STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL-051-170	A. BUILDING: _____ B. WING _____	R 02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDREN UNDER CONSTR TREATMENT CEN	42 JEWEL LANE FOUR OAKS, NC 27524

(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 2/17/25. The complaint was unsubstantiated (Intake #NC00226460). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents. This facility is licensed for 4 and has a current census of 4. The survey sample consisted of audits of 3 current clients.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross,	V 108		

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V 108	Continued From page 1 the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 3 of 3 audited staff (#1, Qualified Professional (QP), and House Manager) received training to meet the MH/DD/SA needs of the clients. The findings are: Review on 2/12/25 of staff #1's personnel record revealed: - Hired: 2/28/23 - Title: Direct Care Staff - No documentation of diabetes management and insulin administration training Review on 2/12/25 of the House Manager's personnel record revealed: - Hired: 5/3/24 - No documentation of diabetes management and insulin administration training Review on 2/12/25 of the QP's record revealed: - Hired: 5/25/12 - No documentation of diabetes management and insulin administration training Interview on 2/12/25 client #2 reported: - Been a diabetic since he was 5 years old	V 108		

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V 108	Continued From page 2 - He wore a monitor that tracked his blood sugar levels - He used his insulin pen daily usually when he ate or his blood sugar (BS) was high Interview on 2/7/25 the House Manager reported: - Client #1 was diabetic - He wore a monitor that checked his BS levels - The staff documented his BS readings that were done at the facility in the evenings and on the weekends Interviews on 2/12/25 the Chief Executive Officer (CEO) reported: - He reached out to his Registered Nurse (RN) around September 2024 about diabetes training, but she was going out of the countryd at that time - His RN was an Independent Contractor that did all of his medication trainings - No follow up call to the RN was made since that initial phone call last Sept. 2024 - He would give the RN a call to schedule a training This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 108		
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	V 117		

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V 117	Continued From page 3 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 (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 record review, observation and interview, the facility failed to ensure the packaging label of each prescription drug had the current dispensing and expiration date affecting 1 of 3 audited clients (#2). The findings are: Review on 2/7/25 of client #2's record revealed: - Admitted: 5/14/24 - Age: 17 years old - Diagnoses: Diabetes, Major Depressive Disorder, and Posttraumatic Stress Disorder (PTSD) - Physician order dated 7/29/24 revealed: - Gvoke HypoPen 1 milligram (mg)/0.2 milliliter (ml), as needed, (Diabetes)	V 117		

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V 117	Continued From page 4 Observation on 2/7/25 approximately 3:00pm of the Gvoke HypoPen label revealed: - dispensed 12/13/23 - discard 12/14/24 - 2 refills remaining until 12/12/24 Observation on 2/7/25 approximately 3:00pm of the Gvoke HypoPen medication revealed: - expired 5/2025 Interview on 2/7/25 the House Manager reported: - this was the box the medication came in when client #2 was admitted - she normally checked for expired medications monthly - she had never checked the Gvoke HypoPen and "I just assumed it was up to date" - His social worker took him to the endocrinologist every 3 months Interview on 2/12/25 the Chief Executive Officer reported: - stated that he was not always at the facility and the house manager was responsible for checking medications - "It should be me" checking behind the house manager to make sure medications were correct - "Life be lif'n" but he would start checking again and "will do better"	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	V 118		

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CHILDREN UNDER CONSTR TREATMENT CEN	42 JEWEL LANE FOUR OAKS, NC 27524

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V 118	Continued From page 5 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 with a physician. This Rule is not met as evidenced by: Based on record review, observation and interview the facility failed to have a written authorization for a client to self-administer his medication affecting 1 of 3 audited clients (#2) and to administer medications on the written order of a physician affecting 2 of 3 audited clients (#3, #4). The findings are:	V 118		

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V 118	Continued From page 6 A. Review on 2/7/25 of client #2's record revealed: - Admitted: 5/14/24 - Age: 17 years old - Diagnoses: Diabetes, Major Depressive Disorder, and Posttraumatic Stress Disorder (PTSD) - Physician order dated 7/29/24 revealed: - Humalog JR 100 unit, use as directed up to maximum daily dose of 50 units (diabetes) - Insulin Glargine Solostar U100, use as directed up to maximum daily dose of 50 units (diabetes) - Gvoke HypoPen 1 milligram (mg)/0.2 milliliter (ml), inject 0.2 ml under the skin as needed (diabetes) - no written authorization from a physician to self-administer his insulin Interview on 2/7/25 client #2 reported: - staff gave him his medications except his insulin - he administers his insulin himself because "I know how to do it" Interview on 2/7/25 the House Manager reported: - she gave the client's their medications - client #2 did his insulin himself - "it has been that way since he was admitted" Interview on 2/12/25 the Chief Executive Officer reported: - client #2 had diabetes and carried his insulin pen on him daily - he's been giving himself his insulin since he came to the facility - his guardian said that he could give himself his insulin - if there was a physician'sorder for him to give it to himself, his guardian would have it	V 118		

