STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-219			(X2) MULTIPLE CO A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			B. WING				
				02/02/2022			
IAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE			
NSPIRAT	IONZ		_HAVEN DRIVE N-SALEM, NC 271	07			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 000	INITIAL COMMENTS		V 000				
	An annual survey was completed on 2/2/2022. A deficiency was cited.						
		d for the following service 27G .1700 Residential re for Children or					
	The survey sample co current clients.	onsisted of audits of 2					
V 118	27G .0209 (C) Medic	ation Requirements	V 118				
	 only be administered order of a person auti drugs. (2) Medications shall clients only when auti client's physician. (3) Medications, inclu administered only by unlicensed persons tr pharmacist or other le privileged to prepare (4) A Medication Adm all drugs administered current. Medications a recorded immediately MAR is to include the (A) client's name; (B) name, strength, a (C) instructions for ac (D) date and time the 	stration: n-prescription drugs shall to a client on the written horized by law to prescribe be self-administered by horized in writing by the ding injections, shall be licensed persons, or by ained by a registered nurse, egally qualified person and and administer medications. inistration Record (MAR) of d to each client must be kept administered shall be after administration. The following: nd quantity of the drug;					

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-219			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING		02	2/02/2022	
iame of Pf	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE		
NSPIRATI	ONZ		LHAVEN DRIVE	07		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN (OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	O THE APPROPRIATE	COMPLET DATE
V 118	Continued From page 1		V 118			
	checks shall be recor	r medication changes or rded and kept with the MAR pointment or consultation				
	interviews, the facility	ews, observations and / failed to ensure the MAR affecting 2 of 2 clients (#1 &				
	Review on 2/1/2022 or revealed:					
	Trauma; Mild Intellec	Disorder; Unspecified				
	(ADHD); Disruptive M Oppositional Defiant - Age: 17					
	1 capsule QHS (ever 2/25/2021.	r Vistaril 25mg (milligrams), y day at bedtime), dated				
	- No physician's orde	er for Vyvanse.				
	11/1/2021 to 1/28/202					
	capsule QHS, was pr	uctions for Vyvanse 25mg, 1 resent with staff initials administered every day.				
	- Vistaril was not pres					
		oximately 11:07am on 1's medications revealed:				

STATE FORM

VX9C11

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-219			(X2) MULTIPLE CC		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		B. WING	02	2/02/2022		
IAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE		
NSPIRAT	IONZ		_HAVEN DRIVE IN-SALEM, NC 2710)7		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	O THE APPROPRIATE	COMPLET
V 118	Continued From page 2		V 118			
	 No Vyvanse was present. Hydroxyzine pamoate (generic for Vistaril) 25mg, 1 capsule QHS, filled on 11/30/2021 was present. Review on 2/1/2022 of Client #2's record revealed: Admission date: 8/5/2020 Diagnoses: Unspecified Disruptive/Impulsive Control/Conduct Disorder; Borderline Intellectual Functioning; Disruptive Mood Disorder; and ADHD, Combined Presentation. Age: 17 A physician's order for risperidone 2mg, 1 tablet BID (twice daily), dated 10/29/2020. 					
		uctions for: "Risperidone et: Take 2 (2mg) tablet by				
	Observation at appro 1/28/2022 of Client # - Risperidone 2mg, 1 12/29/2021 was pres	2's medications revealed: tablet BID, filled on				
		2 with Client #1 revealed: nad been taking the correct ly.				
		2 with Client #2 revealed: g the correct doses of his ly.				

STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: MHL034-219 NAME OF PROVIDER OR SUPPLIER STREET			(X2) MULTIPLE CO A. BUILDING:			(X3) DATE SURVEY COMPLETED	
				02/02/2022			
		I	ADDRESS, CITY, STATE		02	.102/2022	
			LHAVEN DRIVE	,			
NSPIRATI	IONZ	WINSTO	ON-SALEM, NC 271	07			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLET DATE	
V 118	Continued From page 3		V 118				
	 The errors had been fixed. Clients #1 and #2 had been administered the correct medications at the correct doses. 						
	Interview on 2/1/2022 with the Qualified Professional (QP) revealed: - She did not have oversight of Clients #1 and #2's medications.						
	reviewing MARs for a - She believed that C	rse (RN) was responsible for accuracy. Clients #1 and #2 had been rect medications every day.					
	Interview on 1/28/2022 with the RN revealed: - She was responsible for ensuring that MARs were correct.						
	errors.	IARs were typographical tions and doses had been					
	administered to Clier						
	- She would work wit	h the Director to develop a It MARs were correct in the					
	Director revealed: - The RN reviewed M	,					
	not Vyvanse as the N - The errors on the N	taking hydroxyzine (Vistaril), /ARs indicated. /ARs were typographical					
	had been administer	tions and medication doses ed to Clients #1 and #2. ne RN and get the MARs					
	corrected immediate	-					

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