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THE LIGHTHOUSE II OF CLAYTON	2016 FORT DRIVE CLAYTON, NC 27520

(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 A complaint survey was completed on 3/3/20. The complaints were substantiated (Intakes #NC00161265 and NC00161302). 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 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	DHSR-Mental Health MAR 2 0 2020 Lic. & Cert. Section	

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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 four of seven audited staff (#1, #2, #3 and the House Manager) failed to demonstrate competency in the area of medication administration affecting three of three current clients (#1, #2 and #3) and one of one former client (FC#5). The findings are: Cross Reference Tag 120 10A NCAC 27G .0209 Medication Requirements Based on record reviews and interviews, the facility failed to ensure medications were in a securely locked cabinet affecting three of three current clients (#1, #2 and #3) and one of one former client (FC #5). Cross Reference Tag 296 10A NCAC 27G .1704 Minimum Staffing Requirements Based on record reviews and interviews the facility failed to ensure minimum staffing requirements were met by direct care staff when children or adolescents are present and awake affecting three of three clients (#1, #2 and #3) and one of one former client (FC #5). a. Review on 2/26/20 of client #1's record revealed: -Admission date of 7/20/19. -Diagnoses of Bipolar Disorder, Generalized Anxiety Disorder and Oppositional Defiant Disorder. -He is 14 years old.	V 118		

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V 118	Continued From page 2 -Assessment dated 7/19/19 had the following: Client #1 had a history of self harm thoughts, increased anxiety, negative thinking, feeling hopeless, racing thoughts, irritability, decreased energy/motivation and suicidal ideation's/behaviors. -Physician's order dated 1/30/20 for Quetiapine 100 milligrams (mg), one tablet as needed; Clonidine 0.1 mg, one tablet at bedtime; Adderall 20 mg, one capsule in the morning; Adderall 10 mg, one capsule at 3 pm, Fluoxetine 20 mg, one capsule daily and Ziprasidone 40 mg, one capsule at bedtime. -Hospital Discharge summary dated 2/20/20. Client #1 was admitted on 2/11/20. Client #1 intentionally overdosed on Adderall, Seroquel and Prozac. Client #1 had intermittent confusion due to drug effect. Client #1 received Ativan and Haldol for agitation and hyperactivity. The discharge diagnosis was suicide attempt by drug ingestion. -The medications were used for the following: Quetiapine Fumarate-used to treat Schizophrenia in adults and children; Ziprasidone-used to treat Bipolar Disorder; Clonidine-used to treat Attention Deficit Hyperactivity Disorder; Adderall- used to treat Attention Deficit Hyperactivity Disorder and Fluoxetine-used to treat Major Depressive Disorder. b. Review on 2/26/20 of client #2's record revealed: -Admission date of 11/22/19. -Diagnosis of Oppositional Defiant Disorder. -He is 14 years old. -Physician's order dated 11/11/19 for Vyvanse 30 mg, one capsule every morning and Divalproex ER 250 mg, three tablets at bedtime.	V 118		

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V 118	Continued From page 3 -The medications were used for the following: Vyvanse-used to treat Attention Deficit Hyperactivity Disorder and Divalproex Sodium-used to treat manic episodes related to Bipolar Disorder c. Review on 2/26/20 of client #3's record revealed: -Admission date of 7/15/19. -Diagnoses of Oppositional Defiant Disorder, Post Traumatic Stress Disorder, Reactive Attachment Disorder, Impulse Control Disorder and Conduct Disorder. -He is 16 years old. -Physician's order dated 1/29/20 for Melatonin 5 mg, one tablet as needed at bedtime and Aripiprazole 10 mg, one tablet in the morning. A physician's dated 12/18/19 for Concerta 54 mg, one tablet in the morning; Clonidine HCL 0.1 mg, one tablet in the morning and Lamotrigine 200 mg, one tablet in the morning. d. Review on 2/26/20 of FC #5's record revealed: -Admission date of 10/17/18. -Diagnoses of Oppositional Defiant Disorder and Other specified trauma and stress related disorder. -He is 16 years old. -He was discharged on 2/14/20. -Assessment dated 10/17/18 had the following: FC #5 had a long history of behavioral disruptions including physical and verbal aggression, property damage, deceitful and deviant behaviors. He had anxiety and compulsive behaviors. -Physician's order dated 1/30/20 for Melatonin 10 mg, one capsule at bedtime; Ziprasidone 60 mg, two tablets at 6 pm; Quetiapine Fumarate 50 mg, 1 ½ tablets at bedtime and Clonidine 0.3 mg, one	V 118		

