STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601533	A. BUILDING: _____ B. WING _____	02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDREN BEST CARE FACILITY	6418 REDDMAN ROAD, UNIT B CHARLOTTE, NC 28212

(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 survey was completed on 2-3-25. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600B Supervised Living For Minors With Developmental Disability. This facility is licensed for 3 and currently has a census of 2. The survey sample consisted of audits of 2 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 drug.	V 118		

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V 118	Continued From page 1 (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 and interviews the facility failed to ensure the MARs of all drugs administered were kept current affecting 1 of 2 clients (client #2). The findings are: Review on 1-24-25 of client #2's record revealed: -Date of admission 10-14-24. -Age: 15. -Diagnoses: Autism Spectrum Disorder; Obsessive Compulsive Disorder; Attention Deficit Hyperactive Disorder (ADHD); Severe Intellectual Developmental Disability; Mood Dysregulation Disorder; Gastroesophageal Reflux Disease; Constipation. -Physicians orders dated 10-14-24 for the following medications: Thorazine (mood) 25mg (milligrams) Oral am and 3pm; Thorazine 75mg Oral bedtime; Tenex (ADHD) 1mg Oral am, bedtime; clonidine (ADHD) 0.2mg Oral bedtime; omeprazole (GERD) 20mg Oral; colace (constipation) 100mg Oral am, bedtime; Dulcolax (constipation) 1200 mg chews 2 gummies; Penicillin VK (toe infection) 500 mg Review on 1-24-25 of client #2's MARs for 10-14-24 to 1-24-25 revealed: -No staff initials to indicate the medication was administered for the following:	V 118		

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V 118	Continued From page 2 -Penicillin VK (Vertrayulich-Potassium) 500 mg. Take by mouth till gone (twice a day). Package date 10-11-24. No staff initials on 10-14-24 thru 10-24-24. No staff initials for the am doses on 10-25-24 or 10-29-24. No staff initials for the pm doses on 10-26-24, and 10-27-24. On 10-28-24 Penicillin was documented as given 3 times (7am, 7pm and initialed under the 7pm time). -Guanfacine 1 mg take by mouth twice a day. Package date 10-11-24. No staff initials on 10-14-24 through 10-17-24. No staff initials on 10-19-24 or 10-20-24. No staff initials for the am doses on 10-18-24, 10-22-24, 10-23-24, 10-24-24, 10-25-24 or 10-29-24. No staff initials for the pm doses on 10-27-24 or 10-31-24. -Chlorpromazine HCL (Hydrochloric Acid) 25mg take by mouth twice a day. Package date 10-11-24. No staff initials on 10-14-24 until the 3pm dose on 10-16-24. No staff initials for the am doses on 10-16-24, 10-17-24, 10-18-24, 10-19-24, 10-27-24, 10-30-24 and 10-31-24. No staff initials for the pm doses on 10-27-24, 10-30-24 or 10-31-24. -Chlorpromazine HCL 75mg take by mouth at bedtime. Package date 10-11-24. No staff initials from 10-14-24 until 10-17-24. No staff initials on 10-27-24 or 10-31-24. -Clonidine HCL 0.2 mg take by mouth at bedtime. Package date 10-11-24. No staff initials from 10-14-24 until 10-18-24. No staff initials on 10-27-24 or 10-31-24. -Omeprazole 20mg take by mouth every morning. Package date 10-11-24. No staff initials from 10-14-24 until 10-21-24. No staff initials on 10-22-24 through 10-26-24 or on 10-29-24. -Docusate 100 mg take by mouth twice a day. Package date 10-11-24. No staff initials from 10-14-24 until 7pm dose on 10-18-24. No staff initials for doses on 10-19-24. No staff initials for the am doses on 10-20-24, 10-22-24, 10-23-24,	V 118		

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V 118	Continued From page 3	V 118		

10-24-24 or 10-25. No staff initials for the doses on 10-27-24 or 10-31-24. No staff initials for doses from 12-1-24 through 12-6-24 or 1-13-25.
-Dulcolax Chews 1200 mg take by moth every morning, two gummies. No staff initials from 10-14-24 until 7am on 10-21-24. No staff initials from 10-22-24 through 10-26-24 or 10-29-24.

Attempted interview on 1-27-25 with client #2 unsuccessful due to client being non-verbal.

Interview on 1-27-25 with staff #1 revealed:
-"I think there was some issues with [client #2] (client #2's medication administration], not that he (client #2) was not getting his medication, the staff was giving him the meds, but he would spit them (medications) out because he didn't like the taste or texture (of the medications). Now his meds are all liquid and we mixed them with chocolate milk and that (client #2 spitting out his medications) is not a issue any further."

Interview on 1-30-25 with staff #2 revealed:
-"Yes, when he (client #2) came (admitted to the facility) he would spit out the pills, I guess because of his diagnosis, he has Autism and I guess it was a texture thing with him. We (staff) would try to give him his medication and he would take them and spit them out..."
-"Yes, we (staff) documented in the T-logs (electronic system) since we couldn't really tell if he was getting any of the meds."

