Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-398	A. BUILDING: ___ B. WING ___	R 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLSTICE EAST, LLC	530 UPPER FLAT CREEK ROAD WEAVERVILLE, NC 28787

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V 000	INITIAL COMMENTS An annual and follow up survey was completed on June 27, 2019. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1300, Residential Treatment for Children or Adolescents.	V 000	RECEIVED JUL 29 2019 DHSR-MH Licensure Sect	
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.	V 111	V111 Failure to comply with the stated rule is the result of not providing documented strategies in the student's record. Staff are trained to use precautions, safety measures and strategies for all new clients, as well as review the individual safety and crisis plan for the client. However, individualized strategies are not documented in their record. To remedy this and ensure clinical recommendations are recorded regarding individual strategies specific to each client, therapists will complete the Intake Assessment document which will contain client history and strategies for working with the client, prior to when a Master Treatment Plan is created. CORRECTION: For current clients that do not already have a Master Treatment Plan in place, their Intake Assessment will be amended to include specific strategies. PREVENTION: Going forward, when there is a new admission the Intake Assessment document will be completed, shared with Direct Care Staff and saved to the client's record. MONITORING: The Clinical Director and Assistant Clinical Directors will review all new client records to ensure that an Intake Assessment document has been completed and made available to Direct Care Staff. The Clinical Director and/or Assistant Clinical Directors' signature on the document will be confirmation that they reviewed the strategies contained in the plan.	New process started immediately but will ensure full compliance no later than 8/26/19

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rick Pollard | TITLE: Executive Director | (X6) DATE: 25 July 2019

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V 111	Continued From page 1	V 111		

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to document strategies to address a client's presenting problems prior to the establishment of the treatment/habilitation or service plan for 1 of 9 audited clients (former client #11). The findings are:

Review on 6/26/19 of former client #11's (FC#11) record revealed:
- 16 year old female.
- Admission date 5/8/19, discharge date 5/23/19.
- Diagnoses included major depressive disorder, moderate and Post Traumatic Stress Disorder.
- Assessment dated 5/9/19 included a documented history of hospitalization for suicide threats and attempts (threats to jump off of a building and an overdose), running away, and self harm.
- No documented strategies to address FC#11's presenting problems.

Review on 6/27/19 of emails from FC#11's Primary Therapist, the Residential Director, and her Team Manager to her assigned "team" revealed:
- Email dated 5/14/19 at 8:56 pm, from FC#11's Team Manager, subject "[FC#11] Plan!"
- "She [FC#11] has expressed resistance to moving out of the basement, and we think it would be very damaging to the milieu for her to escalate if we apply too much pressure. this means we want to maintain the pressure/expectation that she move out of the basement. This will look like asking her about

NOTE: The space referred to in this documentation as the basement, is the lower level of the residence, which is a finished walk-out basement containing offices, mailroom, laundry room, staff break room, student phone call room, a student room with access to a private student bath and a student den with couches. The student room/den are provided for students that may be temporarily disruptive to the rest of the milieu or need a space for regulation away from other distractions and activities.

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V 111	Continued From page 2 once a shift if she is ready or willing to move out of the basement to the hazel group room, or move out of the basement to join the team. - "This also means that we should be aware of not releasing the pressure for [FC#11]. For now she can hang with mentors by chatting, coloring, journaling, playing games, or reading (or doing phase work if she's willing). Please try not to reward [FC#11] with special treats or visits to see the animals or things of that nature. The line between building connection and releasing pressure is going to be very blurry and very thin so please please text . . . if you have a question about whether or not something is appropriate, and do not just assume that something is ok." - "[FC#11] is very past focused right now. . . . so it's important that we redirect her to focusing on problem solving. When she starts to spiral set firm boundary of - hey, I'm not going to engage with you when you're really past focused- sounds like you have a lot of grief/anger about the past and that's warranted please journal about it an let me know when you want to talk about how we can make positive choices about the future, etc." - "We are hoping to slowly increase the pressure by allowing other students to come to the basement to chat with her, allowing her to have visits outside of the basement for breakfast/lunch/dinner, or asking her to join the team for certain activities. We want to be careful with this increase, so please don't allow kids to go into or allow [FC11] out of the basement without first running it by me." - Email dated 5/15/19 at 5:20 pm from the Residential Director, subject "[FC#11] Plan!" - "I want to add to this email as [FC#11] has had an uptick in risky behaviors this afternoon." - "New boundary for [FC#11]: Staff will physically intervene if [FC#11] begins to break or pull away the dry wall in the basement. She is aware of the	V 111		