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V 118	Continued From page 4 tablet at 6 pm. -Hospital Discharge summary dated 2/20/20. FC #5 was admitted on 2/10/20. FC #5 was admitted due to intentional polysubstance overdose. FC #5 reported he had suicidal ideation's and intent with a plan. Per report FC #5 took twenty three 10 mg Adderall pills, twenty two 20 mg Adderall pills, twenty five Seroquel pills, twenty Clonidine pills and five Prozac pills. FC #5 was increasingly sleepy/drowsy. FC #5 received Narcan and Intravenous fluids. FC #5 was discharged to a psychiatric hospital on 2/20/20. -The medications were used for the following: Melatonin-used to treat sleep disorders; Quetiapine Fumarate-used to treat Schizophrenia in adults and children; Ziprasidone-used to treat Bipolar Disorder, Schizoaffective Disorder and Schizophrenia and Clonidine-used to treat Attention Deficit Hyperactivity Disorder; a. Review on 3/3/20 of the facility's personnel files revealed: -Staff #1 had a hire date of 1/16/20. -Staff #1 was hired as a Residential Advisor I. -No documentation of medication administration training. b. Review on 3/3/20 of the facility's personnel files revealed: -Staff #2 had a hire date of 5/15/18. -Staff #2 was hired as a Lead Residential Advisor. -Medication administration training was completed on 4/12/19. c. Review on 3/3/20 of the facility's personnel files revealed: -Staff #3 had a hire date of 7/27/17. -Staff #3 was hired as a Residential Advisor I. -Medication administration training was	V 118		

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V 118	Continued From page 5 completed on 10/6/17. d. Review on 3/3/20 of the facility's personnel files revealed: -The House Manager had a hire date of 12/30/15. -Medication administration training was completed on 4/12/19. Review of facility records on 2/26/20 revealed the following: -Incident report dated 2/10/20- "On 2/10/20 at approximately 3:15 pm, [House Manager] was preparing to distribute medication to [Client #1]. [House Manager] noticed at that time that all of [Client #1's] medications were missing from his medication box as well as some from another consumers boxes. [House Manager] questioned [Staff #1] and [Clients' #1 and #2]. [FC #5] was observed sleeping. Staff immediately began searches throughout the house and outside premises looking for missing medication. After discovering nine bubble packs and two bottles, [Client #2] led staff to hiding space ...[Client #1] stated I took my meds (medications) and [FC #5] took his meds (medications) after me ...[FC #5] was laying on the floor and stated to staff he was feeling really bad ..." Interview with FC #5 on 3/2/20 revealed: -There was a recent incident with his medication. -He had to be hospitalized due to taking too much medication. -He stole the medications from the kitchen area at the group home. -Staff left the medication unlocked in the kitchen area. -Staff #1 was working alone at the group home when he stole the medication. -The House Manager was away from the home when he stole the medication.	V 118		

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V 118	Continued From page 6 Interview with client #1 on 2/26/20 revealed: -A few weeks ago there was an incident with his medication. -The medication was in his medication box unlocked in the kitchen area. -He and FC #5 decided to steal all of his medications. -They also stole a few of FC #5's medications and some of client #2's medication. -Staff #1 was in the den area while they stole the medication. -The House Manager had left the group home with client #3. -Staff #1 was working alone when the medication was stolen. -He and FC #5 went into their bedroom and took all the medication they stole. -He thought he possibly took a combination of 25 pills or more. -He started to hallucinate from taking the medications. -He had to go to the hospital that evening after that incident. -He thought he was in the hospital for over a week. -He wanted to take extra medication in order to get high. -He did not realize he would overdose on those medications. Interview with client #2 on 2/26/20 revealed: -Staff #1 was working alone when client #1 and FC #5 stole the medication. -The House Manager had left the group home and went to the store. -He did not see client #1 and FC #5 steal any medication. -He did tell staff to look in the air conditioning unit for the missing medication.	V 118		

