If continuation sheet 1 of 12

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ R B. WING MHL014-087 03/13/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2419 MORGANTON BOULEVARD THE LANDING LENOIR, NC 28645 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 000 INITIAL COMMENTS V 000 DHSR - Mental Health A follow up survey for the Type B was completed on 3/13/18. Deficiencies were cited. APR 162018 This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Lic. & Cert. Section Treatment Staff Secure for Children or Adolescents. The position of residential V 118 27G .0209 (C) Medication Requirements V 118 3/14/18 coordinator was established 10A NCAC 27G .0209 MEDICATION to oversee facility REQUIREMENTS (c) Medication administration: operations. Residential (1) Prescription or non-prescription drugs shall Coordinator has selected only be administered to a client on the written specific staff each shift to order of a person authorized by law to prescribe druas. administer medications and (2) Medications shall be self-administered by those staff have received clients only when authorized in writing by the client's physician. additional training in (3) Medications, including injections, shall be medication administration and administered only by licensed persons, or by unlicensed persons trained by a registered nurse. documentation from the pharmacist or other legally qualified person and Program Director. Staff have privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of been assigned to check the all drugs administered to each client must be kept med box each day and fill out current. Medications administered shall be recorded immediately after administration. The a log which the Residential MAR is to include the following: Coordinator will check once a (A) client's name: week. A memo was distributed (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; to all staff on 3/13/18 that (D) date and time the drug is administered; and outlines the following: Any (E) name or initials of person administering the drug. time there is a medication (5) Client requests for medication changes or error the QI Director, checks shall be recorded and kept with the MAR file followed up by appointment or consultation Program Director, and Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE lal Q1 Director

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STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					X3) DATE SURVEY COMPLETED	
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		MHL014-087	B. WING			/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
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V 118	Continued From pa	ge 1	V 118	Residential Coordinator	must	2.55
	with a physician.			be notified when the err	ror is	
				discovered; For each		
				medication error a pharm	macist	
				must be notified at the	time	
	This Rule is not me			the error is discovered	and	
		view and interviews, the		staff must document the	time,	
	facility failed to keep the MAR current and failed to follow the written order of a physician affecting			date, and the name of the	ne	
	•	nts (Client #1, #2 and #3). The		pharmacist they spoke to	o; and	
	findings are:			If a medication is not	in the	
	Cross Referenced: 10A NCAC 27G .0209 Medications Requirements (Tag V123). Based on record review and interviews, the facility failed to immediately notify a physician or pharmacist of medication errors for 2 of 3 sampled clients (Client #1 and #2).			facility to administer v	vhen	
				talking to the pharmacis	st you	
				must follow up with the		
				pharmacist why the medic		
				has not been delivered,	and	
		6/18 for Client #1 revealed: 10/13/17 with diagnoses of peractivity Disorder (ADHD)		that information must be	9	
				communicated to the QI		
		d Dysregulation Disorder		Director, Program Direct	cor,	
	(DMDD). -Age-15			and the Residential		
	-Physician ordered	ician ordered medications included:		coordinator. Residential	L	
		ointment apply to affected rash ordered 3/3/17.		Coordinator has been		
•				designated as the contact	et	
	Review on 3/6/18 of MARs revealed:	February and March 2018		person for southern phan	macy	
-Mupirocin was initialed as administered		aled as administered at 8am		when there are issues wi	Lth	
	on 2/29/18Mupirocin was blank from March 1-6 (survey			medications to ensure th	ne	l
	entrance) with no di			issue is handled		
	Record review on 3/6/18 for Client #2 revealed:			appropriately and in a t	imely	
	-Admission date of	2/2/18 with diagnoses of corder, Post-Traumatic Stress		manner.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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MHL014-087		B. WING		03/13	/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
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V 118	Continued From pa	ge 2	V 118	Residential coordinator	will	***
	Disorder (PTSD) an	-		ensure that all MARS are	9	
	-Age-16			current and up to date.		
		medications included: 2 tabs twice daily for tremors		Residential Coordinator		
	ordered 12/21/17.			reviewed policies at the	•	
	-Strattera 25mg ond 2/16/18.	ce daily for ADHD ordered		staff meeting and is		
	2/10/16.			responsible for monitori	ng	
	Review on 3/6/18 of February 2018 MAR revealed: -Primodone was not given at 8am on 2/4/18-2/9/18. Notes on back of MAR dated			floor staff's competency	rin	
				medication administration	n and	
				documentation. Residenti	.al	
	2/4/18 and 2/7/18 in facility."	dicated "medication was not		coordinator will review	the	
	-Primodone was not given at 8pm on 2/6/18-2/9/18Strattera was not initialed as administered until 2/22/18 (6 days after ordered).			MARs at least once a wee	k to	
			ensure they are accurat up to date and will kee		and	
					a	
		*		log of with the time and	l date	
		/6/18 for Client #3 revealed: 11/3/17 with diagnoses of		of each review and alert	the	
	Oppositional Defian	t Disorder, ADHD and		QI Director if there are	any	
	Persistent Depressi -Age-15	ve Disorder.		issues. QI director will	meet	
	-Physician ordered medications included: -Cetirizine 10mg 1 tab at bedtime for allergies -Trazodone 50mg 1 ½ tabs at bedtime for sleep -Aptensio XR 20mg once daily for ADHD -Intuniv 4mg once daily for ADHD			with the residential		
				coordinator monthly to r	review	
				MARs, and logs.		
Review on 3/6/18 of February and March 201		February and March 2018				
	MARs revealed: -Cetirizine was not initialed as administered on					
	2/6/18.					
	-Trazodone was not initialed as administered on 2/6/18.					
		mented twice - initialed as /18 on handwritten MAR and				
	on 2/7/18 on typed p	pharmacy MAR.				
		as administered on 2/7/18				