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boundary but please remind her before going hands on."
- "She began doing this earlier today after becoming upset about a letter from her Mom. At one point she put an unknown item from the wall into the waistband of her shorts and would not turn it back over to staff. After a brief hold and some regulation time, she eventually turned over a nail that had been exposed during the "demolition."
- "All the exposed nails have been removed from the wall but we should intervene before she manages to expose more. Because she has such high SI [self-injury], this is now a safety issue and no longer just destruction of property."
- Email dated 5/20/19 at 10:17 pm, from FC11's Primary Therapist, "Subject: [FC#11]'s Updated Parameters."
- "Our goal is to get her out of the basement and into the milieu and our priority is still to keep her safe . . . believes she is not safe here . . . believes she can refuse until she gets her way out of here."
- "1) [FC#11] is to follow the Solstice schedule. This looks like-lights on when the other kids get up in the morning. If she does not get out of bed you can take the mattress out from under her. Today we removed the mattress safely and gently after telling her that we would if she didn't choose to get up. She can engage in chores, workout videos, etc. She has been very resistant to following the schedule at this time, however, if she is willing to do more of the schedule and you need more parameters text . . . and we will guide you!!"
- "2) [FC11] may not have books of any kind at this time unless she is following the schedule and it is designated study hall time."
- "3) If [FC#11] is sleeping during a non sleeping time please engage her in conversation to make

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V 111	Continued From page 4	V 111		

it uncomfortable to sleep."
- "4) Conversation with [FC#11] should be around the choices she is making and her goals for the program-not fun topics."
- "5) While her verbal threats of harming herself are still high she needs to shower with a bathing suit on with one arm out of the shower, counting"
- "6) Please continue to keep a food and water intake log"
- "This is a kid who is making severe verbal threats to harm herself and others. We need to take her threats seriously and keep her safe even though right now she is showing that her bark is worse than her bite. At this time we need to be setting clear boundaries with her around what she can and cannot do so that she is aware of the expectations and boundaries. Please follow your gut and set safe boundaries if you feel uncomfortable. Some of the boundaries we have set are: not pulling away or breaking the drywall, not picking at the outlets, walking to the bathroom in linked arms with two staff, peripheral vision in the bathroom following a hold."
- ". . . Our goal to get her uncomfortable may look like dysregulation for her and we will send her the message that she can make choices and we will keep her safe."

During interviews on 6/26/19 and 6/27/19 the Operations Director stated the above emails were the only "strategies" identified for FC#11's behaviors.

During interview on 6/27/19 the Executive Director stated he understood the requirement to document strategies to address a client's presenting problems prior to the establishment of a treatment/habilitation or service plan.

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V 112	Continued From page 5	V 112		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to develop and implement strategies based on assessment and identified needs for 1 of 9 clients (#1). The findings are: Review on 6/26/19 of client #1's record revealed:	V 112		

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V 112	Continued From page 6 -Date of Admission: 4/4/19. -16 year old female. -Diagnoses of Major Depressive Disorder (d/o); General Anxiety d/o; Post-Traumatic Stress d/o. -Psychological evaluation dated 9/26/18 revealed client #1 "struggles with depression with suicidal ideation, anxiety, trauma stress and disordered eating." There were 2 interrupted suicide attempts in September 2018. -Treatment plan dated 5/24/19 with no strategies to address suicidal ideation. Review on 6/26/19 of facility incident reports revealed: -Incident report for client #1 for an incident that occurred 5/10/19 for "suicide ideation." -"Description of Incident: After a peer fainted, client became verbally and nonverbally unresponsive and left the area into the art room where she sat and began banging her forehead against the wall, hitting progressively harder to the point that dents were made in the wall. Staff 1 attempted to place a pillow between client's head and wall and client flailed arms and continued to bang her head. Client punched wall several times before getting up and leaving the building. Client walked down to pond, still unresponsive, then walked around to the end of the dock and dunked her head into the water. Action taken: At this time, Staff 2 initiated transport hold from the left and Staff 1 joined on the right and pulled client out of the water. Client struggled and tried to get head into the water and staff pulled her back out. When client began hitting her head against the dock, Staff 3 placed her hand between client's head and dock. Client stopped hitting her head. Results of Action: After a few minutes client said she was ready to transition inside. Staff 1 and 2 maintained transport hold until resident was inside."	V 112	V112 Failure to comply with the stated rule is the result of therapist failing to document strategies for suicidal ideation in the Master Treatment Plan. CORRECTION: Client #1's Master Treatment Plan will be updated with strategies for suicidal ideation. Clinical Director will re-review all Master Treatment Plans for current clients to ensure appropriate strategies are documented in each plan. PREVENTION: Clinical Director and Assistant Clinical Directors will review new Master Treatment Plans after creation, ensuring appropriate strategies are included. Their signature on the document will be confirmation that they reviewed the strategies contained in the plan. MONITORING: After Master Treatment Plans are created (within 30 days of admission) they will be shared with the Clinical Director and/or Assistant Clinical Directors and they will be required to review and sign the plan to confirm they have reviewed it for strategies.	08/26/19

