STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL014-006	A. BUILDING: _____ B. WING _____	R 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKWELL	3476 MORGANTON BOULEVARD LENOIR, NC 28645

(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	INITIAL COMMENTS An annual and follow up survey was completed on September 10, 2024. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for 8 and has a current census of 8. The survey sample consisted of audits of 3 current clients.	V 000		
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	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL014-006	A. BUILDING: _____ B. WING _____	R 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKWELL	3476 MORGANTON BOULEVARD LENOIR, NC 28645

(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 118	Continued From page 1 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. This Rule is not met as evidenced by: Based on record reviews, interviews, and observation, the facility failed to ensure medications were administered on the written order of a physician and that MARs were kept current affecting 3 of 3 audited clients (#1, #2, #3). The findings are: Reviews on 9/3/24 and 9/4/24 of Client #1's record revealed: -Date of admission: 5/28/24. -Age: 16 years old. -Diagnoses: Other Specified Disruptive, Impulsive-Control and Conduct Disorder; Major Depressive Disorder, Recurrent Episode, Mild; Attention Deficit Hyperactivity Disorder (ADHD), Combined Type. -Physician orders dated 4/15/24: -Lamotrigine (mood) 100 milligram (mg) 1 tablet (tab) twice daily. -Guanfacine (ADHD) 2mg 1 tab twice daily. -Trazodone 100mg (sleep) 1 tab at bedtime. -Albuterol hydrofluoroalkane (HFA) 90 micrograms (mcg)/actuation/inhaler inhale 2 puffs every 6 hours as needed (PRN) for wheezing. -Standing Physician orders for over the counter (OTC) medications dated 5/29/24 to follow manufacturer's instructions for:	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL014-006	A. BUILDING: _____ B. WING _____	R 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKWELL	3476 MORGANTON BOULEVARD LENOIR, NC 28645

(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 118	Continued From page 2 -Calcium Carbonate (Heartburn) - no strength identified. -Hydrocortisone cream/Calamine (insect bite, poison ivy) - no strength identified. -Acetaminophen or Ibuprofen (mild pain or fever) 200 to 500mg. -Diphenhydramine (itching and allergies) - no strength identified. -Guaifenesin (chest congestion) 400mg. -Generic mouthwash (oral hygiene). Review on 9/4/24 of Client #1's MARs from 6/1/24-9/3/24 revealed: -Lamotrigine not initialed as administered on 7/11/24 and 8/10/24. -Intuniv not initialed as administered on 7/11/24 and 8/10/24. -Trazodone not initialed as administered on 7/11/24. -"Inhaler" initialed as administered on 6/11/24, 6/26/24, 7/25/24 but no documentation of strength or quantity administered. -OTC medications initialed as administered on the back of the MAR: -"Antacid" initialed as administered on 8/9/24 but no documentation of strength or quantity administered. -"Itch cream" initialed as applied on 6/27/24, 8/3/24 and 8/19/24 but no documentation of strength applied. -Ibuprofen initialed as administered on 7/13/24, 8/8/24 and 8/20/24 but no documentation of strength or quantity administered and on 7/14/24-7/16/24 and 8/4/24 but no documentation of quantity administered. -Diphenhydramine initialed as administered once with no date and on 7/3/24 but no documentation of strength administered. -Guaifenesin initialed as administered on 6/18/24 but no documentation of strength	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL014-006	A. BUILDING: _____ B. WING _____	R 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKWELL	3476 MORGANTON BOULEVARD LENOIR, NC 28645

(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 118	Continued From page 3	V 118		

administered.
-Mouthwash initialed as administered on 8/2/24, 8/5/24, 8/6/24, 8/8/24, 8/9/24, 8/12/24-8/14/24, 8/21/24, 8/23/24, and 8/26/24-8/30/24 but no documentation of quantity administered.

Interview on 9/3/24 with Client #1 revealed:
-"...staff always give me my meds (medications)."
-"If I have a headache I'll ask staff for something (medication)."

