

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL081-127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/05/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FOOTHILLS AT RED OAK RECOVERY	STREET ADDRESS, CITY, STATE, ZIP CODE 517 CUB CREEK ROAD ELLENBORO, NC 28040
--	--

(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	<p>INITIAL COMMENTS</p> <p>An annual, complaint and follow up survey was completed on 12/5/22. The complaint was unsubstantiated (NC#00195114). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600D Supervised Living for Minors with Substance Abuse Dependency.</p> <p>This facility is licensed for 16 and currently has a census of 13. The sample consisted of audits of 3 current clients.</p>	V 000		
V 114	<p>27G .0207 Emergency Plans and Supplies</p> <p>10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES</p> <p>(a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority.</p> <p>(b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.</p> <p>(c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies.</p> <p>(d) Each facility shall have basic first aid supplies accessible for use.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that fire and disaster drills were completed quarterly and repeated for each</p>	V 114		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL081-127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/05/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FOOTHILLS AT RED OAK RECOVERY	STREET ADDRESS, CITY, STATE, ZIP CODE 517 CUB CREEK ROAD ELLENBORO, NC 28040
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 114	<p>Continued From page 1</p> <p>shift. The findings are:</p> <p>Review on 11/29/22 and 11/30/22 of the facility's fire and disaster drills dated 10/1/21-9/30/22 revealed:</p> <p>Orange shift:</p> <ul style="list-style-type: none"> -no disaster drill documented for the first quarter (January-March 2022); -no documentation that clients were present and included in disaster drills for second quarter, 2022 (April-June) or third quarter, 2022 (July-September); <p>Blue shift:</p> <ul style="list-style-type: none"> -no documentation that clients were present and included in disaster drills for fourth quarter, 2021 (October-December), second quarter, 2022 (April-June), and third quarter, 2022 (July-September) and fire drills for first quarter, 2022 (January-March). <p>Interview on 11/29/22 with Client #1 revealed:</p> <ul style="list-style-type: none"> -had not participated in any fire or disaster drills since he was admitted (10/17/22). <p>Interview on 11/29/22 with Client #2 revealed:</p> <ul style="list-style-type: none"> -had not participated in any fire or disaster drills since he was admitted (10/21/22); -when he was admitted, he was shown a sign of an exit plan and where everyone would meet in case of a fire. <p>Interview on 12/1/22 with the Shift Supervisor #1 revealed:</p> <ul style="list-style-type: none"> -supervised the "blue" shift; -there were two shifts at the facility for the direct care staff which were identified as the orange shift and blue shift and each run 7 days on and 7 days off with overlap on Thursdays; -shift supervisors worked a different 7 day schedule; his shift was Monday to Monday; 	V 114		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL081-127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/05/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FOOTHILLS AT RED OAK RECOVERY	STREET ADDRESS, CITY, STATE, ZIP CODE 517 CUB CREEK ROAD ELLENBORO, NC 28040
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 114	<p>Continued From page 2</p> <ul style="list-style-type: none"> -fire and disaster drills were run by the Facilities Manager and were completed on Thursdays; -the Facilities Manager was responsible for documenting the drills; -fire and disaster drills were usually conducted with staff only but would sometimes include clients. <p>Interviews on 11/29/22 and 11/30/22 with the Quality Assurance Officer (QAO) revealed:</p> <ul style="list-style-type: none"> -the orange and blue shifts worked 7 days on and 7 days off with overlap of both shifts on Thursdays; -the facility tried to run drills on Thursdays when both shifts were working; -the Facilities Manager was responsible for running the drills and the Administrative Specialist (AS) was responsible for recording the drills; -he spoke to the Facilities Manager who thought maybe the AS didn't write down the number of clients present for the drills; -thought clients were present for the drills and maybe it was a documentation issue. 	V 114		
V 117	<p>27G .0209 (B) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</p> <p>(b) Medication packaging and labeling:</p> <p>(1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible;</p> <p>(2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of</p>	V 117		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL081-127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/05/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FOOTHILLS AT RED OAK RECOVERY	STREET ADDRESS, CITY, STATE, ZIP CODE 517 CUB CREEK ROAD ELLENBORO, NC 28040
--	--