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V 118	Continued From page 7 Interview with client #3 on 2/28/20 revealed: -He thought he was with the House Manager when the medication was stolen. -He and the House Manager had gone out to run some errands. -He had gone out with the House Manager several times that day. -The House Manager had been in and out of the home all day. -Staff #1 was working alone at the home with the other clients. -Later that evening client #1 told him he was seeing things. -He knew something was wrong with FC #5 because he was sitting on the couch slumped over. Interview with staff #1 on 2/28/20 revealed: -There was an incident with client #1 and FC #5 on 2/10/20. -He had been working at the group home for about a month prior to that incident. -When he came in for 1st shift staff #3 was still at the home. -Staff #3 was the 3rd shift staff. -When he went into the kitchen area he noticed there were several bottles/packets of medication. -He thought the medication was laying on the kitchen counter and not in a locked container. -He did not touch the medication because he had not been trained to administer medication. -He left the medication on the kitchen counter and did not attempt to secure the medications. -Staff #3 left the group home and he was alone with the clients. -The House Manager arrived to the home about 15-20 minutes later for 1st shift. -The House Manager was in and out of the home running errands that day.	V 118		

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V 118	Continued From page 8 -He thought the House Manager left the home that day on at least 5 separate occasions. -He did work alone at the home with clients for most of 1st shift. -They noticed some of the medications were missing around 3 pm. -The House Manager was getting ready to administer medications and the medication was missing. -They looked for the medications and asked the clients about the medication. -Client #1 later admitted that he and FC #5 had stolen the medications. -Client #1 told them they ingested all the medication they stole. -They found the empty medication packets in the air conditioning unit in the back yard. -They found several empty packets/bottles of medication. -He thought the medications were Depakote, Melatonin, Adderall, Seoquel, Vyvanse and Geodon. -He thought client #1 and FC #5 possibly ingested over 100 pills between the two of them. -He thought something was wrong with FC #5 because he got really sleepy. -FC #5 seemed to be "out of it." -He did not recall client #1 initially showing any symptoms. -Both clients went to the hospital due to ingesting the medication. -As far as he knew the medication was unlocked in the kitchen area for all of 1st shift. -He did not lock up the medications in the kitchen area prior to the incident. -He never saw the House Manager lock up the medications. Interview with staff #2 on 2/26/20 revealed: -There was a medication incident with client #1	V 118		

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V 118	Continued From page 9 and FC #5 on 2/10/20. -He normally worked 2nd shift and would report to duty around 4 pm. -The day of the incident he came in around 3:15 pm. -When he came in staff #1 was at the home alone with client #1, client #2 and FC #5. -He thought client #3 was in the community with the House Manager. -He knew something was off with FC #5 because he was laying on the couch. -FC #5 normally did not lay around. -He asked FC #5 why he was laying around and he mumbled he was tired. -Client #1 also told him that he did something earlier, he did not want him to get mad. -He noticed there was some medication in a plastic bin unlocked in the kitchen area. -He never asked about the medication being unlocked. -He did not attempt to lock away the medications in the plastic bin. -The House Manager and client #3 arrived a few minutes later. -The House Manager went into the kitchen area to give client #1 his 3 pm medication. -The House Manager realized some of the medication was missing. -They looked around the home for the missing medications. -Client #2 told them later that the medication packets were hidden in the air conditioning unit in the back yard. -When they found the medication packets/bottles they were all empty. -He thought both clients possibly ingested over 100 pills between the two of them. -He thought they ingested a combination of Adderall, Melatonin, Seroquel, Vyvanse and Geodon.	V 118		

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V 118	Continued From page 10 -The majority of the medication belonged to FC #5 and client #1. -They also stole some of client #2's medication. -Once they realized both clients had ingested those medications they decided they would seek medical services. -Both clients had to be hospitalized due ingesting those medications. -Staff #1 was working alone with three clients when the medication was stolen. -He thought the Home Manager was in the community running errands when the medication was stolen. Interview with staff #3 on 2/28/20 revealed: -She normally worked at the home during 3rd shift. -She knew there was a recent incident with clients stealing medication. -She worked with staff #4 during 3rd shift earlier. -Third shift staff would normally administer medications for the clients prior to leaving their shift. -She did administer medications that morning and there were no issues with her medication count. -Staff #1 came in for 1st shift and staff #4 left the home. -She thought client #2 and FC #5 left for school before she left the home. -Clients #1 and #3 remained in the home because they were suspended from school. -Prior to leaving her shift she left the medication in a plastic bin unlocked in the kitchen area. -Third shift staff would normally leave the medication in the plastic bin unlocked prior to leaving the shift. -The medication was left in the plastic bin because 1st shift staff would take the medications to the other home. -Clients #1 and #3 were not in school and were	V 118		

