STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mhl041-818	A. BUILDING: _____ B. WING _____	09/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUCCESSFUL TRANSITIONS, LLC RESIDENTIAL CAF	1458 LONDON DRIVE HIGH POINT, NC 27262

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V 000	INITIAL COMMENTS An annual, follow up and complaint survey was completed on September 24, 2018. The complaint was substantiated (Intake #NC00141931). Deficiencies were 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	V 118		

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V 118	Continued From page 1	V 118		

checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to report immediately to a physician or pharmacist missed doses of prescribed medication for 1 of 1 Former Client (FC #1). The findings are:
Review on 9/19/18 of FC #1's record revealed:
-An admission date of 9/14/17
-Age 15
-Diagnoses of Oppositional Defiant Disorder, Unspecified Impulse Control Disorder and Unspecified Mood Disorder
-A discharge date of 8/27/18

Further review of FC #1's record revealed:
-Physician's orders, dated 1/24/18 and 7/30/18 for the following medications: Lithium 150mg take one by mouth twice daily and Clozapine 100mg, one and ½ by mouth at 6pm

Review on 9/19/18 of FC #1's MARs from January 1, 2018 to August 27, 2018 revealed:
-3/3/18 to 3/10/18, Clozapine 100mg, was not administered as ordered
-An "8" was listed as the Omissions Code Revised
-An "8" meant missed medications
-5/6/18, 5/7/18, 5/8/18 and 8/16/18, Lithium 150mg, was not administered as ordered.

Interview on 9/20/18 with FC #1 revealed:
-Went without his Lithium and Clozapine "two or

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V 118	Continued From page 2 three times" -Felt sick when he did not take his medications Interview on 9/20/18 with staff #1 revealed: -FC #1's medications were not administered 3/1/18 to 3/8/18 as ordered by the physician as he was out of his medications. -Was not aware FC #1's physician or pharmacist needed to be contacted each and every time medications were not administered as ordered Interviews on 9/19/18 and 9/20/18 with the Qualified Professional revealed: -Was in the role of acting Licensee due to the Licensee being out of the state -Was responsible for ensuring the MARs were accurate as well as ensuring medications were filled in a timely manner. -There was an issue with FC #1's insurance -"[FC #1] missed 7 to 10 days of his Clozapine. I called the pharmacist, but did not document it. I think it would be best, in the future to add a line to call the pharmacist to the Level I internal incident reporting form. That will trigger staff to call and document it."	V 118		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (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 reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. .	V 123		

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V 123	Continued From page 3	V 123		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to report immediately to a physician or pharmacist missed doses of prescribed medication for 1 of 1 Former Client (FC #1). The findings are:

Review on 9/19/18 of FC #1's record revealed:
-An admission date of 9/14/17
-Age 15
-Diagnoses of Oppositional Defiant Disorder, Unspecified Impulse Control Disorder and Unspecified Mood Disorder
-A discharge date of 8/27/18

Further review of FC #1's record revealed:
-Physician's orders, dated 1/24/18 and 7/30/18 for the following medications: Lithium 150mg take one by mouth twice daily and Clozapine 100mg, one and ½ by mouth at 6pm

Review on 9/19/18 of FC #1's MARs from January 1, 2018 to August 27, 2018 revealed:
-3/3/18 to 3/10/18, Clozapine 100mg, was not administered as ordered
-An "8" was listed as the Omissions Code Revised
-An "8" meant missed medications
-5/6/18, 5/7/18, 5/8/18 and 8/16/18, Lithium 150mg, was not administered as ordered.

Interview on 9/20/18 with FC #1 revealed:
-Went without his Lithium and Clozapine "two or three times"
-Felt sick when he did not take his medications

Interview on 9/20/18 with staff #1 revealed:

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V 123	Continued From page 4 -FC #1's medications were not administered 3/1/18 to 3/8/18 as ordered by the physician as he was out of his medications. -Was not aware FC #1's physician or pharmacist needed to be contacted each and every time medications were not administered as ordered Interviews on 9/19/18 and 9/20/18 with the Qualified Professional revealed: -Was in the role of acting Licensee due to the Licensee being out of the state -Was responsible for ensuring the MARs were accurate as well as ensuring medications were filled in a timely manner. -There was an issue with FC #1's insurance -"[FC #1] missed 7 to 10 days of his Clozapine. I called the pharmacist, but did not document it. I think it would be best, in the future to add a line to call the pharmacist to the Level I internal incident reporting form. That will trigger staff to call and document it."	V 123		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Tag #736 Based on observations and interviews, the facility staff failed to maintain the facility grounds in a safe, clean and attractive manner. The findings are:	V 736		

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V 736	Continued From page 5 Observations on 9/19/18, at 9:09am, of the outside of the facility revealed: -Debris was in the rain gutters -A dead vine was growing on the front of the facility -The far left front window was broken and a piece of plywood covered the window -The outside trash can was overflowing with items and had a slight odor to it Further observations on 9/19/18, at 9:33am, of the inside of the facility revealed: -A continuous beeping from a smoke detector -2 chairs in the client's dining area were broken -The entrance to the kitchen area had peeled off paint -The kitchen window and blinds needed to be cleaned -In the clients' computer/den area, there was no outlet covering to the immediate left -A pile of discarded linoleum was against the wall near the television -The blinds in the computer/den area were broken -In client #2's bedroom, the window was missing blinds/curtains -Client #2's light switch plate was missing in the bedroom -There was also a hole in the wall, approximately 4 inches by 3 inches, behind the bedroom door Further observations on 9/19/18, at 1:13pm, of the inside of the facility, revealed: -The clients' bathroom was dirty and had a strong odor of urine -The tub in the clients' bathroom had gray stains inside -The blinds in the clients' bathroom were broken -There was a towel bar bracket on the bathroom	V 736		

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V 736	Continued From page 6 wall that was broken -In client #3's bedroom, the chest of drawers was off tract Further observations on 9/24/18, at 9:52am, of the outside of the facility revealed: -The facility's full trashcan was at the curb -Approximately 6 bags of trash were on top of the trashcan -A facility client, staff #1 and the Qualified Professional (QP) removed bags from the top of the trashcan to several different neighborhood trashcans. Interviews on 9/19/18 with clients #2, #3 and #4 revealed: -They had not noticed any repairs needed to the facility -One of the clients had not taken the trash to the curb on 9/17/18 Interview on 9/19/18 with the QP revealed: -Was in the role of acting Licensee due to the Licensee being out of the state -The Licensee's husband was aware of the items that needed to be repaired -There was recently an unexpected expense of having to replace the entire a/c unit	V 736		