Reviews on 9/3/24 and 9/4/24 of Client #2's record revealed:
-Date of admission: 12/26/23.
-Age: 17 years old.
-Diagnoses: Conduct Disorder, High Risk Sexual Behaviors.
-Physician orders:
-2/20/24:
-Vitamin D3 (bone strength) 50 micrograms (mcg) 1 capsule (cap) every morning.
-Melatonin (sleep) 5mg 1 tab at bedtime.
-2/27/24:
-Loratadine (allergies) 10mg 1 tab daily.
-Fluticasone (allergies) 50mcg 1 spray in each nostril twice daily.
-1/30/24:
-Ventolin HFA 90mcg 1 puff every 4-6 hours PRN.
-1/23/24:
-Clindamycin/Benzoyl peroxide gel (acne) 1.2-5% apply 1 gram to skin daily as directed (discard 60 days after fill date).
-7/31/24:
-Prevident toothpaste Sodium Fluoride (cavities) twice daily.
-Mupirocin (skin infection) 2% ointment apply to affected areas twice daily for 10 days.
-Standing Physician orders dated 1/4/24 to follow

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL014-006	A. BUILDING: _____ B. WING _____	R 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKWELL	3476 MORGANTON BOULEVARD LENOIR, NC 28645

(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 118	Continued From page 4	V 118		

manufacturer's instructions for:
-Diphenhydramine (itching and allergies) - no strength identified.
-Bismuth subsalicylate (diarrhea) - no strength identified.
-Guaifenesin (chest congestion) 400mg.
-Acetaminophen or Ibuprofen (mild pain or fever) 200 to 500mg.
-Polysporin ointment (triple antibiotic/Bacitracin zinc ointment) (abrasions).
-Rubbing alcohol (abrasions) - no strength identified.
-Hydrogen peroxide (abrasions).

Review on 9/4/24 of Client #2's MARs from 6/1/24-9/3/24 revealed:
-Vitamin D3 not initialed as administered on 8/6/24.
-Melatonin not initialed as administered on 7/29/24.
-Loratadine not initialed as administered on 8/19/24 and 8/24/24.
-Fluticasone was coded as "C" (medication not in the facility) on 8/5/24-8/9/24 for the morning doses but not documented as not in the facility 8/5/24-8/9/24 for the evening doses.
-Fluticasone not initialed as administered on 6/2/24 and 8/5/24 for the morning doses and on 6/1/24, 8/5/24-8/10/24, 8/23/24, 8/25/24 and 8/28/24 for the evening doses (14 doses missed).
-"Inhaler" initialed as administered on the back of the MAR on 7/11/24, 7/28/24, 8/3/24, 8/17/24, 8/19/24, 8/26/24, and 8/30/24 but no documentation of strength or quantity administered.
-Clindamycin not initialed as applied on 6/1/24, 7/13/24, 8/9/24, 8/10/24, 8/23/24, and 8/25/24 and initialed as applied twice on 8/1/24 and 8/2/24.
-Prevident toothpaste not initialed as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL014-006	A. BUILDING: _____ B. WING _____	R 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKWELL	3476 MORGANTON BOULEVARD LENOIR, NC 28645

(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 118	Continued From page 5	V 118		

administered on 8/1/24, 8/2/24, and 8/4/24 for the morning doses and on 8/1/24, 8/3/24, 8/13/24, 8/26/24, and 8/30/24 for the evening doses.

-Mupirocin not initialed as applied on 8/1/24-8/7/24 for the morning and evening doses and on 8/8/24-8/10/24 for the evening doses.

-OTC medications initialed as administered on the back of the MAR:

-Rubbing alcohol initialed as applied on 7/28/24 but no documentation of strength or quantity applied.

-Diphenhydramine initialed as administered on 7/1/24 but no documentation of strength administered and on 6/3/24, 6/5/24, and 6/23/24 but no documentation of strength or quantity administered.

-Bismuth subsalicylate initialed as administered on 6/4/24 and 7/28/24 but no documentation of strength or quantity administered.

-Guaifenesin 400mg initialed as administered on 6/17/24 but no documentation of quantity administered.

-Ibuprofen initialed as administered on 6/30/24 and 7/1/24 but no documentation of quantity administered, and on 7/27/24 but no documentation of strength administered.