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V 118	Continued From page 11 supposed to go to the other home that day. Interview with the House Manager on 2/28/20 revealed: -There was a medication incident with FC #5 and client #1 on 2/10/20. -The day of the incident he was supposed to be on shift at 8:00 AM. -He thought he arrived to the home around 8:30 AM. -Staff #1 was alone at the home with clients #1 and #3 when he arrived. -Client #2 and FC #5 were both at school. -He noticed the medications were stored in a plastic bin when he arrived. -The medication for all four clients were in the kitchen area unlocked. -He didn't ask any questions about the reason why the medication was stored that way. -He did not lock up the medications. -He normally had to run errands for the group home during the day. -He did leave staff #1 alone with clients several times throughout the day during 1st shift. -Client #2 and FC #5 returned from school around 1:45 PM. -He had to leave the home again that afternoon. -He had to go to the grocery store and get gas for the van. -He took client #3 with him during that outing. -Staff #1 remained at the home with FC #5, client #1 and client #2. -When he returned to the home he had to administer client #1's 3 pm medications. -He realized all of client #1's medications were missing. -He realized a little later some of FC #5's and client #2's medications were missing as well. -They searched the home for the missing medications.	V 118		

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V 118	Continued From page 12 -Client #2 told staff to look in the air conditioning unit in the back yard. -They found several empty bottles/packets of medication in air conditioning unit. -Client #1 confessed that he and FC #5 ingested all of the missing medications. -He thought both clients ingested Adderall, Depakote, Vyvanse and Melatonin. -He thought both clients possibly ingested over 100 pills between the two of them. -He knew something was wrong with FC #5 because he was really sleepy. -FC #5's gait was also unsteady and he started laying on the floor. -Client #1 was talking really fast and talking to himself. -Client #1 was also making really "weird" facial expressions. -FC #5 and client #1 were hospitalized due to that incident of ingesting the medication. -He thought both clients were in the hospital over a week. Interview with the Program Manager 2/26/20 and 3/3/20 revealed: -There was an incident a few weeks ago with client #1 and FC #5. -Client #1 and FC #5 stole several packets/bottles of medications. -Staff #1 and the House Manager were working together during that incident. -She was told the House Manager left the medication in the kitchen area unlocked. -Client #1 and FC #5 took the medications from the kitchen area. -She was informed the clients ingested Adderall, Melatonin and Seroquel. -She was not sure about the other medications the clients possibly ingested. -Staff #2 came in that afternoon and noticed	V 118		

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V 118	Continued From page 13 something was wrong with FC #5. -Both clients went to the hospital due to ingesting the medication. -Client #1 was in the hospital for at least a week. -Client #1 never told her why he ingested those medications. -As far as she knew FC #5 was still hospitalized. -FC #5 admitted to staff that he ingested the medication because he wanted to kill himself. -She confirmed staff failed to demonstrate competency in the area of medication administration. Interview with the Director of Operations 2/26/20 and 3/3/20 revealed: -He was aware there was an incident with client #1 and FC #5 stealing medication. -The House Manager informed him of the incident with client #1 and FC #5. -He was informed staff left the medication in the kitchen area unlocked. -Client #1 and FC #5 ingested the medications they stole. -Both clients had to be hospitalized due to this incident. -He confirmed staff failed to demonstrate competency in the area of medication administration. Review on 3/3/20 of a Plan of Protection written by the Program Manager dated 3/3/20 revealed: What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm?: "Beginning immediately, KMG will ensure that staff are properly storing medication as required by state regulations. KMG will ensure that we are with staff/client ratio at all times. KMG will ensure that staff are handling the medications in the proper manner when transporting medication from one	V 118		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 118	Continued From page 14 facility to the other. KMG will ensure that all staff are properly trained on medication management and security of medication." Describe your plans to make sure the above happens: "While administering medication, two staff members must be present to ensure that consumers are properly taking medication and that consumers do not have the opportunity to steal medication. Residential staff will ensure that medication is only given in the dining room section under well lit areas. Staff will ensure that all medication is properly stored in consumer's personal lock boxes and that those lock boxes are placed in a locked closet at all times. KMG will ensure that one staff is not allowed to be left alone with consumers. If needed management will call in for additional back-up to ensure that we are within ratio at all times. KMG will have a medication management training in the third week of March as well as any additional training that will ensure staff competency." Clients served in the facility had various diagnoses. Clients had a history of suicidal ideation's/behaviors, deceitful and deviant behaviors, anxiety and compulsive behaviors. The clients age range was between 14 to 16 years old. On 2-10-20 staff #3 left clients' #1, #2, #3 and FC #5's medication unlocked in kitchen area prior to leaving her shift. The medication was left in a plastic bin in order for 1st shift staff to transport the medications to the other home (sister facility). Staff #1 came in during 1st shift and saw the unlocked medications in the kitchen area. The House Manager later reported for 1st shift and was required to be present at the home with staff #1. The House Manager ran errands several times throughout 1st shift leaving staff #1 who was not trained in medication administration alone with the clients. The House Manager was in	V 118		

