STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-424	A. BUILDING: _____ B. WING _____	R 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAIYALYNN BURRELL CHILD CRISIS CENTER	277 BILTMORE AVENUE ASHEVILLE, NC 28801

(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	INITIAL COMMENTS An annual, complaint and follow up survey was completed on May 1, 2024. The complaint was substantiated (intake #NC00214689). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5000 Facility Based Crisis Service for Individuals of all Disability Groups. The facility is licensed for 16 and currently has a census of 15. The survey sample consisted of audits of 2 current clients and 1 deceased client.	V 000		
V 117	27G .0209 (B) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (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 unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and	V 117		

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V 117	Continued From page 1 (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. This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure prescription medications had the required labeling information for 10 of 67 Former Clients (FC#1, #3, #8, #9, #12, #14, #15, #20, #33 and #61). The findings are: Observation on 4/29/24 at approximately 12:50 pm of the facility's medication room and review of the facility's client census dated 6/30/23-4/29/24 revealed: -Clients' medications stored inside a medication cart with 5 drawers. -Drawer #5 of the medication cart contained 25 bottles of individual prescription medications dispensed from 8 local pharmacies. -The clients' names on the pharmacy dispensing labels of all 25 prescription medication bottles had been crossed out with black ink with a permanent marker. -The clients' names on 15 of the 25 prescription medication bottles were lightly crossed out and were identifiable when matched up with the names of 10 Former Clients on the census sheet as follows: -Polyethylene Glycol 3350 dispensed 7/7/23 for FC #1. -Olanzapine ODT dispensed 8/4/23 for FC#3.	V 117		

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V 117	Continued From page 2 -Sertraline dispensed 5/10/23 for FC#8. -Aripiprazole dispensed 5/11/23 for FC#8. -Ondansetron ODT dispensed 5/30/23 for FC#9. -Hyoscyamine Sulfate dispensed 6/8/23 for FC#12. -Fluoxetine HCL dispensed 8/18/23 for FC#14. -Topamax dispensed 8/18/23 for FC#14. -Naltrexone dispensed 8/18/23 for FC#14. -Hydroxyzine HCL dispensed 10/27/23 for FC#15. -Hydroxyzine dispensed 11/29/23 for FC#15. -Buspirone dispensed 10/16/23 for FC#20. -Escitalopram Oxalate dispensed 5/23/23 for FC#33. -Clonidine ER dispensed 2/23/24 for FC#61. -The clients' names on the other 10 prescription medication bottles were crossed out with heavier, darker black ink and the clients' names could not be identified as follows: -Olanzapine dispensed 8/10/23. -Mirtazapine dispensed 9/2/23. -Olanzapine dispensed 7/5/23. -Hydroxyzine HCL dispensed 8/2/23. -Risperidone dispensed 7/5/23. -Trazodone dispensed 5/1/23. -Clonidine HCL dispensed 5/7/23. -Fluoxetine HCL dispensed 5/19/23. -Fluoxetine HCL dispensed 10/17/23. -Fluoxetine HCL dispensed 11/6/23. -Risperidone dispensed 2/29/24. Interview on 4/30/24 with Staff #1 revealed: -Former Clients' medications were sometimes kept in the medication room for "overflow." -Overflow medications would be used if there was a shortage of medication. -"Sometimes ...we can cross the name off the med (medication) for the client that is discharged	V 117		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 117	Continued From page 3 ...the RN (Registered Nurse) makes sure it matches. That's how it's been since I started working here. I guess it's the RN that marks the name off the meds, I don't do any of that, I just go by the MAR (medication administration record)." -He did not "recall ever having to give a medication from overflow." Interview on 4/30/24 with the Licensed Practical Nurse (LPN) revealed: -"If a client comes in with a prescription and they don't bring their medication bottles with them, or if they run out of their meds, we can use overstock ...If discharged clients have medication changes and the older prescription is left at the facility, we can add it to the overstock drawer." -"Either myself, or [RN] just cross out the names." -"I don't remember if I ever had to administer an overstock medication to any clients. They (clients) usually come in with their own prescription bottles. It would be really rare to run out of a medication." Interview on 4/30/24 with the RN revealed: -" When the pharmacy sends us discharge meds they are in a bottle for the client, and if the client doesn't go home, we hang on to the bottles. We can't return bottles, only unopened punch packs, so if it's something we regularly use we keep it because sometimes kids come in without meds even if they are asked to bring them for admission ...honestly it isn't all that frequent that they are used. It's usually just when the kid admits with no meds, and we usually have those punch packs from the pharmacy in less than a day ... If it's a controlled med it is sent back to the pharmacy, but any other prescription medication in a bottle we keep for overflow." Interview on 5/1/24 with the Regional Operations	V 117		