PRINTED: 03/29/2018 **FORM APPROVED** Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R B. WING MHL014-087 03/13/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2419 MORGANTON BOULEVARD THE LANDING LENOIR, NC 28645 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 118 V 118 Continued From page 3 on handwritten MAR and on 2/7/18 on typed pharmacy MAR. -According the medication count written above initials on each MAR revealed the Intuniv supply ran out on 2/13/18, 2 days prior to the discontinue order dated 2/15/18. Review on 3/6/18 of Medication Error Level 1 Incident Reports from 2/2/18-3/6/18 revealed: -5 Medication Error/Level 1 incident reports. -2 Medication Error/Level 1 incident reports regarding Client #2 were for "medication undelivered by pharmacy." Incidents occurred 2/6/18-2/9/18 and 2/4/18-2/9/18. Review on 3/8/18 of Group Supervision Meetings revealed: -Meeting on 12/20/17, the former Healthcare Coordinator reviewed a new way to document on the MAR. "If the medication has been ordered and is not in the facility it does not have to be put on the MAR sheet until day three. At day three, the Lead QP must be called to inform them the medication is not there." -Meeting on 1/23/18, Staff #1 discussed new pharmacy forms and that Over the Counter (OTC) meds and external medication would be kept in a different cabinet. -Meeting on 2/22/18, the Program Director "spoke first about the current med errors and the plan of correction we are under. What she wants to happen is each person should send her a text if

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they discover a med error and the staff still have to do an incident report (which should have been done that day) it needs to be sent to the Lead at that time and we should not be negligent ..."