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V 112	Continued From page 7 -Incident report for client #1 for an incident that occurred 6/12/19 for "suicide ideation." -"Description of Incident: [Client #1] was refusing to go to school, so she sat on a couch in the dorm. She was not receptive to using regulation skills when prompted, and she instead curled in a ball and cried. She began to talk about why she should not be on safety phase, and rolled her eyes when staff did not engage. She curled into a ball again and put a pillow over herself. Staff asked her to move the pillow so that they could see her hands. When she did not respond, staff moved the pillow, and [client #1] moved it back onto herself. Staff moved the pillow again, and explained that they needed to see her hands to keep her safe. [Client #1] did not respond or indicate that she heard staff. She picked up a metal fork from a plate of food, and staff took the fork from her. [Client #1] then stood, and staff asked her to communicate with them if she wanted to go somewhere. [Client #1] walked quickly to the door without communicating, and staff set the boundary that she not leave. She attempted to get out of the building, so staff went into an escort hold. [Client #1] struggled against staff and broke free, falling to the ground and began hitting her head into the concrete. Staff attempted to get her into an escort hold or have her stand, but she fought against them, trying to run, banging her head into the ground, or trying to choke herself. A third staff placed pillows under [client #1]'s head to soften the blows as the other two staff held her arms in an escort hold position. Staff moved [client #1] over to the grass, and [client #1] breathed heavily, did not make eye contact, and did not verbally communicate with staff. Program Director [Residential Program Director (RPD)] was called, and she came to assist staff. [Client #1] began choking herself, and staff moved her hands from around her neck.	V 112		

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[Client #1] then began to stand and tried to run away, and [RPD] and another staff put [client #1] in an escort hold. They asked her to move inside with them, and she agreed. Staff remained hands on with [client #1], slowly releasing her as she communicated with them and began using regulation skills. [RPD] asked [client #1] if she understood why they had to put their hands on her, and [client #1] said yes. She shared with staff that she had a plan to run away from Solstice and jump off of a bridge over the highway as a way to kill herself. The therapist on call and clinical director were notified of the incident an suicide plan. Action taken: [Client #1] is already on full precautions from a previous incident and SI. The therapist on call determined that the risk for [client #1] to complete her suicide plan was great, so [client #1] was escorted to the hospital by a sheriff. [Client #1] was admitted to the adolescent psychiatry unit for stabilization."

Review on 6/27/19 of client #1's Master Treatment Plan revealed no specific goal for suicidal ideation and no strategies to address this history. Goal #1 was to "report a significant improvement in mood and sense of well-being." The short-term objective was "articulate the relationship between cognition and emotion as it relates to depressed mood by 7/30/2019 and cite 3 personal example(s) of how thought processes effect mood." The interventions listed were all therapy related and no specific strategies for staff to address client #1's suicidal ideation.

Review on 6/27/19 of emails from client #1's Therapist to client #1's assigned "team" revealed:
-Email dated 6/25/19 at 10:55AM "[Client #1]'s precautions are the same as they were over the weekend right now and she is still on safety as she has not finished all her assignments yet.

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V 112	Continued From page 9 Arms length, Periphs in the bathroom, sleeping in the common area, she needs to be wearing non sneakers however she can travel to other buildings at this time she does not have to be confined to the dorm, If she is under a blanket or her hands are hidden it is expected that she show her hands. Please just use your intuition with this kid. She is pretty easy to read before she gets dysregulated - she requires a high amount of attunement - however we don't want to feed into her negative behaviors. Please be direct with her and if she says things like 'I don't' know why people care about me' you can say - 'what would you say to me, if I said that about myself?' Please use the rating scale 1 being lowest 10 being the highest to rate her impulsivity and suicidal thoughts. If it feels high - use a skill. This kid is working on regulation and her identity not being her dysregulation. We are going to be moving towards taking her on and off precautions more quickly to help her practice regulating - stay tuned for that change. Thank you for your work with this kiddo. If you have any questions at all please please ask! I am happy to answer any questions." -Email dated 6/25/19 at 6:05PM "[Client #1] was in a hold again this evening. Thank you to those people who were there and kept her safe. Due to her dysregulation she is still on safety and full precautions. [client #1] is internally a very dysregulated kid who snaps, and goes to dysregulation very quickly - therefore she requires high attunement. If you are her staff and need to be switched out for any reason please do so to ensure your supervision capabilities and her safety. This will require communication and flexibility as a staff team right now on Hazel (client #1's team name) - support each other and be open with your needs! Utilize the whole campus if it's feeling strained and see what other teams ca support etc. [Client #1]'s dysregulation is	V 112		

