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	MHL034-219	A. BUILDING: _____ B. WING _____	R 11/06/2018

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 11/6/2018. The complaint was unsubstantiated (intake #NC144038). 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 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 ensure MARs were kept up to date, medications were recorded immediately after administration, and the MAR included the clients' name and time the drug was administered affecting 2 of 2 audited current clients (#1 & #2) and 1 of 1 audited former clients (FC) (FC #3). The findings are: Review on 10/31/2018 of client #1's record revealed: - Admission date: 9/6/2018 - Diagnoses: Bipolar Disorder, Unspecified Type; Oppositional Defiant Disorder; History of Schizoaffective Disorder, Bipolar Type; Generalized Anxiety Disorder; and Nocturnal Enuresis - Age: 18 - Physicians orders for the following medications: - Cymbalta 60 milligrams (mg), 1 tablet twice daily (BID), dated 9/5/2018; - Vistaril 25 mg, 1 tablet BID, dated 9/5/2018; - Abilify 20 mg, 1 tablet every night at bedtime (QHS), dated 9/5/2018; - Desmopressin 0.2 mg, 3 tablets QHS, dated 9/5/2018; - Benadryl 50 mg, 1 tablet QHS, dated 9/5/2018; Review on 10/31/2018 of client #1's MARs dated 9/7/2018 to 10/31/2018 revealed:	V 118		

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V 118	Continued From page 2	V 118		

- Only client #1's last name was listed on the MARs;
- Cymbalta 60 mg administration instructions were noted as 1 tablet every morning (QAM) rather than BID as ordered;
- Other than "AM" or "PM" printed above the dates, no administration times were noted for Cymbalta, Vistaril, Abilify, desmopressin, or Benadryl.

Review on 11/1/2018 of additional MAR documents for client #1 revealed:
- "PM" MARs for September and October were provided with administration instructions for the evening dose of Cymbalta;
- The MARs differed from the ones provided on 10/31/2018 in that client #1's first and last name were listed, and the initials of the staff that administered the "PM" medication did not consistently match the initials present on the previously provided MARs.

Review on 10/31/2018 of client #2's record revealed:
- Admission date: 8/31/2018
- Diagnoses: Major Depressive Disorder; Post Traumatic Stress Disorder; Generalized Anxiety Disorder; Personal history of sexual abuse in childhood; and Lactose Intolerance;
- Age: 16
- Physicians orders for the following medications:
    - Buspirone hydrochloride (HCL) 20 mg, 1 tablet three times daily (TID), dated 8/19/2018;
    - Vitamin D3 1,000 IU (International units), 1 tablet every day (QD), dated 8/19/2018;
    - Omeprazole DR 20 mg, 1 tablet QD, dated 8/19/2018;
    - Seroquel (quetiapine) 400 mg, 1 tablet QHS, dated 8/19/2018;
    - Miralax (polyethylene glycol) 17 grams

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V 118	Continued From page 3 (gm), 17 gm in 8 ounces (oz.) water QD, dated 8/28/2018; - Lactaid tablets, over the counter as package instructions for eating dairy, dated 8/28/2018; - Patanax nasal spray 665 micrograms (mcg), 2 sprays BID dated 8/28/2018. Review on 10/31/2018 of client #2's MARs dated 9/1/2018 to 10/31/2018 revealed: - Only client #2's first initial and last name were listed on the MARs; - Vitamin D3 was listed as "Vitamin D#", "1000 BU" on the October MAR; - Other than "AM" or "PM" printed above the dates, no administration times were noted for buspirone, Vitamin D3, Omeprazole, and Seroquel; - Miralax, Lactaid and Patanax were not on the September or October MARs. Review on 11/1/2018 of additional MAR documents for client #2 revealed: - "AM" MARs for September and October were provided with administration instructions for the routinely ordered Miralax, Lactaid and Patanax; - The MARs differed from the ones provided on 10/31/2018 in that client #2's first and last name were listed, and the initials of the staff that administered the "AM" medication did not consistently match the initials present on the previously provided MARs. Review on 10/31/2018 of FC #3's record revealed: - Admission date: 2/28/2018 to a level 2 sister facility; - Transfer to the facility on 9/4/2018; - Discharge to a local hospital psychiatric unit on 9/27/2018; - Diagnoses: Attention Deficit Hyperactivity	V 118		

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V 118	Continued From page 4 Disorder; Oppositional Defiant Disorder; and Disruptive Mood Dysregulation Disorder - Age: 14 - A Physician's order for the following medication: - Mirtazpine 30 mg, 1 tablet QHS, dated 4/18/2018. Review on 11/1/2018 of FC #3's MARs dated 9/4/2018 to 9/27/2018 revealed: - There was no documentation of administration of mirtazapine from 9/4/2018 to 9/27/2018. Interview on 10/31/2018 with staff #1 revealed: - Staff #1 was the staff responsible for ensuring MARs were correct; - The reason that there were missing MARs on 10/31/2018 was because she had been organizing the them in order to make them easier to read; - She would sent the missing MARs for clients #1 and #2 for the Surveyor to review on 11/1/2018; - Clients #1, #2 and FC #3 had been administered all of their medications correctly; - She did not know that the clients' full name and the times that medications were administered needed to be on the MARs; Interview on 10/31/2018 with the Qualified Professional/Director (QP/D) revealed: - The QP/D did not know that administration times had to be listed on MARs; - Morning medications were always administered at 5:30 AM due to the early time the clients' school busses arrived; - Evening medications were administered at 5:30 PM; - Some of the MARs for clients #1 and #2 left at the facility when they were brought to the office for Surveyor review on 10/31/2018; - Clients #1, #2 and FC #3 had been	V 118		

