STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411015	A. BUILDING: _____ B. WING _____	R 01/16/2019

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DAYMARK GUILFORD RESIDENTIAL TREATMENT FA	5209 WEST WENDOVER AVENUE HIGH POINT, NC 27265

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 1/16/2019. The complaint was unsubstantiated (intake #NC143412). Deficiencies were cited. This facility is licensed for the following service categories: 10A NCAC 27G .3300 Outpatient Detoxification For Substance Abuse; 10A NCAC 27G .3400 Residential Treatment/Rehabilitation For Individuals With Substance Abuse Disorders; 10A NCAC 27G .3700 Day Treatment Facilities For Individuals With Substance Abuse Disorders; 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program; 10A NCAC 27G .4500 Substance Abuse Comprehensive Outpatient Treatment Program; and 10A NCAC 27G .5600E Supervised Living for Adults with Substance Abuse Dependency.	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.	V 118		

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V 118	Continued From page 1 (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 with a physician. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure medications were administered as ordered by an authorized person affecting 1 of 3 current clients (#1) and 2 of 2 former clients (FC) (FC #4 & FC #5). The findings are: Review on 1/15/2019 of client #1's record revealed: - Admission date: 11/14/2018 - Diagnoses: Alcohol Use Disorder; Cocaine Use Disorder; and Cannabis Use Disorder; - Physicians order for the following medication: - Topiramate 100 mg (milligrams), 1 tablet TID (3 times a day), dated 6/25/2018. Review on 1/15/2019 of client #1's MARs dated 11/14/2018 to 1/14/2019 revealed: - Client #1's topiramate was not administered for	V 118		

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a total of 11 doses from the time of her 8:00pm dose on 12/14/2018 through her 8:00am dose on 12/18/2018.

Review on 1/15/2019 of FC #4's record revealed:
- Admission date: 10/18/2018
- Diagnoses: Cocaine Use Disorder; and Post Traumatic Stress Disorder;
- Physicians orders for the following medications:
  - Quetiapine (Seroquel) 300 mg, 1 tablet QHS, dated 11/6/2018;
  - Amlodipine 10mg, 1 tablet QD, dated 10/18/2018.

Review on 1/15/2019 of FC #4's MARs dated 10/18/2018 to 1/11/2019 revealed:
- FC #4 did not receive her doses of quetiapine at 8:00pm on 12/19/2018 or Amlodipine at 8:00am on 12/20/2018 due to having no medications available.

Review on 1/15/2019 of FC #5's record revealed:
- Admission date: 10/24/2018
- Diagnoses: Alcohol Use Disorder; Adjustment Disorder with Depressed Mood; and Rule Out Generalized Anxiety Disorder;
- Physicians order for the following medication:
  - Thorazine 25 mg, 1 tablet TID, dated 10/24/2018.

Review on 1/15/2019 of FC #4's MARs dated 10/24/2018 to 11/27/2018 revealed:
- FC #5's Thorazine was not administered for a total of 17 doses from the time of his 8:00pm dose on 11/7/2018 until the medication was discontinued on 11/13/2018.

Interview on 1/16/2019 with client #1 revealed:
- She had run out of her medications, but only for one day.

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V 118	Continued From page 3 An interview was attempted on 1/16/2019 with FC #4, but was not completed due to no return call having been received prior to the time of exit. An interview was attempted on 1/16/2019 with FC #5, but was not completed due to no return call having been received prior to the time of exit. Interview on 1/16/2019 with the Residential Shift Lead (RSL) revealed: - When clients' were admitted to the facility, they were supposed to bring a 30 day supply of medications with them; - If clients' were about to run out of medications, the facility would coordinate an appointment with a local behavioral health clinic for psychotropic medication refills or a medical clinic for other medications; - The Nurse, the RSL, the Residential Supervisor (RS) and the Center Director were involved with ensuring clients' did not run out of medications. Interview on 1/16/2009 with the RS revealed: - Following the last Division of Health Service Regulation (DHSR) annual survey completed on 12/8/2017, the facility had made improvements by following the plan of correction related to medication administration that was developed by facility management; - A new Nurse had been hired in 2018, and she took over responsibilities of ensuring clients did not run out of medications; - The Nurse was supposed to count medications regularly and order refills prior to the medications actually running out; - When clients were admitted to the facility, they were supposed to bring a 30 day supply of medications and have a mean to obtain refills if	V 118		

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they were at the facility longer than 30 days;
- If clients needed new prescriptions while at the facility, they were taken to appointments with local behavioral health and medical health clinics to obtain them.

