		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		A. BUILDING:		R				
MHL011-369		B. WING		06/17/2019				
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE				
CYNTHIA	CYNTHIA'S PLACE 45 EYE VIEW ROAD							
(VA) ID	CHMMA DV CTA	TEMENT OF DEFICIENCIES	R, NC 28715	PROVIDER'S PLAN OF CORRECTI	ON	(VE)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE		
V 000	INITIAL COMMENT	rs	V 000					
	An annual and follo on 6/17/19. Deficie	w up survey was completed encies were cited.						
	This facility is licensed for the following service categories: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.							
V 123	27G .0209 (H) Medication Requirements		V 123					
	10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted.							
	This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure medication errors were reported immediately to a physician or pharmacist affecting 2 of 4 clients (Client #1 and Client #3). The findings are:							
	Record review on 6/13/19 for Client #1 revealed: -Admission date on 1/31/19 with diagnoses of Adjustment Disorder, Oppositional Defiant Disorder (ODD), Attention Deficit Hyperactivity Disorder (ADHD) and Neurodevelopmental DisorderAge-15 years -Ordered medications included Vyvanse for							

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
				F	₹	
		MHL011-369	B. WING			7/2019
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CVNTUI	A'S PLACE	45 EYE VI	EW ROAD			
CTNTHI	A 5 PLACE	CANDLER	R, NC 28715			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
V 123	Continued From pa	ge 1	V 123			
	ADHD, Clonidine for ADHD, Latuda for depression, Trazadone for depression, Clotrimazole for rash, Griseofulvin Ultra for fungal infection and Gavilax Powder for constipation. Record review on 6/13/19 for Client #3 revealed: -Admission date on 4/10/19 with diagnoses of Mild Intellectual Disability, ADHD and Post-Traumatic Stress Disorder (PTSD)Age-15 years -Ordered medications included Vyvanse for ADHD, Aripiprazole for depression, Divalproex for behaviors, Lithium Carbonate for bipolar, Melatonin for sleep, Clonidine for ADHD, Neutrogena Cream for rash, Clindamycin for acne and Hydroxyzine for anxiety.					
	Review on 6/13/19 of incident reports from January - May 2019 revealed: -6 reports of missed medications -On 1/21/19 Client #1 missed a medication. No specific medication was listed and no documentation of physician or pharmacist contactOn 2/3/19 Client #3 missed a medication. No specific medication was listed and no documentation of physician or pharmacist contact. Interview on 6/14/19 with the Associate Professional (AP) revealed: -He was responsible for supervising staff in this					
	homeHe had trained staff to document incident reports for any missed or refused medications as soon as it is realized or discovered as well as contacting a pharmacist or physicianHe was not aware staff had not completed the entire report but thought staff had probably contacted the pharmacist.					

Division of Health Service Regulation

STATE FORM 6899 JBWS11 If continuation sheet 2 of 6

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
				R		
		MHL011-369	B. WING		06/1	7/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CYNTHIA	A'S PLACE		IEW ROAD R, NC 28715			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	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)	LD BE	COMPLETE DATE
V 123	Continued From pa	ge 2	V 123			
		ning staff to make that and document completely on is missed.				
V 294	27G .1702 Residen P	tial Tx. Child/Adol -Req. for Q	V 294			
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Division of Health Service Regulation

STATE FORM 6899 JBWS11 If continuation sheet 3 of 6

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		A. BUILDING:			R		
MHL011-369		B. WING			06/17/2019		
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE			
CYNTHIA	A'S PLACE		IEW ROAD R, NC 28715				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
V 294	(2) oversight (3) provision services to children (4) participati meetings; (5) coordinat adolescent's treatm	of emergencies; of direct psychoeducational or adolescents; ion in treatment planning ion of each child or	V 294				
	This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure the qualified professional (QP) performed a minimum of 10 hours per week of clinical and administrative services in the facility, 70% of the time when clients were awake and present. The findings are: Record review on 6/13/19 for QP revealed: -Date of hire-5/8/14 -Job descriptions for both QP and Associate Professional (AP).						
	-Documentation of 2/25/19-3/3/19Documentation of 3/4/19-3/10/19Documentation of 3/11/19-3/17/19. No other document was available.	of QP log revealed: 10 or more hours for 10 or more hours for 10 or more hours for ation of QP time in the facility 9 with the AP revealed:					

Division of Health Service Regulation

STATE FORM 6899 JBWS11 If continuation sheet 4 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
MHL011-369		B. WING			R 06/17/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CYNTHIA	A'S PLACE		EW ROAD R, NC 28715			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 294	-The QP had been playing basketball tinjury just 2 days prothe documentation May 2019 with him him with work concumentation He and the QP wouthis facility and a sist switched QP/AP roleacility more than the Interview on 6/13/11 revealed: -The QP was in the	involved in a horrific accident hat involved a severe head for. He felt like the QP had of facility time for March thru but was reluctant to bother erns. rked well together between ster facility where they les. They both were in the ne required time. 9 with Clients #1 and #2 facility at least twice weekly.	V 294			
V 297	27G .1705 Residential Tx. Child/Adol - Req. for L P 10A NCAC 27G .1705 REQUIREMENTS OF LICENSED PROFESSIONALS (a) Face to face clinical consultation shall be provided in each facility at least four hours a week by a licensed professional. For purposes of this Rule, licensed professional means an individual who holds a license or provisional license issued by the governing board regulating a human service profession in the State of North Carolina. For substance-related disorders this shall include a licensed Clinical Addiction Specialist or a certified Clinical Supervisor. (b) The consultation specified in Paragraph (a) of this Rule shall include: (1) clinical supervision of the qualified professional specified in Rule .1702 of this Section; (2) individual, group or family therapy services; or		V 297			

Division of Health Service Regulation

STATE FORM 6899 JBWS11 If continuation sheet 5 of 6

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
MHL011-369		B. WING			R 17/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, S	STATE, ZIP CODE		
CYNTHIA	A'S PLACE		/IEW ROAD R, NC 28715			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 297	specific treatment prissues.	ent in child or adolescent plans or overall program	V 297			
	failed to ensure ser Addiction specialist Supervisor for clien	and record review, the facility vices from a licensed Clinical or a certified Clinical ts with substance-related 1 of 4 current clients (Client				
	Record review on 6/13/19 for Client #2 revealed: -Admission date on 12/3/18 with diagnoses of Oppositional Defiant Disorder and Cannabis Use DisorderAge-14 years					
	(AP) revealed: -The LP was a Lice (LCSW)He was not aware	9 with Associate Professional nsed Clinical Social Worker they needed to refer clients issues to substance abuse				

Division of Health Service Regulation STATE FORM

JBWS11 If continuation sheet 6 of 6