STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: mbl067, 122		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		mb1067 133	B. WING		11/08/2024	
	IAME OF PROVIDER OR SUPPLIER STREET A		ADDRESS, CITY, STATE, ZIP CODE		1 11/	08/2024
			ERLEAF DRIV			
SILVERL	EAF LODGE		NVILLE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / 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 THE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMENTS		V 000			
	An annual and follow up survey was completed on November 8, 2024. A deficiency was cited.					
	This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff-Secure for Children and Adolescents.					
		sed for 4 and has a census of ple consisted of audits of 2				
V 118	27G .0209 (C) Med	ication Requirements	V 118			
	 only be administered order of a person a drugs. (2) Medications shat clients only when a client's physician. (3) Medications, include the distribution of the distributication of 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 regally qualified person and re and administer medications. Iministration Record (MAR) of red to each client must be kep s administered shall be ely after administration. The				

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
		mhl067-133	B. WING		11/	11/08/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
SILVERL	EAF LODGE		VERLEAF DRIV				
(X4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF	CORRECTION	ORRECTION (X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE	
V 118	Continued From page 1		V 118				
	checks shall be rec	for medication changes or corded and kept with the MAR appointment or consultation					
		eview and interview the facility s current for 1 of 3 current					
	 14 year old male. Admission date of Diagnoses of Pos Intellectual Develop 	of client #2's record revealed: f 08/29/24. ttraumatic Stress Disorder. omental Disability, Reactive er and Autism Spectrum					
	orders dated 10/15. - Olanzapine (antip 1 at noon and at be - Miralax (stool soft - Clonidine (treats to tablets in the morni - Metamucil Fiber C 2 in the morning.	sychotic) 10 milligrams (mg) -	-				
	Review on 11/07/24 and November 202 October 2024 ealth Service Regulation	4 of client #2's October 2024 24 MARs revealed:					

STATE FORM

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: mhl067-133		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		B. WING		11/	11/08/2024		
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
SILVERI	EAF LODGE		VERLEAF DRIV				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	LAN OF CORRECTION		
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
V 118	Continued From page 2		V 118				
	10/31/24. - Clonidine - no stat administration on 1 - Metamucil Fiber G indicate administrat - Oxcarbazepine - r administration on 1 November 2023 - Olanzapine - no s administration on 1 - Metamucil Fiber G indicate administrat Interview on 11/07/2 his medication daily Interview on 11/07/2 stated: - Clients received th - Staff may have for client #2. Interview on 11/07/2 stated she understo signed to ensure m as ordered. Due to the failure to medication adminis	 0/05/24 thru 10/08/24 and ff initials to indicate 0/31/24. Gummies - no staff initials to tion on 10/14/24 thru 10/16/24 no staff initials to indicate 0/31/24 am and pm. taff initials to indicate 1/04/24 pm. Gummies - no staff initials to tion on 11/04/24. 24 client #2 stated he received by staff. 24 the Associate Professional heir medications as ordered. rgotten to initial the MARs for 24 the Program Manager cod the MARs needed to be hedications were administered b accurately document stration, it could not be lient received medication as 					

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