STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-103	A. BUILDING: _____ B. WING _____	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALCON CREST RESIDENTIAL CARE 3 INC	3309-A NC HIGHWAY 49 BURLINGTON, NC 27217

(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 survey was completed on September 23, 2025. A deficiency was 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 four and has a current census of three. The survey sample consisted of audits of three 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
	MHL001-103	A. BUILDING: _____ B. WING _____	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALCON CREST RESIDENTIAL CARE 3 INC	3309-A NC HIGHWAY 49 BURLINGTON, NC 27217

(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 and interview, the facility failed to keep the MAR current affecting one of three audited clients (#3). The findings are: Review on 9/23/25 of Client #3's record revealed: -Admission date of 1/26/24. -Diagnoses of Borderline Intellectual Functioning; Attention Deficit Hyperactivity Disorder, Predominantly Inattentive Presentation; Major Depressive Disorder, Recurrent Episode, Moderate; Other Specified Trauma and Stressor Related Disorder, Complex Post Traumatic Stress Disorder; Generalized Anxiety Disorder. -Physician's order dated 3/11/25: -Ketoconazole Shampoo (anti-dandruff)- Use 3 times a week when active-Reduce to once weekly when controlled. -Physician's order dated 9/11/25: -Clobetasol 0.05% Shampoo anti-dandruff)- Apply topically to affected area every other day. Observation on 9/23/25 at about 2:35 pm of Client #3's medications revealed: -Ketoconazole Shampoo was available. -Clobetasol 0.05% Shampoo was available. Review on 9/23/25 of Client #3's MARs for July	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-103	A. BUILDING: _____ B. WING _____	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALCON CREST RESIDENTIAL CARE 3 INC	3309-A NC HIGHWAY 49 BURLINGTON, NC 27217

(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 2025 through September 23, 2025 revealed: -July: -Ketoconazole Shampoo- Facility staff marked the shampoo as being administered daily. -Clobetasol 0.05% Shampoo- There were no markings from staff indicating that the shampoo had been administered. -August: -Ketoconazole Shampoo- Facility staff marked the shampoo as being administered daily. -Clobetasol 0.05% Shampoo- Facility staff marked the shampoo as being administered daily. -September: -Ketoconazole Shampoo- Facility staff marked the shampoo as being administered daily. -Clobetasol 0.05% Shampoo- Facility staff marked the shampoo as being administered daily. Interview on 9/23/25 with the program Director revealed: -He was not aware that staff were marking the shampoos wrong on the MAR for Client #3. -He would review the MARs with staff to make sure they were to be inputting the correct marks on the right days. -He confirmed the MARs was not kept current for Client #3. Due to the failure to accurately document medication administration for Client #3, it could not be determined if he received the medicated shampoos as ordered by his physician.	V 118		