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Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:		
		MHL080-214	B. WING		08/3	R 80/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
TGH RESI	DENTIAL SERVICES		ONCORD ROA Y, NC 28144	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	completed on 8/30/21	and complaint survey was . The complaint was 179802). Deficiencies were				
		d for the following service 27G .1700 Residential re for Children or				
V 114	27G .0207 Emergend	y Plans and Supplies	V 114			
	AND SUPPLIES (a) A written fire plan area-wide disaster plashall be approved by authority. (b) The plan shall be and evacuation proceposted in the facility. (c) Fire and disaster coshall be held at least repeated for each shi under conditions that	an shall be developed and				
	facility failed to ensure	iew and interviews. the e Fire and disaster drills in a neld at least quarterly and ft. The findings are: with the Qualified				

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MIII 000 044	B WING		R
		MHL080-214	D: 11110		08/30/2021
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA		
TGH RESIDENTIAL SERVICES		OCONCORD ROA URY, NC 28144	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 114	Continued From page	e 1	V 114		
	-1st shift 7am-3pm; -2nd shift 3pm-11pm; -3rd shift 11pm-7am;				
	-done a fire drill; -don't remember the l	with client #1 revealed: ast time;			
	-done a tornado drill -go in a room with no windows and in the closet. Interview on 8/25/21 with client #2 revealed: -not done any drills; -don't remember last time did any drills.				
		with client #3 revealed: In the middle of the night; minute;"			
	Interview on 8/23/21 -been here 3-4 month -work 2nd shift 230pm				
	Interview on 8/26/21 started at this facility -not done any drills ye				
	Review on 8/26/21 of disaster drill documer revealed: -no 3rd shift fire drill f-no 1st or 2nd shift di 1/1/21-3/31/21;	ntation from 8/1/20-8/26/21 rom 1/1/21-3/31/21;			
	-no 1st and 3rd shift of 4/1/21-6/30/21; -no disaster drills from				
	Interview on 8/30/21	with the Director revealed:			

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-thought had to only do one disaster drill every

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		MHL080-214	B. WING		R 08/30/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	
	DENEMA 050/4050	328 OLD	CONCORD ROAD		
IGH RESI	DENTIAL SERVICES	SALISBU	JRY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
V 114	Continued From page	: 2	V 114		
	three months; -will ensure drills com This deficiency consti and must be corrected	tutes a re-cited deficiency			
V 118	27G .0209 (C) Medica	ation Requirements	V 118		
	only be administered order of a person authorugs. (2) Medications shall clients only when authorient's physician. (3) Medications, inclusion administered only by unlicensed persons to the privileged to prepare and the	stration: n-prescription drugs shall to a client on the written norized by law to prescribe be self-administered by norized in writing by the ding injections, shall be licensed persons, or by ained by a registered nurse, regally qualified person and and administer medications. inistration Record (MAR) of it to each client must be kept administered shall be after administration. The following:			

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with a physician.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		MHL080-214	B. WING		R 08/30/2021
NAME OF PE	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
TGH RESI	DENTIAL SERVICES		CONCORD ROA	ND.	
			JRY, NC 28144		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
V 118	Continued From page	e 3	V 118		
	interviews, the facility medications were adr written order of a pers prescribe drugs, a Me Record (MAR) of all of client was kept currer administered shall be administration affectir #3). The findings are: Finding #1: Review on 8/26/21 arrecord revealed: -admission date of 5/2-diagnoses of PTSD(IDisorder), DMDD(Dis Disorder), DMDD(Dis Disorder), ODD(Oppo ADD(Attention Deficit Trauma and Stressor-physician's order dat 10mg one tablet in the-physician's order dat 25mg one tablet a nig-physician's order dat 1mg one tablet at night Observations on 8/26 medications revealed -fluoxetine 10mg one 8/1/21; -hydroxyzine 25mg of	riew, observations and failed to ensure ministered to a client on the son authorized by law to edication Administration drugs administered to each and medications recorded immediately aftering 3 of 3 clients(#1, #2 and and 8/27/21 of client #1's 24/21; Post Traumatic Stress ruptive Mood Dysregulation ositional Defiant Disorder), Disorder) and Unspecified Related; red 7/15/21 for fluoxetine e am; red 6/26/21 for hydroxyzine sht; red 6/26/21 for Melatonin ht.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			7. DOILDING.		R	
		MHL080-214	B. WING		08/30/2	2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
TGH RESIDENTIAL SERVICES		CONCORD ROA JRY, NC 28144	AD			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	Continued From page	÷ 4	V 118			
	5/1/21-8/26/21 reveal -fluoxetine 10mg one May 2021 MAR, not listed on July 20 MAR with administrat -hydroxyzine 25mg or documented as administed on Aug-Melatonin 1mg one transparent documented as administration of the Aug-Melatonin 1mg one transparent documented as administration of the Aug-Melatonia one transparent documented as administration on the Aug-Melatonia one transparent documented as administration on the Aug-Melatonia on the Aug-Melatonia on the Aug-Melatonia one transparent documented as administration on the Aug-Melatonia on th	tablet in the am listed on isted on June 2021 MAR 21 MAR and August 2021 ion as ordered; he tablet a night histered from 7/1/21-7/31/21 just 2021 MAR; ablet at night not on site histered from 7/1/21-7/31/21 just 2021 MAR. 6/21 of client #1's record Intinue orders for fluoxetine e am, hydroxyzine 25mg if Melatonin 1mg one tablet e record; and 7/2/21 for hydroxyzine gift with handwritten on order and ffective 7-31-21" not signed and handwritten on order ffective 7-31-21" not signed with client #1 revealed: cations) every morning and give him his meds; his meds.				