-Acetaminophen initialed as administered on 7/7/24, 7/14/24, and 7/15/24 but no documentation of quantity administered, and on 7/5/24 and 7/27/24 but no documentation of strength or quantity administered.

-Triple antibiotic/bacitracin zinc ointment initialed as applied on 6/24/24 and 8/2/24-8/7/24 but no documentation of strength applied.

Interview on 9/3/24 with Client #2 revealed:
-"...take my meds every day."

Reviews on 9/3/24 and 9/4/24 of Client #3's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL014-006	A. BUILDING: _____ B. WING _____	R 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKWELL	3476 MORGANTON BOULEVARD LENOIR, NC 28645

(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 118	Continued From page 6 record revealed: -Date of admission: 5/19/23. -Age: 15 years old. -Diagnosis: Conduct Disorder, Adolescent-Onset Type. -Physician orders dated 4/3/24: -Sertraline (mood) 50mg tab,1 tab every morning. -No Physician order for Triamcinolone 0.1% Cream. -Standing Physician orders dated 8/23/23 to follow manufacturer's instructions for: -Bismuth subsalicylate (diarrhea) - no strength identified. -Acetaminophen or Ibuprofen (mild pain or fever) 200 to 500mg. -Polysporin ointment (triple antibiotic ointment) (abrasions). -Rubbing alcohol (abrasions) - no strength identified. -Hydrogen peroxide (abrasions). -Generic mouthwash (oral hygiene). Review on 9/4/24 of Client #3's MARs from 6/1/24-9/3/24 revealed: -Sertraline (Zoloft) 50mg tab, take 1 tab every morning. Morning is crossed out and "night" is handwritten in on the June and July MAR. Sertraline not initialed as administered on 6/3/24 and 7/11/24. -Triamcinolone 0.1% cream apply to affected area(s) twice a day PRN typed on June and July's MAR initialed as applied on 6/2/24-6/4/24, 6/8/24-6/13/24, 6/15/24-6/17/24, 6/19/24, 6/25/24, 6/26/24, 6/28/24-6/30/24, 7/1/24-7/5/24, 7/8/24-7/12/24, 7/16/24, 7/19/24, 7/24/24, and 7/31/24. -Triamcinolone initialed as applied on the back of the MAR on 8/2/24 and 8/4/24 but no documentation of strength applied. -OTC medications initialed as administered on	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL014-006	A. BUILDING: _____ B. WING _____	R 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKWELL	3476 MORGANTON BOULEVARD LENOIR, NC 28645

(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 118	Continued From page 7	V 118		

the back of the MAR:
-Bismuth subsalicylate initialed as administered on 6/3/24, 6/7/24, 6/8/24, 6/11/24, 6/12/24, 7/3/24, 7/10/24, 7/11/24, 7/18/24-7/21/24, and 7/23/24-7/25/24 but no documentation of strength or dosage administered.
-Ibuprofen initialed as administered on 6/1/14, 7/1/24, 8/12/24, 8/15/24, and 8/20/24 but no documentation of strength or quantity administered, on 6/4/24 but no documentation of strength administered, and on 6/8/24, 6/26/24, 6/29/24 and 8/8/24 but no documentation of quantity administered.
-Acetaminophen initialed as administered on 7/8/24 but no documentation of strength or quantity administered.
-Triple antibiotic ointment initialed as applied on 6/1/24 but no documentation of strength applied.
-Mouthwash handwritten and initialed as administered on 8/1/24, 8/7/24, 8/9/24, 8/14/24, 8/16/24, 8/20/24, and 8/23/24 but no documentation of strength or quantity.

Observation on 9/3/24 at 2:57pm of Client #3's medications revealed:
-Sertraline (Zoloft) 50mg tab, 1 tab every morning, dispensed on 8/15/24.

Interview on 9/3/24 with Client #3 revealed:
-"...always take my meds."

