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V 000	INITIAL COMMENTS An annual and follow up survey was completed August 25, 2023. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for 4 and currently has a census of 3. The survey sample consisted of audits of 3 current and 1 former client.	V 000		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the	V 118		

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V 118	Continued From page 1 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. This Rule is not met as evidenced by: Based on record reviews, observations and interviews the facility failed to administer medications as ordered by a physician affecting 3 of 3 current clients (#1, #2, and #3) and to keep the MAR current for 1 of 3 current clients (#3). The findings are: Review on 8/22/23 of client #1's record revealed: - 15 year old male admitted 1/20/22. - Diagnoses included Post Traumatic Stress Disorder (PTSD) and Attention Deficit Hyperactivity Disorder (ADHD). - Physician's orders signed as follows: - 9/13/22: fluoxetine (depression) 10 milligrams (mg) 1 capsule daily; risperidone (antipsychotic) 0.5 mg 1 tablet twice daily. - 10/14/22: cetirizine (antihistamine) 1 mg/milliliter (ml) 1 teaspoonful daily. - 4/20/23 Restasis 0.05% eye drops (dry eyes) 1 drop each eye twice daily. - 4/24/23: olopatadine 0.2% eye drops (antihistamine) 1 drop each eye daily. - 5/23/23 fiber gummies (fiber supplement) chew and swallow 1 gummy twice daily. Review on 8/22/23 of client #1's MARs for June - August 2023 revealed:	V 118		

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- Transcriptions for cetiizine, fluoxetine, olopatadine eye drops, fiber gummies, risperidone, and Restasis eye drops to be administered at 8:00 am.
- No staff initials to document administration of 8:00 am medications on 8/22/23.
- Staff documentation of administration of olopatadine eye drops daily 8/18/23 - 8/21/23.

Observation on 8/22/23 at 10:30 am of client #1's medications on hand revealed:
- Cetirizine 1 mg/ml 1 teaspoonful daily dispensed 8/10/23.
- Fluoxetine 10 mg 1 capsule daily dispensed 6/14/23.
- Fiber gummies chew and swallow 1 gummy twice daily and risperidone 0.5 mg 1 tablet twice daily dispensed 7/06/23.
- No olopatadine eye drops available.

During interview on 8/22/23 client #1 stated:
- He took his medications daily.
- He "did not get it this morning because we were still asleep at 8:00 . . . and then you came and we didn't get a chance to get everything done."
- Clients were not permitted to leave their bedrooms before 9:00 am.

Review on 8/22/23 of client #2's record revealed:
- 12 year old male admitted 1/28/23.
- Diagnoses included Oppositional Defiant Disorder; and ADHD.
- Physician's orders signed as follows:
  - 4/26/23: lamotrigine (anticonvulsant) 25 mg 2 tablets daily; Concerta (ADHD) 36 mg 2 tablets daily; cyproheptadine (antihistamine) 4 mg 1/2 tablet daily; clonidine (antihypertensive) 0.1 mg 2 tablets twice daily.
  - 7/05/23 quetiapine (antipsychotic) 100 mg 1 tablet twice daily; clonidine 0.1 mg 1 tablet twice

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daily as needed (PRN) for agitation/aggression.
- MAR transcriptions for lamotrigine, Concerta, cyproheptadine, clonidine, and quetiapine to be administered at 8:00 am, and for clonidine to be administered twice daily PRN for agitation/aggression.

Review on 8/22/23 of client #2's MARs for June - August 2023 revealed:
- Transcriptions for lamotrigine, Concerta, cyproheptadine, clonidine, and quetiapine to be administered at 8:00 am.
- No staff initials to document administration of 8:00 am medications on 8/22/23.
- Transcription for clonidine to be administered twice daily PRN for agitation/aggression.
- Staff documentation of clonidine 0.1 mg PRN was administered three times on 8/04/23.
- No staff documentation of administration of Concerta 7/24/23 - 7/26/23 with no explanation for the blanks.

Observation on 8/22/23 at 10:40 am of client #2's medications on hand revealed:
- Lamotrigine 25 mg 2 tablets daily dispensed 6/21/23.
- Concerta 36 mg 2 tablets daily dispensed 7/24/23.
- Cyproheptadine 4 mg 1/2 tablet daily dispensed 7/06/23.
- Clonidine 0.1 mg 2 tablets twice daily dispensed 7/19/23.
- Quetiapine 100 mg 1 tablet twice daily dispensed 8/02/23.
- Clonidine 0.1 mg 1 tablet twice daily PRN dispensed 7/05/23.