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V 118	Continued From page 15 the process of administering the 3 pm dose of medication to client #1. The Home Manager realized there were several medications missing for client #1, client #2 and FC #5. It came to staff attention later that client #1 and FC #5 went into the kitchen area earlier that day and stole the missing medication. Staff #1, staff #2 and the House Manager all noticed the medication was unlocked in the kitchen area throughout 1st shift and made no attempts to lock up the medication in a cabinet. The ingested medications were Vyvanse, Divalproex, Ziprasidone, Quetiapine Fumarate, Clonidine, Melatonin, Adderall and Fluoxetine. Client #1 and FC #5 possibly ingested a combination of over 100 pills. Client #1 and FC #5 both displayed overdose symptoms from ingesting the medication. Client #1 and FC #5 were both hospitalized due to ingesting the medications for over a week. This deficiency constitutes a Type A1 rule violation for serious harm and neglect and must be corrected within 23 days. An administrative penalty of $5000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500 per day will be imposed each day the facility is out of compliance beyond the 23rd day.	V 118		
V 120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications	V 120		

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V 120	Continued From page 16 shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure medications were in a securely locked cabinet affecting three of three current clients (#1, #2 and #3) and one of one former client (FC #5). The findings are: a. Review on 2/26/20 of client #1's record revealed: -Admission date of 7/20/19. -Diagnoses of Bipolar Disorder, Generalized Anxiety Disorder and Oppositional Defiant Disorder. -He is 14 years old. -Physician's order dated 1/30/20 for Quetiapine 100 milligrams (mg), one tablet as needed; Clonidine 0.1 mg, one tablet at bedtime; Adderall 20 mg, one capsule in the morning; Adderall 10 mg, one capsule at 3 pm, Fluoxetine 20 mg, one capsule daily and Ziprasidone 40 mg, one capsule at bedtime. b. Review on 2/26/20 of client #2's record revealed: -Admission date of 11/22/19. -Diagnosis of Oppositional Defiant Disorder.	V 120		

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V 120	Continued From page 17 -He is 14 years old. -Physician's order dated 11/11/19 for Vyvanse 30 mg, one capsule every morning; Olanzapine 5mg, dissolve one tablet under tongue every morning; Sertraline 50 mg, one tablet daily; Olanzapine 10 mg, dissolve one tablet under tongue at bedtime and Divalproex ER 250 mg, three tablets at bedtime. c. Review on 2/26/20 of client #3's record revealed: -Admission date of 7/15/19. -Diagnoses of Oppositional Defiant Disorder, Post Traumatic Stress Disorder, Reactive Attachment Disorder, Impulse Control Disorder and Conduct Disorder. -He is 16 years old. -Physician's order dated 1/29/20 for Melatonin 5 mg, one tablet as needed at bedtime and Aripiprazole 10 mg, one tablet in the morning. A physician's order dated 12/18/19 for Concerta 54 mg, one tablet in the morning; Clonidine HCL 0.1 mg, one tablet in the morning and Lamotrigine 200 mg, one tablet in the morning. d. Review on 2/26/20 of FC #5's record revealed: -Admission date of 10/17/18. -Diagnoses of Oppositional Defiant Disorder and Other specified trauma and stress related disorder. -He is 14 years old. -He was discharged on 2/14/20. -Physician's order dated 1/30/20 for Atomoxetine HCL 60 mg, one capsule in the morning; Melatonin 10 mg, one capsule at bedtime; Sertraline 50 mg, one tablet two times daily; Mirtazapine 7.5 mg, one tablet at night; Ziprasidone 60 mg, two tablets at 6 pm; Quetiapine Fumarate 50 mg, 1 ½ tablets at bedtime and Clonidine 0.3 mg, one tablet at 6	V 120		

