SUMMARY STA CH DEFICIENCY SULATORY OR LS - COMMENT L COMMENT Mual, Compla	SERVICES, INC 105 ROB WILLIAM	B. WING DRESS, CITY, S <sup>-</sup> ERSON DRIVE STON, NC 27 ID PREFIX TAG	E	
SUMMARY STA CH DEFICIENCY SULATORY OR LS COMMENT	SERVICES, INC       105 ROB WILLIAM         TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ERSON DRIVE STON, NC 27 ID PREFIX TAG	892 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLET
SUMMARY STA CH DEFICIENCY SULATORY OR LS - COMMENT L COMMENT Mual, Compla	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	STON, NC 27	892 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLET
CH DEFICIENCY SULATORY OR LS COMMENT Sual, Compla	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLET
ual, Compla eted on June		V 000		
eted on June	int and Follow Up Survey was			
ncies were c cility is licens ry: 10A NCA	ed for the following service C 27G .1700 Residential			
205 (C-D) sment/Treatn	nent/Habilitation Plan	V 112		
MENT/HABI e plan shall b ment, and in responsible ission for clice services be e plan shall i ent outcome( ed by provisioned ategies; iff responsiblischedule for r ly in consulta sible person sis for evalua ne achievement sible party, o	LITATION OR SERVICE be developed based on the partnership with the client or person or both, within 30 days ents who are expected to yond 30 days. nclude: s) that are anticipated to be on of the service and a chievement; e; review of the plan at least titon with the client or legally or both; ation or assessment of ent; and or agreement by the client or or a written statement by the			
ried 28 CT earriseeeeadahseatsee	y: 10A NCA ent Staff Sec cents 205 (C-D) ment/Treatn AC 27G .02 MENT/HABI plan shall to ment, and in esponsible ssion for clic services be plan shall i nt outcome( d by provision date of ac tegies; f responsibl chedule for i y in consulta sible person is for evalua e achievement sible party, or r stating why	y: 10A NCAC 27G .1700 Residential ent Staff Secure For Children or cents 205 (C-D) ment/Treatment/Habilitation Plan AC 27G .0205 ASSESSMENT AND MENT/HABILITATION OR SERVICE e plan shall be developed based on the ment, and in partnership with the client or esponsible person or both, within 30 days ssion for clients who are expected to services beyond 30 days. e plan shall include: nt outcome(s) that are anticipated to be d by provision of the service and a ed date of achievement; ttegies; f responsible; chedule for review of the plan at least y in consultation with the client or legally sible person or both; is for evaluation or assessment of e achievement; and ten consent or agreement by the client or sible party, or a written statement by the r stating why such consent could not be d.	y: 10A NCAC 27G .1700 Residential ent Staff Secure For Children or cents V112 V112 Co5 (C-D) V112 AC 27G .0205 ASSESSMENT AND MENT/HABILITATION OR SERVICE e plan shall be developed based on the ment, and in partnership with the client or esponsible person or both, within 30 days ssion for clients who are expected to services beyond 30 days. e plan shall include: nt outcome(s) that are anticipated to be d by provision of the service and a ed date of achievement; ttegies; f responsible; chedule for review of the plan at least y in consultation with the client or legally sible person or both; is for evaluation or assessment of e achievement; and ten consent or agreement by the client or sible party, or a written statement by the r stating why such consent could not be d.	y: 10A NCAC 27G .1700 Residential ant Staff Secure For Children or sents 205 (C-D) V112 Went/Treatment/Habilitation Plan AC 27G .0205 ASSESSMENT AND MENT/HABILITATION OR SERVICE 1 plan shall be developed based on the ment, and in partnership with the client or esponsible person or both, within 30 days sesion for clients who are expected to services beyond 30 days. • plan shall include: in outcome(s) that are anticipated to be d by provision of the service and a ed date of achievement; tegies; f responsible; -hedule for review of the plan at least y in consultation with the client or legally ible person or both; is for evaluation or assessment of e achievement; and ten consent or agreement by the client or islep arty, or a written statement by the r stating why such consent could not be d.

Division of H	lealth Service Re	egulation				i oran	/
STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMI			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		MHL058-022		B. WING			२   <b>4/2021</b>
NAME OF PROV	IDER OR SUPPLIER	5	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
			105 ROBE	RSON DRIV	E		
AWANI RESI	DENTIAL/HUIWIAN	I SERVICES, INC	WILLIAMS	STON, NC 2	7892		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FI SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 112 Co	ntinued From pa	ge 1		V 112			
Bas dev trea #20 Re De Stru his Re dat dis pro wa: Fac	sed on record re velop and implem atment plan for o ). The findings a view on 06/02/27 -Admitted: 05/0 -Discharged: 07 -Diagnoses: Co ficit Hyperactivity ess Disorder, He tory. view on 06/02/27 view on 06/02/27 view on 06/02/27 ed 05/20/20 reve -Previous level rupted due to ag perty, defiance a -Prior to admiss s in a PRTF (Ps) cility) setting in A -Listed goals th he following disc	1 of FC #20's record re 4/20 2/15/21 onduct Disorder, Attent / Disorder, Post Traum eart Murmur and Negle 1 of FC #20's treatmen ealed: III residential placeme gression, destruction of and lack of progress. sion to this group homo ychiatric Residential Tr ugust 2019 lat included reduce syr orders such as Conduc	nts (FC evealed: tion natic ect per nt plan ent of e, he reatment mptoms ct and				
ski	lls/competencies	peractivity and increas related to transitioning	g to the				
	-No updates or	revisions since 05/20/	/20				
sta	ted the following -Was "very goo hnology	/21 the Associate Profe about FC #20: d" with electronics and 'hacked into the					
Division of Health	Service Regulation						