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-diagnoses of Adjustment Disorder with Mixed

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Division	of Health Service Regu	lation	_		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					_
			D WING		R
MHL080-214 B. WING				08/30/2021	
NAME OF D	ROVIDER OR SUPPLIER	STDEET AI	DDRESS, CITY, STA	TE ZIR CODE	
NAIVIE OF FI	NOVIDER OR SUFFLIER				
TGH RESI	DENTIAL SERVICES		CONCORD ROA	AD	
		SALISBU	RY, NC 28144		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	()
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE DATE
				DEFICIENCY)	
V 118	Continued From page	5	V 118		
V 110	Continued From page	- 3	110		
	Anxiety and Depresse	ed Mood and ADHD;			
		ated 3/11/21 for Guanfacine			
		certirizine 10mg one at bed;			
	•	ted 4/19/21 for risperidone			
	0.5mg one tablet twic	•			
	_	ted 6/15/21 for trazadone			
	100mg one at night;	icu o/ 15/21 for trazadone			
		ted 7/16/21 for trazadone			
		led //10/21 for trazadone			
	50mg two at night.				
	01	2/04 -t 40-07f -l:t #0 -			
	•	3/21 at 10:37am of client #2's			
	medications revealed				
	•	e at bed dispensed 8/1/21;			
	•	at bed dispensed 8/1/21;			
	-risperidone 0.5mg or	ne tablet twice daily			
	dispensed 8/1/21;				
	-trazadone 100mg on	e at night dispensed 8/1/21;			
	-Guanfacine 1mg one	e twice daily dispensed			
	8/13/21.				
	Review on 8/26/21 of	client #2's MARs from			
	6/1/21-8/26/21 reveal	ed:			
	-Guanfacine 1mg one	e at bed documented as			
	administered on 6/31				
		at bed documented as			
	administered on 6/31	:			
		ne tablet twice documented			
	as administered on 6/				
		e at night documented as			
	administered on 6/31	•			
		twice daily documented as			
	administered 8/1/21-8	<u> </u>			
	44111111111111111111111111111111111111	J. 2012 1.			
	Further review on 9/2	6/21 of client #2's record			
		n's order for Guanfacine 1mg			
	one twice daily prese	nt on the record.			
	International Co. 0/05/04	with aliant #0 may I - I			
		with client #2 revealed:			
	-takes his meds;				