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V 120	Continued From page 18 pm. Interview with FC #5 on 3/2/20 revealed: -There was a recent incident with his medication. -He stole medications from the kitchen area at the group home. -Staff left the medication unlocked in the kitchen area. Interview with client #1 on 2/26/2020 revealed: -A few weeks ago there was an incident with his medication. -The medication was in his medication box unlocked in the kitchen area. -He and FC #5 decided to steal all of his medications. -They also stole a few of FC #5's medications and some of client #2's medication. Interview with staff #1 on 2/28/20 revealed: -There was an incident with client #1 and FC #5 on 2/10/20. -Client #1 and FC #5 stole medication during 1st shift. -He had been working at the group home for about a month prior to that incident. -When he came in for 1st shift staff #3 was still at the home. -Staff #3 was the 3rd shift staff. -When he went into the kitchen area he noticed there were several bottles/packets of medication. -He thought the medication was laying on the kitchen counter and not in a locked container. -He did not touch the medication because he had not been trained to administer medication. -He left the medication on the kitchen counter and did not attempt to secure the medications. -Staff #3 left the group home and he was alone with the clients. -The House Manager arrived to the home about	V 120		

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V 120	Continued From page 19 15-20 minutes later for 1st shift. -As far as he knew the medication was unlocked in the kitchen area for all of 1st shift. -He did not lock up the medications in the kitchen area prior to the incident. -He never saw the House Manager lock up the medications. -He confirmed the facility failed to ensure medications were in a securely locked cabinet. Interview with staff #2 on 2/26/20 revealed: -The day of the incident with the medication he came in around 3:15 pm. -He noticed there was some medication in a plastic bin unlocked in the kitchen area. -He never asked about the medication being unlocked. -He did not attempt to lock away the medications in the plastic bin. -He confirmed the facility failed to ensure medications were in a securely locked cabinet. Interview with staff #3 on 2/28/20 revealed: -The day of the medication incident she administered medications prior to leaving her shift. -Prior to leaving her shift she left the medication in a plastic bin unlocked in the kitchen area. -Third shift staff would normally leave the medication in the plastic bin unlocked prior to leaving the shift. -The medication was left in the plastic bin because 1st shift staff would take the medications to the other home. -Clients #1 and #3 were not in school and were supposed to go to the other home that day. -She confirmed the facility failed to ensure medications were in a securely locked cabinet. Interview with the House Manager on 2/28/20	V 120		

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V 120	Continued From page 20 revealed: -The day of the medication incident he noticed the medications were stored in a plastic bin. -The medication for all four clients were in the kitchen area unlocked. -He didn't ask any questions about the reason why the medications were stored that way. -He did not lock up the medications. -He confirmed the facility failed to ensure medications were in a securely locked cabinet. Interview with the Program Manager 2/26/20 through 3/3/20 revealed: -There was an incident with client #1 and FC #5 stealing medication. -She was told the House Manager left the medication in the kitchen area unlocked. -She was not aware of 3rd shift leaving medication unlocked prior to leaving their shift. -She confirmed the facility failed to ensure medications were in a securely locked cabinet. Interview with the Director of Operations 2/26/20 through 3/3/20 revealed: -He was aware there was an incident with client #1 and FC #5 stealing medication. -He was informed staff left the medication in the kitchen area unlocked. -He confirmed the facility failed to ensure medications were in a securely locked cabinet. This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (Tag V-118) for a Type A1 rule violation and must be corrected within 23 days.	V 120		
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing	V 296		

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V 296	Continued From page 21 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the	V 296		

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V 296	Continued From page 22 child or adolescent's individual strengths and needs as specified in the treatment plan. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure minimum staffing requirements were met by direct care staff when children or adolescents are present and awake affecting three of three current clients (#1, #2 and #3) and one of one former client (FC #5). The findings are: a. Review on 2/26/20 of client #1's record revealed: -Admission date of 7/20/19. -Diagnoses of Bipolar Disorder, Generalized Anxiety Disorder and Oppositional Defiant Disorder. -He is 14 years old. b. Review on 2/26/20 of client #2's record revealed: -Admission date of 11/22/19. -Diagnosis of Oppositional Defiant Disorder. -He is 14 years old. c. Review on 2/26/20 of client #3's record revealed: -Admission date of 7/15/19. -Diagnoses of Oppositional Defiant Disorder, Post Traumatic Stress Disorder, Reactive Attachment Disorder, Impulse Control Disorder and Conduct Disorder. -He is 16 years old.	V 296		

