STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-207	A. BUILDING: _____ B. WING _____	R 08/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A SURE HOUSE, INC	1265 ARBOR ROAD WINSTON-SALEM, NC 27104

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V 000	INITIAL COMMENTS An annual and follow up survey was completed on 8/30/18. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children and 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 record review and interview, the facility failed to ensure a Medication Administration Record (MAR) of all drugs administered to each client was kept current and medications administered were recorded immediately affecting 3 of 3 clients (#1, #2 and #4). The findings are: Review on 8/27/18 and 8/29/18 of client #1's record revealed: - An admission date of 11/27/17 - Diagnoses of Intellectual Disability, Mild; Adjustment Disorder (D/O) with Mixed Disturbance of Emotions and Conduct; Rule-Out Intellectual Alcohol Use D/O; Rule-Out Cannabis Use D/O, Mild; Seasonal Allergies and Near-Sightedness Physician's orders for the following medications: - Lithium Carbonate 300 mg 4 tab (tablets) PO (by mouth) at bed - Vitamin D 1000 IU (International Unit) 1 tab PO one time daily - Guanfacine ER 3 mg 1 tab PO every morning - Clozapine 100 mg 1 tab PO daily at bedtime - Clozapine 25 mg 1 tab PO twice a day Review on 8/28/18 of client #1's MARs from 6/1/18-8/28/18 revealed: - No staff initials which reflected client #1 had been administered Lithium Carbonate 300 mg on 7/15/18; 7/30-7/31/18 at bedtime	V 118		

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V 118	Continued From page 2 - Staff initials on the following dates which reflected client #1 had been administered Vitamin D 1000 IU on the following dates in June 2018: 6/15/18; 6/22/18; 6/23/18; and 6/25/18 only - All other dates on the June 2018 MAR remained blank - Staff initials on the following dates which reflected client #1 had been administered Vitamin D 1000 IU on the following dates in July 2018: 7/6/18; 7/13/18; 7/20/18 and on 7/27/18 only - All other dates on the July 2018 MAR remained blank - Staff initials on the following dates which reflected client #1 had been administered Vitamin D 1000 IU on the following dates in August 2018: 8/3/18; 8/10/18; 8/17/18 and on 8/24/18 only - All other dates on the August 2018 remained blank - No staff initials which reflected client #1 had been administered Guanfacine ER 3 mg on 8/21/18 - No staff initials which reflected client #1 had been administered Clozapine 100 mg on 7/24-7/25/18 and on 7/28/18 - No staff initials which reflected client #1 had been administered Clozapine 25 mg on 6/27/18 and on 8/21/18 at 7 am Review on 8/28/18 of client #2's record revealed: - An admission date of 4/25/18 - Diagnoses of Attention Deficit Hyperactivity D/O, Combined Presentation, Moderate; Post-Traumatic Stress D/O; Disruptive Dysregulation D/O and Disinhibited Social Engagement D/O Physician's orders for the following medications: - Adderall XR 20 mg 1 cap PO every morning - Amphetamine/Dextrose 10 mg 1 tab PO every afternoon	V 118		

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V 118	Continued From page 3 - Risperidone 0.25 mg Dissolve 1 tab PO every morning and 2 tab at bedtime - Clonidine ER 0.1 mg 1 tab PO every morning - Clonidine ER 0.1 mg 1 tab PO at bedtime - Hydroxyzine Pamoate 25 mg 1 cap PO at bedtime - Divalproex DR 250 mg 1 tab PO twice a day Review on 8/29/18 of client #2's MARs from 6/1/18-8/29/18 revealed: - No staff initials which reflected client #2 had been administered Adderall XR 20 mg on 6/1/18 and on 7/1/18 - No staff initials which reflected client #2 had been administered Divalproex DR 25 mg on 6/1/18; 6/6/18 and on 6/18/18 at 7 am - No staff initials which reflected client #2 had been administered Divalproex DR 25 mg on 6/3/18; 7/25-7/26/18 and 7/30-7/31/18 at 7 pm - No staff initials which reflected client #2 had been administered Clonidine ER 0.1 mg on 6/1/18 and on 7/31/18 - No staff initials which reflected client #1 had been administered Hydroxyzine Pamoate 25 mg on 6/1-6/3/18; 6/5-6/7/18; 6/9-6/10/18; 6/12/18; 6/14-6/18/18; 6/19/18; 6/21/18; 6/23/18-6/24/18 and 6/26-6/30/18 Review on 8/28/18 of client #4's record revealed: - An admission date of 1/26/18 - Diagnoses of Attention Deficit Hyperactivity D/O, Combined Presentation, Moderate; Conduct D/O, Childhood Onset Type and Disruptive Mood Dysregulation D/O Physician's orders for the following medications: - Guanfacine 1 mg 1 tab PO in the morning and 2 tab PO at night	V 118		