Interviews on 9/3/24-9/5/24 with Staff #1 revealed:
-She was responsible for updating and checking MARs and Physician orders.
-She was "just checking for medication errors and that staff were signing the back (of the MARs)."
-Staff were supposed to look at MAR,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL014-006	A. BUILDING: _____ B. WING _____	R 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKWELL	3476 MORGANTON BOULEVARD LENOIR, NC 28645

(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 118	Continued From page 8	V 118		

prescriptions and medications before pulling a client's medication for administration.
-Review of the MARs and Physician orders are "...part of my job...not as detailed as I should have been...I'm the only one reviewing (the MARs)."
-Did not catch the missing initialed as administered dates on the MARs, "...I missed it...on me, would be an oversight."
-She was not sure why the Sertraline instructions for administering in the morning were crossed out and "night" was handwritten in for June and July MARs, "...I don't have an answer for that...when I checked at the end of the month I didn't check for that...which is on me."
-When she would notice a medication was not initialed as administered she would ask the clients if they got their meds, "...they would say yes...staff just didn't mark it."
-She would check the client's medication to see if it was given and if the number sequence on the MAR was off, missing initials on the MAR were and "oversight of the staff not writing it down when they passed it (administered the med).

Interviews on 9/4/24 and 9/5/24 with the Director revealed:
-The expectation was the Staff #1 reviewed the MARs and meds for accuracy.
-There was "no oversight" after Staff #1 reviewed and submitted the MAR to the facility's records department at the end of each month.
-He changed the medication review process to have a nurse review the MARs and medications for the facility.
-"Once the MAR is transcribed by [Staff #1] it will be check by RN (Registered Nurse) before used in facility."
-The way staff will be trained in medication administration will be "more in-depth...more

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL014-006	A. BUILDING: _____ B. WING _____	R 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKWELL	3476 MORGANTON BOULEVARD LENOIR, NC 28645

(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 118	Continued From page 9 thorough" moving forward.	V 118		
V 119	27G .0209 (D) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction. (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge. This Rule is not met as evidenced by:	V 119		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL014-006	A. BUILDING: _____ B. WING _____	R 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKWELL	3476 MORGANTON BOULEVARD LENOIR, NC 28645

(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 119	Continued From page 10 Based on record reviews, interviews and observation, the facility failed to dispose of medications in a manner that guarded against diversion or accidental ingestion affecting 3 of 3 audited clients (#1, #2, #3). The findings are: Observation on 9/5/24 at 10:30am of Client #1's medications revealed: -Calcium Antacid 750 milligram (mg) tablets (tab) with an expiration date of 6/2024. Review on 9/5/24 of Client #1's August 2024 Medication Administration Record (MAR) revealed: -Calcium Antacid initialed as administered on 8/9/24. Observation on 9/3/24 at 2:40pm of Client #2's medications revealed: -Melatonin 5mg tabs with an expiration date of 11/2023. -Clindamycin 1.2-5% gel with a pharmacy label to discard 60 days after the fill date dispensed 2/2/24. Reviews on 9/3/24 and 9/4/24 of Client #2's June-September 2024 MAR revealed: -Clindamycin initialed as applied on 6/2/24-9/2/24. -Melatonin initial as administered on 6/1/14-9/2/24. Observation on 9/5/24 at 11am of Client #3's medications revealed: -70% rubbing alcohol with an expiration date of 3/2024. Review on 9/5/24 of Client #3's August 2024 MAR revealed: -70% rubbing alcohol initialed as applied on 8/2/24.	V 119		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL014-006	A. BUILDING: _____ B. WING _____	R 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKWELL	3476 MORGANTON BOULEVARD LENOIR, NC 28645

(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 119	Continued From page 11 Interviews on 9/3/24 and 9/4/24 with Staff #1 revealed: -She was "just checking for med (medication) errors and that staff were signing the back (of the MARs)" at the end of each month. -No meds were administered to Client #2 from the expired Melatonin bottle, "...it (Melatonin) was just there (in the medication bin)." -She would check the meds to see if it was administered and if the number sequence on the MAR was off, "...if they (staff) done a med error the med count would of been off." Interview on 9/5/24 with the local Pharmacist revealed: -There were "no adverse effects" of administering/applying the following medications/treatments which had expired: Clindamycin, Melatonin, rubbing alcohol, Calcium Antacid; -Clindamycin "...just would lose it's effectiveness." Interviews on 9/4/24 and 9/5/24 with the Director revealed: -The expectation was that Staff #1 reviewed the meds for accuracy. -There was "no oversight" after Staff #1 reviewed the medications. -He changed the medication review process to have a nurse review the MARs and medications for the facility each month. -The way staff will be trained in medication administration will be "more in-depth...more thorough" moving forward.	V 119		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION	V 123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL014-006	A. BUILDING: _____ B. WING _____	R 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKWELL	3476 MORGANTON BOULEVARD LENOIR, NC 28645