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V 296	Continued From page 23 -There was no documentation that client #3 could be supervised by one staff away from the facility. d. Review on 2/26/20 of FC #5's record revealed: -Admission date of 10/17/18. -Diagnoses of Oppositional Defiant Disorder and Other specified trauma and stress related disorder. -He is 14 years old. -He was discharged on 2/14/20. Interview with FC #5 on 3/2/20 revealed: -There was a recent incident with his medication. -The day of the incident with his medication staff #1 was working alone at the group home. -The House Manager was away from the home when he stole the medication. Interview with client #1 on 2/26/20 revealed: -A few weeks ago there was an incident with his medication. -The House Manager had left the group home with client #3. -Staff #1 was working alone when the medication was stolen. Interview with client #2 on 2/26/20 revealed: -Staff #1 was working alone when client #1 and FC #5 stole the medication. -The House Manager had left the group home and went to the store. Interview with client #3 on 2/28/20 revealed: -He thought he was with the House Manager when the medication was stolen. -He and the House Manager had gone out to run some errands. -He had gone out with the House Manager several times that day. -The House Manager had been in and out of the	V 296		

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V 296	Continued From page 24 home all day. Interview with staff #1 on 2/28/20 revealed: -There was an incident with client #1 and FC #5. -He had been working at the group home for about a month prior to that incident. -When he came in for 1st shift staff #3 was still at the home. -Staff #3 was the 3rd shift staff. -Staff #3 left the group home and he was alone with the clients. -The House Manager arrived to the home about 15-20 minutes later for 1st shift. -The House Manager was in and out of the home running errands that day. -He thought the House Manager left the home that day on at least 5 separate occasions. -He did work alone at the home with clients for most of 1st shift. -The House Manager had left him alone with clients at the home on other occasions. -The House Manager would normally run errands for the home during the day. -He confirmed the facility failed to ensure minimum staffing requirements were met by direct care staff when children or adolescents are present and awake. Interview with staff #2 on 2/26/20 revealed: -The day of the incident when the residents had taken the medication he came in around 3:15 pm. -When he came in staff #1 was at the home alone with client #1, client #2 and FC #5. -He thought client #3 was in the community with the House Manager. -Staff #1 was possibly working alone with three clients when the medication was stolen. -He thought the Home Manager was in the community running errands when the medication was stolen.	V 296		

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V 296	Continued From page 25 -He confirmed the facility failed to ensure minimum staffing requirements were met by direct care staff when children or adolescents are present and awake. Interview with staff #3 on 2/28/20 revealed: -She normally worked at the home during 3rd shift. -She worked with staff #4 during 3rd shift earlier. -Staff #1 came in for 1st shift and staff #4 left the home. -When she left the home staff #1 was alone with clients #1 and #3. -She confirmed the facility failed to ensure minimum staffing requirements were met by direct care staff when children or adolescents are present and awake. Interview with the House Manager on 2/28/20 revealed: -The day of the medication incident he was supposed to be on shift at 8:00 AM. -He thought he arrived to the home around 8:30 AM. -Staff #1 was alone at the home with clients #1 and #3 when he arrived. -He had arrived to the home after 8:00 AM on other occasions. -He did leave staff #1 alone with clients several times throughout the day during 1st shift. -He had to go to the grocery store and get gas for the van the day of the incident. -He took client #3 with him during that outing. -Staff #1 remained at the home with FC #5, client #1 and client #2. -He confirmed the facility failed to ensure minimum staffing requirements were met by direct care staff when children or adolescents are present and awake.	V 296		

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V 296	Continued From page 26 Interview with the Program Manager 2/26/20 through 3/3/20 revealed: -The day of the medication incident staff #1 and the House Manager were working together. -She was not aware staff #1 was possibly working alone when the medication was stolen. -She confirmed the facility failed to ensure minimum staffing requirements were met by direct care staff when children or adolescents are present and awake. This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (Tag V-118) for a Type A1 rule violation and must be corrected within 23 days.	V 296		

PLAN OF CORRECTION

LH2

Complaint Survey completed on March 3, 2020

KMG Holdings, Inc.

