3/20/20

If continuation sheet 1 of 27

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ C B. WING MHL051-138 03/03/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2016 FORT DRIVE THE LIGHTHOUSE II OF CLAYTON CLAYTON, NC 27520 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRFFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) V 000 INITIAL COMMENTS V 000 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 11 Treatment Staff Secure for Children or Adolescents. 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. (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 DHSR-Mental Health current. Medications administered shall be recorded immediately after administration. The MAR 2 0 2020 MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; Lic. & Cert. Section (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 Division of Health Service Regulation LABORATORY DIRECTOR'S OF PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE

PRINTED: 03/09/2020

**FORM APPROVED** Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ C B. WING MHL051-138 03/03/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2016 FORT DRIVE THE LIGHTHOUSE II OF CLAYTON CLAYTON, NC 27520 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 118 | Continued From page 1 V 118 checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. 1, 3 8 6 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:

Division of Health Service Regulation

Disorder.

-He is 14 years old.

revealed:

Cross Reference Tag 120 10A NCAC 27G .0209

Cross Reference Tag 296 10A NCAC 27G .1704

requirements were met by direct care staff when children or adolescents are present and awake affecting three of three clients (#1, #2 and #3)

Based on record reviews and interviews the facility failed to ensure minimum staffing

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

Medication Requirements

former client (FC #5).

Minimum Staffing Requirements

and one of one former client (FC #5).

-Admission date of 7/20/19.

a. Review on 2/26/20 of client #1's record

-Diagnoses of Bipolar Disorder, Generalized Anxiety Disorder and Oppositional Defiant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

MHL051-138

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION
A. BUILDING:

B. WING

Division of Health Service Regulation

(X3) DATE SURVEY COMPLETED

C
03/03/2020

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

### THE LIGHTHOUSE II OF CLAYTON

2016 FORT DRIVE CLAYTON, NC 27520

	CLAYTON	I, 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 118	Continued From page 2	V 118		ROLL
Al	-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			
NA Tè	energy/motivation and suicidal ideation's/behaviorsPhysician's order dated 1/30/20 for Quetiapine 100 milligrams (mg), one tablet as needed; Clonidine 0.1 mg, one tablet at bedtime; Adderall			28
et ener	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.			(X) (A)P
	-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			
843 134	Haldol for agitation and hyperactivity. The discharge diagnosis was suicide attempt by drug ingestion.			Control of the Contro
1	-The medications were used for the following: Quetiapine Fumarate-used to treat Schizophrenia in adults and children; Ziprasidone-used to treat Bipolar Disorder;			
11	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 11/22/19Diagnosis of Oppositional Defiant Disorder.			The state of the s
	-He is 14 years oldPhysician's order dated 11/11/19 for Vyvanse 30 mg, one capsule every morning and Divalproex ER 250 mg, three tablets at bedtime.			ent of section charges and the section of the secti

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES	
AND PLAN OF CORRECTION	

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION	
A. BUILDING:	

(X3) DATE SURVEY COMPLETED

MHL051-138

B. WING \_

C 03/03/2020

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

### THE LIGHTHOUSE II OF CLAYTON

2016 FORT DRIVE

THE EIG	HTHOUSE II OF CLAYTON CLAYTON	I, 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 118	Continued From page 3	V 118		180x CD
S. Ai	-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			201
Id	Bipolar Disorder			
13-	c. Review on 2/26/20 of client #3's record revealed:			
	-Admission date of 7/15/19Diagnoses of Oppositional Defiant Disorder, Post Traumatic Stress Disorder, Reactive Attachment			UMP TE
	Disorder, Impulse Control Disorder and Conduct DisorderHe is 16 years old.			
4	-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.			R.(1
	d. Review on 2/26/20 of FC #5's record revealed: -Admission date of 10/17/18Diagnoses of Oppositional Defiant Disorder and			
	Other specified trauma and stress related disorder.			- Transport
	-He is 16 years oldHe was discharged on 2/14/20Assessment dated 10/17/18 had the following: FC #5 had a long history of behavioral disruptions			Estate de la companya
es.	including physical and verbal aggression, property damage, deceitful and deviant behaviors. He had anxiety and compulsive			
ALX	behaviorsPhysician'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			

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING MHL051-138 03/03/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2016 FORT DRIVE THE LIGHTHOUSE II OF CLAYTON CLAYTON, NC 27520 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 118 | Continued From page 4 V 118 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, 11 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 -Staff #2 had a hire date of 5/15/18. Staff #2 was hired as a Lead Residential Advisor.

Division of Health Service Regulation

revealed:

-Medication administration training was

-Staff #3 had a hire date of 7/27/17.

c. Review on 3/3/20 of the facility's personnel files

-Staff #3 was hired as a Residential Advisor I. -Medication administration training was

completed on 4/12/19.