(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 117	<p>Continued From page 3</p> <p>unit-of-use packaged drugs, a zip-lock plastic bag may be adequate;</p> <p>(3) The packaging label of each prescription drug dispensed must include the following:</p> <p>(A) the client's name;</p> <p>(B) the prescriber's name;</p> <p>(C) the current dispensing date;</p> <p>(D) clear directions for self-administration;</p> <p>(E) the name, strength, quantity, and expiration date of the prescribed drug; and</p> <p>(F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner.</p> <p>This Rule is not met as evidenced by: Based on record reviews, interviews and observations, the facility failed to ensure that medications for administration were labeled as required affecting 1 of 3 audited clients (Client #3). The findings are:</p> <p>Review on 11/30/22 of Client #3's record revealed:</p> <p>-date of admission: 11/14/22;</p> <p>-age: 16;</p> <p>-diagnoses: Severe Cannabis Use Disorder (d/o), Moderate Major Depressive d/o, recurrent episode, Other Specified Trauma and Stressor Related d/o.</p> <p>-physician orders dated 11/17/22 for:</p> <p>-Albuterol inhaler (asthma), take 2 puffs before or after exercise for wheezing;</p> <p>-Dapsone gel 7.5%, apply daily for acne;</p>	V 117		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL081-127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/05/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FOOTHILLS AT RED OAK RECOVERY	STREET ADDRESS, CITY, STATE, ZIP CODE 517 CUB CREEK ROAD ELLENBORO, NC 28040
--	--

(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 117	<p>Continued From page 4</p> <p>-Adapalene and Benzoyl 0.3% (acne), apply thin layer once per day to affected areas; -there was no physician's order for the Fluticasone nasal spray.</p> <p>Observation at 2:20pm on 11/30/22 of Client #3's medications revealed: Prescription: -Albuterol inhaler (asthma) in the manufacturer's box; -Dapsone gel (acne) 7.5% with the manufacturer's label; -Adapalene and Benzoyl (acne) with the manufacturer's label; Non-prescription: -Fluticasone nasal spray (allergies) with the manufacturer's label; -the medications did not include the client's name, prescriber, dispense date, name, strength, and quantity of the medication or the pharmacy which dispensed the medication.</p> <p>Interview on 11/30/22 with the Client Services Manager revealed: -recently took over helping with the medication until they hired a new Registered Nurse; -Client #3's guardian brought his medications to the facility at admission and explained what they were and how they were to be administered; -"thought" the inhaler may have come from the Emergency Room.</p> <p>Interview on 12/5/22 with the Chief Executive Officer revealed: -he will ensure that medications are labeled with the required information.</p> <p>This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type A2 rule violation and must be</p>	V 117		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL081-127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/05/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FOOTHILLS AT RED OAK RECOVERY	STREET ADDRESS, CITY, STATE, ZIP CODE 517 CUB CREEK ROAD ELLENBORO, NC 28040
--	--

(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 117	Continued From page 5 corrected within 23 days.	V 117		
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 checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL081-127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/05/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FOOTHILLS AT RED OAK RECOVERY	STREET ADDRESS, CITY, STATE, ZIP CODE 517 CUB CREEK ROAD ELLENBORO, NC 28040
--	--

(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	<p>Continued From page 6</p> <p>This Rule is not met as evidenced by: Based on record reviews, interviews and observations, the facility failed to ensure that medications were administered only on the written order of a person authorized to prescribe medications and failed to keep the MARs current for 3 of 3 audited clients (Clients #1, #2, and #3). The findings are:</p> <p>CROSS REFERENCE: 10A NCAC 27G .0209 Medication Requirements (V117). Based on record reviews, interviews and observations, the facility failed to ensure that medications for administration were labeled as required affecting 1 of 3 audited clients (Client #3).</p> <p>Review on 11/30/22 of the MARs for Client #1, #2 and #3 revealed: -MARs were completed on a weekly basis; -at the top of each MAR was the date range in the box labeled "shift;" -there were columns for each day of the week starting with Friday and ending with Thursday; the individual columns for each day of the week were not dated individually; -the year was not included in the weekly date range; -Client #1 had a MAR dated 10/21-10/27 and Client #2 had a MAR dated 10/20-10/27.</p> <p>Review on 11/29/22 of Client #1's record revealed: -date of admission: 10/17/22; -age 16; -diagnoses of Cannabis Use Disorder (d/o), moderate, Other Hallucinogen Use d/o, mild, Social Anxiety d/o (social phobia) and Unspecified Depressive d/o.</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL081-127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/05/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FOOTHILLS AT RED OAK RECOVERY	STREET ADDRESS, CITY, STATE, ZIP CODE 517 CUB CREEK ROAD ELLENBORO, NC 28040
--	--