Interview on 3/6/18 with Client #1 revealed: -He got his meds every time it was scheduled. -He didn't think he had missed any meds.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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MHL014-087		B. WING	19.11	03/13/2018		
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
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V 118	Continued From pa	ge 4	V 118			
	Interview on 3/6/18 -He knew all the me on timeHe did not receive because the pharmHis Intuniv had bee Interview on 3/6/18 -He received his me and never missed a -He did not believe dose of any meds. Interview on 3/8/18 -She had spoken to 2/8/18 to find they hwrong pharmacyScript for Primodor 2/9/18, was filled an Interview on 3/8/18 -The Strattera (for C strength and had to -It was filled on 2/19 with delivery at 8pm lock box on 2/20/18 -The pharmacy had emergency meds we -The pharmacy had	with Client #2 revealed: eds he took and received them his Primodone for 3-4 days acy hadn't delivered it. en discontinued. with Client #3 revealed: eds when he was supposed to ny. he ever received a double with Pharmacy Tech revealed: the neurologist office on ad sent the script to the ne was sent to pharmacy on d delivered 2/10/18. with the Pharmacist revealed: Client #2) was an uncommon be ordered. lient #2 was an uncommon be ordered. lient #2 was delivered to facility at 2am. a back-up system when ere needed. provided a training for staff cluded this on-call system for				
	revealed: -She completed her her audit check-she -She would typically	review on 2/28/18 and gave ets to the Program Director. inform the staff of review person was outside on the				

Division of Health Service Regulation

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R B. WING __ MHL014-087 03/13/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2419 MORGANTON BOULEVARD THE LANDING 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 phoneShe must have overlooked the absence of notes on the back of the MAR for Client #2's Primodone. (No note for 2/5/18 am dose, 2/6/18 am and pm doses, 2/7/18 pm dose, 2/8/18 am and pm doses or 2/9/18 am and pm doses.) -She missed blank spaces on the MAR for Client #3 Trazadone and Zyrtec for 2/6/18She missed possible double administration of Intuniv and Aptensio for Client #1 on 2/7/18 which was marked as given on two February MARs. Interview on 3/8/18 with Staff #1 revealed: -She left 2 messages at doctor's office regarding script for Primodone. "When the nurse called back she reported to the Health Care Coordinator (HCC) the script was sent again to the pharmacy." -The HCC sent an email on 2/7/18 to the doctor regarding the Primodone scriptThought Client #1 was finished with Mupirocin since the rash had cleared despite not having a discontinue order.	V 118		
	Interview on 3/8/18 with the Lead QP revealed: -Licensee changed pharmacies to prevent this delay in receiving medicationsContracted RN completed audit on all meds and MAR on 2/26/18"We know we screwed up but we thought the medication (Primodone) was coming." -Staff didn't think to check the lock box on the patio (for the Strattera). Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician.			

Division of Health Service Regulation

MHL014-087 NAME OF PROVIDER OR SUPPLIER THE LANDING A. BUILDING: B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2419 MORGANTON BOULEVARD	40	
MHL014-087 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2419 MORGANTON BOULEVARD	40	
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LENOIR, NC 28645		
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V 118 Continued From page 6 V 118		
signed by QI Director on 3/13/18 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? -Residential Coordinator will select specific staff each shift to administer medicationsSpecific Staff will receive additional training in medication administration and documentation from the Program DirectorStaff will be assigned to check the med box each day and fill out a log. RC will check the log once a weekA memo will be distributed to all staff on 3/13/18 that outlines the following: -Any time there is a medication error the QI Director, Program Director and Residential Coordinator must be notified when the error is discoveredFor each medication error a pharmacist must be notified at the time of the error is discovered and staff must documents the time, date and name of the pharmacist they spoke toIf a medication is not in the facility to administer when talking to the pharmacist you must follow up with the pharmacist why the medication has not been delivered and that information must be communicated to the QI Director, Program Director and Residential CoordinatorResidential Coordinator has been designated as the contact person for Southern Pharmacy when there are issues with medicationsQI Director will complete POC for all documented medications errors and follow up with the Residential Coordinator to follow through with recommendationsResidential Coordinator position requires QP status and enhanced knowledge/understanding of medication requirements and facility operations.		