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ C B. WING \_\_ MHL051-138 03/03/2020

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

### THE LIGHTHOUSE II OF CLAYTON

2016 FORT DRIVE CLAYTON, NC 27520

	CLAYTON	I, 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 118	Continued From page 5	V 118		PROVEL
Si Ai	completed on 10/6/17.			100
N- TF	d. Review on 3/3/20 of the facility's personnel files revealed: -The House Manager had a hire date of 12/30/15Medication administration training was completed on 4/12/19.			387
	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			(X5) (X4) (X4) (X4)
. (1)   1)   2)   2)	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			1.0/110
To a	[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]			
ř	stated I took my meds (medications) and [FC #5] took his meds (medications) after me[FC #5]			- Andrews
	was laying on the floor and stated to staff he was feeling really bad"			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
6.5	Interview with FC #5 on 3/2/20 revealed: -There was a recent incident with his medicationHe had to be hospitalized due to taking too much medication.			The State of
	-He stole the medications from the kitchen area at the group homeStaff left the medication unlocked in the kitchen			ALCO AND
Tir	areaStaff #1 was working alone at the group home			N. Com. (Person)
	when he stole the medication.  -The House Manager was away from the home when he stole the medication.			and the contract of the contra
vision of Hea	alth Service Regulation			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	MHL051-138	B. WING	C 03/03/2020

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

# THE LIGHTHOUSE II OF CLAYTON

2016 FORT DRIVE

(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 6	V 118		1000.01
5				2-681 (- c)
	Interview with client #1 on 2/26/20 revealed:			EY
	-A few weeks ago there was an incident with his			
	medication.			
AND THE RESERVE	-The medication was in his medication box			
λ.	unlocked in the kitchen area.			
7.1	-He and FC #5 decided to steal all of his			
71.	medications.			
SAN PERSON NA	-They also stole a few of FC #5's medications			W. Marin on Production
	and some of client #2's medication.			1.40 1.40 1.40
	-Staff #1 was in the den area while they stole the medication.			Date
	-The House Manager had left the group home			~ pres' people - 1 19/30
15.	with client #3.			N / FIG
	-Staff #1 was working alone when the medication			West Will
4-	was stolen.			100
	-He and FC #5 went into their bedroom and took			
	all the medication they stole.			
	-He thought he possibly took a combination of 25			
10	pills or more.			
	-He started to hallucinate from taking the			
11	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	1		accompliant country
	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			
No.	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.  alth Service Regulation		A <sup>2</sup>	

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING: C MHL051-138 B. WING \_ 03/03/2020 NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

#### THE LIGHTHOUSE II OF CLAYTON

2016 FORT DRIVE

THE EIG	CLAYTON CLAYTON	N, 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 118	Continued From page 7	V 118		120 v. d.s
	Page /	110		STEEL & CALLE
31	Interview with alient #2 on 2/20/20 more last			157
	Interview with client #3 on 2/28/20 revealed: -He thought he was with the House Manager			
	when the medication was stolen.			
ANTO LATE A FO	-He and the House Manager had gone out to run			. 221
11,2	some errands.		2	
	-He had gone out with the House Manager			
73-	several times that day.			
100 Kinds	-The House Manager had been in and out of the			A Company of the Comp
i	home all day.			(25) OMPL - 11.
	-Staff #1 was working alone at the home with the			Date
4-4-	other clients.			1271.27 (1971
	-Later that evening client #1 told him he was seeing things.			15-03-16-18
42	-He knew something was wrong with FC #5			
Al	because he was sitting on the couch slumped			12.9
	over.			
	Interview with staff #1 on 2/28/20 revealed:			123
N* 1	-There was an incident with client #1 and FC #5			
	on 2/10/20.			
19	-He had been working at the group home for			100
es 1110	about a month prior to that incident.			
	-When he came in for 1st shift staff #3 was still at			226
	the home.			raids and
Zo. 12	-Staff #3 was the 3rd shift staff.			LICENS CONTRACTOR
79	-When he went into the kitchen area he noticed there were several bottles/packets of medication.			
	-He thought the medication was laying on the			
A S	kitchen counter and not in a locked container.			
	-He did not touch the medication because he had			1
	not been trained to administer medication.			
100.00	-He left the medication on the kitchen counter			1
26	and did not attempt to secure the medications.			S. Commercial Commerci
	-Staff #3 left the group home and he was alone			N. Harding
	with the clients.			A) A
H	-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.  alth Service Regulation			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING:

