. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP		
					R		
	MHL078-170		B. WING		05/02/2019		
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE			
CHADAD	DAL VOLITH SERVIC	5973 MCI	EOD DRIVE				
CHAPAR	RAL YOUTH SERVIC	es, LLC MAXTON	, NC 28364				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TION SHOULD BE THE APPROPRIATE		
V 000	INITIAL COMMENT	-S	V 000				
		w-up survey was completed deficiency was cited.					
	category: 10A NCA	sed for the following service C 27G .1700 Residential cure For Children or					
V 118	27G .0209 (C) Med	ication Requirements	V 118				
	only be administered order of a person andrugs. (2) Medications shat clients only when an client's physician. (3) Medications, included and individual of the privileged to prepare (4) A Medication Administered only bunlicensed persons pharmacist or other privileged to prepare (4) A Medication Administer current. Medication recorded immediate MAR is to include the (A) client's name; (B) name, strength, (C) instructions for (D) date and time the (E) name or initials drug.	inistration: non-prescription drugs shall ad 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, a legally qualified person and and administer medications. Ininistration Record (MAR) of a de to each client must be kept a sadministered shall be ally after administration. The and quantity of the drug; and quantity of the drug; and drug is administered; and of person administering the					
	(5) Client requests to checks shall be rec	for medication changes or orded and kept with the MAR appointment or consultation					

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL078-170	B. WING			R 02/2019
	PROVIDER OR SUPPLIER	ES LLC 5973 MC	DDRESS, CITY, S CLEOD DRIVE N, NC 28364	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From pa with a physician.	ge 1	V 118			
	interview, the facilit medications on the and failed to keep t	et as evidenced by: view, observation and y failed to administer written order of a physician he MARs current affecting two ents (#1 and #2). The findings				
	revealed: - 15 year old male Admission date of - Diagnoses of Pos	9 of client #1's record f 12/27/18. t Traumatic Stress Disorder od Dysregulation Disorder.				
	medication orders of a Guanfacine (treats milligrams (mg) - 1 - Fluticasone (Flona 1 spray in each nos - Hydroxyzine (treat every evening Quetiapine (antips at bedtime Trazodone (antide tablet at bedtime.	ase-treats seasonal allergies)	t			
		9 of client #1's March 2019 Rs revealed the following				

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Division	of Health Service Re	egulation					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
MHL078-170		B. WING		R 05/02/2019			
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CHAPARRAL YOUTH SERVICES LLC 5973 MCL			EOD DRIVE NC 28364				
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETE	
V 118	Continued From pa	ge 2		V 118			
	blanks for staff sign medication adminis March 2019 - Guanfacine - 03/2 03/31/19 Fluticasone - 03/2 03/26/19 x 1 and 03 - Hydroxyzine - 03/2 03/31/19 Quetiapine - 03/26 03/31/19 Trazodone - 03/26 03/31/19 Loratadine - 03/02 03/07/19, 03/09/19, 03/17/19, 03/19/19, 03/26/19 thru 03/31 April 2019 - Guanfacine - 04/2 - Fluticasone - 04/2 - Fluticasone - 04/2 - Trazodone - 04/2 - Trazodone - 04/25/19, 04/27/19 Interview on 05/01/19 interview on 05/01/19 interview on 05/01/19 revealed: - 17 year old male Admission date of - Diagnoses of Atte Disorder (ADHD), 0 Intermittent Explosi	natures and/ortration: 3/19 and 03/ 3/19 x 1, 03/ 3/29/19 thru 026/19 and 03/2 6/19 and 03/2 6/19 and 03/2 6/19 and 03/2 6/19 and 03/2 6/19, 03/03/19, 03/ 6/19, 03/20/19, 03/ 6/19 and 04/ 6/19 thru 04/0 6/19, 04/27/19 6/19 thru 04/0 6/19	30/19 thru 24/19 x 1, 03/31/19 x 2, /28/19 thru 28/19 thru 28/19 thru 28/19 thru 9, 03/05/19, 3/12/19 thru 3/22/19, 03/23/19, 28/19. 27/19 thru 9 and 04/28/19, 04/19, 04/06/19, ou 04/23/19, ou outper care es record Hyperactivity				

STATE FORM 6899 If continuation sheet 3 of 5 1C2I11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		A. BOILDING.		R		
		MHL078-170	B. WING			2/2019
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY, S	STATE, ZIP CODE		
CHAPAR	RAL YOUTH SERVIC	FS. LLC	EOD DRIVE NC 28364			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
V 118	Continued From pa	ge 3	V 118			
V 118	Review on 05/01/19 medication orders in 04/22/19 - Adderall (treats Aldaily Aripiprazole (treat daily Omeprazole (treat 1 tablet daily Sertraline (antider tablet daily Melatonin (assists daily at bedtime Gabapentin (treat tablet daily at bedtime. Review on 05/01/19 revealed the followin	9 and 05/02/19 of client #2's revealed: DHD) 30mg - take 1 tablet s Bipolar) 15mg - take 1 tablet ts reflux disease) 20mg - take pressant) 100mg - take 1 s with sleep) - take 1 tablet s neuropathic pain) - take 1	V 118			
	administration: - Addreall - 04/20/1 out, 04/27/19 and 0 - Aripiprazole - 04/0 thru 04/26/19 - med - Omeprazole - 04/1 medication out, 04/ Sertraline - 04/13/ medication out, 04/ Melatonin - 04/25/ Gabapentin - 04/2 medication out, 04/ Interview on 05/01/ his medications as Interview on 05/01/ Professional stated - She was aware th	9 thru 04/23/19 - medication 4/28/19. 06/19, 04/07/19 and 04/20/19 dication out. 20/19 thru 04/22/19 - 27/19 and 04/28/19. 19, 04/20/19 thru 04/23/19 - 27/19 and 04/28/19. 19, 04/27/19 and 04/28/19. 27/19 and 04/28/19 - 27/19 and 04/28/19. 27/19 and 04/28/19. 19 client #2 stated he received ordered.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:		(X3) DATE COME	(3) DATE SURVEY COMPLETED	
MHL078-170		B. WING R 05/02/2		R 02/2019		
	PROVIDER OR SUPPLIER	ES LLC 5973 MCL	DRESS, CITY, S EOD DRIVE NC 28364	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 118	- Client #2 had run days Client #2's physici during the recent he She would ensure the facility with scrip Due to the failure to medication adminis	out of his medication for a few an would not fill medications bliday. new clients are admitted to ots for medications. accurately document tration it could not be sereceived their medications	V 118			

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Division of Health Service Regulation STATE FORM