| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|-------------------------|---|-----------------------------------|-------------------------|
| | | | A. BUILDING: B. WING | | R 09/27/2024 | |
| | | MHL047-103 | | | | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| PREMIER | R HEALTHCARE SVC | S-SILVER LINING | |) | | |
| | | | RD, NC 28376 | PROVIDER'S PLAN OF | | (XE) |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| {V 000} | INITIAL COMMEN | rs | {V 000} | | | |
| | A follow up survey was completed on September 27, 2024. A deficiency was cited. | | | | | |
| | This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents. | | | | | |
| | | sed for 12 and has a current survey sample consisted of clients. | | | | |
| {V 118} | 27G .0209 (C) Med | lication Requirements | {V 118} | | | |
| | only be administered order of a person a drugs. (2) Medications shat clients only when a client's physician. (3) Medications, ind administered only built unlicensed persons pharmacist or other privileged to prepare (4) A Medication Act all drugs administered current. Medication frecorded immediate MAR is to include t (A) client's name; (B) name, strength (C) instructions for (D) date and time t | inistration: non-prescription drugs shall ed to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be by licensed persons, or by a trained by a registered nurse r legally qualified person and re and administer medications dministration Record (MAR) of red to each client must be kep is administered shall be ely after administration. The | | | | |

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STATE FORM

| Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE A. BUILDING: _ | | (X3) DATE SURVEY COMPLETED | | |
|---|---|---|-----------------------------|--|--------------------------------|--------------------------|
| | | MHL047-103 B. WING | | | R 09/27/2024 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | |
| PREMIE | R HEALTHCARE SVC | S-SILVER LINING | RNPIKE ROAD RD, NC 28376 |) | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE IE APPROPRIATE | (X5) COMPLETE DATE |
| {V 118} | drug. (5) Client requests checks shall be rec | age 1 for medication changes or corded and kept with the MAR appointment or consultation | {V 118} | | | |
| | Based on record re facility failed to kee | et as evidenced by: views and interviews, the p the MARs current affecting d clients (#1 and #3). The | | | | |
| | -Admission date of -Diagnoses of Disru Disorder, Attention (ADHD) and Unspe -She was 13 years -Physician's order of (Valved holding cha directed two times Fluticasone-Salmet | uptive Mood Dysregulation Deficit Hyperactivity Disorder ecified Asthma. old. dated 2/7/24 for Aero chamber amber for inhaler), use as | | | | |
| | revealed: | of MARs for client #1 ndicate the medication was e following- | | | | |
| | | 8/23 am dose. eterol 45-21 mcg on 8/11 pm e and 8/23 am dose. | | | | |

Division of Health Service Regulation STATE FORM

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|-----------------------------|--|---------------------------------|-------------------------------|--|
| | | MUL 047 402 | B. WING | | | R | |
| | | MHL047-103 | | | 09/. | 27/2024 | |
| IAME OF I | PROVIDER OR SUPPLIER | | DDRESS, CITY, STAT | E, ZIP CODE | | | |
| PREMIE | R HEALTHCARE SVC | S-SILVER LINING | RNPIKE ROAD RD, NC 28376 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE HE APPROPRIATE | (X5) COMPLET DATE | |
| {V 118} | Continued From pa | ge 2 | {V 118} | | | | |
| | -Admission date of -Diagnoses of ADH Disruptive Mood Dy Post-traumatic Stre -She was 17 years -Physician's order of 25 mg (Anxiety), on -Physician's order of Methylphenidate 36 morning. -Physician's order of Oxcarbazepine 600 tablet twice a day; L -Physician's order of mg (Sleep), dissolv bedtime; Guanfacin mg (ADHD), one ta -Physician's order of 10 mg (Allergies), of -Physician's order of 10 mg (Allergies), of -Physician's order of Review on 9/24/24 revealed: No staff initials to in administered for the -September 2024: Fluticasone Propion 9/23. Loratadine 10 mg of | D, Major Depressive Disorder, /sregulation Disorder and ss Disorder. old. lated 8/27/24 for Hydroxyzine le tablet at bedtime. lated 8/26/24 for 6 mg (ADHD), one tablet in the lated 7/2/24 for 9 mg (Bipolar Disorder), one Lab work every 3 months. lated 6/12/24 for Melatonin 10 e one tablet sublingually at ne HCI Extended Release 1 blet at bedtime. lated 5/28/24 for Loratadine one tablet daily. lated 3/1/24 for Fluticasone spray (Allergic Rhinitis), instill nostril daily. of MARs for client #3 indicate the medication was a following- nate 50 mcg spray on 9/17 and in 9/23. | | | | | |

STATE FORM

GEQJ12

If continuation sheet 3 of 5

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|---------------|--|--|---|---|-------------------------------|-----------------|
| | | MHL047-103 | B. WING | | R 09/27/2024 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, ST | TATE, ZIP CODE | | |
| PREMIE | R HEALTHCARE SVC | S-SILVER LINING | RNPIKE ROAD D, NC 28376 | | | |
| (X4) ID | | | ID | PROVIDER'S PLAN OF CO | | (X5) |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY) | E APPROPRIATE | COMPLET DATE |
| {V 118} | Continued From pa | age 3 | {V 118} | | | |
| | Hydroxyzine 25 mg on 7/11. Methylphenidate 36 mg on 7/13, 7/14 and 7/17. Oxcarbazepine 600 mg on 7/13, 7/14 and 7/17 am doses; 7/11, 7/13, 7/14, 7/17 and 7/18 pm doses. Melatonin 10 mg on 7/11. Guanfacine HCI ER 1 mg on 7/11. Loratadine 10 mg on 7/13, 7/14 and 7/17. Fluticasone Propionate 50 mcg on 7/13, 7/14, 7/17 and 7/22. There was no documentation of lab orders completed for nursing staff. Interview on 9/24/24 with Registered Nurse (RN) #2 revealed: Client #3 went on therapeutic leave in July 2024. "All of the nurses were not aware they were | | | | | |
| | supposed to put a (#3] was on therape -Some of the other their initials to indic administered. -The clients get the -"Some of the nurs forgot to sign off or -The labs were dor | C in the grid on the days [client putic leave." nurses didn't consistently put ate a medication was ir medications as prescribed. es are newer and just possibly in the MARs." | | | | |
| | was done for client | #3. MARs were not kept current | | | | |
| | Administration reve -She wasn't not aw MARs for clients #' -They had conferer Director (ED) twice | are there were issues with 1 and #3. nce calls with the Executive a week. | | | | |
| ision of H | -The ED for that fa attention. ealth Service Regulation | cility never brought that to her | | | | |

Division of Health Service Regulation STATE FORM

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GEQJ12

If continuation sheet 4 of 5

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|-----------------------------|--|--|-----------------|
| | or connection | DENTIFICATION NOMBER. | A. BUILDING: _ | | | |
| | | MHL047-103 | B. WING | | | R 27/2024 |
| AME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | ATE, ZIP CODE | ORRECTION IN SHOULD BE E APPROPRIATE | |
| REMIEF | R HEALTHCARE SVO | | RNPIKE ROAD RD, NC 28376 | | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF C | | (X5) |
| PRÉFIX TAG | | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC | HE APPROPRIATE | COMPLET DATE |
| {V 118} | Continued From page 4 | | {V 118} | | | |
| | -She confirmed the MARs were not kept current for clients #1 and #3. | | | | | |
| | | nstitutes a re-cited deficiency cted within 30 days. | | | | |
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