STATE FORM

Division	of Health Service Re	egulation			FORM	APPROVED	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY IPLETED	
				R / <b>14/2021</b>			
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE			
AMANI R	ESIDENTIAL/HUMAN	SERVICES INC	ERSON DRIVE				
		WILLIAM	ISTON, NC 278				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE	
V 112	Continued From pa	ge 2	V 112				
	Staff were not sure pass the password computer/internet a their guardians had Interview on 06/02/2 stated the following -Several incident the school (sending teachers, looking up home (obtaining co- cell phones) that inv as FC #20 -Was discharge reasons including h HIPPA (Health Insu Accountability Act) is contacted law enfor via the internet to re hospital. FC #20 did information he had how he was able to place. -Treatment team Services guardian, staff) members wer accessed computer	nts occurred that involved both i inappropriate emails to o personal information) and mputer passwords, hacking volved cyber security as well ed on 02/15/21 for various e threatened to disclose rance Portability and nformation of his peers, recement and political figures eport he wanted to go to the d not share specific obtained about his peers or get pass security measures in m (Department of Social Managed Care Organization e aware that client had rs at home and school. The s strategies or develop					
V 121	10A NCAC 27G .02 REQUIREMENTS (f) Medication revie (1) If the client rece	w: ives psychotropic drugs, the	V 121				
		operator shall be responsible w of each client's drug					

Division of Health Service Regulation STATE FORM

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If continuation sheet 3 of 6

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY		
MHL058-022		A. BUILDING:		COMPLETED		
		B. WING			R 14/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	RESIDENTIAL/HUMAN	SERVICES INC	ERSON DRIVE			
		WILLIAN	ISTON, NC 27			
(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 ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 121	Continued From pa	ge 3	V 121			
regimen at least every shall be to be perform physician. The on-site the client's physician i the review when medi (2) The findings of the		ery six months. The review rmed by a pharmacist or site manager shall assure that n is informed of the results of edical intervention is indicated. the drug regimen review shall client record along with				
	failed to assure two who received psych	et as evidenced by: view and interview, the facility of four clients (#1 and #2) notropic drugs obtained a drug east every six months. The				
	revealed: -Admitted: 05/0 -Diagnoses: Ma Attention Deficit Hy and History of self h -Age: 16	ajor Depressive Disorder, peractivity Disorder (ADHD) narm				
	following psychotro psychiatric disorder Zoloft 25 m (used to treat depre Adderal XL	g (milligram) one tablet daily ession) 25 mg one tablet in the				
	Record listed initials given	1 Medication Administration s Zoloft and Adderal were f psychotropic drug review				

Division of Health Service Regulation STATE FORM

6899

STATEMEN	of Health Service Re TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL058-022		B. WING			R 06/14/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
AMANI R	RESIDENTIAL/HUMAN	I SERVICES INC	ERSON DRIVE			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
V 121	Continued From pa	age 4	V 121			
	revealed: -Admitted: 06/1 -Diagnoses: Ma ADHD and Opposit -Age: 17 -Physician's ord Lamotrigine 100 mg Bipolar disorder and -Physician's ord Trazadone 100 mg (antidepressant and Depression) -Physician's ord Vyvanse 70 mg ond ADHD) -March-April 20 Record listed initial Vyvanse were given -No evidence of completed by pharr During interview on Professional stated -He was aware 2019 by the Divisio for not completing to review -The agency ut pharmacy to fill clie -He had spoken pharmacist regarding review. The pharma do or what was req -No psychotrop completed for clien	ajor Depressive Disorder, tional Defiant Disorder der dated 10/20/20 listed g one tablet daily (used to treat d seizures) der dated 11/18/20 listed one tablet at night d sedative used to treat der dated 11/20/20 listed e tablet daily (used to treat 021 Medication Administration s Lamotrigine, Trazadone, n of psychotropic drug review macist or physician a 06/01/21, the Associate l: the facility had been cited in n of Health Service Regulation the psychotropic medication the psychotropic medication silized a national chain on with the national chain ng a psychotropic medication acist was not aware of what to uired. bic medication review had been				
		e medication reviews				

STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	OF CORRECTION	DENTIFICATION NOMBER.	A. BUILDING:			
MHL058-022		B. WING			R <b>14/2021</b>	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
MANI R	ESIDENTIAL/HUMAN	A SERVICES INC	BERSON DRIVE			
			ISTON, NC 27	PROVIDER'S PLAN OF	CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 121	Continued From pa	age 5	V 121			
	medication reviews -He did not hav medication reviews physician This deficiency con	nysicians completed				