During interview on 8/22/23 client #2 stated:
- He took his medications every day.
- He took his morning medications; "[Staff #4]

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V 118	Continued From page 4 gave them. Everyone got them." Review on 8/22/23 of client #3's record revealed: - 12 year old male admitted 6/09/22. - Diagnoses included ADHD and Autism Spectrum Disorder. - Physician's orders signed as follows: - 10/12/22: atomoxetine (ADHD) 100 mg 1 capsule daily; hydroxyzine (antihistamine) 25 mg 1 tablet three times daily. - 4/26/23 aripiprazole (antipsychotic) 20 mg 1 tablet daily. - 7/19/23 amantadine (ADHD) 50 mg/5 ml 1 teaspoonful twice daily. - 8/16/23 quetiapine 50 mg 1 tablet twice daily PRN for agitation. - MAR transcriptions for atomoxetine, aripiprazole, amantadine, and hydroxyzine to be administered at 8:00 am. Review on 8/22/23 of client #3's MARs for June - August 2023 revealed: - Transcriptions for atomoxetine, aripiprazole, amantadine, and hydroxyzine to be administered at 8:00 am. - No staff initials to document administration of 8:00 am medications on 8/22/23. - No transcription for quetiapine 50 mg 1 tablet twice daily PRN on the August 2023 MAR. Observation on 8/22/23 at 10:45 am of client #3's medications on hand revealed: - Atomoxetine 100 mg 1 capsule daily, aripiprazole 20 mg 1 tablet daily; amantadine 50 mg/ml 1 teaspoonful twice daily, and hydroxyzine 25 mg dispensed 7/19/23. - Quetiapine 50 mg 1 tablet twice daily PRN, dispensed 8/16/23. During interview on 8/22/23 client #3 stated:	V 118		

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V 118	Continued From page 5 - He took his medications daily. - He had not taken his morning medications. - "We didn't get a chance yet, but we're going to." - Clients were not permitted to leave their bedrooms before 9:00 am. Review on 8/22/23 of staff #4's personnel record revealed: - Paraprofessional hired 3/01/23. - Medication Administration training 4/30/19. During interview on 8/22/23 staff #4 stated: - One of his responsibilities was to administer medications. - He did not administer morning medication because he "didn't have time." - He arrived at the facility at 8:00 am; the clients were still in their bedrooms asleep; "they don't leave their rooms until 9:00." - There was a 2 hour window for medication administration "one hour before and an hour after" the time documented on the MAR. - He usually gave clients their medications with breakfast. - He was "sweeping around" between 8:00 and 9:00 and was the only staff person at the facility. - If he made a medication error he would report it to his supervisor and then follow protocol. During interview on 8/22/23 the Qualified Professional/House Manager stated: - She was not aware morning medications were not administered as ordered. - She understood failure to administer medications as ordered was considered a medication error and would ensure incident reports were completed. - She understood MARs were to be kept current and accurately reflect medication orders.	V 118		

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V 118	Continued From page 6 This deficiency has been cited 3 times since the original cite on 11/23/21 and must be corrected within 30 days.	V 118		
V 295	27G .1703 Residential Tx. Child/Adol - Req. for A P 10A NCAC 27G .1703 REQUIREMENTS FOR ASSOCIATE PROFESSIONALS (a) In addition to the qualified professional specified in Rule .1702 of this Section, each facility shall have at least one full-time direct care staff who meets or exceeds the requirements of an associate professional as set forth in 10A NCAC 27G .0104(1). (b) The governing body responsible for each facility shall develop and implement written policies that specify the responsibilities of its associate professional(s). At a minimum these policies shall address the following: (1) management of the day to day day-to-day operations of the facility; (2) supervision of paraprofessionals regarding responsibilities related to the implementation of each child or adolescent's treatment plan; and (3) participation in service planning meetings. This Rule is not met as evidenced by: Based on record review and interview the facility failed to employ an Associate Professional (AP) who provided services to the group home on a full time basis. The findings are:	V 295		

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V 295	Continued From page 7 Review on 8/22/23 of the "Division of Health Service Regulation . . . Client and Staff Census" form completed by staff #4 and reviewed by the Qualified Professional/House Manager (QP/HM) revealed no AP listed. During interview on 8/22/23 the QP/HM stated the facility did not have an AP. During interview on 8/22/23 the Office Manager stated: - There was not an AP employed at the facility. - AP's "come and go, but we don't have one right now." - An AP was last employed at the facility in May 2023. - "We know it's required and we are looking."	V 295		
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff	V 296		

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V 296	Continued From page 8 during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan. This Rule is not met as evidenced by: Based on observation, record reviews, and interviews the facility failed to provide the minimum number of direct care staff required when children or adolescents were present and awake. The findings are: Observations on 8/22/23 at approximately 9:15	V 296		

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am revealed 1 staff (staff #4) present in the facility with 3 clients; the Qualified Professional/House Manager arrived at the facility at approximately 10:10 am.

Review on 8/22/23 of client #1's record revealed:
- 15 year old male admitted 1/20/22.
- Diagnoses included Post Traumatic Stress Disorder (PTSD) and Attention Deficit Hyperactivity Disorder (ADHD).
- Assessment dated 12/30/21 included documented history of physcial aggression towards peers and staff, property destruction, elopement and sexually inappropriate behaviors.

During interview on 8/22/23 client #1 stated:
- There were "usually" 2 staff at the facility "even at night."
- One staff left at 9:00 pm leaving 1 staff to work overnight.