(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	<p>Continued From page 7</p> <p>-there were no medication orders from the date of admission until the first visit with the facility's Physician Assistant (PA) on 10/20/22.</p> <p>Review on 11/30/22 and 12/5/22 of psychiatric progress notes by the facility's PA for Client #1 revealed: Psychiatric Initial Intake dated 10/20/22 listed the current medications: -Lorazepam 1mg (milligram), BID (twice daily), GAD (Generalized Anxiety d/o); -Lexapro 10mg, QD (daily) MDD (Major Depressive d/o); -Risperidone 2 mg BID, drug induced psychosis; -Plan-"Mother reports he is tapering off Risperidone and Lorazepam;" -Continue current medication; -Begin tapering medications on next visit; -the 11/21/22 note documented "continue Risperidone taper, will change dosage next visit ... follow up in 1 week, earlier if needed;" -there were no psychiatric progress notes after 11/21/22.</p> <p>Review on 12/1/22 and 12/5/22 of physician orders for Client #1 revealed: -Lexapro (Escitalopram) 10mg, QD, Lorazepam 1mg BID, Risperidone 2 mg BID ordered 10/20/22; -Lorazepam 1mg, qam (every morning) and ½ tab (tablet) every evening ordered 10/27/22 with orders for the following tapering schedule: -11/1 -decrease Lorazepam 1mg, ½ tab qam and ½ tab every evening; -11/5 -decrease Lorazepam 1mg ½ tab qam only; -11/9 -d/c (discontinue) Lorazepam 1mg; -Risperidone 0.5mg 4 tabs (2mg) qam and 3 tabs (1.5mg) qhs (bedtime) ordered 10/27/22; -Risperidone 0.5mg to 3 tabs (1.5mg) qam and</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL081-127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/05/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FOOTHILLS AT RED OAK RECOVERY	STREET ADDRESS, CITY, STATE, ZIP CODE 517 CUB CREEK ROAD ELLENBORO, NC 28040
--	--

(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	<p>Continued From page 8</p> <p>continue 3 tabs (1.5mg) qhs x 14 days ordered 11/14/22.</p> <p>Review on 11/30/22 and 12/2/22 of Client #1's MARs dated 10/14/22-12/1/22 revealed:</p> <ul style="list-style-type: none"> -at 1:50pm on 11/30/22, the following MARs were available for review: 10/21-10/27, 11/10-11/17, 11/17-11/24, and 11/25-12/1; -there were no MARs for 10/28/22-11/14/22; -at approximately 4:00pm on 11/30/22, Shift Supervisor #1 provided the following MARs for Client #1: -10/14-10/20, 10/21-10/27, and 11/3-11/10; -on the MAR dated 10/14-10/20, there were no initials to indicate that the client received the medications that he was taking when admitted (Lexapro, Risperidone, and Lorazepam as documented by the PA in his psychiatric intake note on 10/20/22); -the dates of the 11/3-11/10 MAR did not align with the days of the week; 11/3 was a Thursday and the first day initialed on the MAR was a Friday; -there were 2 MARs for the dates of 11/10-11/17; the dates on the MAR did not align with the days of the week; 11/10 was a Thursday and the first day initialed on the MAR was a Friday; -the 11/17-11/24 MAR did not align with the days of the week; 11/17 was a Thursday and the first day initialed on the MAR was a Friday; -there were 2 MARs for 10/21-10/27; -Escitalopram 10mg and Risperidone 2mg were documented as administered on 10/21/22 on both MARs; -there were no initials on either of the MARs dated 10/21-10/27 for the pm dose of Lorazepam 1mg; -10/27/22-no initials or explanation for the pm dose of Risperidone 2mg; -on the Friday of the 11/3-11/10 MAR (11/3/22 	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL081-127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/05/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FOOTHILLS AT RED OAK RECOVERY	STREET ADDRESS, CITY, STATE, ZIP CODE 517 CUB CREEK ROAD ELLENBORO, NC 28040
--	--