(X3) DATE SURVEY COMPLETED

MHL051-138

B. WING \_\_

C 03/03/2020

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

### 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)	COMPLETE DATE
V 118	Continued From page 8	V 118		1 180yab
	-He thought the House Manager left the home			146.00
26	that day on at least 5 separate occasions.			ALV.
	-He did work alone at the home with clients for			
	most of 1st shift.			
*** * * * * * * * * * * * * * * * * *	-They noticed some of the medications were			
187.	missing around 3 pm.			
	-The House Manager was getting ready to			
11:	administer medications and the medication was			
Mer track	missing.			A School As the state of the state of
F	-They looked for the medications and asked the			0.55 OMPL = 115
	clients about the medication.			1,40
	-Client #1 later admitted that he and FC #5 had			. desired in the second
Allas ofice	stolen the medications.			F103, E10
	-Client #1 told them they ingested all the medication they stole.			140000000000000000000000000000000000000
31 A	-They found the empty medication packets in the			1.5
	air conditioning unit in the back yard.			
	-They found several empty packets/bottles of			
	medication.			0.00
\$16.	-He thought the medications were Depakote,			
	Melatonin, Adderall, Seoquel, Vyvanse and	1		
776	Geodon.			
10000	-He thought client #1 and FC #5 possibly ingested			
	over 100 pills between the two of them.			1000
	-He thought something was wrong with FC #5			1000
1040	because he got really sleepy.			100000
	-FC #5 seemed to be "out of it."			110000000000000000000000000000000000000
19	-He did not recall client #1 initially showing any			1997 3-5123
	symptomsBoth clients went to the hospital due to ingesting			6.17
	the medication.			
	-As far as he knew the medication was unlocked			
	in the kitchen area for all of 1st shift.			net (te
	-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:			- The state of the
	-There was a medication incident with client #1			and the second

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If continuation sheet 9 of 27

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

MHL051-138

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION
A. BUILDING:

B. WING

O3/03/2020

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

### THE LIGHTHOUSE II OF CLAYTON

2016 FORT DRIVE

	CLAYTON	I, 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 118	Continued From page 9	V 118		-Revise
A P COLUMN	and FC #5 on 2/10/20.			Charles o process as
	-He normally worked 2nd shift and would report to			
	duty around 4 pm.		2	
	-The day of the incident he came in around 3:15			
	pm.			1020
NA	-When he came in staff #1 was at the home			
	alone with client #1, client #2 and FC #5.			
1	-He thought client #3 was in the community with			The same
NOTE OF A PROPER	the House Manager.			
-	-He knew something was off with FC #5 because			185
	he was laying on the couch.			367:
A Prior trai	-FC #5 normally did not lay around.			
21/4	-He asked FC #5 why he was laying around and			
	he mumbled he was tiredClient #1 also told him that he did something			
	earlier, he did not want him to get mad.			1
	-He noticed there was some medication in a			1
	plastic bin unlocked in the kitchen area.			Bury Colo
11-100	-He never asked about the medication being			
1.0	unlocked.			
	-He did not attempt to lock away the medications			
11	in the plastic bin.			
	-The House Manager and client #3 arrived a few			
	minutes later.			190
	-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.			No.
	-Client #2 told them later that the medication			
	packets were hidden in the air conditioning unit in			Milken
	the back yard.			
	-When they found the medication packets/bottles			
	they were all empty.			Yanna
	-He thought both clients possibly ingested over			
	100 pills between the two of them.			
	-He thought they ingested a combination of			1.8
	Adderall, Melatonin, Seroquel, Vyvanse and			
	Geodon.			
vision of Hea	alth Service Regulation			

Division of Health Service Regulation

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING:

C

MHL051-138

B. WING

03/03/2020

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

### THE LIGHTHOUSE II OF CLAYTON

2016 FORT DRIVE CLAYTON, NC 27520

	CLAYTON	I, 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 118	Continued From page 10	V 118		-k0/90
L.L.	-The majority of the medication belonged to FC			01 1 Fa 2
4.6	#5 and client #1.			
	-They also stole some of client #2's medication.			
	<ul> <li>Once they realized both clients had ingested</li> </ul>			N. D. Y
ACMEDICAL ST	those medications they decided they would seek			
Pirk	medical services.			
7 in	-Both clients had to be hospitalized due ingesting those medications.			
	-Staff #1 was working alone with three clients			and the second
	when the medication was stolen.			(8.5)
	-He thought the Home Manager was in the			36394144
aybre.	community running errands when the medication			- de-
A Vice	was stolen.			100 500
	Interview with staff #3 on 2/28/20 revealed:			
	-She normally worked at the home during 3rd			-
	shift.			1
	-She knew there was a recent incident with			- Comment
	clients stealing medication.			
1575	-She worked with staff #4 during 3rd shift earlier.			D-FD-G-PR
4.5	-Third shift staff would normally administer			BO, Cres
11	medications for the clients prior to leaving their shift.			or (c) and or
1	-She did administer medications that morning and			123
T .	there were no issues with her medication count.			as as as
	-Staff #1 came in for 1st shift and staff #4 left the			and the same of th
	home.			riberio consed
	-She thought client #2 and FC #5 left for school			4
	before she left the home.			4
	-Clients #1 and #3 remained in the home because they were suspended from school.			all a
	-Prior to leaving her shift she left the medication			ower lands
	in a plastic bin unlocked in the kitchen area.			
	-Third shift staff would normally leave the			26 A 20 A
	medication in the plastic bin unlocked prior to			Commen
	leaving the shift.			The state of the s
	-The medication was left in the plastic bin			45
	because 1st shift staff would take the medications to the other home.			Average and a second
	-Clients #1 and #3 were not in school and were			
VP-04/2	alth Service Regulation			

