be ely after administration. The				

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

(X6) DATE TITLE

DIVISION	of Health Service Re	guiation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMP	LEIEU	
		MHL047-170	B. WING		07/2	2/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			LE CREEKS			
SHARON	I LEAK AFL		D, NC 28376			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	DN .	(X5)
PRÉFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	TRIAIL	DAIL
	.) / / / A			
V 118	Continued From pa	ge 1	V 118			
	with a physician.					
	This Rule is not me	et as evidenced by:				
		view, observation and				
		failed to ensure the				
	medication administration record (MAR) was					
		ne audited client (#1). The				
	findings are					
	Review on 7/21/21	of Client #1's record revealed:				
	- Admission date of					
		sm Disorder; Disruptive				
		; Mild Developmental Disability				
	Disorder; Attention	Deficit Hyperactivity Disorder.				
	Paviou on 7/21/21	of Client #1's Physicians order				
	review on 7/21/21	of Cliefft #1's Physicians order				
	-Order dared 10/22	/20·				
		nilligram (mg) - Take one				
	tablet at bedtime.					
	-Orders dated 3/19/					
		0 mg- Take one tablet every				
	day.	00 international unit (iii) Taka				
	one tablet every da	00 international unit (iu)- Take				
		e 300 mg- Take 6 milliliters				
	(mls) (350 mg) Twic					
	-Quillichew 20 r	ng- Chew and swallow one				
	tablet a day. Take w	vith 30 mg for total of 50 mg.				
		ng- Chew and swallow one				
	tablet a day. Take w	vith 20 mg for total of 50 mg.				
	Observation on 7/2	1/21 at 9:45 a.m. of Client #1's				
		the following was available:				

Division of Health Service Regulation

STATE FORM 6899 C9Q111 If continuation sheet 2 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL047-170	B. WING		07/2	2/2021
SHARON I FAK AFI 255 CAST		DRESS, CITY, S LE CREEKS D, NC 28376				
(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	-Vitamin C 1000 -Vitamin D3 200 -Oxcarbazepine -Quillichew 20 n -Quillichew 30 n Review on 7/21/21 MAR for June 2021 blanks on the follow -Vitamin C 1000 -Vitamin D3 200 -Oxcarbazepine -Quillichew 20 n -Quillichew 30 n In addition, review or revealed that dates filled in with staff's i Interview on 7/21/20 revealed: -Staff was trained to -She would make s medications dailyStaff #1 reported the staff of the reported that a recently which mad paperworkShe acknowledged	0 mg. 00 iu. 20 iu. 20 300 mg. mg. mg. and 7/22/21 of Client #'1's and July 2021 revealed ving dates: 0 mg 7/1/21-7/21/21 20 iu 7/1/21-7/21/21 20 300 mg 7/1/21-7/21/21 mg 7/1/21-7/21/21 mg 7/1/21-7/21/21 of the MAR for June 2021 were checked off and not	V 118			
V 736	10A NCAC 27G .03 EXTERIOR REQUI (c) Each facility and maintained in a safe	ty and Grounds Maintenance 03 LOCATION AND REMENTS I its grounds shall be e, clean, attractive and orderly e kept free from offensive	V 736			

Division of Health Service Regulation

STATE FORM 6899 C9Q111 If continuation sheet 3 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		MHL047-170	B. WING		07/2	2/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
SHARON	I LEAK AFL		LE CREEKS			
	OLIMANA DV. OTA		D, NC 28376		ON!	4
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 736	Continued From pa	ge 3	V 736			
	odor.					
	This Dula is not my	at an avidanced by:				
	This Rule is not met as evidenced by: Based on observation and interviews, the facility was not maintained in a safe, clean, orderly and					
	attractive manner.	The findings are:				
Observation on 7/21/21 at about 10:15 am of		1/21 at about 10:15 am of the				
	dining area revealed: -Boxes with items were cluttering and covering the floorWall that separated the dining area from the living area was unfinished and showing unfinished and unpainted drywall.					
	unimished and unp	ainted drywaii.				
	Observation on 7/21/21 at about 10:18 am of the living area revelaed: -Wall that separated the living area from the					
		ssing one side of the drywall				
		eams. Drywall was also				
	unfinished and unpa- -Walls were dirty/sta					
		with items on the floor.				
		1/21 at about 10:20 am of the				
	bathroom revealed: -Water stains obser					
	Interview on 7/21/2	1 WITH staff #1 revealed:				
	-She had been out	of town recently and had				
	brought in things in: at the porch.	side the house that had been				
		ed to her and she was				
	planning to put ther	n away.				
	 She wanted to sep 	arate the living area from the				

Division of Health Service Regulation

dining area and had started construction work

STATE FORM 6899 C9Q111 If continuation sheet 4 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMP	(X3) DATE SURVEY COMPLETED	
		MHL047-170	B. WING		07/2	2/2021
NAME OF PROVIDER OR SUPPLIER STREET ADI			ORESS, CITY, S	STATE, ZIP CODE		
SHARON I FAK AFI		LE CREEKS), NC 28376				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 736	stop because she dinside the homeShe had not been the construction wo -Her husband was owork that needed to	nitting, but then work had to lid not want to bring anyone able to find someone to finish rk.	V 736			

Division of Health Service Regulation STATE FORM

6899 C9Q111 If continuation sheet 5 of 5