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V 118	Continued From page 4 - Benztropine 1 mg ½ tab PO 2 times daily - Vyvanse 40 mg 1 capsule PO every morning - Metformin ER 500 mg 2 tab PO daily with breakfast - Geodon 40 mg 1 cap PO 2 times daily with meals Review on 8/29/18 of client #3's MARs from 6/1/18-8/29/18 revealed: - No staff initials which reflected client #4 had been administered Guanfacine 1 mg on 8/27/18 at 8 pm - No staff initials which reflected client #4 had been administered Benztropine 1 mg on 6/4/18 and on 8/27/18 - No staff initials which reflected client #4 had been administered Metformin ER 500 mg on 6/18/18 - No staff initials which reflected client #4 had been administered Geodon 40 mg on 6/4/18; 6/11/18; 6/13/18 and 6/15/18 Continued review of clients (#1, #2 and #4's) MARs revealed: - Their medications had been listed twice on the MARS and staff had documented on each of the listings for the medications Interviews on 8/24/18 with clients (#1, #2 and #4) revealed: - Staff ensured they received their medications as prescribed Interviews on 8/28/18, 8/29/18 and on 8/30/18 with the Executive Director revealed: - Staff had administered client #1's Vitamin D on a weekly basis as this was what had been discussed with his physician	V 118		

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V 118	Continued From page 5 - She had believed that the medication order had been updated to reflect the change in dosing - She did not realize the medication order still read that the Vitamin D should be administered on a daily basis - The clients' medication orders are sent to the pharmacy electronically and are not always provided to either her or her staff while at the physician's office - She met with client #1's physician on 8/30/18 and he stated that he remembered their conversation; however offered no additional information as to why the order had not been changed - The physician provided a letter which documented that client #1 having been administered his dose of Vitamin D on a weekly basis instead of on a daily basis should not be a problem due to his diet and his exposure to the sun - The physician changed his medication order to reflect client #1 could continue to receive a dose of Vitamin D on a weekly basis - The physician also requested that client #1's psychiatrist include an order for check on client #1's Vitamin D level when he went for his scheduled appointment on 8/31/18 for lab work - Based on results of the lab work, he would decide if client #1 would continue to receive his Vitamin D on a weekly basis versus on a daily basis - She also believed that client #2's medication order for his Hydroxyzine Pamoate been changed to "PRN (as needed)" by his physician - Her pharmacist had not provided her the June MAR by the first of June 2018 which lead to there being blanks on the MARs for that date - She had spoken with the pharmacist as well as a pharmacy representative regarding her concerns and would be willing to change	V 118		

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V 118	Continued From page 6 pharmacist if the accuracy MARs continued to be an issue - She had spoken with staff about how to document on just one of the listings for the medication on the client's MARs; however, staff had failed to follow her directives - Although the clients' MARs did not reflect it, she felt certain the client's had received their medications - She would follow up with the clients (#1 and #2) physicians to ensure their medication orders accurately reflected how the medications were to be administered. Review on 8/30/18 of documents provided by client #1's physician confirmed what the ED reported regarding her earlier conversation with the physician. The deficiency is a re-cited deficiency and must be corrected within 30 days.	V 118		