TATEMENT	f Health Service Regu OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL080-035	B. WING		09	/26/2024
IAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
IMBER R	IDGE TREATMENT CEN	TER	BER TRAIL			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	9/26/24. The complai (intakes #NC0022110 NC00221094). A defi This facility is license category: 10A NCAC Therapeutic Camps fo of all Disability Group This facility is license	ciency was cited. d for the following service 27G .5200 Residential or Children and Adolescents is. d for 60 and has a current rvey sample consisted of				
V 118	27G .0209 (C) Medic	ation Requirements	V 118			
	 only be administered order of a person aut drugs. (2) Medications shall clients only when aut client's physician. (3) Medications, inclu administered only by unlicensed persons to pharmacist or other le privileged to prepare (4) A Medication Adm all drugs administered current. Medications 	istration: n-prescription drugs shall to a client on the written horized by law to prescribe be self-administered by horized in writing by the ding injections, shall be licensed persons, or by rained by a registered nurse, egally qualified person and and administer medications. inistration Record (MAR) of d to each client must be kept				
	MAR is to include the (A) client's name;	following: nd quantity of the drug;				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL080-035	B. WING		09	/26/2024
iame of Pi	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
IMBER R	NIDGE TREATMENT CEN	ITER	BER TRAIL IILL, NC 28071			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From page	e 1	V 118			
	 (E) name or initials o drug. (5) Client requests for checks shall be record 	e drug is administered; and f person administering the or medication changes or rded and kept with the MAR opointment or consultation				
	facility failed to keep	as evidenced by: ews and interview, the the MARs current affecting d clients (#1, #2, #3). The				
	-Admission date of 4, -Diagnoses of Oppos (ODD), Attention Def (ADHD), Intermittent -Physician order date -Fluoxetine 20 m capsule by mouth on -Guanfacine 3m take one tablet by mo -Hydroxyzine HC mouth twice a day fo -Divalproex sodi (DR) 500mg, take on at 9am and 4pm for m	sitional Defiant Disorder icit Hyperactivity Disorder Explosive Disorder. ed 8/26/24 revealed: nilligram (mg), take one ce daily for mood. g Extended Release (ER), buth once daily for ADHD. CL 25mg, take one tablet by r mood. um (SOD) delayed release te tablet by mouth twice daily mood. mg, take one and ½ tablets				
		f MARs dated from July 2024				

STATE FORM

LF1411

If continuation sheet 2 of 7

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
		MUL 000 005				
	ROVIDER OR SUPPLIER	MHL080-035	ADDRESS, CITY, STATE		09	/26/2024
	CONDER OR SUPPLIER		BER TRAIL	, ZIF CODE		
IMBER R	IDGE TREATMENT CEN	NTER	IILL, NC 28071			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pag	e 2	V 118			
		following medications: 8 500mg on 7/14, 7/25, 7/30,				
	administration of the -Fluoxetine 20mg on -Guanfacine 3mg on -Methylphenidate 54 -Divalproex SOD DF 8/16, 8/17, 8/19, 8/2 -Hydroxyzine HCL 2 8/1, 8/8, 8/14, 8/15, 8 8pm. -Quetiapine 100mg of	8/30. mg on 8/30. 8 500mg on 8/30 at 9am;				
	document administra medications: -Fluoxetine 20mg on -Guanfacine 3mg on -Methylphenidate 54 -Divalproex SOD DR 9/19 at 9am; 9/5, 9/6	9/9, 9/10, 9/16, 9/19. 9/9, 9/10, 9/16, 9/19. mg on 9/9, 9/10, 9/16, 9/19. \$ 500mg on 9/9, 9/10, 9/16,				
	-Admission date of 1 -Diagnoses of Disrup ADHD, Post Trauma Major Depressive Di -Physician order date	otive Mood Dysregulation, tic Stress Disorder (PTSD), sorder. ed 8/26/24 revealed: Omg, take one cap by mouth				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL080-035	B. WING		09	/26/2024
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
IMBER R	RIDGE TREATMENT CEN	ITFR	BER TRAIL ILL, NC 28071			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pag	e 3	V 118			
	in each nostril twice a -Oxcarbazepine mouth twice a day fo -Clonidine 0.1mg three times a day for -Melatonin 10mg bedtime for regulatio Review on 9/25/24 o through September 2 revealed: -July 2024- No staff i administration of the -Atomoxetine 40mg o -Fluticasone 50mcg o 8pm. -Oxcarbazepine 1500 5:30pm. -Clonidine 0.1mg on 7/31 at 8pm.	150mg, take one tablet by r mood. g, take one tablet by mouth ADHD. g, take one tablet by mouth at n of sleep. f MARs dated from July 2024 25, 2024 for client #2 initials to document following medications:				
	administration of the -Atomoxetine 40mg of 8/22, 8/23. -Fluticasone 50mcg of 8/21, 8/22, 8/23 at 9a 5:30pm. -Oxcarbazepine 1500 8/22, 8/23 at 9am; 8/ 8/17, 8/19 at 5:30pm -Clonidine 0.1mg on at 9am; 8/17, 8/19, 8 8/16/, 8/17, 8/23 at 8	8/17, 8/20, 8/21, 8/22, 8/23 /20, 8/30, 8/31 at 2pm; 8/15,				
	-September 1-25, 20 document administra	24 -No staff initials to ition of the following				