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION	
A. BUILDING:	

(X3) DATE SURVEY COMPLETED

MHL051-138

B. WING \_\_\_\_\_

C 03/03/2020

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

# 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 118	Continued From page 11	V 118		ROYEL
anki S	supposed to go to the other home that day.			***
	as present a great me time, memo time, day.			
	Interview with the House Manager on 2/28/20 revealed:			
- Tuber	-There was a medication incident with FC #5 and			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
N	client #1 on 2/10/20.			
7 8-	-The day of the incident he was supposed to be on shift at 8:00 AM.			
e Section Control	-He thought he arrived to the home around 8:30			
	AM.			(32)
	-Staff #1 was alone at the home with clients #1			15/F4 - 17.
tan, gene	and #3 when he arrived.			
, fig.	-Client #2 and FC #5 were both at schoolHe noticed the medications were stored in a			
	plastic bin when he arrived.			
7.	-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.			22
NIA.	-He did not lock up the medicationsHe normally had to run errands for the group			
74	home during the day.			
(K.) (6.46)	-He did leave staff #1 alone with clients several			
	times throughout the day during 1st shift.			(4).
	-Client #2 and FC #5 returned from school			
40-1-	around 1:45 PMHe had to leave the home again that afternoon.			
9/1	-He had to go to the grocery store and get gas for			
	the van.			
Al	-He took client #3 with him during that outing.			
	-Staff #1 remained at the home with FC #5, client			9
	#1 and client #2When he returned to the home he had to			- Control
	administer client #1's 3 pm medications.			
	-He realized all of client #1's medications were			was become
	missing.			200
	-He realized a little later some of FC #5's and			
	client #2's medications were missing as well.			1
	-They searched the home for the missing medications.			- Parties
	alth Service Regulation			

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6UCF11

If continuation sheet 12 of 27

03/03/2020

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING: C B. WING \_\_\_ MHL051-138

NAME OF PROVIDER OR SUPPLIER

T.M.

STREET ADDRESS, CITY, STATE, ZIP CODE

### 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 118	Continued From page 12	V 118		ROSEL
	-Client #2 told staff to look in the air conditioning			1981 (1,5 mg) A
(11)	unit in the back yard.			174
	-They found several empty bottles/packets of			
	medication in air conditioning unit.			
MR N artiferior	-Client #1 confessed that he and FC #5 ingested			3 2 3
200	all of the missing medications.			
	-He thought both clients ingested Adderall,			
E 6-	Depakote, Vyvanse and Melatonin.			
SELECTION TO SELEC	-He thought both clients possibly ingested over			- Complete and the late of the late of the
<u> </u>	100 pills between the two of them.			126
	-He knew something was wrong with FC #5			DAT:
1.\//	because he was really sleepy.			Will a pure again of approximation
	-FC #5's gait was also unsteady and he started laying on the floor.			100
	-Client #1 was talking really fast and talking to			31 - 19-23
	himself.			
	-Client #1 was also making really "weird" facial			
	expressions.			
	-FC #5 and client #1 were hospitalized due to that			
600	incident of ingesting the medication.			
	-He thought both clients were in the hospital over			
1.7	a week.			
M. State Co.	Interview with the Program Manager 2/26/20 and			
	3/3/20 revealed:			Walter 12
	-There was an incident a few weeks ago with			
face :	client #1 and FC #5.			April 1997 - Papini nav
17	-Client #1 and FC #5 stole several packets/bottles			
	of medications.			- Control
	-Staff #1 and the House Manager were working			1
	together during that incident.			2.00
	-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.			Ì
	-She was informed the clients ingested Adderall,			and a
	Melatonin and Seroquel.			Co'Theory
	-She was not sure about the other medications			
	the clients possibly ingested.			No.
	-Staff #2 came in that afternoon and noticed			1

Division of Health Service Regulation

STATE FORM

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6UCF11

If continuation sheet 13 of 27

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION A. BUILDING: C MHL051-138 B. WING \_ 03/03/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