(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	<p>Continued From page 9</p> <p>was a Thursday), there were no initials or explanation for Risperidone 1.5mg before bed; -Risperidone 1.5mg, take ½ tablet once daily was administered 11/15/22-12/1/22 without a written physician's order; -Risperidone 0.5mg 3 tabs (1.5mg) qam and continue 3 tabs (1.5mg) qhs x 14 days ordered 11/14/22 was not listed on the MARs from 11/15-12/1; -Lorazepam 0.5mg before bed was administered for 5 days during the week of 11/3-11/10 but the dates and days of the MAR did not align; there was no way to determine what date Client #1 received this medication; -the order on 10/27/22 was for 0.5mg in the morning beginning 11/5/22 not before bed as listed and initialed on the MAR; -there was no documentation that Lorazepam 1 mg ½ tab qam was administered from 11/1/22-11/4/22.</p> <p>Interview on 11/29/22 with Client #1 revealed: -was admitted on 10/17/22; -took medications but he didn't know the names of them; -took his medications when staff administered them to him.</p> <p>Review on 11/29/22 of Client #2's record revealed: -date of admission: 10/21/22; -age: 17; -diagnoses: Moderate Alcohol Use d/o, in early remission; Mild Cannabis Use d/o, severe Tobacco Use d/o, and Attention Deficit Hyperactivity d/o (ADHD); -psychiatric progress note written by the facility's PA dated 10/24/22 documented to continue Mydayis (ADHD) 37.5mg daily.</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL081-127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/05/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FOOTHILLS AT RED OAK RECOVERY	STREET ADDRESS, CITY, STATE, ZIP CODE 517 CUB CREEK ROAD ELLENBORO, NC 28040
--	--

(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	<p>Continued From page 10</p> <p>Review on 11/30/22 of physician orders for Client #2 revealed: -Mydayis (ADHD) 37.5mg one capsule daily ordered 10/24/22; -Nicotine patch (smoking), apply one patch daily ordered 10/31/22.</p> <p>Review on 11/30/22 and 12/2/22 of Client #2's MARs dated 10/20/22-12/1/22 revealed: -at 1:50pm on 11/30/22, the following MARS were available for review: 10/20-10/27, 11/10-11/17, 11/17-11/24 and 11/25-12/1; -there were no MARs for 10/28/22-11/9/22 for the Mydayis 37.5mg and 11/1-11/9 for the Nicotine patch; -at approximately 4:00pm on 11/30/22, Shift Supervisor #1 provided a second MAR for 10/20-10/27 to the surveyor; -the dates on the 10/20-10/27 did not align with the days of the week; 10/20 was a Thursday and the first day of the MAR week was a Friday; -on one MAR for 10/20-10/27, there was an "X" on the Friday for Mydayis 37.5mg with a note "Friday administered prior to arrival" and the Nicotine Patch was not listed on this MAR; -on the second MAR dated 10/20-10/27, Mydayis was initialed as administered from Friday-Sunday and the Nicotine Patch initialed as administered from Friday-Thursday; -based on the documentation on the second MAR, the Nicotine Patch was administered for 7 days without a physician's order.</p> <p>Interview on 11/29/22 with Client #2 revealed: -took Mydayis for his ADHD and a nicotine patch; he received a new nicotine patch every 24 hours; -took his medications every day; there had been no issues with his medications.</p> <p>Review on 11/30/22 of Client #3's record</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL081-127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/05/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FOOTHILLS AT RED OAK RECOVERY	STREET ADDRESS, CITY, STATE, ZIP CODE 517 CUB CREEK ROAD ELLENBORO, NC 28040
--	--