Interview on 1-24-25 and 1-27-25 with the Qualified Professional/QP revealed:
-"We (staff) were administering him (client #2) his medications but because he was spitting them out we were not sure if he was getting any of the medications or how much of the medications he was actually getting (ingesting). We would give

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V 118	Continued From page 4 him the medication with the [candy] and he would chew it up then spit it out when he got to the pill but the pill would be chewed up, or it would be a half of a pill and the staff couldn't determine how much of the medication he (client #2) actually was getting." -"We really didn't know how to document it (client #2 spitting out his medications). There was nothing on the MAR, nothing in the legend (on the back of the MAR) that addressed medications being spit out. He (client #2) wasn't refusing the medications and we were not missing the medications. When you look on the back of the MARs there is nothing on the back that accurately described what was happening (him spitting out the med)." -"We documented it in the T-Logs. I didn't know we could document it on the MARs." -"Finally his doctor changed his scripts (10-24-24) from pills to liquid and I found a pharmacy that would compound the medications..."	V 118		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider	V 366		

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V 366	Continued From page 5 specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:	V 366		

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V 366	Continued From page 6 (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law.	V 366		

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This Rule is not met as evidenced by:
Based on record review and interviews the facility failed to implement written policy's governing their response to level 1 incidents. The findings are:

Review on 1-24-25 of client #2's MARs for 10-14-24 to 1-24-25 revealed:
-No staff initials to indicate the medication was administered for the following:
-Penicillin VK (Vertrayulich-Potassium) 500 mg. Take by mouth till gone (twice a day). Package date 10-11-24. No staff initials on 10-14-24 thru 10-24-24. No staff initials for the am doses on 10-25-24 or 10-29-24. No staff initials for the pm doses on 10-26-24, and 10-27-24. On 10-28-24 Penicillin was documented as given 3 times (7am, 7pm and initialed under the 7pm time).
-Guanfacine 1 mg take by mouth twice a day. Package date 10-11-24. No staff initials on 10-14-24 through 10-17-24. No staff initials on 10-19-24 or 10-20-24. No staff initials for the am doses on 10-18-24, 10-22-24, 10-23-24, 10-24-24, 10-25-24 or 10-29-24. No staff initials for the pm doses on 10-27-24 or 10-31-24.
-Chlorpromazine HCL 25mg take by mouth twice a day. Package date 10-11-24. No staff initials on 10-14-24 until the 3pm dose on 10-16-24. No staff initials for the am doses on 10-16-24, 10-17-24, 10-18-24, 10-19-24, 10-27-24, 10-30-24 and 10-31-24. No staff initials for the pm doses on 10-27-24, 10-30-24 or 10-31-24.
-Chlorpromazine HCL 75mg take by mouth at bedtime. Package date 10-11-24. No staff initials

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from 10-14-24 until 10-17-24. No staff initials on 10-27-24 or 10-31-24.
-Clonidine HCL 0.2 mg take by mouth at bedtime. Package date 10-11-24. No staff initials from 10-14-24 until 10-18-24. No staff initials on 10-27-24 or 10-31-24.
-Omeprazole 20mg take by mouth every morning. Package date 10-11-24. No staff initials from 10-14-24 until 10-21-24. No staff initials on 10-22-24 through 10-26-24 or on 10-29-24.
-Docusate 100mg take by mouth twice a day. Package date 10-11-24. No staff initials from 10-14-24 until 7pm dose on 10-18-24. No staff initials for doses on 10-19-24. No staff initials for the am doses on 10-20-24, 10-22-24, 10-23-24, 10-24-24 or 10-25. No staff initials for the doses on 10-27-24 or 10-31-24. No staff initials for doses from 12-1-24 through 12-6-24 or 1-13-25.
-Dulcolax Chews 1200 mg take by moth every morning, two gummies. No staff initials from 10-14-24 until 7am on 10-21-24. No staff initials from 10-22-24 through 10-26-24 or 10-29-24.

Review on 1-24-25 of the facility's incident reports for 10-14-24 to 1-24-25 revealed:
-No Risk/Cause/Analysis for incidents regarding missing initials on client #2's medication Administration record (MARs) between 10-14-25 and 1-24-25.

Interview on 1-30-25 with staff #2 revealed:
-"Yes, when he (client #2) came (admitted to the facility) he would spit out the pills, I guess because of his diagnosis, he has Autism and I guess it was a texture thing with him. We (staff) would try to give him his medication and he would take them and spit them out..."
-"No, no we didn't do incident reports because he was taking the medication, we were not missing giving him his meds."

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V 366	Continued From page 9 Interview on 1-24-25 and 1-27-25 with the Qualified Professional revealed: -She was unsure of how to properly document incidents were staff were administering client #2 his medications but client #2 was spitting out his medications. -"We (staff) were administering him (client #2) his medications but because he was spitting them out we were not sure if he was getting any of the medications or how much of the medications he was actually getting (ingesting). We would give him the medication with the [candy] and he would chew it up then spit it out when he got to the pill but the pill would be chewed up, or it would be a half of a pill and the staff couldn't determine how much of the medication he (client #2) actually was getting." -The MAR was left blank when client #2 would spit out his medications. -No incident reports were completed because client #2 was not refusing his medications and the staff was administering the medication. -"No, we didn't do incident reports. We documented it in the T-Logs.."	V 366		