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V 112	Continued From page 10 presenting very 'gamey' right now - meaning that [client #1] seems to ramp up when things feel uncomfortable for her and her tolerance for discomfort is very low. When [client #1] is regulated we want her to be close to the team and practicing skills as much as she can tolerate. Our goal is to get her to communicate when she needs to step away - regulate and rejoin. Please be interacting with her a neutral as possible when she is dysregulated - particularly when she is talking of suicide and not wanting to be alive. I know this may feel counterintuitive - however this is when [client #1] is used to hearing positive affirmations such as 'you deserve t live, we care about you'. Please give her positive attention instead when she is regulated. [Client #1] is used to feeling 'seen' in crisis as this was a longstanding pattern before Solstice - we are working on correcting that pattern here with these measures. Let me/[unidentified staff]/[RPD] know if you have questions about how to work with this. Current Expectations: Safety and Full Precautions expectations for [client #1] are that if she is regulated she can be on milieu safety. If she is not regulated she can be in group room to regulate then rejoin when you as the mentor feel safe and supposed brining her out. I trust you guys to make that call. If you are questioning it - please text [unidentified staff]! Arms length from mentor, Com (communication) block - needs based communication only with mentors - coregulation is approved as well, Reading, writing, phase work, drawing - no sleeping, Periphs in bathroom and counting, sleeping in hall, must have hands showing when under blankets, if you feel like she is not in a safe space to take a shower then she can hold one hand outside the shower or wait until later/tomorrow to shower THANK YOU so much for work with this kid and or the support you have given Hazel team	V 112		

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V 112	Continued From page 11 while we work with this kid. please please please don't hesitate to reach out with questions." Interview was not attempted with client #1 due to her currently being in a crisis situation during the survey. Interview on 6/26/19 and 6/27/19 with Operations Director revealed the above emails were the only "strategies" that had been identified for client #1's SI other than the therapy information located in her Master Treatment Plan.	V 112		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to conduct disaster drills per shift per quarter. The findings are:	V 114	V114 Failure to comply with this rule was due to a misunderstanding with between staff on the requirement of fire drills -AND - additional emergency drills quarterly per shift. There was also a change in staffing that occurred during this time. CORRECTION: We are unable to go back and perform drills, but going forward we are moving the emergency drills responsibility to the Residential Director while the Facilities Director will remain responsible for the Fire Drills. PREVENTION: Responsibility is being shared between departments. The Residential Director is more aware of staffing schedules and can better arrange a time to perform emergency drills. MONITORING: Monitoring will be done by the Operations Director who will be required to initial the drill report instead of accepting verbal confirmation that a drill was completed to ensure proper documentation is maintained.	07/27/19 All drills will be completed during 3rd Quarter 2019 and going forward

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Review on 6/26/19 of the facility fire and disaster drills from June 2018 - June 2019 revealed no disaster drills on 2nd and 3rd shift in one quarter and no disaster drills on 1st and 2nd shift in another quarter.

Interview on 6/27/19 client #2 stated she had been at the facility for about 4 months. "I haven't done any of those (disaster drills) since I've been here. I've only done a fire drill."

Interview on 6/27/19 client #3 stated she had been at the facility about 8 months. She further stated "I think we've done the one (disaster drill) where you go under the desk. We've done that one. I think we've talked about if an intruder comes, what we would have done."

Interview on 6/27/19 client #5 stated "I have not been there for one of them (disaster drills). I am not sure if they do them."

Interview on 6/26/19 the Operations Director stated the facility shifts were 7:00 am - 5:00 pm, 4:30 pm - 10:30 pm, and 10:00 pm - 7:00 am or 8:00 am on school days.

V 118	27G .0209 (C) Medication Requirements	V 118		

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.