Interview on 1/16/2019 with the Nurse revealed:
- The Nurse counted medication once weekly;
- She only worked part time at the facility;
- Because many of the facility's clients were indigent, they did not always have medication refills;
- Clients who needed new medication prescriptions were taken to local behavioral health and medical clinics to obtain them;
- Client #1's topiramate ran out and the cost to get a refill was originally quoted as over $400, which client #1 could not afford because her Medicaid coverage had expired;
- FC #5's Thorazine ran out because it was too expensive to purchase a refill;
- The Nurse thought that an appointment with a psychiatrist had been scheduled for the day before he ran out of Thorazine, but something happened that caused him to miss that appointment.

Interview on 1/16/2019 with the Center Director revealed:
- Improvements with medication administration process had been made following the last DHSR annual survey;
- The RSL and RS had been counting clients" medications twice weekly to ensure they did not run out of medication;
- After the new Nurse started and assumed responsibility for medication oversight, there was an increase in incident reports related to missed medication doses;
- The Center Director had addressed this with the

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V 118	Continued From page 5 Nurse on at least two occasions. This deficiency constitutes a re?cited deficiency and must be corrected within 30 days.	V 118		
V 754	27G .0304(c) Comfort Zone 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (c) Comfort Zone: Each 24-hour facility shall provide heating and air-cooling equipment to maintain a comfort range between 68 and 80 degrees Fahrenheit. (1) This requirement shall not apply to therapeutic (habilitative) camps and other 24-hour facilities for six or fewer clients. (2) Facilities licensed prior to October 1, 1988 shall not be required to add or install cooling equipment if not already installed. This Rule is not met as evidenced by: Based on observations and interviews, the facility was not maintained within a comfort range of 68-80 degrees Fahrenheit (F). The findings are: Observation at approximately 1:40pm on 1/14/2019 revealed: - The air temperature in the client bedrooms on the "B" hallway were uncomfortably cold; - There were four thermostat control in the Nurses station; - The thermostat for the B hall displayed a temperature of 60 degrees F. Observation at approximately 11:40 am on 1/15/2019 revealed: - The bedrooms on hall B remained cold;	V 754		

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V 754	Continued From page 6 - The thermostat for the B hall display was turned off. Interview on 1/15/2019 with the County Maintenance Worker revealed: - The Maintenance Department had received a work order on 1/14/2019 to service the facility's heating units; - A part for the condenser in the heating unit had to be replaced; - He was not aware of any other issues with the heating unit. Observation at approximately 2:30pm on 1/16/2019 revealed: - The air temperature in the bedrooms on the B hall remained cool, but was warmer than 1/15/2019; - The thermostat for the B hall displayed a temperature of 67 degrees F. Review of a local news station's weather report revealed: - The current temperature was 34 degrees F; The anticipated high temperature for the day was 53 degrees F, with a low of 30 degrees F. Interview on 1/15/2019 with client #2 revealed: - Hall B had been cold in "recent days"; - Facility staff had provided clients with extra blankets due to the temperature being so cold. Interview on 1/16/2019 with the Residential Shift Lead (RSL) revealed: - The facility had problems with the heating and cooling system periodically; - The facility had to call the County Maintenance Department approximately every two or three months to make repairs to the heating and cooling system;	V 754		

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- B hall felt like a "refrigerator";
- There were 24 client beds on the B hall;
- B hall would be full on 1/16/2019;
- There were no other bedrooms available to move clients to while the heating system was being repaired;
- Extra blankets had been purchased for clients and clients were allowed to wear hoodies and hats as a means to keep warm;
- The thermostat was typically set between 70-74 degrees F.

Interview on 1/16/2009 with the Residential Supervisor (RS) revealed:
- The heating unit in the building had stopped working in the past, but had never been off for as long as the current breakdown;
- The lack of heat was first noticed on 1/14/2019;
- Something had "burned out" during the night of 1/13/2019-1/14/2019 which caused the fire alarm to sound twice;
- Facility staff thought that the County Maintenance Department staff had repaired the heating system on 1/15/2019, but it was still not working correctly;
- Additional blankets had been purchased to help clients on B hall to stay warm;
- The thermostat was typically set on 72 degrees F.

Interview on 1/16/2019 with the Center Director revealed:
- Clients had complained about being cold;
- Additional blankets were purchased to help client stay warm while the system was being repaired;
- She had been told that something had melted inside the heating system and a part had to be replaced;
- The melted part had to be replaced twice

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V 754	Continued From page 8 between 1/15/2019 and 1/16/2019; - When repairs were needed at the facility, the County Maintenance Department was notified immediately; - The County was responsible for maintaining the building; - In the fall of 2018, a discussion about replacing the heating/cooling system occurred, but the County never moved forward with replacing it.	V 754		