STATE FORM

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL080-035	B. WING		09	/26/2024
IAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE		
	RIDGE TREATMENT CEN	ITER	BER TRAIL ILL, NC 28071			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pag	e 4	V 118			
	8pm. -Oxcarbazepine 1500 9/1, 9/11 5:30pm. -Clonidine 0.1mg on -Melatonin 10mg on Review on 9/23/24 or -Admission date of 2 -Diagnoses of ODD, -Physician order date -Concerta 36mg every morning for AE -Aripiprazole 5m twice daily at lunch a -Guanfacine HC mouth at bedtime for -Melatonin 10mg table by mouth at bed	on 9/1, 9/9, 9/10 9am; 9/11 at mg on 9/1, 9/9, 9/10 at 9am; 9/1, 9/9, 9/10 at 9am. 9/11. f client #3's record revealed: /12/24. ADHD, Conduct Disorder. ed 8/26/24 revealed: , take two tablets by mouth DHD. ng, take one tablet by mouth nd bedtime for mood. L ER 4mg take one tablet by ADHD. g TR (Triple Action), take one				
	through September 2 revealed: -July 2024- No staff i administration of the -Concerta 36mg on 7 -Aripiprazole 5mg on -Guanfacine HCL ER -Melatonin 10mg TR -Trazodone 50mg on -August 2024- No sta administration of the	f MARs dated from July 2024 25, 2024 for client #3 nitials to document following medications: 7/21. 7/31. 8 4mg on 7/31. on 7/31. 1 7/31. aff initials to document following medications: 8/3, 8/10, 8/11, 8/17, 8/19,				

STATE FORM

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
		MHL080-035	B. WING		09	0/26/2024
IAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
IMBER R	IDGE TREATMENT CEN	TFR 665 TIM	BER TRAIL			
		GOLD H	IILL, NC 28071			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From page	e 5	V 118			
	-Guanfacine HCL ER 8/17, 8/23. -Melatonin 10mg TR 8/23.	8/16, 8/17, 8/23 at 8pm. 4 4mg on 8/2, 8/15, 8/16, on 8/2, 8/15, 8/16, 8/17, 8/2, 8/15, 8/16, 8/17, 8/23.				
	-Aripiprazole 5mg on 9/11, 9/12, 9/20 at 8p	tion of the following: /1, 9/9, 9/10, 9/16, 9/19. 9/12, 9/13 at 12:30pm;				
	-Trazodone 50mg on	on 9/11, 9/12, 9/20, 9/22. 9/11, 9/12, 9/20, 9/22. I with Clients #1, #2, #3				
	revealed:	en administered daily, no				
		with the Registered Nurse				
	-It was the RN's resp monthly for errors.	onsibility to review the MARs all the clients received their				
	medication on time da -"Clients receive their not put their initials or	aily. r medications but staff did n the MARs."				
	-"I'm behind on it, wit	h everything else."				
	revealed:	with the Clinical Director onsibility to review the MARs				
	Due to the failure to a medication administration					

STATE FORM

6899

If continuation sheet 6 of 7

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL080-035	B. WING		09	/26/2024
AME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	ZIP CODE		
IMBER R	IDGE TREATMENT CEN	ITER	BER TRAIL IILL, NC 28071			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From page	e 6	V 118			
	as ordered by the phy	ysician.				