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-staff never forget to give them.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	B WING			R	
MHL080-214			B. WING		08/30/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	FE, ZIP CODE	
TGH RES	IDENTIAL SERVICES		CONCORD ROA JRY, NC 28144	D	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 118	Continued From page	e 6	V 118		
	record revealed: -admission date of 2/ -diagnoses of ADHDphysician's order dat hydroxyzine 10mg 1/2 then one tablet at bec- copy of a pharmacy hydroxyzine 10mg 1/2 then one tablet at bec "D/C per [unknown in 6/21/21;" -no physician's discortablet at bed for one vif needed; -physician's order for in the evening; -no physician's order for in the evening: -no physician's discortable for one vife needed; -physician's order for in the evening: -no physician's discortable for one vife needed; -physician's order for in the evening: -no physician's discortable for one vife needed; -physician's order for in the evening: -no physician's discortable for one vife needed; -physician's order for in the evening: -no physician's discortable for one vife needed; -physician's order for in the evening: -no physician's discortable for one vife needed; -physician's order for in the evening: -no physician's discortab	and Parent/Child conflict; led 5/19/21 and 7/15/21 for 2 tablet at bed for one week d if needed; refill request dated 6/4/21 for 2 tablet at bed for one week d if needed with handwritten dividual's first name] 3pm htinue order for 10mg 1/2 week then one tablet at bed mirtazapine 15mg 1/2 tablet for mirtazapine 15mg one 1/21 at 10:08am of client #3's : //2 tablet at bed for one week d if needed dispensed 2 tablet in the evening tablet daily dispensed client #3's MARs from ed: //2 tablet at bed for one week d if needed listed on the May 1 MAR and August 2021			

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listed on the June 2021 MAR;

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		7.1. 50.25.1.10.		R
	MHL080-214	B. WING		08/30/2021
NAME OF PROVIDER OR SUPPLI	ER STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
TGH RESIDENTIAL SERVIC	ES	CONCORD ROA RY, NC 28144	AD	
PREFIX (EACH DEF	IARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
8/13/21 not listed Interview on 8/3-take meds and staff never forced Interview on 8/3-not sure why consultation and sure why consultation and sure why consultation and sure why consultation and sure which is a sure week by a licenter that is Rule, licenter individual who license issued a human service Carolina. For such is a sure week is a sure week by a licenter that is reproved in each week by a licenter that is reproved in a sure week by a licenter that is reproved in a sure week by a licenter that is reproved in a sure week by a licenter that is reproved in a sure week by a licenter that is reproved in the sure week by a licenter that is repr	ing 1 tablet daily dispensed and on the August 2021 MAR. 25/21 with client #3 revealed: I get them daily; get his meds. 30/21 with the Director revealed: liscrepancy in medications; e issues with medication and documentation with staff. idential Tx. Child/Adol - Req. for L 6.1705 REQUIREMENTS OF OFESSIONALS e clinical consultation shall be the facility at least four hours a used professional. For purposes of sed professional means an anolds a license or provisional by the governing board regulating the profession in the State of North substance-related disorders this licensed Clinical Addiction certified Clinical Supervisor. tation specified in Paragraph (a) of	V 118	DEFICIENCY)	

