Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: R MHL011-398 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SOLSTICE EAST, LLC S30 UPPER FLAT CREEK ROAD WEAVERVILLE, NC 28787 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED R O5/10/2018 PREFIX (EACH CORRECTION OF CORRECTION OF CORRECTION OF CORRECTION OF COMPLETE DATE OF COMPLETE DATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE	DIVISION OF FIGARITY SE											
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An annual and follow-up survey was completed	I											
on 5/10/18. Deficiencies were cited.	on 5/10/18											
	c											
This facility is licensed for the following service												
category: 10A NCAC 27G .1300 Residential												
Treatment for Children or Adolescents.	Treatment											
V 118 27G .0209 (C) Medication Requirements V 118	V 118 27G .0209											
	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 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.

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

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED					
			A. Boilbino.		R					
		MHL011-398	B. WING		05/10/2018					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE										
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SOLSTICE EAST, LLC WEAVERVILLE, NC 28787										
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V 118	Continued From page 1		V 118							
	failed to ensure drugs client only on the writt authorized to prescrib clients audited (Client Review on 5/10/18 of -admitted 2/28/18 -age 17 -diagnoses Major Dep Post-Traumatic Stress Disorder, Alcohol Dep Relational Problems. Review on 5/10/18 of Administration Record revealed: -Lamotrigine, 25 mg, administered -Trazodone, 50 mg, 1 administered -Hydroxyzine hcl 25 m needed; administered once in April. Review on 5/10/18 of	and record review the facility is were administered to a sten order of a person of the drugs affecting 1 of 6 is #6). The findings are: Client #6's record revealed: Client #6's record revealed: Dressive Disorder, cannabis Use bendency, and Parent-Child Client #6's Medication of from 3/1/18 through 5/9/18 1 every morning was at bedtime was at two times in March, and a Physician der form dated 2/28/18 for 1 every morning at bedtime								
		28/18 and 3/12/18 by each								

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
		MHL011-398	B. WING		05	R 5/ 10/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
SOLSTICE	E EAST, LLC		PER FLAT CREEK R	OAD		
		ATEMENT OF DEFICIENCIES	RVILLE, NC 28787	PROVIDER'S PLAN OF	CORRECTION	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From page	e 2	V 118			
	-digitally signed on 5/	9/18 by the physician				
	revealed:	with Registered Nurse #1				
	admission					
		as on vacation at the time le to get an order signed				
	-the facility doctor sig	ned the order 5/9/18.				
	This deficiency const and must be correcte	itutes a re-cited deficiency d within 30 days.				

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