THE LIGHTHOUSE II OF CLAYTON

2016 FORT DRIVE CLAYTON NC 27520

	CLAYTON	I, 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 118	Continued From page 13	V 118		4805545
	something was wrong with FC #5.			Angles of the Angles
Ā	-Both clients went to the hospital due to ingesting the medication.			7
	-Client #1 was in the hospital for at least a week.			Difference of the second
( action	-Client #1 never told her why he ingested those		•	
NA	medications.			historianda, (
1 1	-As far as she knew FC #5 was still hospitalizedFC #5 admitted to staff that he ingested the			and the same of th
	medication because he wanted to kill himself.			APPLICATION OF THE PROPERTY OF
	-She confirmed staff failed to demonstrate			
	competency in the area of medication			20.491
	administration.			79/23/20 11:57:41
				5.8 (0.650)
	Interview with the Director of Operations 2/26/20			The second secon
4.5	and 3/3/20 revealed:			- Contraction of the Contraction
	-He was aware there was an incident with client #1 and FC #5 stealing medication.			- Address
	-The House Manager informed him of the incident			- Lander - L
	with client #1 and FC #5.			
3	-He was informed staff left the medication in the			
	kitchen area unlocked.			
11	-Client #1 and FC #5 ingested the medications			
	they stole.			
	-Both clients had to be hospitalized due to this incident.			
10	-He confirmed staff failed to demonstrate			
	competency in the area of medication			
	administration.			150 C - 1
				and the second
	Review on 3/3/20 of a Plan of Protection written			1 seppensi
	by the Program Manager dated 3/3/20 revealed: What will you immediately do to correct the above			and the state of t
	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			Ch for more
	regulations. KMG will ensure that we are with			
	staff/client ratio at all times. KMG will ensure that			Towns of the Control
	staff are handling the medications in the proper			
77-01(0)	manner when transporting medication from one			

Division of Health Service Regulation

PRINTED: 03/09/2020 Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING: C MHL051-138 B. WING \_\_\_ 03/03/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2016 FORT DRIVE THE LIGHTHOUSE II OF CLAYTON CLAYTON, NC 27520

<u></u>	CLAYTON	I, 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 118	Continued From page 14	V 118		ROVED
	facility to the other. KMG will ensure that all staff			2000
	are properly trained on medication management and security of medication."			
*****	Describe your plans to make sure the above happens: "While administering medication, two			0.24
MA	staff members must be present to ensure that			
	consumers are properly taking medication and			
1 4	that consumers do not have the opportunity to			
Total Control	steal medication. Residential staff will ensure that		41	2 74 (10 A) (10 A) (10 A)
111	medication is only given in the dining room section under well lit areas. Staff will ensure that			13.5+ 35.6PE+ FE
Les I	all medication is properly stored in consumer's			17A++
ingent o	personal lock boxes and that those lock boxes			STANDARD SERVICE
374	are placed in a locked closet at all times. KMG			
	will ensure that one staff is not allowed to be left			
W.16	alone with consumers. If needed management			100
	will call in for additional back-up to ensure that we are within ratio at all times. KMG will have a			STEP STEP STEP STEP STEP STEP STEP STEP
	medication management training in the third			
74	week of March as well as any additional training			-
	that will ensure staff competency."			4
0.0				-
****	Clients served in the facility had various			
7	diagnoses. Clients had a history of suicidal ideation's/behaviors, deceitful and deviant			100 100
	behaviors, anxiety and compulsive behaviors.			
all e	The clients age range was between 14 to 16			A Charles Carlon
	years old. On 2-10-20 staff #3 left clients' #1, #2,			
	#3 and FC #5's medication unlocked in kitchen			7
539	area prior to leaving her shift. The medication			Page 1
	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			-
514	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			
	alth Service Regulation			- 1

Division of Health Service Regulation

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C MHL051-138 B. WING 03/03/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2016 FORT DRIVE THE LIGHTHOUSE II OF CLAYTON CLAYTON, NC 27520 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) V 118 | Continued From page 15 V 118 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 71 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 120 27G .0209 (E) Medication Requirements V 120 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

Division of Health Service Regulation

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

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C MHL051-138 B. WING 03/03/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2016 FORT DRIVE THE LIGHTHOUSE II OF CLAYTON CLAYTON, NC 27520 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) V 120 | Continued From page 16 V 120 shall be kept in a separate, locked compartment or container: (C) separately for each client: (D) separately for external and internal use: dia. (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of \* 1 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.

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revealed:

b. Review on 2/26/20 of client #2's record

-Diagnosis of Oppositional Defiant Disorder.

-Admission date of 11/22/19.

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

(X2) MULTIPLE CONSTRUCTION
A. BUILDING:

(X3) DATE SURVEY COMPLETED

MHL051-138

IDENTIFICATION NUMBER:

B. WING \_\_\_\_\_

C 03/03/2020

NAME OF PROVIDER OR SUPPLIER

AND PLAN OF CORRECTION

Div.