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V 118	Continued From page 13 (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 with a physician. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to administer medications (meds) as ordered by a physician for ? of ? clients and ? of 6 staff failed to demonstrate competency when administering medications. The findings are: 1. Review on 6/26/19 of client #1's record revealed: -Date of Admission (DOA): 4/4/19. - 16 year old female. -Diagnoses of Major Depressive Disorder (D/O); General Anxiety D/O; Post-Traumatic Stress D/O (PTSD).	V 118	V118 Failure to comply with the stated rule is the result of a variety of medication errors by medication trained mentor staff and signifies the need for additional mentor education. CORRECTION: A Medication Trained Mentor Remediation Program has been created to address the specific areas of need. An education sheet will be provided to all medication trained staff no later than 7/27/19. This will be followed up with a mandatory in-person training for all medication trained mentors in the month of August. The course will be taught by a Registered Nurse. The content covered aims to increase education around common facility medication administration errors, how to prevent them, and how to document them properly if they occur. PREVENTION: The content of the Remediaton Program will be incorporated in our Med Admin Training and Annual Recertifications. MONITORING: The efficacy of the course will be monitored by a Registered Nurse. Medication administration record (MAR) audits will be completed on a weekly basis to identify errors in a timely manner and to ensure that appropriate documentation has been completed (incident report, MAR corrections, physician notification). Following this audit, appropriate actions will be taken according to the root cause of the error (physician order changes, suspension of medication administration privileges, policy changes, etc). - See next page -	7/27/19

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V 118	Continued From page 14 Review on 6/26/19 of client #1's physician's orders revealed: -Oxcarbazine (mood stabilization) 600 milligrams (mg) 1 twice a day (BID) -4/4/19. -Oxcarbazine 300 mg 1 tablet BID - 6/19/19. -Aripiprazole (Abilify) (mood stabilization) 5 mg once daily - given at 1PM - 4/4/19. -Gabapentin (mood stabilization) 300 mg take 1 capsule by mouth 4 times a day at 8AM, 1PM, 6PM and 8PM - 4/4/19. Review on 6/26/19 of facility incident reports revealed: -Incident report for client #1 dated 4/7/19 at 2:49PM revealed "Staff (Mentor #5) forgot to administer medication in noon window. Medication was administered 50 minutes after med window was closed." Medication administered late was Abilify and Gabapentin. -Incident report dated 6/20/19 at 7:30(AM) client #1 received an incorrect dose of Oxcarbazine. Report revealed "Staff (Mentor #5) gathered meds that she believed were correct to give to client after seeing that client had recent medication changes. Staff contacted nursing when client mentioned that meds had changed recently. Staff administered meds and was informed by nurse that client had taken the wrong medication and switched out incorrect medication for correct medication in client's box." Review on 6/27/19 of client #1's June 2019 MAR revealed on 6/20/19 "Mentor (#5) incorrectly administered old dose of 600 mg. (Oxcarbazine). [Dr. notified]." Review on 6/27/19 of client #1's MARs from March 2019 - June 2019 revealed the following med errors or meds not given as ordered: -Gabapentin - no initials for 1PM dose on 4/15/19.	V 118	- continuation from previous page - Remediation Course Content Odd Time Medication Protocol - There is a recurring alarm set on the lead staff phone to alert the designated mentor medication administrator of the need to administer an odd time medication. This mentor is to be accountable to ensure that physician ordered medication is administered within allotted administration period. Medication Administration Resident Mouth Check Protocol - Medications are to be prepared in front of the resident utilizing OPUS cassettes, bar code scanner, and electronic medication administration record. All medications are to be prepared in medication cup and handed to resident to self-administer. Supervision will include resident receiving medications to administer directly the medications directly from the cup to their mouth. A visual inspection of the mouth will be performed to ensure that all oral medications are present prior to resident swallowing. Following this, the resident will swallow medications with water and perform another mouth check upon completion during which under the tongue and along all gum lines will be visualized. For residents determined to be higher risk for medication "cheeking" or "stashing" behaviors, a swish and spit protocol will be implemented. - see next page -	

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V 118	Continued From page 15 -Abilify - no initials for 1PM dose on 4/15/19. 2. Review on 6/27/19 of client #2's record revealed: -DOA 2/26/19. -17 year old female. -Diagnoses of Major Depressive D/O, recurrent episode, moderate; Cannabis use D/O, moderate; ADHD (Attention Deficit Hyperactivity D/O), combined presentation; General Anxiety D/O; other specified trauma-and stressor-related D/O. Review on 6/27/19 of client #2's June 2019 MAR and physician orders revealed the following medications as indicated they were administered on 6/12/19 in the evening: -Divalproex SOD ER (Depakote) (used to treat bipolar d/o) 500 mg 2 tablets at bedtime - order dated 2/26/19. -Minocycline 50 mg 1 capsule y mouth twice daily (8AM and 8PM) - order dated ordered dated 4/30/19. -Multi for her (multivitamin) - 1 capsule at bedtime - order dated 4/30/19. Review on 6/26/19 of incident reports for client #2 revealed: -Incident on 6/12/19 at 10:00(PM). -"Describe the Incident: Client hid their night time medications in their hand without staff knowing. Before bed a pill fell from the clients bed with staff in the room. The client got down from her bunk and handed staff two pills. After the team manager was notified and a few minutes went by staff approached the client and asked if they had anything else. The client claimed that she flushed the rest of the pills that she had. The client later stated that she had a 'few' days worth' of pills that	V 118	- continued from previous page - Medication Changes During LOA - All over-the-counter medications and supplements, outside provider medication orders, and desired medication timing changes are to be communicated to Registered Nurse by medication trained mentor prior to implementation. Registered Nurse will communicate changes/additions/deletions to resident's Psychiatrist for approval and electronic medication administration record (MAR) will be updated accordingly. Medication Interval Dosing - Prior to the administration of all PRN medications, the documentation of time of the last dose administered must be determined. If the medication has not been administered within the fixed time interval (e.g., 2 hours, 4 hours) then the mentor may assist with the resident's self-administration of the medication. - see next page -	