(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	<p>Continued From page 11</p> <p>revealed:</p> <ul style="list-style-type: none"> -date of admission: 11/14/22; -age:16; -diagnoses: Severe Cannabis Use d/o, Moderate Major Depressive d/o, recurrent episode, Other Specified Trauma and Stressor Related d/o. <p>Review on 11/30/22 of the physician orders dated 11/17/22 for Client #3 revealed: "Continue with current medication, which includes:"</p> <ul style="list-style-type: none"> -Duloxetine (MDD) 30mg qam; -Trazodone (insomnia) 50mg qhs; -Cefuroximeaxetil (sinus infection) 250mg, BID x14 days; -Doxycycline (acne) 50mg BID; -Dapsone gel 7.5% (acne); -Adapalene and Benzoyl 0.3% (acne), topical daily on affected areas; -Zyrtec (seasonal allergies), 1 tab daily; -Albuterol (asthma) 2 puffs before and after exercise. <p>Review on 11/30/22 of Client #3's MARs from 11/14/22-12/1/22 revealed:</p> <ul style="list-style-type: none"> -the following medications were administered 11/14/22-11/17/22 without a written physician order: Trazodone 50mg qhs; Duloxetine 30mg qam; Cefuroximeaxetil 250mg, BID x14 days, Doxycycline 50mg BID; Dapsone gel 7.5%, and Adapalene and Benzoyl 0.3%, topical daily; -on the 11/10-11/17 and 11/25-12/1 MARs, Trazodone 50mg was written as a PRN (as needed); -on the 11/17-11/24 MAR, Trazodone 50mg was written "1 tablet before bed" and documented as administered on the Wednesday and Thursday of that week; -Zyrtec was written as "1 tablet every 24 hours" and "PRN" was written on the line next to it; it was 	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL081-127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/05/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FOOTHILLS AT RED OAK RECOVERY	STREET ADDRESS, CITY, STATE, ZIP CODE 517 CUB CREEK ROAD ELLENBORO, NC 28040
--	--

(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	<p>Continued From page 12</p> <p>administered on Thursday of the week 11/10-11/17.</p> <p>Observation at 2:20pm on 11/30/22 of Client #3's medications revealed: -Trazodone 50mg one tablet qhs PRN; -there was no supply of Zyrtec 10mg in Client #3's medications.</p> <p>Observation at 2:41pm on 11/30/22 of Over The Counter (OTC) medications revealed: -OTC medications were kept in the top drawer of the medication cart located in the staff office; -there was Zyrtec 10mg packaged as individual doses which included the Manufacturer's directions on the package.</p> <p>Interview on 11/29/22 with Client #3 revealed: -he received medications at the staff office; -there were certain medication times during the day; -some of his medications were in a bubble pack and other medications were in a bottle; -a medication trained supervisor took it out of the bottle or bubble pack and gave it to him; -was good about taking his medications.</p> <p>Interview on 11/30/22 with the Client Services Manager revealed: -recently took over managing the medications and MARs; he did medications at the men's campus (sister facility) so he agreed to take on the role in the interim; -they did not get orders for the medications that a client brought with them at admission to the facility; -did not get a release for the prescribing provider for medications that clients brought with them at admission; -clients saw the facility's PA soon after they were</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL081-127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/05/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FOOTHILLS AT RED OAK RECOVERY	STREET ADDRESS, CITY, STATE, ZIP CODE 517 CUB CREEK ROAD ELLENBORO, NC 28040
--	--

(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	<p>Continued From page 13</p> <p>admitted;</p> <ul style="list-style-type: none"> -received physician orders from the facility's PA via email or through their EHR (electronic health record); -was not sure what happened with the missing MARs; they were not in the MAR binder; -was not sure why there was no documentation for Client #1's medications from 10/18/22-10/20/22. <p>Review on 11/29/22 of Shift Supervisor #1's record revealed:</p> <ul style="list-style-type: none"> -date of hire: 5/24/21; -annual refresher training by a Registered Nurse (RN) for medication administration was 10/24/22. <p>Interview on 11/30/22 and 12/1/22 with Shift Supervisor #1 revealed:</p> <ul style="list-style-type: none"> -was trained to administer medications; -when administering medications, looked at the MAR and the medication prior to administering; once administered, both staff and clients signed the MAR; -shift supervisors did not make changes to the MAR; "[Client Services Manager] prints the MARs" and gave them to staff; -the clients did not self-administer medications; -if a client refused their medication, staff documented it with an "R" on the MAR and both staff and the client signed the MAR; -the blanks on Client #1's MAR on 10/27/22 for the pm doses of Lorazepam and Risperidone were due to Client #1 "tapering off" the medications. <p>Interviews on 11/30/22 and 12/2/22 with the Quality Assurance Officer revealed:</p> <ul style="list-style-type: none"> -they did not have an RN currently; but a new RN started earlier in the week and was in the onboarding process; 	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL081-127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/05/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FOOTHILLS AT RED OAK RECOVERY	STREET ADDRESS, CITY, STATE, ZIP CODE 517 CUB CREEK ROAD ELLENBORO, NC 28040
--	--