STREET ADDRESS, CITY, STATE, ZIP CODE

### THE LIGHTHOUSE II OF CLAYTON

2016 FORT DRIVE

	CLAYTON	I, 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 120	Continued From page 17	V 120		ROVED
A. 1	-He is 14 years old.	75 25.00000		44 W 0F2
AN.	-Physician's order dated 11/11/19 for Vyvanse 30			
	mg, one capsule every morning; Olanzapine 5mg,			
	dissolve one tablet under tongue every morning;			
er we have	Sertraline 50 mg, one tablet daily; Olanzapine 10			1 A. 1
YA	mg, dissolve one tablet under tongue at bedtime			
7° F.	and Divalproex ER 250 mg, three tablets at bedtime.			
Market Co.	beduirie.			
1	c. Review on 2/26/20 of client #3's record			(85)
1	revealed:			10000
	-Admission date of 7/15/19.			
JAV2	-Diagnoses of Oppositional Defiant Disorder, Post			* MAGGINE ON L.
	Traumatic Stress Disorder, Reactive Attachment			51 2 2 3
5.	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			
11.4	Aripiprazole 10 mg, one tablet in the morning. A			
	physician's order dated 12/18/19 for Concerta 54			
7.5	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.			1755
	200 mg, one tablet in the morning.			
	d. Review on 2/26/20 of FC #5's record revealed:			a a a a a a a a a a a a a a a a a a a
	-Admission date of 10/17/18.			The state of the state of
	-Diagnoses of Oppositional Defiant Disorder and			
	Other specified trauma and stress related			9 S S
	disorder. -He is 14 years old.			3,7774
	-He was discharged on 2/14/20.			Commen
	-Physician's order dated 1/30/20 for Atomoxetine			C. Armon
	HCL 60 mg, one capsule in the morning;			T III.
	Melatonin 10 mg, one capsule at bedtime;			n) Thriften
	Sertraline 50 mg, one tablet two times daily;			Complete
y remine.	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			
	alth Service Regulation			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING:

(X3) DATE SURVEY COMPLETED

MHL051-138

B. WING \_

C 03/03/2020

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

### 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 120	Continued From page 18	V 120		ROVEO
Ar.	pm.			NS (0 \$2.2)
NA Y k-	Interview with FC #5 on 3/2/20 revealed: -There was a recent incident with his medicationHe stole medications from the kitchen area at the group homeStaff left the medication unlocked in the kitchen area.			1551
t.	Interview with client #1 on 2/26/2020 revealed: -A few weeks ago there was an incident with his medication.			18.5. 3MPL1 PL DA1
	-The medication was in his medication box unlocked in the kitchen areaHe and FC #5 decided to steal all of his medications.			The state of the s
1,0	-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.			The second secon
	-Client #1 and FC #5 stole medication during 1st shiftHe had been working at the group home for about a month prior to that incidentWhen he came in for 1st shift staff #3 was still at			HAPPY AND REPORTED TO SERVICE STATES AND THE
	the homeStaff #3 was the 3rd shift staffWhen he went into the kitchen area he noticed there were several bottles/packets of medicationHe thought the medication was laying on the			TO THE
age of the second	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			A pro- of the pro-
	and did not attempt to secure the medicationsStaff #3 left the group home and he was alone with the clientsThe House Manager arrived to the home about alth Service Regulation			de oper-management, (mojec, m. esto

Division of Health Service Regulation

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING:

C

MHL051-138

B. WING

03/03/2020

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

### THE LIGHTHOUSE II OF CLAYTON

2016 FORT DRIVE CLAYTON, NC 27520

	CLAYTON	I, 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 120	Continued From page 19	V 120		E0014 5.53
		V 120		240.50.3 4502.1
A.	15-20 minutes later for 1st shiftAs 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.			
No.	-He never saw the House Manager lock up the			
8.6	medications.			
The state of the s	-He confirmed the facility failed to ensure			
1	medications were in a securely locked cabinet.			(35)
1	Interview with staff #2 on 2/26/20 revealed:			3,01115
	-The day of the incident with the medication he			COAVE.
	came in around 3:15 pm.			An and an area area.
	-He noticed there was some medication in a			4
	plastic bin unlocked in the kitchen area.			
4.47	-He never asked about the medication being			Automotive
	unlocked.			No.
	-He did not attempt to lock away the medications in the plastic bin.			70
	-He confirmed the facility failed to ensure			de la companya de la
	medications were in a securely locked cabinet.			1000
TI-				State
	Interview with staff #3 on 2/28/20 revealed:			47724-6-7
	-The day of the medication incident she			Contract
	administered medications prior to leaving her shift.			1. Appear
rae-file.	-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			- 1
	medication in the plastic bin unlocked prior to			
	leaving the shift.			
	-The medication was left in the plastic bin			24/134-7
	because 1st shift staff would take the medications to the other home.			and the second
	-Clients #1 and #3 were not in school and were			W. Cr. College
	supposed to go to the other home that day.			Control of the Contro
	-She confirmed the facility failed to ensure			1
	medications were in a securely locked cabinet.			The constitution of
	1-1			200
	Interview with the House Manager on 2/28/20			
vision of Hea	alth Service Regulation			

Division of Health Service Regulation

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING: MHL051-138 B. WING \_ 03/03/2020