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V 118	Continued From page 16 she flushed and was hiding them in her shelf on her bunk." "Results of Action: Client shut down and did not respond. She eventually went outside and tried to run." -Incident on 6/12/19 at 10:30(PM). -Describe the incident: The client was placed on safety and precautions for hiding her medications and flushing them down the toilet. After being told this the client was shut down and refused to do the full body check in and move into the common area..." Interview on 6/27/19 client #2 stated: -Had been at the facility for 4 months. -She had been made to sleep in the common area at one time because "I was stock piling my meds in my room. One med fell out of my bed. My whole room had to sleep in the common area. Then do a full room search the next day." -The facility now has a new med protocol. "You take the pills and they have to see them all in your mouth and you have to show them each side of your mouth. I specifically have to do the swish and spit after." It's done with every medication administration. 3. Review on 6/26/19 of client #3's record revealed: -DOA 10/4/18. -16 year old female. -Diagnoses of Intermittent Explosive D/O (IED); Oppositional Defiant D/O (ODD); ADHD, predominantly inattentive presentation; Cannabis use D/O, mild; PTSD. Review on 6/26/19 of client #3's medication orders revealed: -Straterra - 60 mg every night start on 6/6/19 (was previously receiving this in the AM)- order dated 6/5/19.	V 118	- continued from previous page - Response to Specific Incidents: -Regarding client #4 receiving Ibuprofen 200mg and Tylenol 325mg ten minutes apart on 03/12/2019, standing orders permit these medications to be administered in this manner. This is not a medication error and thus no additional action required. -Regarding the delay in the beginning of Benadryl Allergy dated on 06/11/2019, there was a technological error resulting in only partial fax transmission from ordering physician to pharmacy. These orders were implemented once the error had been corrected. -NOTE: Delays in the timeframe between doctor's orders and medication being administered is often out of our control and due to the pharmacy's hours, deliveries, backorders or issues with communication such as fax transmission errors, as mentioned above. -Regarding client #4, the medication Estarylla was administered on 5/5/19 based off physician's directive to begin medication after next menstrual cycle.	

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-Tums (acid reflux) - take 2 by mouth three times a day before meals - order dated 5/23/19.
-Allegra-D 180 mg every AM - order dated 4/30/19.

Review on 6/26/19 of incident reports for client #3 revealed the following:
-Incident on 6/15/19 at 20:30 (8:30PM). Sub Incident Type: "Missed Medication."
-Description of Incident: "Client refused to take Tums, stating they had not taken them during their recent LOA (leave of absence). They also reported having taken their Straterra in the morning, that their father had wanted to change when they took their med. Results of Action: Client did not receive medications."
-Incident on 6/16/19 at 11:57 for "medication refused." No indication as to what medication was refused.
-Description of Incident: "Staff (Mentor #5) called client to med room to have client take 6pm medication. Client refused medication saying 'It doesn't do anything for me anymore and I don't need it'. Staff did not have opportunity to contact nursing department."
-Incident on 6/16/19 at 20:45 for "Medication refused." Medication refused was Atomoxetine (Straterra).
-Description of Incident: "Staff (Mentor #5) called student to med room to receive evening meds. She told staff that she no longer took this medication at night and she should be taking it in the morning. Staff did not have opportunity follow up with nurses to verify and student did not take medication."

Review on 6/27/19 of May 2019 MAR revealed:
-Allegra-D not given 5/1/19 and 5/2/19.

Review on 6/27/19 of June 2019 MAR revealed:

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-Initials on the block for Tums on 6/15/19 at 6:23PM with circles around the initials. In the "Exceptions" section indicates "refused". "Client said she does not need to take them any longer."
-Initials on the block for Straterra on 6/15/19 at 8:00PM, with circles around the initials. In the "Exceptions" section indicates "Leave of absence."

