STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mhl047-091	A. BUILDING: _____ B. WING _____	R 08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HORIZON GROUP HOME, LLC	497 NORTHWOODS DRIVE RAEFORD, NC 28376

(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 8/9/18. Deficiencies were 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	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 drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation	V 118		

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V 118	Continued From page 1 with a physician. This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to keep the MAR current affecting three of three clients (#1, #2 and #3). The findings are: a. Review on 8/9/18 of client #1's record revealed: -Admission date of 1/26/18. -Diagnoses of Bipolar II Disorder, Post Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder and Disruptive Mood Dysregulation Disorder. -Physician's order dated 8/3/18 for Vyvanse 50 mg, one capsule every morning Monday through Friday; Vyvanse 40 mg, one capsule on Saturday and Sunday; Aripiprazole 5 mg, one tablet in the morning and Trazodone 50 mg, one tablet at bedtime. -The August 2018 MAR had the following error: Vyvanse 40 mg was not listed. -The July 2018 MAR had the following errors: Aripiprazole 5 mg and Trazodone 50 mg had blank spaces on 7/28 through 7/31. Vyvanse 40 mg had staff's initials on 7/4, 7/5, 7/11, 7/12, 7/14 through 7/22. Vyvanse 40 mg order was for medication to be given on weekends only. -The June 2018 MAR had the following errors: Vyvanse 40 mg had staff's initials on 6/1 through 6/6, 6/9, 6/10, 6/16, 6/17, 6/24, 6/26 and 6/29. Vyvanse 40 mg order was for medication to be given on weekends only. Observation on 8/9/18 at 2:00 PM of the	V 118		

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V 118	Continued From page 2 medication area revealed: -Vyvanse 40 mg was in client #1's medication box although it was not listed on the August 2018 MAR. b. Review on 8/9/18 of client #2's record revealed: -Admission date of 12/20/17. -Diagnoses of Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Fetal Alcohol Spectrum Disorder, Cyclothymia and Peanut Allergy. -Physician's order dated 8/3/18 for Methylphenidate 20 mg, one tablet in the morning. -Physician's order dated 7/6/18 for Methylphenidate 10 mg, one and one half tablets in the morning, Vitamin D3 1000 units, three tablets in the morning and Lithium Carbonate 300 mg, two tablets at bedtime. -Physician's order dated 6/1/18 for Risperidone 0.5 mg, one tablet daily. -Physician's order dated 5/4/18 for Clonidine 0.1 mg, one tablet at bedtime. -Discontinuation order for Vitamin D3 1000 units dated 8/3/18. -Discontinuation order for Methylphenidate 10 mg dated 8/3/18. -Discontinuation order for Risperidone 0.5 mg dated 7/6/18. -The August 2018 MAR had the following errors: Methylphenidate 20 mg was not listed. Vitamin D3 1000 units was discontinued on 8/3/18 and staff continued to document 8/4 through 8/7. -The July 2018 MAR had the following errors: Methylphenidate 10 mg had blank spaces on 7/26 through 7/31; Vitamin D3 1000 units and Clonidine 0.1 mg had blank spaces on 7/27 through 7/31; Lithium Carbonate 300 mg had blank spaces on 7/28 through 7/31. Risperidone	V 118		

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V 118	Continued From page 3 0.5 mg was discontinued on 7/6/18, however staff continued to document 7/7 through 7/11. -The June 2018 MAR had the following errors: Risperidone 0.5 mg and Vitamin D3 1000 units had blank spaces on 6/27 through 6/29; Methylphenidate 10 mg blank spaces on 6/20 through 6/22 and 6/27 through 6/29. Observation on 8/9/18 at 1:30 PM of the medication area revealed: - Methylphenidate 20 mg was in client #2's medication box although it was not listed on the August 2018 MAR. c. Review on 8/9/18 of client #3's record revealed: -Admission date of 7/12/18. -Diagnoses of Oppositional Defiant Disorder, Post Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, Disruptive Mood Dysregulation Disorder, Major Depressive Disorder, Speech Problems and Nocturnal Enuresis. -Physician's order dated 8/3/18 for Dextroamphetamine 40 mg, one tablet at noon and Adderall XR 20 mg, one tablet in the morning. -The August 2018 MAR had the following errors: Dextroamphetamine 40 mg and Adderall XR 20 mg were not listed. Observation on 8/9/18 at 2:42 PM of the medication area revealed: -Dextroamphetamine 40 mg and Adderall XR 20 mg were in client #3's medication box although it was not listed on the August 2018 MAR. Interview with staff #1 on 8/9/18 revealed: -Some of the issues with the MAR's were related to their new pharmacy. -There were no issues with the clients getting	V 118		

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V 118	Continued From page 4 their medications. -She confirmed staff failed to keep the MAR current for clients' #1, #2 and #3. Interview with the Qualified Professional on 8/9/18 revealed: -She felt like the majority of the medication errors were because they just recently switched pharmacies. -Facility staff were told each time a medication is completed they must change the MAR. -That was why there were blank spaces on the June and July MAR's. -There were no issues with the clients not getting their prescribed medications. -She confirmed staff failed to keep the MAR current for clients' #1, #2 and #3.	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	V 119		

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V 119	Continued From page 5 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: Based on observation, record review and interview the facility staff failed to dispose of prescription medications in a manner that guards against diversion or accidental ingestion affecting one of three clients (#2). The findings are: Review on 8/9/18 of client #2's record revealed: -Admission date of 12/20/17. -Diagnoses of Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Fetal Alcohol Spectrum Disorder, Cyclothymia and Peanut Allergy. -Physician's order dated 11/18/17 for Epipen Jr 0.15 mg, inject as directed for allergic reactions as needed. Observation on 8/9/18 at 1:30 PM of the medication area revealed: -The medication box for client #2 had an Epipen that expired in March 2018. Interview on 8/9/18 with the Qualified Professional revealed: -She felt like the majority of the medication errors were because they just recently switched pharmacies.	V 119		

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V 119	Continued From page 6 -She felt like the pharmacy should have realized the Epipen had expired. -The pharmacy should have sent them a new Epipen for client #2. -She confirmed the facility staff failed to ensure medications were disposed of in a manner that guards against diversion or accidental ingestion.	V 119		