Review on 8/22/23 of client #2's record revealed:
- 12 year old male admitted 1/28/23.
- Diagnoses included Oppositional Defiant Disorder; and ADHD.
- Assessment dated 2/14/22 included documented history of physical aggression toward peers, defiant, impulsive and disruptive behaviors, and property destruction.
- Assessment addendum dated 2/07/23 included client #2 was moved into the facilty following sexualized behaviors with a peer at a previous placement.

During interview on 8/22/23 client #2 stated:
- There were usually 2 staff at the facility.
- Sometimes staff #1 "has things to do" and she was not at the facility.
- One staff left at 9:00 pm and 1 staff stayed until the overnight shift started at midnight.

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V 296	Continued From page 10 - There was 1 staff on overnight shift "because we're asleep." Review on 8/22/23 of client #3's record revealed: - 12 year old male admitted 6/09/22. - Diagnoses included ADHD and Autism Spectrum Disorder. - Assessment dated 6/10/22 included documented history of verbal and physical aggression, defiance, property destruction, self-harming behaviors and poor impulse control. During interview on 8/22/23 client #3 stated: - There were usually 2 staff at the facilty, "but not everyday." - One staff worked the overnight shift. During interview on 8/22/23 staff #4 stated: - He was the only staff person at the facility with 3 clients. - When he arrived at the facility there was 1 staff person present. - He did not know why there was only 1 staff at the facility. - Staff #1 was scheduled to be at the facilty, but she had an appointment. - There were usually 2 staff at the facility. - He thought there were 2 staff until 9:00 pm; 1 staff left at 9:00 pm and 1 staff worked 9:00 pm until 8:00 pm. During interview on 8/23/23 staff #1 stated: - There should always be 2 staff present at the facility. - She made the staff schedule and always scheduled 2 staff for each shift. - She was originally scheduled to work day shift 8/22/23 but had an appointment and her "replacement" did not show up.	V 296		

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V 296	Continued From page 11 During interview on 8/22/23 the Qualified Professional/House Manager stated: - There were supposed to be 2 staff at the facility at all times. - She was not aware only 1 staff worked the overnight shift. - She "saw" there was only 1 staff on duty when she arrived at the facility. - Staff #1 "had an emergency" and "that's why he [staff #4] was here alone."	V 296		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified	V 367		

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or responding.
(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:
(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).
(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:
(1) medication errors that do not meet the

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V 367	Continued From page 13 definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed ensure a critical incident was reported within 72 hours as required. The findings are: Review on 8/22/23 of a facility survey completed 9/14/22 revealed an allegation of client abuse by a staff member was not reported via the North Carolina Incident Response Improvement System (IRIS) within 72 hours as required. During interview on 8/25/23 the Office Manager stated the allegation of client abuse was not entered into IRIS following the survey completed 9/14/22. It was her understanding that all allegations would be reported "going forward."	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-034	A. BUILDING: _____ B. WING _____	R 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 367	Continued From page 14 This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 367		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observations and interview the facilty was not maintained in a safe, clean attractive and orderly manner. The findings are: Observations on 8/22/23 between 9:15 am and approximately 12:15 pm and on 8/23/23 between 12:25 pm and approximately 12:45 pm revealed: - Smoke detectors throughout the facility beeped at regular intervals. - The textured ceiling paint was peeling throughout the facility. - The vinyl floor covering was separated at the seams throughout the facility. - No switch plate on the kitchen light switch by the hall door. - The window blind in the kitchen window was too small for the window. - The air grate in the hall ceiling had a coating of dust. - Two baseball sized holes and a large crack in the wall by client #3's bed. - Two broken drawers in client #1's chest of drawers. - A broken outlet plate in client #1 and #3's bathroom; the bathroom window blind had broken and missing slats.	V 736		

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V 736	Continued From page 15 - A pile of dirty clothes on the floor behind client #2's headboard. - A softball sized hole in the wall under the light switch in client #2's bedroom. - The single window in the vacant bedroom would not open; the metal frame appeared to be broken in the upper right hand corner. - A mouse trap in the corner of the gameroom. - A sheet of drywall stored behind a chest freezer in the gameroom. - Arm chairs in the gameroom with the black vinyl peeling off. - A chest freezer with frozen red liquid on the inside floor. - Cobwebs were present at the tops of the living room walls. - An approximately 1 inch hole in the dining room wall. - Loose shingles and other items were on the roof of the facilty. - Seven decorative window muntins were missing from the exterior gameroom door. - The front porch was sagging away from the front door. During interviews on 8/22/23 and 8/23/23 the Qualified Professional/House Manager stated: - Client #3 "had behaviors last week" and caused some of the wall damage noted. - She could not get the window in the vacant room to open; she was not aware of the damage to the window.. - The batteries in the smoke detectors had been changed recently. - A work order was submitted to have a switch plate installed on the light switch in the kitchen. This deficiency has been cited 3 times since the original cite on 11/23/21 and must be corrected within 30 days.	V 736		

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