Interview on 6/27/19 client #3 stated:
-Had been at the facility for 8 months.
-She missed some meds one day when staff put them in their pocket and she forgot to remind them to give them to her after breakfast. She likes to take her meds after breakfast because she gets an upset stomach if she takes them before she eats. Therefore, staff had been putting the meds in their pocket and gave them to her after breakfast. On one particular incident, she "forgot" to remind staff to give her her meds. "I talked to staff about it. I talked to the staff and they talked to the nurse. I talked to the staff because I wanted to apologize to the person (for not reminding them)." "There is a new protocol now where they can't do that (keep meds in their pockets) so I just go to the med window after I eat....I think it was recent (when they put the new protocol in place.)...They (staff/nurses) check your mouth to make sure you take meds. They always did it but "recently" doing it more thoroughly."

4. Review on 6/26/19 of client #4's record revealed:
-DOA 10/29/18.
-15 year old female.
-Diagnoses of Major Depressive D/O, recurrent episode, in partial remission; Other specified trauma - and stressor-related D/O; Parent-child relational problem.

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Review on 6/26/19 of client #4's medication orders revealed:
-Tylenol (pain reliever) 325 mg take 1-2 tablets (tabs) every 4-6 hours as needed - order 10/29/18.
-Ibuprofen (pain reliever) 200 mg 1-2 tabs every 4-6 hours as needed - order 10/29/18.
-Estarylla (hormone) .25-.035 mg 1 every day - order dated 4/29/19.
-Q-Dryl (benadryl allergy) - 12.5 mg/5ml (milliliters) 20 minutes before bedtime - order dated 6/11/19.
-Triamcinolone (nasal spray) use 1 to 2 sprays in each nostril once daily - order dated 2/6/19.

Review on 6/26/19 of an incident report for client #4 dated 6/10/19 revealed:
-Sub Incident Type: "Wrong dose".
-Description of Incident: "Student [client #4 initials] returned from LOA with a different dosage amount of Tylenol. Mentor administered this higher dose without checking if it was already in the MAR, and when she checked saw that it was not. [Client #4] got 250 mg more of Tylenol than she usually does at Solstice, but it was the same amount she has been taking per her father."

Review on 6/26/19 of client #4's March - June 2019 MARs revealed:
-3/12/19 - Ibuprofen 200 mg was given at 7:12AM and Tylenol 325 mg was given at 7:21AM by different staff.
-Estarylla not initialed as given until 5/5/19 even though order was written 4/29/19.
-Estarylla not initialed as given on 6/7/19 nor any indication of leave of absence for that day.
-Benadryl Allergy - not administered until 6/20/19 even though the order was written 6/11/19.
-Triamcinolone - not administered 6/7/19 nor any

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indication of leave of absence for that day.
-6/15/19 - Tylenol 325 mg 2 tablets were given at 4:10PM and again at 6:23PM.

5. Review on 6/26/19 of client #5's record revealed:
-DOA 6/3/19.
-14 year old female.
-Diagnoses of Major Depressive D/O, recurrent, severe without psychotic features; Generalized Anxiety D/O; Social Anxiety Disorder; Gender Dysphoria.

Review on 6/26/19 of client #5's physician orders revealed:
-Trazadone - 50 mg every evening; may repeat in 1 hour if still awake - order dated 5/30/19.

Review on 6/26/19 of incident report dated 6/11/19 for client #5 revealed:
-Sub Incident Type "Wrong dose" of Trazadone. Received 100 mg instead of the 50 mg as ordered.
-Description of Incident: "Mentor [#1] administered meds from the cassettes and from a bottle. The med in the bottle, Trazadone, had also been put in a cassette, thus was administered twice." Action Taken: "Mentor [#1] was familiar with the med and knew there was no danger. She notified Nurse-On-Call immediately and reassured the client that the dose was not dangerous and that she would be more sleepy. Mentor [#1]informed client's staff to let her go to bed a little earlier." Results of Action:"Nursing confirmed that the medication was not dangerous at that dose and advised Mentor [#1] to do an incident report."

Review on 6/26/19 of client #5's June MAR did

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not indicate Trazadone had been administered in a double dose on 6/11/19.

Interview on 6/27/19 client #5 stated she received too much Trazadone on one occasion. "If I take one I start feeling tired about 20 to 30 minutes after. Started feeling tired about 10 to 15 minutes afterwards (on that occasion). I get it late night. It was one of the staff [Mentor #1]. They have containers that they give us our meds. The trazadone was in there twice and I don't think she like saw it. We figured it out later. I don't remember exactly (when). It was like a few minutes after like we just noticed."