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDEN		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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V 118	policies at the upcoresponsible for more competency in med documentation. Refereive the MARs at they are accurate a log with the time an alert the QI Director Director will meet we monthly to review Market to medicate administered 12 downs not administering Clien 2/29/18. Because document the MARket to monthly to review Market to the discontinuity of the discontin	nator will review all relevant uning staff meeting and will be nitoring floor staff's dication administration and esidential Coordinator will the least once a week to ensure and up to date and will keep and date of each review and rif there are any issues. Qluith the Residential Coordinator MARs and logs." If not following procedures to bitaining refills or newly ions, Client #1 was not uses of Mupirocin; Client #2 and 10 doses of Primodone or 6 Staff falsely documented at #1's topical ointment on staff failed to correctly a for Client #3 it cannot be ceived Intuniv, Aptensio, cras ordered for 2 days. In ran out of Intuniv supply 2 days nue order. The outside RN dito audit medication issues incerns in her review. Staff diately notify a lan when an ordered	V 118			

NAME OF PROVIDER OR SUPPLIER THE LANDING STREET ADDRESS. CITY, STATE_LEP CODE 2419 MORGANTON BOULEVARD LENDIR, NC 2845 PRESTX TAG SUMMARY STATEMENT OF DEFCIENCES BY PULL PRESTX TAG CHECH CORRECTION WILST BE PRECEDED BY PULL PRESTX TAG V123 Continued From page 8 V123 V123 V123 V123 V123 V123 The position of residential coordinator was established to oversee facility operations. Residential coordinator has selected specific staff each shift to administer medication errors. Drug administrated and the drug reaction shall be properly recorded in the drug reaction and intended and the drug reaction and intended to mover see facility failed to immediately notify a physician or pharmacist of medication errors for 2 of 3 sampled clients (Client #1 and #2). The findings are: Record review on 3/6/18 for Client #1 revealed: -Admission date of 10/13/17 with diagnoses of Attention Deficit Hyperactivity Disporder (ADHD) and Disruptive Mood Dysregulation Disorder (DMDD)Age-16 ROWNEES PLAN OF CORRECTION SHOULD PRESTX TAG PROVIDERS PLAN OF CORRECTION PROVIDED PRESTX TAG PROVIDERS PLAN OF CORRECTION CORRECTION PROVIDED PRESTX TAG PROVIDERS PLAN OF CORRECTION CORRECTION PROVIDED PROVIDED PROPENT CORNECTION PROVIDED PROVIDED PROPENT CONSTRUCTION SHOULD PRESTX TAG PROVIDERS PLAN OF CORRECTION CORNECTION COMMENTS TO COMPLETE COMMENTS TAG PROVIDERS PLAN OF CORRECTION CORNECTION COMMENTS TAG PROVIDERS PLAN OF CORRECTION COMMENTS TAG PROVIDERS PLAN OF CORRECTION COMMENTS TAG The position of residential coordinator was established to oversee facility operations. Residential Coordinator has selected specific staff each shift to administer medication on addiction and those staff have been assigned to check the med box each day and fill out a log which the Residential Coordinator will check once a week. A memo was distribute	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		000		E SURVEY IPLETED	
NAME OF PROVIDER OR SUPPLIER THE LANDING SUMMARY STATEMENT OF DEFCIENCES (PACH DEFICIENCY MUST BE PRECEDED BY TULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 123 V 123 Continued From page 8 V 123 V 124 V 125 Continued From page 8 V 126 V 127 IOA NCAC 27G .0209 (H) Medication Requirements V 127 IOA NCAC 27G .0209 MEDICATION RECUIREMENTS (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 reactor. A client's refusal of a drug shall be charted. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to immediately notify a physician or pharmacist of medication errors for 2 of 3 sampled clients (Client #1 and #2). The findings are: Record review on 3/6/18 for Client #1 revealed: -Admission date of 10/13/17 with diagnoses of Attention Deficit Hyperactivity Disorder (ADHD) and Disruptive Mood Dysregulation Disorder (PTSD) and Tremors. Record review on 3/6/18 for Client #2 revealed: -Admission date of 20/21/18 with diagnoses of Attention Deficit Hyperactivity Disorder (ADHD). Conduct Disorder, Post-Traumatic Stress Disorder (PTSD) and Tremors.				A. BUILDING	NO		P	
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Continued From page 8 V123 The position of residential coordinator was established to oversee facility operations. Residential coordinator has selected and the drug reaction shall be reported immediately notify a physician or pharmacist of medication errors for 2 of 3 sampled clents (Client #1 revealed: -Admission date of 10/13/17 with diagnoses of Attention Defici Hyperactivity Disorder (ADHD). Record review on 3/6/18 for Client #2 revealed: -Admission acte of 2/2/18 with diagnoses of Attention Deficit Hyperactivity Disorder (ADHD). Conduct Disorder, Pors Traumatic Stress Disorder (PTSD) and Tremors.	NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE			
