STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mhl078-197	A. BUILDING: _____ B. WING _____	R 02/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON CENTER II	111 TAYLOR STREET RED SPRINGS, NC 28377

(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 000	INITIAL COMMENTS An annual and follow up survey was completed on February 3, 2020. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.	V 000		
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 ensure fire and disaster drills were held quarterly and repeated on each shift. The findings are: During interview on 01/30/2020 the Associate Professional (AP) revealed the shifts of the facility were: -First shift 7:30am-3:30pm	V 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mhl078-197	A. BUILDING: _____ B. WING _____	R 02/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON CENTER II	111 TAYLOR STREET RED SPRINGS, NC 28377

(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 114	Continued From page 1 -Second shift 3:30pm-11:30pm -Third shift 11:30pm-7:30am Review on 01/30/2020 of facility records from January 2020 thru December 2019 revealed: - No 1st shift fire drill in the second quarter of 2019. - No 1st shift fire drill in the 3rd quarter of 2019. -No 1st shift disaster drill in the 2nd quarter of 2019. -No 3rd shift disaster drill in the 3rd quarter of 2019. During interview on 02/03/2020 clients #1, #2 and #3 revealed they completed fire and disaster drills at the facility. Interview on 01/30/2020 the Qualified Professional stated: -She would ensure all the drills were completed on each shift for every quarter.	V 114		
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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mhl078-197	A. BUILDING: _____ B. WING _____	R 02/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON CENTER II	111 TAYLOR STREET RED SPRINGS, NC 28377

(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 2 (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 keep the MARs current affecting three of three clients (#1, #2 and #3). The findings are: Finding #1 Review on 01/30/2020 of client #1's record revealed: -17 year old male. -Admission date of 08/13/19 -Diagnoses of Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, combined presentation. Review on 01/30/2020 of client #1's Physician orders revealed: 01/09/2020 -Abilify (used to treat the symptoms of psychotic conditions such as schizophrenia and bipolar I disorder) 10mg Take 1 tablet by mouth everyday.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mhl078-197	A. BUILDING: _____ B. WING _____	R 02/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON CENTER II	111 TAYLOR STREET RED SPRINGS, NC 28377

(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 3 -Concerta (used to treat attention deficit hyperactivity disorder) 54mg Take 1 capsule by mouth in the morning. -Guanfacine (used to treat attention deficit hyperactivity disorder) 3mg Take 1 tablet by mouth everyday. 09/13/19 -Vitamin D3 (Treats vitamin D deficiency) 400iu Take once a day by mouth. 10/10/19 -Atomoxetine (used to treat attention deficit hyperactivity disorder) 80mg Take 1 capsule by mouth in the morning. Review on 01/30/2020 of client #1's January 2020 MAR revealed no initials on the following dates to indicate the medication had been administered: -Abilify 10mg- 1/07/2020 at 8am. -Vitamin D3 400iu- 01/07/2020 at 8am. -Concerta 54mg- 01/07/2020 at 8am. -Guanfacine 3mg- 01/07/2020 at 8am. Atomoxetine 80mg- 01/07/2020. During interview on 02/03/2020 client #1 revealed he received his medication daily. Finding #2 Review on 01/30/2020 of client #2's record revealed: -15 year old male. -Admission date of 01/28/19. -Diagnoses of Conduct Disorder and Disruptive Mood Dysregulation Disorder. Review on 01/30/2020 of client #2's Physician orders revealed: 01/09/2020 -Vyvanse (treat attention deficit hyperactivity disorder) 60mg Take 1 capsule by mouth every morning.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mhl078-197	A. BUILDING: _____ B. WING _____	R 02/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON CENTER II	111 TAYLOR STREET RED SPRINGS, NC 28377

(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 4 -Saphris (used to treat schizophrenia in adults, and bipolar I disorder in adults and children who are at least 10 years old) 10mg Take 1 tablet under tongue nightly. Review on 01/30/2020 of client #2's November 2019 and January 2020 MAR's revealed no initials on the following dates to indicate the medication had been administered: -Vyvanse 60mg- 01/07/2020 at 8am. -Saphris 10mg- 11/14/19 at 8pm. During interview on 02/03/2020 client #2 revealed he received his medication daily. Finding #3 Review on 01/30/2020 of client #3's record revealed: -9 year old male. -Admission date of 12/31/19. -Diagnoses of Attention Deficit Hyperactivity Disorder, Combined Type, Oppositional Defiant Disorder, Upbringing away from biological parents, Conduct Disorder. Review on 01/30/2020 of client #3's Physician orders revealed: 01/16/2020 -Risperidone 1mg (used to treat schizophrenia in adults and children) Take 1 tablet by mouth 2 times a daily. 01/28/2020 -Vyvanse 30mg (treat attention deficit hyperactivity disorder) Take one capsule by mouth everyday in the morning. 12/18/19 -Montelukast 5mg (treats allergies) Chew and swallow 1 tablet by mouth every night. -Fluticasone Spray 50mcg (treats allergies) Use 1 spray in each nostril daily.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mhl078-197	A. BUILDING: _____ B. WING _____	R 02/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON CENTER II	111 TAYLOR STREET RED SPRINGS, NC 28377

(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 5 Review on 01/30/2020 of client #3's January 2020 MAR revealed no initials on the following dates to indicate the medication had been administered: -Risperidone 1mg-01/07/2020 at 8am. -Vyvanse 30mg- 01/07/2020 at 8am. -Montelukast 5mg-01/05/2020, 01/12/2020, 01/19/2020, 01/25/2020. -Fluticasone Spray 50mcg-01/20/2020. During interview on 02/03/2020 client #3 revealed he received his medication daily. During interview on 02/03/2020 the Associate Professional revealed: -She was the one that reviewed the MAR's for the facility. -She would ensure the staff are completing the MAR's daily. Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician.	V 118		