Interview on 6/27/19 the Nurse stated:
-The process for med errors depends on if nursing is on call of if there is a med tech there. The staff will let nursing know and nursing immediately notifies the Doctor. Families/Parents are only notified for major meds. "Sometimes we let the Pharmacy know." Everything should be in the Incident Report. Mentors have 24 hours per the policy to get the incident report done. "But there are occasions where the mentors don't do that."
-Medication refusals are treated just like med errors and an Incident Report is done.
-Monitoring of PRN meds in regards to the error with client #4 being given the Ibuprofen and Tylenol 9 minutes apart - "I wasn't aware of that error." With those 2 meds, they should not have been given back to back. "In that instance, the staff should have seen the first med on the MAR."
-In regards to the Electronic MAR, the med window is 90 minutes before and 90 minutes after. At midnight the MAR rolls over to the next day and they can't document. Then they have to notify nursing. Staff can't administer if late until notify the nurse and physician is contacted.

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	MHL011-398	A. BUILDING: ______ B. WING ______	R 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLSTICE EAST, LLC	530 UPPER FLAT CREEK ROAD WEAVERVILLE, NC 28787

(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 118	Continued From page 22 Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118		
V 784	27G .0304(d)(12) Therapeutic and Habilitative Areas 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (d) Indoor space requirements: Facilities licensed prior to October 1, 1988 shall satisfy the minimum square footage requirements in effect at that time. Unless otherwise provided in these Rules, residential facilities licensed after October 1, 1988 shall meet the following indoor space requirements: (12) The area in which therapeutic and habilitative activities are routinely conducted shall be separate from sleeping area(s). This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure sleeping areas were separate from areas in which therapeutic and habilitative activities are routinely conducted for 3 of 9 audited clients (#2,#3,& #5). The findings are: Review on 6/27/19 of client #2's record revealed: - 17 year old female. - Date of admission 2/26/19. - Diagnoses of Major Depressive D/O, recurrent	V 784	V784 We are reviewing this rule with Sonya Elridge and Robin Sulfridge to discuss the limitations the design of our facility place on our ability to maintain the safety of our clients should we be required to meet the requirements of this ruling. Additional information will be provided once our current policy is reviewed by the above DHHS employees.	under review

Division of Health Service Regulation

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V 784	Continued From page 23	V 784		

episode, moderate; Cannabis use D/O, moderate; ADHD (Attention Deficit Hyperactivity D/O), combined presentation; General Anxiety D/O; other specified trauma-and stressor-related D/O.

During interview on 6/27/19 client #2 stated:
- She had slept in the "common area" when she was put on safety precautions for self-harm and "stock piling" her medications.
- All of her roommates had to sleep in the common area because she saved her medications; the entire bedroom was searched the next day.

Review on 6/26/19 of client #3's record revealed:
-16 year old female.
- Date of Admission 10/4/18.
- Diagnoses of Intermittent Explosive D/O (IED); Oppositional Defiant D/O (ODD); ADHD, predominantly inattentive presentation; Cannabis use D/O, mild; PTSD.

During interview on 6/27/19 client #3 stated:
- She was put on "safety" for 5 days in the last week.
- "Safety" included sleeping in the common area where overnight staff could easily monitor her.
- The lights in the common area were left on overnight.
- There was no privacy in the common area.

Review on 6/26/19 of client #5's record revealed:
- 14 year old female.
- Date of Admission 6/3/19.
- Diagnoses of Major Depressive D/O, recurrent, severe without psychotic features; Generalized Anxiety D/O; Social Anxiety Disorder; Gender Dysphoria

Division of Health Service Regulation

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V 784	Continued From page 24	V 784		

During interview on 6/27/19 client #5 stated:
- She had slept in the common area for the last couple of nights because she acted on some "self-harm urges."
- She took her mattress to the common area; overnight staff turned most of the lights off, but some lamps were left on.
- Sleeping in the common area did not bother her because she took medications to help her sleep.

During interview on 6/27/19 Mentor #2 stated:
- Clients were required to sleep in the common area, stay 10 feet away from others, and engage in "needs based communication" only when on safety precautions.
- The decision to place a client on safety precautions was made by the client's Primary Therapist and the Team Manager.
- Clients were put on safety precautions for creating an unsafe environment for their peers, staff, and for themselves.

During interview on 6/27/19 the Executive Director stated clients who were put on safety precautions slept in the common areas so staff could easily monitor them overnight. He understood the requirement for sleeping areas to be separate from areas in which therapeutic and habilitative activities are routinely conducted. His team would explore ways to meet the rule requirement and still ensure the safety of the clients.