

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL059-079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/10/2023
NAME OF PROVIDER OR SUPPLIER MACKEY CREEK HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1225 MACKEY CREEK ROAD OLD FORT, NC 28762		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	<p>INITIAL COMMENTS</p> <p>An annual and follow up survey was completed on January 10, 2023. A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living.</p> <p>This facility is licensed for 2 and currently has a census of 2. The survey sample consisted of audits of 2 current clients and 1 former client.</p> <p>A sister facility is identified in this report. The sister facility will be identified as sister facility A and the former client identified as Client #A1.</p>	V 000		
V 289	<p>27G .5601 Supervised Living - Scope</p> <p>10A NCAC 27G .5601 SCOPE</p> <p>(a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence.</p> <p>(b) A supervised living facility shall be licensed if the facility serves either:</p> <p>(1) one or more minor clients; or</p> <p>(2) two or more adult clients.</p> <p>Minor and adult clients shall not reside in the same facility.</p> <p>(c) Each supervised living facility shall be licensed to serve a specific population as designated below:</p> <p>(1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses;</p> <p>(2) "B" designation means a facility which</p>	V 289		

Division of Health Service Regulation

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

TITLE

(X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL059-079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/10/2023
NAME OF PROVIDER OR SUPPLIER MACKEY CREEK HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 MACKEY CREEK ROAD OLD FORT, NC 28762		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
V 289	Continued From page 1 serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7) (A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1) (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e) (1)(A),(D),(E),(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL).	V 289			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL059-079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/10/2023
NAME OF PROVIDER OR SUPPLIER MACKEY CREEK HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1225 MACKEY CREEK ROAD OLD FORT, NC 28762		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 289	<p>Continued From page 2</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide services within the scope of their license affecting 2 of 2 current clients (#1, #2). The findings are:</p> <p>Review on 12/15/22 of the facility's license revealed: -licensed for Supervised Living for Alternative Family Living with a capacity of 2.</p> <p>Review on 12/15/22 of Client Census revealed: -two clients resided in the facility.</p> <p>Review on 12/15/22 of Client #1's record revealed: -Date of Admission: 6/20/18; -Diagnoses: Moderate Intellectual Developmental Disability, Post-Traumatic Stress Disorder (D/O), Blindness, Anxiety Disorder D/O, and Autistic D/O.</p> <p>Review on 12/15/22 of Client #2's record revealed: -Date of Admission: 2/21/18 -Diagnoses: Fetal Alcohol Syndrome, Post-Traumatic Stress D/O, Generalized Anxiety Disorder, Mixed Obsessional thoughts and acts, Oppositional Defiant D/O, and Schizoaffective D/O, Bipolar Type.</p> <p>Review on 1/10/23 of Sister Facility Client #A1's (Client #A1) record revealed: -Date of Admission: 3/18/21; -Date of Discharge: 10/10/2022; -Diagnoses: Moderate Intellectual Developmental Disability, Autistic D/O, Disruptive Mood D/O, Attention Deficit Hyperactivity D/O,</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL059-079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/10/2023
NAME OF PROVIDER OR SUPPLIER MACKEY CREEK HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1225 MACKEY CREEK ROAD OLD FORT, NC 28762		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 289	Continued From page 3 Persistent Disinhibited Social Engagement D/O, Vitamin D Deficiency and Constipation. Interview on 1/10/23 with AFL Providers #1 and #2 revealed: -licensed for 2 clients; -Client #1 and #2 have resided at the facility for years. -there was a medical emergency at a sister facility a couple months ago and Client #A1 came over with his day worker, spent the night, and then went back to the sister facility where he lived; -Client #A1 stayed in their son's room who was not at home; -aware that it put them above capacity, but it was in Client #A1's best interest at the time.	V 289		