

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL051-138</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  R <b>06/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE LIGHTHOUSE II OF CLAYTON</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2016 FORT DRIVE CLAYTON, NC 27520</b>		
(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	<b>INITIAL COMMENTS</b>  A complaint and follow-up survey was completed on June 14, 2018. One complaint was unsubstantiated (Intake #NC00138027). One complaint was substantiated (Intake #NC00137950). 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.	V 000		
V 118	<b>27G .0209 (C) Medication Requirements</b>  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.	V 118		

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JUN 28 2018

DHSR-MH Licensure Sect

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

*[Handwritten Signature]*  
BA QMHP Program Director

Division of Health Service Regulation

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V 118	<p>Continued From page 1</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility failed to A) assure that medications were administered on the written order of a Physician, B) assure that MARs were kept current, and C) assure that medications administered were recorded immediately after administration affecting 1 of 1 audited clients (#1). The findings are:</p> <p>Review on 6/13/18 of Client #1's record revealed the following information; -- Admitted to this facility on 2/14/18. -- Diagnoses of Disruptive Mood Dysregulation Disorder and Cannabis Use Disorder.</p> <p>Review on 6/13/18 of Client #1's April 2018 MAR revealed the following information; -- A handwritten transcription for Amoxicillin 875 mg. take one tablet twice a day starting 3/28/18, with no documentation that any of this medication had been administered to the client. -- An additional handwritten transcription for Amoxicillin 600 mg. per 5 ML. take 10 ML. twice a day starting on 3/28/18. This had documentation that staff had administered this medication to the client twice a day from 4/1/18 through 4/29/18 (except for 10 times at 8:00 pm where the MAR was left blank).</p> <p>Review on 6/14/18 of documentation From Client</p>	V 118			

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V 118	<p>Continued From page 2</p> <p>#1's Physician dated 6/14/18 which was obtained by the Qualified Professional (QP) on 6/14/18 revealed 2 separate orders dated 3/28/18 for Amoxicillin (one in tablet form and the other in liquid form). Both of these Physician's orders indicated the medication should be taken for 10 days, and only enough of this medication was dispensed by the Pharmacy to be administered for 10 days.</p> <p>Interview on 6/14/18 with the QP revealed the following information regarding the above antibiotic, Amoxicillin;</p> <ul style="list-style-type: none"> <li>-- Client #1 has a difficult time swallowing pills, so the Physician was notified on that date, and subsequently prescribed the Amoxicillin as a liquid so that it would be more easily swallowed.</li> <li>-- The Amoxicillin was not transcribed onto the March 2018 MAR as the client left for a home visit the evening of 3/28/18 with his mother and the staff sent the Amoxicillin with him.</li> <li>-- The Amoxicillin should have been transcribed onto the March 2018 and staff should have documented that it was not administered in the facility on 3/28/18, 3/29/18, 3/30/18 and 3/31/18.</li> <li>-- If the Amoxicillin had been administered as ordered by the Physician, he would have taken the last dose on 4/7/18 at 8:00 am.</li> <li>-- She confirmed that staff miss-transcribed the medication on the April 2018 MAR, and staff were not following required medication administration procedure if the documented administration following the 4/7/18 dose at 8:00 am "they are just being lazy."</li> </ul>	V 118		

PLAN OF CORRECTION  
Survey Completed 06/14/2018

LH2

KMG Holdings, Inc.  
The Lighthouse of Clayton  
2016 Fort Drive  
Clayton, NC 27520  
MHL# 051 - 138

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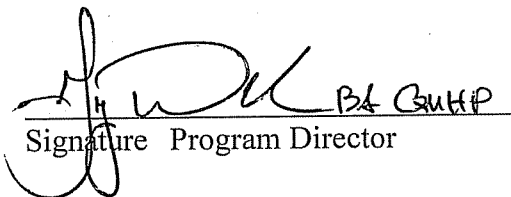
JUN 28 2018

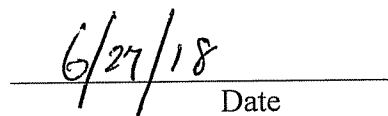
DHSR-MH Licensure Sect

PLAN OF CORRECTION  
Survey Completed 06/14/2018

V 118 27G .0209 (C) Medication Requirements

1. The Program Director, Residential Managers and Residential QP's will ensure during all admissions that all medications are accompanied with written medication orders. The Program Director, Residential Manager and Residential QP's will coordinate with the network pharmacy to ensure all refills are supplied timely for consumer medications. The Program Director, Residential Managers, and Residential QPs will transcribe all consumer medications to MARs to ensure compliance with current consumer medication orders. All residential staff members will participate in refresher course/in-service training for medication administration training on a monthly basis for the next six months to improve overall level of competency. The training will then be delivered quarterly thereafter. The Program Director, Residential Manager and Residential QP's will monitor medication administration records daily to ensure compliance. Medication Review documentation will be organized by the Program Director, Residential Managers and will be presented/discussed in the weekly management team meeting.

  
Signature Program Director

  
Date

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JUN 28 2018

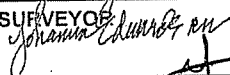
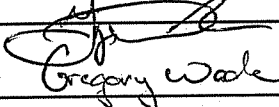
CONSTRUCTION SECTION

## STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER MHL051-138	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 6/14/2018
NAME OF FACILITY THE LIGHTHOUSE II OF CLAYTON	STREET ADDRESS, CITY, STATE, ZIP CODE 2016 FORT DRIVE CLAYTON, NC 27520	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0107	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 27G .0202 (A-E)	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	06/14/2018	LSC _____	_____	LSC _____	_____
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	_____	LSC _____	_____	LSC _____	_____
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
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REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR 	DATE 6/14/18
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE Program Director 	DATE 6/27/18
FOLLOWUP TO SURVEY COMPLETED ON 3/7/2018		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		