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DIVISION	of Fleatill Service Regu	ialion	_			
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
			_			
						R
		MHL080-214	B. WING		08/	30/2021
NAME OF P	ROVIDER OR SUPPLIER	STREETAD	DRESS, CITY, STA	ATE, ZIP CODE		
TOU DESI	DENTIAL SERVICES	328 OLD	CONCORD ROA	AD.		
I GH KESI	DENTIAL SERVICES	SALISBU	RY, NC 28144			
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO		COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE		DATE
				DEFICIENCY)		
V 297	Continued From page	8	V 297			
	T. D					
	This Rule is not met					
		iew and interviews, the				
	facility failed to ensure					
	Professional(LP) prov	vided clinical oversight and				
	therapy to address the	e clients' Mental Health(MH)				
	needs affecting 3 of 3	clients(#1, #2 and #3). The				
	findings are:	,				
	Review on 8/26/21 an	nd 8/27/21 of client #1's				
	record revealed:	id G/27/21 of Gliotic // 1 o				
	-admission date of 5/2	24/24				
		Post Traumatic Stress				
		ruptive Mood Dysregulation				
		ositional Defiant Disorder),				
	ADD(Attention Deficit	Disorder) and Unspecified				
	Trauma and Stressor	Related;				
	-no documentation of	a substance abuse				
	diagnosis or issues in					
	Interview on 8/25/21 v	with client #1 revealed:				
	-sees a therapist;	with onotic // 1 To vocalod.				
	-every Tuesday and T	hureday:				
	-do it here on-line by 2	20011.				
	D : 0/00/04	10/07/04 5 1: 1 //01				
		nd 8/27/21 of client #2's				
	record revealed:					
	-admission date of 2/2					
	,	nent Disorder with Mixed				
	Anxiety and Depresse	ed Mood and ADHD;				
	-no documentation of	a substance abuse				
	diagnosis or issues in	the record.				
	.3 2 3333.33					
	Interview on 8/25/21 v	with client #2 revealed:				
	-see a therapist every					
	_ ·					
	-was in person, now v					
		at his school and at the				
	facility.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPLI	LIED
		MHL080-214	B. WING		08/3	0/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
TCH DESI	DENTIAL SERVICES	328 OLD C	ONCORD ROA	AD		
TOH KESI	DENTIAL SERVICES	SALISBUR	Y, NC 28144			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
V 297	Continued From page	9	V 297			
	Review on 8/26/21 ar record revealed: -admission date of 2/-diagnoses of ADHD, -no documentation of diagnosis or issues in Interview on 8/25/21 v-don't see other peop-sometimes a counse remember last time. Review on 8/25/21 of revealed: -hire date of 8/21/17; -LCAS(Licensed Clinilicense expires 12/31.	nd 8/27/21 of client #3's 16/21; parent/child conflict; a substance abuse the record. with client #3 revealed: le often on Zoom; lor comes here but don't the LP's personnel record ical Addiction Specialist)				
	revealed: -do skills group twice facility; -"that's it;" -do the group by virtu -now that school is in 4pm-5pm; -groups on Mondays -do no clinical oversig facility; -none of the boys have issues. Interview on 8/26/21 of Professional (QP) reverte LP for this house boys here;	do the groups between and Wednesdays; the regarding the boys in the we any substance abuse with the Qualified tealed: the does virtual mainly with				
	-was coming in perso	n; al since boys back in school;				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL080-214	B. WING		R 08/30/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
TGH RESI	DENTIAL SERVICES		ONCORD ROA Y, NC 28144	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 297	different work group I coping skills, social site the LP does not have treatment plans; the LP will give input group, like a goal addedoes get individual the therapists go see click Interview on 8/30/21 v-LP does groups with clients see other the MH issues; was not aware the LI oversight for the MH iscurrent LP was not all chave started intervier role of LP to address already been question 27G .0303(c) Facility 10A NCAC 27G .0303 EXTERIOR REQUIR (c) Each facility and it maintained in a safe,	is and every week does a like anger management, kills, etc; e anything to do with their if she sees something in dressing skills; herapy from other therapists ents at school. With the Director revealed: clients; rapists in the community for P had to provide clinical dissues of the clients and cole to do that; wing for an MH therapist for MH issues as this had ned by the LME/MCO. and Grounds Maintenance 3 LOCATION AND EMENTS	V 297			
	odor. This Rule is not met Based on observation	as evidenced by: ns and interview, the facility n a safe, clean, attractive				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			R
		MHL080-214	B. WING		08	3/30/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
TOU DEG	IDENTIAL CEDVICES		CONCORD ROAD			
IGH RES	IDENTIAL SERVICES	SALISBI	JRY, NC 28144			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 736	Continued From page	e 11	V 736			
	-wooden table with irc kitchen; -one matching stool; -two yellow and meta-table top very wobbly Observation on 8/25/2 uncovered electrical sthe wall between the area. Observation on 8/26/2-overheard light fixtur-walls have patches on client #1's bedroom-unpainted, patched hundone behind door tliving room; -bottom of closet neatop layer of wood on uncovered metal book hallway with red and in empty first bedroos section of window on pane is broken, Plexigattached to wooden ficurtain, no loose fragumetal vent covers so house. Interview on 8/30/21 vertable are stool with the area.	21 at 3:50pm revealed socket in the living room on living room and dining room 21 at 1:00pm revealed: e cover missing in kitchen of blue in laundry room and in last on right of hall; nole with part coming or client #2's bedroom off The front door has missing bottom half; In near ceiling on wall in yellow wires; In on left of hall, lower left facing front of house top glas, broken wedges still rame behind blinds and ments, not sharp; I ratched and dirty throughout with the Director revealed: I not chairs for dining area and				
	_	iglas fixed in the empty				
	-new sturdy red wood chairs;	n/21 at 9:50am revealed: len table and matching en replaced with new pane,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		MHL080-214	B. WING		R 08/30/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
TGH RESIDENTIAL SERVICES 328 OLD CONCORD ROAD SALISBURY, NC 28144					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE COMPLETE
) / 700	V700 0 11 15 40		1/700	DEFICIENCY)	
V 736			V 736		
	no other broken pane	9 S.			

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