(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	<p>Continued From page 14</p> <p>-their former RN/Medical Services Manager left employment on 10/25/22 and the former Medical Services Assistant left employment 10/20/22; -the Client Services Manager was assisting with MARs until the new RN was in the position;</p> <p>Interview on 12/5/22 with the Chief Executive Officer revealed: -shifts overlapped on Thursdays which was reason for MARs having duplicate dates for one day of the week; -the outgoing 7 day shift administered medications through the afternoon and the incoming 7 day shift administered the pm medications; -may put a header on the MAR with the days and times that the MAR was in effect.</p> <p>Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician.</p> <p>This deficiency has been cited 3 times since the original cite on 1/29/20.</p> <p>Review on 12/1/22 of the Plan of Protection completed by the Executive Director on 12/1/22 revealed: "What immediate action will the facility take to ensure the safety of the consumer in your care?"</p> <p>Point of Accountability: Medical Services Manager and Executive Director Immediate Intervention: " All students MARS will be audited, and the necessary changes will be made by 5pm on 12/1/22 by Medical Services Manager and Executive Director. " MAR Protocol will be implemented starting</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL081-127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/05/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FOOTHILLS AT RED OAK RECOVERY	STREET ADDRESS, CITY, STATE, ZIP CODE 517 CUB CREEK ROAD ELLENBORO, NC 28040
--	--

(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	<p>Continued From page 15</p> <p>12/1/22.</p> <p>Describe your plans to make sure the above happens. MAR Protocol: -Medical Services Manager will create and log all student MARs in Medication Binder -Medical Services Manager will audit all MARS once a week -Medical Services Manager will upload full MARS into ZenCharts (electronic health record) once a week -After full MARS are uploaded into ZenCharts, Medical Services Manager will file the full MARs in the student's medical file in medical office. -After student discharges from the program, Medical Services Manger will shred all student MARs."</p> <p>Review on 12/2/22 of the amended Plan of Protection written by the Executive Director on 12/2/22 revealed:</p> <p>"What immediate action will the facility take to ensure the safety of the consumer in your care? Immediate Intervention: Medication label will be attached to the medication</p> <p>Describe your plans to make sure the above happens. Medication Labeling Protocol: " Medical Services Manager will review medications and ensure administration labels are attached to medication " If labels are not attached to medication, Medical Services Manager will contact previous provider per client release of information."</p> <p>This facility serves adolescent males ages 14-17 with substance use disorders and co-occurring</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL081-127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/05/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FOOTHILLS AT RED OAK RECOVERY	STREET ADDRESS, CITY, STATE, ZIP CODE 517 CUB CREEK ROAD ELLENBORO, NC 28040
--	--

(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	<p>Continued From page 16</p> <p>mental health diagnoses which include Cannabis, Alcohol, Other Hallucinogen, and Tobacco Use d/o's, Social Anxiety d/o (social phobia), Unspecified Depressive d/o; ADHD, Major Depression and Other Specified Trauma and Stressor Related d/o. When clients were admitted to the facility, the facility administered their medications based on what the parent/guardian brought for the client to the facility. The facility did not request the physician orders for the medications. This resulted in staff administering medications without a physician's order until the client was seen by the facility's PA during their first week after admission. The MARs were not kept current for Clients #1, #2, and #3. For Client #1, there were discrepancies in the dosages of medications listed on the MAR and the physician orders and blanks on some dates with no explanation. Client #1 and Client #2 had duplicate MARS for the same time period. The weekly dates listed at the top of the MARs did not align with the start day of Friday on the MAR, therefore, it could not be determined if Client #1 and Client #2 received their medications as prescribed. Client #1's tapering of Lorazepam did not follow the physician's order according to how it was documented on the MAR. Four medications for Client #3 were not labeled with client name, prescriber's name, dispensed date, directions for administration, name, address and phone number of the dispensing practitioner.</p> <p>This deficiency constitutes a Type A2 rule violation for substantial risk of serious harm and must be corrected within 23 days. An administrative penalty of \$1,000 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of \$500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL081-127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/05/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER FOOTHILLS AT RED OAK RECOVERY	STREET ADDRESS, CITY, STATE, ZIP CODE 517 CUB CREEK ROAD ELLENBORO, NC 28040
--	--

(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