(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 123	Continued From page 12 REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. . This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure all medication administration errors were reported immediately to a physician or pharmacist affecting 1 of 3 audited clients (#2). The findings are: Reviews on 9/3/24 and 9/4/24 of Client #2's record revealed: -Date of admission: 12/26/23. -Age: 17 years old. -Diagnoses: Conduct Disorder, High Risk Sexual Behaviors. -Physician order dated 2/27/24: -Fluticasone 50 microgram (mcg) (allergies) 1 spray in each nostril twice daily. Review on 9/3/24 of Client #2's August 2024 Medication Administration Record (MAR) revealed: -Fluticasone was coded as "C" (medication not in the facility) on 8/5/24-8/9/24 for the morning doses but not documented as not in the facility 8/5/24-8/9/24 for the evening doses.	V 123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL014-006	A. BUILDING: _____ B. WING _____	R 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKWELL	3476 MORGANTON BOULEVARD LENOIR, NC 28645

(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 123	Continued From page 13 Review on 9/4/24 of Client #2's medication error reports revealed: -No documentation of immediately reporting to a physician or pharmacist for Client #2 not being administered Fluticasone as scheduled on 8/5/24 morning and evening dose, 8/6/24 morning and evening dose, and 8/7/24-8/9/24 evening dose. Interview on 9/3/24 with Client #2 revealed: -"...take my meds (medications) every day." -Did not report missing any Fluticasone. Interviews on 9/3/24 and 9/4/24 with Staff #1 revealed: -She was "just checking for medication errors and that staff were signing the back (of the MARs)" at the end of each month. -Code "C" written on MAR indicated the medication was not available in the facility. Interview on 9/6/24 with local Pharmacist revealed: -There were no adverse effects for an individual missing their Fluticasone nasal spray from 8/5/24-8/10/24, "...doesn't really matter...I wouldn't worry about it." Interview on 9/4/24 with the Director revealed: -The expectation was the Staff #1 reviewed meds for accuracy. -He will be changing the medication review process to having a nurse review medications at the facility.	V 123		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL014-006	A. BUILDING: _____ B. WING _____	R 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKWELL	3476 MORGANTON BOULEVARD LENOIR, NC 28645

(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 736	Continued From page 14 maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to be maintained in safe manner. The findings are: Observation on 9/3/24 at 1:33pm of the facility's interior revealed: -3 out of 5 client bedrooms did not have a door to their bedroom (bedroom #1, #3 and #5). Interview on 9/3/24 with Client #1 revealed: -Did not have a bedroom door. -"Staff need to see us at all times..." Interviews on 9/3/34 and 9/4/24 with Staff #1 revealed: -She "believed" the bedroom doors were missing due to property destruction from previous clients. -The facility's maintenance man was supposed to put the bedroom doors back on, "...our maintenance man left...I didn't check behind and make sure they were put on." -"Can't answer why they (bedroom doors) have not been put on (client bedroom)" -The missing bedroom doors were in the basement of the facility. Interview on 9/4/24 with the Qualified Professional (QP) revealed: -Some of the bedroom doors were removed in the last few years. -"They (clients) have to be in eyesight at all times except in the bathroom." Interviews on 9/4/24 and 9/5/24 with the Director revealed:	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL014-006	A. BUILDING: _____ B. WING _____	R 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKWELL	3476 MORGANTON BOULEVARD LENOIR, NC 28645

(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 736	Continued From page 15 -The bedroom doors were removed due to supervision concerns "...this is a 24-hour supervision home." -"If they (clients) get their doors shut and barricade themselves in there (bedroom) that would be an issue." -"Will put the doors back on (client bedrooms) if we (facility) have to."	V 736		