The Lighthouse II of Clayton

2016 Fort Dr.

Clayton, NC 27520

MHL-051-138

PLAN OF CORRECTION

Complaint Survey completed March 3, 2020

V118 27G .0209 (C) Medication Requirements

10A NCAC 27G .0209 Medication Requirements

During the Complaint Survey the following deficiency was noted:

1. Facility failed to ensure medications were in a securely locked cabinet affecting three of three current clients and one of one former client.

Solution:

KMG Holdings, Inc. Leadership Team will ensure that ALL consumer medication is properly stored in individual consumer lock boxes and these lock boxes will be stored in a locked closet at all times while medication is not be administered. The keys to the lock boxes and locked closet will be on the facility key chain that contains the keys of other pertinent areas that are required to be secured. This key chain will be in the possession of/on the person of the staff member(s) that are on duty. No medication will be removed from the locked closet until it's time for it to be administered. The staff member that's going to administer medication will first ensure that another staff member is present on duty with them. If additional support is needed, a member of management will be contacted to support the process. Once the member of management is present at the facility the medication administration process can/will begin. The staff member administering the medication will be Medication Administration trained. The staff member will

only remove the medication of the individual consumer that's preparing to receive the medication. The medication will only be administered in the kitchen or in the living room of the facility. The staff member will check the MAR and prescriptions prior to administering medication to ensure the proper medication and dosage are being administered to the correct/prescribed consumer. Once the medication is administered to the consumer the staff member will check the consumers mouth thoroughly to ensure the medication was taken and not "cheeked". The consumer will be closely monitored for 15 minutes after receiving the medication to ensure no adverse side effects are present. At the end of this timeframe and if no adverse effects are observed, the staff member will ensure the consumer medication is properly stored back into the lock box and locked closet. If adverse side effects are observed and a member of management is not present, the staff member(s) will immediately contact a member of management to receive further instructions. They will then follow the instructions of the member of management that was contacted. The staff member(s) will also follow the agency's Medication Administration Policy. If no adverse sides effects are noted then the staff member will begin the medication administration process for other consumers that require medication (if applicable). The same process will be followed as listed above. This process will be adhered to until all medication has been properly administered to all affected consumers. Once this process concludes both staff members on duty will physically inspect the lock boxes and locked closet to ensure all consumer medication is properly stored and secured.

V 296 27G. 1704 Residential Tx Child/Adol-Min. Staffing

10A NCAC 27G .1704 Minimum Staffing Requirements

During Complaint Survey the following deficiency was noted:

1. The facility failed to ensure minimum staffing requirements were met by direct care staff when children or adolescents are present and awake affecting three of three clients and one of one former client.

Solution:

The KMG Holdings, Inc. requires its staff to provide line of sight supervision of consumers at all times. The Leadership Team will ensure that at least two staff members are on duty while consumers are present and awake within the facility. This will be accomplished by proper scheduling staff members for duty on the weekly schedule. The weekly schedule will be distributed to the staff members at least one week prior to their scheduled shift(s). This practice will allow for enough time for the affected staff member to let The Management Team know if he/she has a conflict with the scheduled shift. This will also allow The Management Team ample time to make any necessary adjustments to the schedule if required. If it is determined by The Management Team that additional staff members are required to work a particular shift or shifts

to better meet the needs of the consumers served then additional staff members will be contacted and scheduled to come in as additional staff support. Our Clinical Director and Qualified Professional will lead this decision making process to ensure all clinical needs of the consumer(s) are being addressed and met. All staff members have been instructed to inform a member of management immediately if he/she is every left alone to work a shift by a co-worker or if a co-worker fails to report to work. The Management Team will ensure either another staff member is called in to cover the vacated shift immediately or if that's not possible, a member of management will come in to cover the vacated shift. In addition, ALL staff members have been instructed by The Management Team that they are NOT to leave the facility with any consumer(s) and leave their shift partner alone at the facility while there are consumers present and awake. If this happens the staff member that's been left alone has been instructed to contact a member of management immediately. The staff member who left the facility will be counseled by the member of management and this staff member will be removed from the facility schedule. The member of management will then either come in to cover the shift or contact another staff member to do so. This process will ensure that a staff member is never left alone to work a shift.

Our ultimate goal is to ensure the safety of all of our consumers. We feel that by implementing and following up on the steps listed above our agency will be better positioned to safeguard the consumers that are entrusted in our care.

Respectfully submitted,

Delwin Clark, Dir. Of Operations

3/20/20

Date