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V 117	Continued From page 4 Director revealed: -Had a meeting with staff yesterday regarding overflow medications of discharged clients. "Effective immediately, we are not holding any medications and medications will be discharged with the clients, or returned to the pharmacy when clients are discharged."	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	V 118		

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V 118	Continued From page 5 with a physician. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to keep MARs current for 2 of 2 audited current Clients (Client#8 and Client#9) and 1 of 1 audited Deceased Client (DC#1). The findings are: Review on 4/30/24 of Client#8's record revealed: -Date of Admission: 3/31/24. -Diagnoses: Major Depressive Disorder. -Age: 17. Review on 4/30/24 of Client#8's undated MARs revealed: -Scheduled medications documented as administered on day 31 of MAR#1 included: -Mirtazapine (insomnia) 45 milligrams (mg) by mouth (PO) every bedtime (HS). -Melatonin (insomnia) 3 mg PO every HS. -Scheduled medications documented as administered on days 1-29 of MAR#2 included: -Mirtazapine 15 mg PO every HS for 3 days (days 1-3), then 7.5 mg every HS for 3 days (days 4-6), then discontinued. -Aripiprazole (mood) 2 mg PO every morning for 5 days (day 12-16), then 5 mg PO every morning (days 17-29). -Duloxetine (mood) 20 mg PO every morning (days 12-29). -The month and year was not documented on either of the MARs.	V 118		

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V 118	Continued From page 6 Review on 4/30/24 of Client#9's record revealed: -Date of Admission: 4/22/24. -Diagnoses: Attention Deficit Hyperactivity Disorder (ADHD); Major Depressive Disorder; Substance Use Disorder. -Age: 13. -Physician's orders included "Standard PRN (as needed) orders" dated 3/23/24 and 4/22/24 for the following medications: -Tylenol 650 mg PO every 6 hours PRN pain or fever over 100 degrees Fahrenheit. -Ibuprofen 400 mg PO every 6 hours PRN pain or fever over 100 degrees - Fahrenheit. -Pepcid 20 mg PO once daily PRN heartburn. -MiraLAX 17 grams (g) in 8 ounces (oz) of liquid PO once daily PRN constipation. -Mylanta 15 milliliters (ml) PO every 8 hours PRN for indigestion or upset stomach. Review on 4/30/24 of Client#9's undated MAR revealed: -Scheduled medications documented as administered on days 23-29 included: -Sertraline (mood) 75 mg PO every morning (days 23-29). -Dextroamphetamine-Amphetamine (ADHD)30 mg PO every morning (days 23-29). -Guanfacine (ADHD) 1 mg PO twice daily (BID) (days 23-26). -Ziprasidone (mood) 40 mg PO every HS (days 22-25) then 60 mg every HS (days 26-29). -The month and year was not documented on the MAR. -The following PRN medications were handwritten on the MAR with no documentation of the medication name, strength, quantity, frequency, or instructions for administering the medication as follows: -"tyl" -"ibu"	V 118		

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V 118	Continued From page 7 -"mir" -"pep" -"myl" Review on 4/30/24 of DC#1's record revealed: -Date of Admission: 6/26/23. -Diagnoses: ADHD; Bipolar Disorder; Opioid Abuse; Amphetamine Type Substance Use Disorder, Moderate; Cannabis Abuse. -Age: 16. -Date of Discharge: 11/6/23. -Date of Death: 2/3/24. -Physician's orders included: -Lithium Carbonate ER 450 mg PO BID dated 7/24/23. -Prazosin 2 mg PO three times daily (TID) dated 8/25/23. -Hydroxyzine Pamoate 100 mg PO every HS dated 8/21/23. -Clonidine 0.2 mg PO every HS dated 9/4/23. -Omeprazole 20 mg every morning for 14 days dated 10/23/23. -Divalproex Sodium ER 1000 mg PO every HS dated 10/31/23. Review on 4/30/24 of DC#1's MARs for June 2023-November 2023 revealed: -No MAR for November 2023. Interview on 4/30/24 with Staff#1 revealed: -"I don't write out the MARs, I think only RN's (Registered Nurses) are allowed to do that. I just initial the medications. I don't do any other stuff with the MARs." Interview on 4/30/24 with the Licensed Practical Nurse (LPN) revealed: -Nightshift staff reviewed client MARs each night to ensure they were accurate. -MARs were also reviewed at the end of each	V 118		

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V 118	Continued From page 8	V 118		

month by the RN.
-The RN was responsible for preparing new MARs each month.

Interview on 4/30/24 with the RN revealed:
-It was nursing staff's responsibility to accurately prepare each client's MAR.
-The facility has recently been using agency nurses and there has been inconsistency with the formatting of the MARs.
-If she found any discrepancies on a MAR, she would report it to the Nursing Supervisor.
-The Nursing Supervisor "isn't incredibly easy to get a hold of ...We used to have a nursing supervisor in each building (facility) and now that has been cut back to have one supervisor for several facilities, so they are busier."