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

#### THE LIGHTHOUSE II OF CLAYTON

2016 FORT DRIVE CLAYTON NC 27520

	CLAYTO	N, NC 2752	0	
(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 120	Continued From page 20	V 120		PROB HAZ
	- 3	1 120		
\$ P A	revealed: -The day of the medication incident he noticed			1.0 7
	the medications were stored in a plastic bin.			
	-The medication for all four clients were in the			
Condition of the Co	kitchen area unlocked.		1	
likes	-He didn't ask any questions about the reason			
71-	why the medications were stored that wayHe did not lock up the medications.			a said
Control of the	-He confirmed the facility failed to ensure			
	medications were in a securely locked cabinet.			No.
	Interview with the Dragger Manager 2/26/20			No.
<u>Divi</u> s	Interview with the Program Manager 2/26/20 through 3/3/20 revealed:			AT 100 M 100
	-There was an incident with client #1 and FC #5			30.2
	stealing medication.			7
	-She was told the House Manager left the medication in the kitchen area unlocked.			1
	-She was not aware of 3rd shift leaving			a data
	medication unlocked prior to leaving their shift.			Cource 95%
	-She confirmed the facility failed to ensure			Profession and Profes
7	medications were in a securely locked cabinet.			- Armendir of a
	Interview with the Director of Operations 2/26/20			
	through 3/3/20 revealed:			490
	-He was aware there was an incident with client			Lie v
ila- a	#1 and FC #5 stealing medicationHe was informed staff left the medication in the		*	
	kitchen area unlocked.			7-7-2-1
	-He confirmed the facility failed to ensure			[
	medications were in a securely locked cabinet.			200
	This deficiency is cross referenced into 10A			Couperin
	NCAC 27G .0209 Medication Requirements (Tag			
	V-118) for a Type A1 rule violation and must be			3 dywyddiai
	corrected within 23 days.			and a second
V 296	27G .1704 Residential Tx. Child/Adol - Min.	V 296		Sec. Co. Co.
	Staffing			
				Market
ivision of He	ealth Service Regulation			
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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C MHL051-138 B. WING 03/03/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2016 FORT DRIVE THE LIGHTHOUSE II OF CLAYTON CLAYTON, NC 27520 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) V 296 | Continued From page 21 V 296 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 (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: two direct care staff shall be present for one, two, three or four children or adolescents: three direct care staff shall be present for five, six, seven or eight children or adolescents; and 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; two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and 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

Division of Health Service Regulation

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING MHL051-138 03/03/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2016 FORT DRIVE THE LIGHTHOUSE II OF CLAYTON CLAYTON, NC 27520 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) V 296 | Continued From page 22 V 296 child or adolescent's individual strengths and needs as specified in the treatment plan. 11: 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

Division of Health Service Regulation

Disorder.

-He is 16 years old.

Traumatic Stress Disorder, Reactive Attachment Disorder. Impulse Control Disorder and Conduct

STATEMENT	OF DE	FICIENCIES
AND PLAN O	CORF	RECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION	
A. BUILDING:	_

(X3) DATE SURVEY COMPLETED

MHL051-138

B. WING \_

C 03/03/2020

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

### 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 296	Continued From page 23	V 296		300 100
100 (20) (30)	-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 10/17/18Diagnoses of Oppositional Defiant Disorder and Other specified trauma and stress related disorder.			2.920
***************************************	-He is 14 years oldHe was discharged on 2/14/20.			(XS) (MPL) 7
<del>N</del>	Interview with FC #5 on 3/2/20 revealed: -There was a recent incident with his medicationThe day of the incident with his medication staff #1 was working alone at the group homeThe House Manager was away from the home when he stole the medication.			W.
14.6 7.5	Interview with client #1 on 2/26/20 revealed: -A few weeks ago there was an incident with his medicationThe House Manager had left the group home			£45
	with client #3Staff #1 was working alone when the medication was stolen.			(AC- - AC+ - AC+ - C-1
	Interview with client #2 on 2/26/20 revealed: -Staff #1 was working alone when client #1 and FC #5 stole the medicationThe House Manager had left the group home and went to the store.			
201	Interview with client #3 on 2/28/20 revealed: -He thought he was with the House Manager when the medication was stolen.			- 325
	-He and the House Manager had gone out to run some errandsHe had gone out with the House Manager several times that dayThe House Manager had been in and out of the			The state of the s

STATEM	ENT OF	DEFICIENCIES	
AND PLA	NOFC	CORRECTION	

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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING: \_\_\_

