STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-159	A. BUILDING: _____ B. WING _____	R 02/01/2024

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A BETTER WAY RESIDENTIAL SERVICES	220 CALVINS ROAD SHANNON, NC 28386

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V 000	INITIAL COMMENTS An annual and follow up survey was completed on February 1, 2024. 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 4. The survey sample consisted of audits of 3 current clients.	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, observation and interviews, the facility failed to administer medications on the written order of a physician and failed to keep the MARs current affecting two of three clients (#1, #2). The findings are: Finding #1 Review on 1/30/24 of client #1's record reviewed: -13 year old male. -Admitted on 12/8/23. -Diagnoses of Oppositional Defiant Disorder and Attention Deficit Hyperactivity Disorder. -No signed physician orders for Vyvanse 40 milligram (mg) daily, Melatonin 10 mg at bedtime and Loratadine 10 mg daily. Review on 1/30/24 of client #1's MARs from 12/8/23 - 1/30/24 revealed: -Vyvanse 40 mg and Loratadine 10 mg was administered daily since 12/8/23. -Melatonin 10 mg was administered daily since 12/8/23. Observation on 1/30/24 between 2:15pm - 2:30pm of client #1's medications revealed: -Vyvanse 40 mg tablets were available. -Empty prescription bottle of Loratadine 10 mg.	V 118		

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V 118	Continued From page 2 -Over the counter medications for Loratadine 10 mg and Melatonin 10 mg. Interview on 1/30/24 client #1 stated: -He took his medications daily. -His medications included Cetirizine 10 mg, Vyvanse 40 mg and Melatonin 10 mg. Finding #2 Review on 1/30/24 of client #2's record revealed: -12 year old male. -Admitted on 8/29/23. -Diagnoses of Oppositional Defiant Disorder and Attention-Deficit Hyperactivity Disorder Predominantly Hyperactive Type. Review on 1/30/24 of client #2's signed physician orders revealed: -12/11/23 - Adderall XR 25 mg 1 capsules daily. -11/6/23 - Vyvanse 30 mg 2 capsules daily. Review on 1/30/24 of client #2's MARs from 11/1/23 - 1/30/24 revealed: -Adderall XR 25 mg administration was transcribed as 2 capsules daily and began 12/23/24. -Vyvanse 30 mg was discontinued on 12/22/23. Interview on 1/31/24 client #2 stated: -He took his medications daily except when the facility was out of the medications. -He was unsure when he last missed a medication. -He took Adderall, Clonidine and a 3rd medication he was unsure of the name. Interview on 1/30/24 and 1/31/24 staff #8 stated: -She was responsible for all the MARs, picking up medications and ensuring staff were comfortable administering medications.	V 118		

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V 118	Continued From page 3 -The facility had not received any physician orders for client #1. -Client #2's received 1- 25 mg tablet of Adderall, the MAR had a transcription error. -Client #2's Adderall was delayed because the pharmacy needed prior authorization and the pharmacy did not have the medication. -The physician stated they could continue the Vyvanse until they received the Adderall. -The Vyvanse was discontinued when the Adderall was prescribed. -The facility did not have a discontinue order for client #1's Vyvanse. -The facility did not have documentation to continue the Vyvanse and delay the Adderall. Interview on 1/31/24 the Assistant Program Director stated: -Client #1 was admitted with Vyvanse 40 mg. -The facility had not received any physician orders for client #1. -Client #2's Adderall medication was delayed because the pharmacy did not have it available. -There was no signed physician order for over the counter medications. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug	V 123		

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V 123	Continued From page 4 shall be charted. .	V 123		

This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to ensure medication errors were reported immediately to a physician or pharmacist for 1 of 3 audited clients (#2). The findings are:

Review on 1/30/24 of client #2's record revealed:
-12 year old male.
-Admitted on 8/29/23.
-Diagnoses of Oppositional Defiant Disorder and Attention-Deficit Hyperactivity Disorder Predominantly Hyperactive Type.

Review on 1/30/24 of client #2's signed physician orders revealed:
-12/11/23 - Adderall XR 25 mg 1 capsules daily.

Review on 1/30/24 of client #2's Medication Administration Records from 11/1/23 - 1/30/24 revealed:
-Adderall XR 25 mg began on 12/23/24.

Interview on 1/30/24 and 1/31/24 staff #8 stated:
-She was responsible for all the MARs, picking up medications and ensuring staff were comfortable administering medications.
-Client #2's Adderall was delayed because the pharmacy needed prior authorization and the pharmacy did not have the medication.
-The physician stated they could continue the Vyvanse until they received the Adderall.
-The facility did not have documentation to

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V 123	Continued From page 5 continue the Vyvanse and delay the Adderall from the physician. Interview on 1/31/24 the Assistant Program Director stated: -Client #2's Adderall medication was delayed because the pharmacy did not have it available. -The facility did not have any documentation of reports to the physician or pharmacy.	V 123		
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 observation and interview the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are: Observation on 1/30/24 between 11:45am - 12:15pm during a tour of the facility revealed: -Client #1's bedroom door was broken and would not close. -Client #1's bedroom ceiling vent had black dust. -Client #1's night stand drawers were missing knobs. -Client #2's bedroom had paint peeling around the ceiling along the wall at the entrance. -Client #3's bedroom closet had laminate flooring overlapping other laminate flooring and not affix to the floor. The closet wooden rod was cracked and split in the middle. -Client #4's night stand bottom drawer was broken. Client #4's dresser 4th drawer was	V 736		

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V 736	Continued From page 6 broken in sat in the last drawer of the dresser. -The back bathroom had ceiling vent had brownish stains. There was a baseball size hole in the wall by the door. There was paint peeling on the wall around the sink and light switch. -The hallway return vent had brownish stains and was dusty. -The smoke detector had chirped about every minute. Interview on 1/31/24 the Assistant Program Director stated: -She understood the facility should be maintained in a safe, clean, attractive and orderly manner. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		