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PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION V 123 Continued From page 8 V 123 V 123 V 123 Continued From page 8 V 123 V 123 The position of residential coordinator was established to oversee facility operations. Residential Coordinator has selected specific staff each shift to administer and the drug reaction 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 review and interviews, the facility failed to immediately notify a physician or pharmacist of medication errors for 2 of 3 sampled clients (Client #1 and #2). The findings are: Record review on 3/6/18 for Client #1 revealed: -Admission date of 10/13/17 with diagnoses of Attention Deficit Hyperactivity Disorder (ADHD) and Disruptive Mood Dysregulation Disorder (DMDD)Age-16 -Physician ordered medications included: -Mupirocin 2% ointment apply to affected areas twice daily for rash ordered 3/3/17. Record review on 3/6/18 for Client #2 revealed: -Admission date of 12/2/18 with diagnoses of Attention Deficit Hyperactivity Disorder (ADHD), Conduct Disorder, Post-Traumatic Stress Disorder (PTSD) and Tremors.	(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF CORRECTION)N	(X5)	
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to oversee facility operations. Residential Coordinator has selected specific staff each shift to administer medication 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 review and interviews, the facility failed to immediately notify a physician or pharmacist of medication errors for 2 of 3 sampled clients (Client #1 and #2). The findings are: Record review on 3/6/18 for Client #1 revealed: -Admission date of 10/13/17 with diagnoses of Attention Deficit Hyperactivity Disorder (ADHD) and Disruptive Mood Dysregulation Disorder (DMDD)Age-15 -Physician ordered medications included: -Mupirocin 2% ointment apply to affected areas twice daily for rash ordered 3/3/17. Record review on 3/6/18 for Client #2 revealed: -Admission date of 2/2/18 with diagnoses of Attention Deficit Hyperactivity Disorder (ADHD), Conduct Disorder, Post-Traumatic Stress Disorder (PTSD) and Tremors.	V 123	27G .0209 (H) Med	ication Requirements	V 123		shed		
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Disorder (PTSD) and Tremors. the error is discovered and					must be notified at the	time		
Ago 16					the error is discovered	and		
		-Age-16			staff must document the	time,		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R		
MHL014-087		B. WING		03/13/2018			
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE			
THE LAN	NDING			BOULEVARD			
		LENOIR, N	NC 28645				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE PRIATE	(X5) COMPLETE DATE	
V 123	Continued From pa	ge 9	V 123	date, and the name of the	ıe		
20				pharmacist they spoke to	; and		
		f Medication Error Level 1 om 2/2/18-3/6/18 revealed:		If a medication is not i	in the		
		/Level 1 incident reports.		facility to administer v	vhen		
	 -2 reports for Client undelivered by phare 	macy (Primodone for		talking to the pharmacis	st you		
	tremors)."			must follow up with the			
		18 signed by Staff #1 and essional (QP) for "dosage		pharmacist why the medic	macist why the medication		
		18 8am. [Client #2] missed his		has not been delivered,	vered, and		
		one 250mg. Pharmacy did not Lead followed up with the		that information must be	t be		
	prescriber at [local i			communicated to the QI			
	determined they had sent the script to the wrong			Director, Program Direct	or,		
		18 [local medical center] sent obarmacy and the medication		and the Residential	821 201		
	was delivered on 2/	10/18". Time and date of		coordinator.			
		ne of pharmacist indicated					
	"see contact log" but no contact log was in use at that time.			Residential Coordinator	has		
		18 signed by Staff #1 and		been designated as the			
		e omitted 2/6/18-2/9/18 8pm. his pm dose of Primodone		contact person for south	nern		
	500mg. Pharmacy	did not have script on file.		pharmacy when there are			
		ith the prescriber at [local determined they had sent the		issues with medications	to		
	script to the wrong	oharmacy. On 2/9/18 Wake		ensure the issue is hand	iled		
		pt to [local] pharmacy and the ivered on 2/10/18". Time and		appropriately and in a t	imely		
	date of notification a	and name of pharmacist		manner. Residential			
	indicated "see contact log" but no contact log was in use at that time. -No reports were available for Client #1 missing			coordinator will ensure	that		
				all MARS are current and	l up		
	Mupirocin for 6 days	s (3/1/18-3/6/18).		to date. Residential			
	Review on 3/8/18 of	f Disciplinary Notice dated		Coordinator reviewed pol	icies		
		Lead QP to the current 6 staff		at the staff meeting and	lis		
	(including herself) re 2/4/18-2/9/18 revea	egarding dates of violation led:		responsible for monitori			
"When a client's medicine is not in the facility it is adamant that you inform the lead by means of an			floor staff's competency				