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V 118	Continued From page 5 administered their medications correctly.	V 118		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.	V 132		

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V 132	Continued From page 6 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the Health Care Personnel Registry (HCPR) of allegations against 1 of 4 audited staff (#2). The findings are: Review on 10/31/2018 of FC #3's record revealed: - Admission date: 2/28/2018 to a level 2 sister facility; - Transfer to the facility on 9/4/2018; - Discharge to a local hospital psychiatric unit on 9/27/2018; - Diagnoses: Attention Deficit Hyperactivity Disorder (ADHD); Oppositional Defiant Disorder; and Disruptive Mood Dysregulation Disorder - Age: 14 - A Comprehensive Clinical Assessment dated 41/2018 noted a history of negative emotions, dangerous behaviors, antisocial behavior, eloping, blaming others and lack of remorse for her own behavior, verbal aggression, disrespectfulness, and frequent confrontations with authority figures; - No progress notes were available for review due to reported problems with the facility's electronic record system. Review on 10/29/2018 of the North Carolina Incident Response Improvement System (IRIS) revealed:	V 132		

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V 132	Continued From page 7 - There were no incident reports submitted by the facility from 8/28/2018 to 10/29/2018. Review on 11/1/2018 of FC #3's records from a local Hospital revealed: - FC #3 was admitted to the Hospital's adolescent psychiatric unit from 9/27/2018 to 10/18/2018; - On 9/27/2018, " ... 14-year-old female past medical history significant for ADHD and disruptive moo disorder presents in the emergency department for evaluation of suicidal thoughts, behavioral disturbances, and homicidal ideation. History obtained from patient as well as manager of patient's group home (the Qualified Professional/Director (QP/D). Per manager of group home patient has been showing increasingly erratic behavior for the past several days. She states that several times over the past few days patient has allegedly run into traffic with the intention of harming herself ..." - "Care Coordination Update" dated 10/5/2018 noted: " ...Patient states that a staff member [staff #2] put his hands on her stating 'he yanked my arm and it was sore afterwards' but denies bruising from this incident ... Spoke with [the QP/D] by phone, she denies the above events stating that the patient has a history of lying ... [The QP/D] states that [staff #2] has not been at the group home since March and has not put his hands on patient ... Discussed the above accusations that patient has made which [the QP/D] states has not occurred. [The QP/D] states that [staff #2] has not worked full time with group home since February and the few occasions that he did help with group home was in public with other staff and residents ..." - No date that the alleged incident occurred was documented. Review on 11/1/2018 of staff #2's personnel file	V 132		

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V 132	Continued From page 8	V 132		

revealed:
- Hire date: 5/3/2016 as a paraprofessional;
- No documentation of investigation into allegations of "yanking" FC #3's arm.

Interview on 10/303/2018 with FC #3's Guardian revealed:
- FC #3 had a history of making false accusations;
- FC #3 had not told him that any facility staff had mistreated her;
- He had met staff #3 on one occasion during a group outing, and did not have any concerns about him;
- The Guardian did not want FC #3 to be interviewed due to her current psychiatric instability.

No interview with FC #3 was completed at the Guardian's request.

Interview on 11/2/2018 with staff #2 revealed:
- He had never put his hands on FC #3 for any reason;
- He remembered FC #3 having been at community outings with sister facilities at which he was acting as a "chaperone", but "I didn't really work with her at all ..."
- He did not know how investigations into allegations that staff had abused clients were handled by the facility.

Review on 11/1/2018 of text messages from the Licensed Professional (LP) dated 11/1/2018 revealed:
- The LP was not available to speak directly to the Surveyor at that time;
- The LP did not know why an investigation of staff #2 should have been conducted as staff #2 worked on an as needed basis (PRN) and had

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V 132	Continued From page 9 not been working recently; - " ...Besides the information shared by the consumer (FC #3) was falsified. In a meeting at the hospital and on a phone conference it was determined consumer was being untruthful ..." Interview on 10/31/2018 with the QP/D revealed: - While FC #3 was in the Hospital, she had made a false allegation about staff #2 mistreating her; - The QP/D had talked to Hospital staff as well as local Department of Social Services (DSS) staff about the allegation; - FC #3 had not said anything about staff #2 until she got upset that she would be sent to a psychiatric residential treatment facility (PRTF); - FC #3 never clarified what staff #2 had allegedly done to her; - The last time that FC #3 had seen staff #2 would have been at a community group activity in which staff #2 had assisted with supervision of all clients; - She had not completed an HCPR report or conducted an investigation into the allegation against staff #2 because it did not happen; - She had not know she needed to complete HCPR reports for every allegation against staff.	V 132		