(X3) DATE SURVEY COMPLETED

MHL051-138

B. WING \_\_\_\_\_

C 03/03/2020

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

### THE LIGHTHOUSE II OF CLAYTON

2016 FORT DRIVE CLAYTON NC 27520

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
Continued From page 24	V 296		
home all day.			
Interview with staff #1 on 2/28/20 revealed:			
			2.000
			and the last of th
the home.			
-Staff #3 was the 3rd shift staff.			100 Millions
			20/00/1965
			DATE
			- marking (1) - engine
-The House Manager was in and out of the home			N. J. a. li
running errands that day.			
most of 1st shift.			
-The House Manager had left him alone with			
			policy and
minimum staffing requirements were met by			1,854, 11 1,411
present and awake.			
Interview with staff #2 on 2/26/20 revealed:			1.1 1.2
-The day of the incident when the residents had			
taken the medication he came in around 3:15 pm.			
			127
Staff #1 was possibly working alone with three			
clients when the medication was stolen.			Determine the state of
			1111
was stolen.			
	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 #5He had been working at the group home for about a month prior to that incidentWhen he came in for 1st shift staff #3 was still at the homeStaff #3 was the 3rd shift staffStaff #3 left the group home and he was alone with the clientsThe House Manager arrived to the home about 15-20 minutes later for 1st shiftThe House Manager was in and out of the home running errands that dayHe thought the House Manager left the home that day on at least 5 separate occasionsHe did work alone at the home with clients for most of 1st shiftThe House Manager had left him alone with clients at the home on other occasionsThe House Manager would normally run errands for the home during the dayHe 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 aken the medication he came in around 3:15 pmWhen he came in staff #1 was at the home alone with client #1, client #2 and FC #5He thought client #3 was in the community with he House ManagerStaff #1 was possibly working alone with three clients when the medication was stolenHe thought the Home Manager was in the community running errands when the medication	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 #5He had been working at the group home for about a month prior to that incidentWhen he came in for 1st shift staff #3 was still at the homeStaff #3 was the 3rd shift staffStaff #3 left the group home and he was alone with the clientsThe House Manager arrived to the home about 15-20 minutes later for 1st shiftThe House Manager was in and out of the home running errands that dayHe thought the House Manager left the home that day on at least 5 separate occasionsHe did work alone at the home with clients for most of 1st shiftThe House Manager would normally run errands for the home during the dayHe 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 aken the medication he came in around 3:15 pmWhen he came in staff #1 was at the home alone with client #1, client #2 and FC #5He thought client #3 was in the community with he House ManagerStaff #1 was possibly working alone with three clients when the medication was stolenHe thought the Home Manager was in the community running errands when the medication	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 was the 3rd shift staff.  -Staff #3 was the 3rd shift staff.  -Staff #4 ay 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 oresent and awake.  nterview with staff #2 on 2/26/20 revealed:  -The day of the incident when the residents had alken the medication he came in around 3:15 pm. When he came in staff #1 was at the home alone with client #3 was in the community with he 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 with he House Manager.

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 (X3) DATE SURVEY
COMPLETED

MHL051-138

B. WING \_\_\_\_\_

C 03/03/2020

NAME OF PROVIDER OR SUPPLIER

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STREET ADDRESS, CITY, STATE, ZIP CODE

### 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 296	Continued From page 25	V 296		30: 60:
5 A1	-He confirmed the facility failed to ensure minimum staffing requirements were met by direct care staff when children or adolescents are present and awake.			920
N/A T1	Interview with staff #3 on 2/28/20 revealed: -She normally worked at the home during 3rd shiftShe worked with staff #4 during 3rd shift earlier.			
	-Staff #1 came in for 1st shift and staff #4 left the homeWhen she left the home staff #1 was alone with clients #1 and #3.			tours of
	-She confirmed the facility failed to ensure minimum staffing requirements were met by direct care staff when children or adolescents are present and awake.			
14 14	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.			Name of the state
* ************************************	-He thought he arrived to the home around 8:30 AMStaff #1 was alone at the home with clients #1			and and the second and and and and and and and and and a
	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.			Rem CO Text
ana	-He had to go to the grocery store and get gas for the van the day of the incidentHe took client #3 with him during that outingStaff #1 remained at the home with FC #5, client #1 and client #2.			COMAN (METHOR) COME PROCESSION
	-He confirmed the facility failed to ensure minimum staffing requirements were met by direct care staff when children or adolescents are present and awake.			The second secon

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Division	of Health Service Re	egulation			FORM	APPROVE	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/S IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED  C 03/03/2020	
		MHL051-138	B. WING	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE			
THE LIG	HTHOUSE II OF CLAY	ION	RT DRIVE N, NC 27520				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
V 296	through 3/3/20 revel- The day of the med the House Manager -She was not aware alone when the med -She confirmed the minimum staffing re direct care staff whe present and awake. This deficiency is cre NCAC 27G .0209 M	rogram Manager 2/26/20 aled: dication incident staff #1 and were working together. staff #1 was possibly working dication was stolen. facility failed to ensure quirements were met by en children or adolescents are coss referenced into 10A edication Requirements (Tag rule violation and must be	V 296		100	(25) (25) (25) (25) (25) (25)	
N <sub>p</sub> a					- 4	229	
TI.							
134							

Division of Health Service Regulation

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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

Date