PRINTED: 03/29/2018 FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: ___ R B. WING 03/13/2018 MHL014-087 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2419 MORGANTON BOULEVARD THE LANDING LENOIR, NC 28645 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) in medication administration V 123 V 123 Continued From page 10 and documentation. incident report which must be done on the shift it Residential coordinator will was discovered, whether or not you did the med error or not. AND THIS MUST BE DONE EACH review the MARs at least once DAY THE MEDICINE IS NOT IN THE FACILITY! a week to ensure they are If it is an am and pm med then both shifts should fill out an incident report. Then the incident report accurate and up to date and must be scanned directly to [Program Director] will keep a log of with the and [Quality Improvement (QI) Director]. Due to time and date of each review our facility not following protocol we could cost the company some serious monies in pay backs. and alert the QI Director if PLEASE be aware of this as we work together to there are any issues. QI keep all of our clients safe." director will meet with the Interview on 3/8/18 with Staff #1 revealed: residential coordinator -"We only ask the pharmacist the 3 questions on the [level 1 incident report] form; 1) This error monthly to review MARs, and does not threaten the health or safety of the logs. consumer, 2) This error does threaten the health and safety of the consumer ... or 3) This error will result in permanent physical or psychological impairment ..." -"The PRN (as needed) staff didn't know external medications were moved to the cabinet with the OTCs (over the counter)." -She was responsible for keeping the med cart straight and making sure incident reports were done with med errors. -Created a notebook to communicate changes/updates and re-orders but no staff used -Created pharmacy contact log specifically for med errors. -Client #2 had just moved in from sister facility

Primodone.

and she thought the other facility had re-ordered

-"No one communicated with me and no one took up the slack" on her days off regarding Client #2's

-She had called the pharmacy on 2/5/18 after Client #2 who moved on 2/2/18 still had no

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: ___ R 03/13/2018 MHL014-087 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2419 MORGANTON BOULEVARD THE LANDING LENOIR, NC 28645 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 123 V 123 Continued From page 11 Primodone. -She wrote the incident reports and was told by the Lead QP to combine the dates- to do 1 report for the AM and 1 report for the PM Primodone missed. Interview on 3/8/18 with the Lead QP revealed: -"Yes I wrote up all staff including myself because we all screwed up." -"We just got trained on the incident reports but we didn't follow our procedure." This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (tag V118) for an imposed Type B rule violation.

Division of Health Service Regulation STATE FORM