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V 118	Continued From page 7 Interview on 2/14/25 the Diabetes Educator reported: - Gvoke was the emergency pen for client #2 - he was supposed to carry this pen at all times for emergencies - someone else was supposed to give him the injection because he would only use this pen in an emergency - she would have the doctor draft a letter stating that client #2 was to carry his emergency pen at all times B. Review on 2/7/25 client #3's record revealed: - Admitted: 7/3/24 - Age: 13 years old - Diagnosis: Oppositional Defiant Disorder - no physician order for Fluticasone HFA 44mcg (microgram), inhale 2 puffs/rinse mouth after use (nasal congestion) Review on 2/7/25 of client #3's February 2025 MAR revealed: - Fluticasone HFA 44mcg - signed off by staff as medication being administered C. Review on 2/7/25 client #4's record revealed: - Admitted: 4/24/24 - Age: 17 years old - Diagnoses: Attention-Deficit Hyperactivity Disorder, Borderline Intellectual Functioning, Disruptive Impulse Control and Conduct Disorder, Schizophrenia, and Disruptive Mood Dysregulation Disorder - no physician order for the medications listed below Review on 2/7/25 of February 2025's MAR revealed:	V 118		

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V 118	Continued From page 8 - Fluvoxamine Maleate 50mg tablet (tab), 1 tab at bedtime (anxiety) - Lamotrigine 100mg tab, 1 tab daily (mood) - Olanzapine 20mg, 1 tab at bedtime (antipsychotic) - Vyvanse 30mg, 1 capsule (cap) daily (impulsiveness) - Vitamin D 50 mcg, 1 tab daily (supplement) - all medications except the Vitamin D was signed off by staff as medications being administered Observation on 2/7/25 approximately 3:30pm revealed: - no Vitamin D was in client #4's medication box or in the facility Interview on 2/7/25 the House Manager reported: - she was responsible for checking to make sure medications were correct - all physician order's should have been in the client's records - they had been waiting on the pharmacy since August 2024 for client #4's Vitamin D refill - she asked the pharmacist, and they kept saying that it was waiting on an authorization - Client #4 was at a previous doctor before, so she didn't know how to go about getting the authorization - She could ask the guardian because, "I didn't know to do that" to try and get it authorized or discontinued Interview on 2/12/25 the Chief Executive Officer reported: - the House Manager was responsible for checking the medications and orders - "It should be me" checking behind the house manager to make sure medications were correct - "Life be lif'n" but he stated that he would start	V 118		

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V 118	Continued From page 9 checking again and "will do better" - most of the guardians had the physician orders and he would speak with them about getting them for the records This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118		
V 120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. This Rule is not met as evidenced by: Based on observation, record review & interview, the facility failed to ensure all medications were	V 120		

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V 120	Continued From page 10	V 120		

stored appropriately for 1 of 3 audited clients (#2). The findings are:

Review on 2/7/25 of client #2's record revealed:
- Admitted: 5/14/24
- Age: 17 years old
- Diagnoses: Diabetes, Major Depressive Disorder, and Posttraumatic Stress Disorder (PTSD)
- Physician order dated 7/29/24 revealed:
  - Humalog 100 units, use as directed up to maximum daily dose of 50 units (Diabetes)

Observation on 2/12/25 at approximately 2:15pm revealed:
- Client #2 retrieved his daily insulin injection pen out of his pants pocket

Interview on 2/12/25 client #2 reported:
- Diagnosed with diabetes at 5 years old
- He wore a monitor that tracked his blood sugar (BS) levels
- Always carried his insulin pen with him
- He used his insulin pen every day when he ate or when his BS was high
- He knew when his BS was high because his "teeth start shaking" and he would get nauseous

Interview on 2/7/25 the House Manager reported:
- Medications were to be stored and locked in the facility
- Client #2 kept his insulin pen with him at all times

Attempted interview of client #2's guardian on 2/12/25 at 10:30am and 2/13/25 at 12:25pm and was unsuccessful. Voicemail messages were left.

Interview on 2/12/25 the Chief Executive Officer (CEO) reported:

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V 120	Continued From page 11 - Medications were supposed to be stored and locked in the facility - Client #2 had diabetes and carried his insulin pen on him daily - He would make sure that client #2 was carrying the correct pen with him - He would make sure that he spoke with client #2's guardian about getting a letter from the doctor in reference to the use of the insulin pen by client #2 This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 120		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility was not maintained in an attractive and clean manner. The findings are: Observation on 2/7/25 approximately 11:20am revealed: Client #1: - round indentation in his wall behind his door that was not completely a hole - line of peeling paint going down his wall behind his door - 2 patched areas on his wall that were not smoothed out	V 736		

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V 736	Continued From page 12 Client #2 & #3's bedroom: - bedroom door had multiple scratches, brown stains and cracks - several white patches on the walls throughout the room of various sizes Client #2 & 3's bathroom: - several slats from the blinds were missing or bent - 1 out of 3 lightbulbs was missing Client #4's bedroom: - hole in the wall behind his door about the size of a softball - blinds had a couple of broken and missing slats Hallway bathroom: - vent in ceiling was covered with dust - towel bar was missing on the wall by the sink - brown stains on the wall around the light switch - peeling paint on the wall at the top of the front of the shower - missing shower head Living Room: - white patches behind single chair - white patch and some chipped paint on the edge of the wall by the single chair Kitchen and Dining Room: - missing wooden trim on the front of the counter closer to the refrigerator - deep freezer with several pieces of tape on the top of it and multiple dents in the front Exterior: - Large black SUV with a flat tire on the passenger front and a flat tire on the passenger	V 736		

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V 736	Continued From page 13 rear causing the SUV to lean to one side Interview on 2/7/25 the Chief Executive Officer reported: - Was responsible for overseeing the repairs in the facility - Clients were always "destroying" the facility - As soon as he got something fixed, the clients would tear it up again - It wasn't a need in getting things fixed if they were going to keep breaking them - He knew that he would keep getting cited for this - He needed to get the title for the SUV so that he could have it towed, and he planned on doing that soon This deficiency has been cited 7 times since the original cite on 4/12/19 and must be corrected within 30 days.	V 736		