

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL023-220	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 06/27/2023
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NAME OF PROVIDER OR SUPPLIER HEALTHY CHOICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1102 GROVE STREET KINGS MOUNTAIN, NC 28086
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(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>A complaint and follow up survey was completed on 6/27/23. The complaints (#NC 197852 and NC 200599) were unsubstantiated. A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.</p> <p>This facility is licensed for 4 and currently has a census of 2. The survey sample consisted of audits of 2 current clients.</p>	V 000		
V 118	<p>27G .0209 (C) Medication Requirements</p> <p>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;</p>	V 118		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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V 118	<p>Continued From page 1</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure medications were administered on the written order of a physician and failed to keep the MARs current for 1 of 2 clients (Client #2). The findings are:</p> <p>Record review on 6/26/23 for Client #2 revealed: -Date of Admission: 10/18/22. -Diagnoses: Unspecified Disruptive, Impulse-Control and Conduct Disorder, Posttraumatic Stress Disorder, and Other Specified Trauma and Stressor Related Disorder. -11 years old. -Review of physician's orders dated 5/15/23 revealed: -Clonidine ER (extended release) 0.1 mg (milligram) (sedative) 1 tablet in AM and 2 tablets at bedtime. -Risperidone 0.5mg (antipsychotic)- 1 tablet at bedtime. A previous order dated 3/29/23 was written for 2 tablets of 0.25mg at bedtime. -Desmopressin 0.2mg (bedwetting) - 2 tablets at bedtime. -Melatonin ER 1mg (sleep) - 4 tablets at bedtime. Additionally, a previous order was</p>	V 118		

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V 118	<p>Continued From page 2</p> <p>written 1/18/23 for one 3mg tablet at bedtime.</p> <p>Review on 6/14/23 of MARs from 3/10/23-6/25/23 for Client #2 revealed:</p> <ul style="list-style-type: none"> -Clonidine was not initialed as administered on 3/26/23 pm dose. -Risperidone was not initialed as administered on 3/26/23. In addition, the MAR was initialed twice on 3/31/23 for the 0.25mg tablets as well as for the 0.5mg tablet. -Desmopressin was not initialed as administered on 3/26/23 pm dose. -Melatonin was not initialed as administered on 3/26/23, 5/14/23 nor 5/29/23. The June MAR instructions were written as 3 mg 4 tablets and initialed 6/1-6/25/23 although there were no 1mg tablets in the facility. <p>Observation on 6/26/23 at approximately 1pm of medications for Client #2 revealed a melatonin bubble pack of 3mg tablets with 1 tablet in each blister dispensed 6/16/23. There was also an OTC (over the counter) bottle of Melatonin 3 mg tablets with an expiration date of November 2024.</p> <p>Interview on 6/27/22 with Client #2 revealed:</p> <ul style="list-style-type: none"> -He was prescribed clonidine, risperdal, desmopressin and melatonin. He only took 1 tablet of melatonin and was not having any problems sleeping. <p>Interview on 6/27/22 with the Qualified Professional (QP) revealed:</p> <ul style="list-style-type: none"> -The overnight staff had written the MAR for June. He had not noticed that the MAR was incorrectly written but he was pretty sure Client #2 only received 1 tablet each night which was written on the bubble pack. -Immediately contacted the pharmacy who apologized for the mistake stating they had filled 	V 118		

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V 118	<p>Continued From page 3</p> <p>an old prescription.</p> <p>-Client #2 was very aware of the medications he takes and had previously spoken with his doctor about taking so many pills.</p> <p>-"I just didn't catch it. It's ultimately on me."</p> <p>This deficiency constitutes a recite deficiency and must be corrected within 30 days.</p>	V 118		