Interview on 4/30/24 with the facility's Support Supervisor revealed:
-She could not locate DC#1's November 2023 MAR.
-" When clients are discharged the hard copy MARs are pulled and sent to the medical records office and [Medical Records Assistant] is supposed to scan them directly into a priority one folder and they go to HR (Human Resources) and they are uploaded from a scanning que to the medical record number associated with the child (client). [Medical Records Assistant] is not here today, but she might be available later today. If the November MAR is located for [DC#1] we will have [Medical Records Assistant] tell [Regional Operations Director]. I can't find it in her office."

Interview on 4/30/24 with the Regional Operations Director revealed:
-" Only the nurses are allowed to fill out the MARs. If it's a central virtual nurse reviewing it, she will fill it out and send it to the center

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V 118	Continued From page 9 ...Nurses are supposed to compare physician orders with the MARs."	V 118		
V 119	27G .0209 (D) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction. (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge. This Rule is not met as evidenced by:	V 119		

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V 119	Continued From page 10 Based on observation, record review and interview the facility failed to ensure each client's medication supply was disposed of promptly upon discharge affecting 10 of 67 Former Clients (FC#1, #3, #8, #9, #12, #14, #15, #20, #33 and #61). The findings are: Observation on 4/29/24 at approximately 12:50 pm of the facility's medication room revealed: -15 bottles of prescription medication which had been dispensed for clients no longer residing at the facility: -FC#1: Polyethylene Glycol 3350 dispensed 7/7/23. -FC#3: Olanzapine ODT dispensed 8/4/23. -FC#8: Sertraline dispensed 5/10/23 and Aripiprazole dispensed 5/11/23. -FC#9: Ondansetron ODT dispensed 5/30/23. -FC#12: Hyoscyamine Sulfate dispensed 6/8/23. -FC#14: Fluoxetine HCL dispensed 8/18/23, Topamax dispensed 8/18/23, and Naltrexone dispensed 8/18/23. -FC#15: Hydroxyzine HCL dispensed 10/27/23 and Hydroxyzine dispensed 11/29/23. -FC#20: Buspirone dispensed 10/16/23. -FC#33: Escitalopram Oxalate dispensed 5/23/23. -FC#61: Clonidine ER dispensed 2/23/24. Review on 4/29/24 of the facility's client census dated 6/30/23-4/29/24 revealed: -FC#1 discharged from the facility on 7/11/23. -FC#3 discharged from the facility on 8/17/23. -FC#8 and FC#9 discharged from the facility on 8/15/23. -FC#12 discharged from the facility on 9/22/23. -FC#14 discharged from the facility on 9/18/23.	V 119		

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V 119	Continued From page 11 -FC#15 discharged from the facility on 3/7/24. -FC#20 discharged from the facility on 10/17/23. -FC#33 discharged from the facility on 10/29/23. -FC#61 discharged from the facility on 4/19/24. Interview on 4/30/24 with Staff #1 revealed: -Former Clients' medications were sometimes kept in the medication room for "overflow." -Overflow medications would be used if there was a shortage of medication. -"Sometimes ...we can cross the name off the med (medication) for the client that is discharged ...the RN (Registered Nurse) makes sure it matches. That's how it's been since I started working here. I guess it's the RN that marks the name off the meds, I don't do any of that, I just go by the MAR (medication administration record)." -He did not "recall ever having to give a medication from overflow." Interview on 4/30/24 with the Licensed Practical Nurse (LPN) revealed: -"If a client comes in with a prescription and they don't bring their medication bottles with them, or if they run out of their meds, we can use overstock ...If discharged clients have medication changes and the older prescription is left at the facility, we can add it to the overstock drawer." -"Either myself, or [RN] just cross out the names." -"I don't remember if I ever had to administer an overstock medication to any clients. They (clients) usually come in with their own prescription bottles. It would be really rare to run out of a medication." Interview on 4/30/24 with the RN revealed: -" When the pharmacy sends us discharge meds	V 119		

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V 119	Continued From page 12 they are in a bottle for the client, and if the client doesn't go home, we hang on to the bottles. We can't return bottles, only unopened punch packs, so if it's something we regularly use we keep it because sometimes kids come in without meds even if they are asked to bring them for admission ...honestly it isn't all that frequent that they are used. It's usually just when the kid admits with no meds, and we usually have those punch packs from the pharmacy in less than a day ... If it's a controlled med it is sent back to the pharmacy, but any other prescription medication in a bottle we keep for overflow." Interview on 5/1/24 with the Regional Operations Director revealed: -Had a meeting with staff yesterday regarding overflow medications of discharged clients. "Effective immediately, we are not holding any medications and medications will be discharged with the clients, or returned to the pharmacy when clients are discharged."	V 119		