STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-170			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING			R <b>09/20/2021</b>	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
HAPAR	RAL YOUTH SERVIC	SES LLC	LEOD DRIVE N, NC 28364			
(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 ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMEN	TS	V 000			
	An annual and follow up survey was completed on September 20, 2021. Deficiencies were cited.					
	category: 10A NCA	sed for the following service C 27G .1700 Residential cure for Children or				
V 114	27G .0207 Emerge	ency Plans and Supplies	V 114			
	AND SUPPLIES (a) A written fire pla area-wide disaster shall be approved b authority. (b) The plan shall b and evacuation pro posted in the facilit (c) Fire and disaster shall be held at lea repeated for each s under conditions th	er drills in a 24-hour facility st quarterly and shall be shift. Drills shall be conducted nat simulate fire emergencies. all have basic first aid supplies				
	Based on record refacility failed to hav at least quarterly and findings are: Review on 9/16/21-	et as evidenced by: eview and interviews, the re a fire and disaster drills held nd repeated on each shift. The -9/20/21 of the facility records				
		were documented for the 2nd 0/21) of 2021 for 1st and 2nd				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-170				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING		R 09/20/2021			
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
		5973 MC	LEOD DRIVE				
HAPAR	RAL YOUTH SERVIC	ES, LLC MAXTO	N, NC 28364				
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE	
V 114	Continued From pa	age 1	V 114				
	quarter (1/1/21-3/3 shifts. -No disaster drills v quarter (10/1/20-12 -No disaster drills v quarter (7/1/20-9/3 Interview on 9/16/2 -She worked at the -She worked 2nd s	facility since February 2021. hift from 4pm-9pm. or participated in any fire or					
	-He worked all shift	facility about 4 months. ts. r participated in any fire or					
	Licensee/Associate -The facility had 3 s (4pm-12am) and 3 -Fire and Disaster monthly. -She understood fin held at least quarter -She understood al	9/16/21-9/20/21 the e Professional stated: shifts 1st (8am-4pm) 2nd rd (12am-8am). drills were held at least re and disaster drills were to be erly and repeated on each shift Il staff should be know or fire and disaster drills.					
V 118	27G .0209 (C) Med	lication Requirements	V 118				

STATE FORM

6899

NR0311

If continuation sheet 2 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-170		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED R 09/20/2021		
IAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
	RAL YOUTH SERVIC	5973 MC	LEOD DRIVE I, NC 28364			
(X4) ID SUMMARY STATEMENT OF I PREFIX (EACH DEFICIENCY MUST BE PR TAG REGULATORY OR LSC IDENTIFYI		Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLE DATE
V 118	Continued From pa	age 2	V 118			
	clients only when a client's physician. (3) Medications, ind administered only b unlicensed persons pharmacist or othe privileged to prepar (4) A Medication Ad all drugs administe current. Medication recorded immediat MAR is to include t (A) client's name; (B) name, strength (C) instructions for (D) date and time t (E) name or initials drug. (5) Client requests checks shall be reco file followed up by a with a physician.	all be self-administered by uthorized in writing by the cluding injections, shall be by licensed persons, or by s trained by a registered nurse, r legally qualified person and re and administer medications. dministration Record (MAR) of red to each client must be kep is administered shall be ely after administration. The he following: , and quantity of the drug; administering the drug; he drug is administered; and of person administering the for medication changes or corded and kept with the MAR appointment or consultation				
	Based on record re interviews the facili were administered	eviews, observation and ty failed to ensure medications as ordered by a physician and affecting 3 of 3 audited clients				
	Review on 9/16/21	-9/17/21 of client #2's record				

STATE FORM

NR0311

If continuation sheet 3 of 6

14PARRAL YOUTH SERVICES LLC 5973	B. WING T ADDRESS, CITY, S MCLEOD DRIVE TON, NC 28364 ID PREFIX TAG V 118		IPLETED R /20/2021 COMPLET DATE
ME OF PROVIDER OR SUPPLIER STREE <b>IAPARRAL YOUTH SERVICES, LLC</b> X4) ID REFIX X4) ID REFIX X4) ID CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 118 Continued From page 3 revealed: -13 year old male. -Admitted on 4/15/21. -Diagnoses of Attention Deficient Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder. Review on 9/16/21-9/17/21 of client #2's signed physician orders revealed: -No order for Clindamycin Topical Ointment. (Acne) Review on 9/16/21 of client #2's MARs from Ju 1, 2021 to September 16, 2021 revealed: -Clindamycin Topical Ointment was not transcribed on September's MAR. Observation of client #2's medication locked bo	T ADDRESS, CITY, S MCLEOD DRIVE ON, NC 28364 ID PREFIX TAG V 118	TATE, ZIP CODE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLET
MAPARRAL YOUTH SERVICES, LLC       5973 I         X4) ID REFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         V 118       Continued From page 3 revealed: -13 year old male. -Admitted on 4/15/21. -Diagnoses of Attention Deficient Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder.         Review on 9/16/21-9/17/21 of client #2's signed physician orders revealed: -No order for Clindamycin Topical Ointment. (Acne)         Review on 9/16/21 of client #2's MARs from Ju 1, 2021 to September 16, 2021 revealed: -Clindamycin Topical Ointment was not transcribed on September's MAR.         Observation of client #2's medication locked box	MCLEOD DRIVE TON, NC 28364 ID PREFIX TAG V 118	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLET
APARRAL YOUTH SERVICES, LLC       MAXT         X4) ID REFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         V 118       Continued From page 3         revealed: -13 year old male. -Admitted on 4/15/21. -Diagnoses of Attention Deficient Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder.         Review on 9/16/21-9/17/21 of client #2's signed physician orders revealed: -No order for Clindamycin Topical Ointment. (Acne)         Review on 9/16/21 of client #2's MARs from Ju 1, 2021 to September 16, 2021 revealed: -Clindamycin Topical Ointment was not transcribed on September's MAR.         Observation of client #2's medication locked box	ID PREFIX TAGVV	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLET
<ul> <li>X4) ID REFIX TAG</li> <li>V 118</li> <li>Continued From page 3 revealed: -13 year old male. -Admitted on 4/15/21. -Diagnoses of Attention Deficient Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder.</li> <li>Review on 9/16/21-9/17/21 of client #2's signed physician orders revealed: -No order for Clindamycin Topical Ointment. (Acne)</li> <li>Review on 9/16/21 of client #2's MARs from Ju 1, 2021 to September 16, 2021 revealed: -Clindamycin Topical Ointment was not transcribed on September's MAR.</li> <li>Observation of client #2's medication locked box</li> </ul>	V 118	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLET
RÉFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         V 118       Continued From page 3         revealed: -13 year old male. -Admitted on 4/15/21. -Diagnoses of Attention Deficient Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder.         Review on 9/16/21-9/17/21 of client #2's signed physician orders revealed: -No order for Clindamycin Topical Ointment. (Acne)         Review on 9/16/21 of client #2's MARs from Ju 1, 2021 to September 16, 2021 revealed: -Clindamycin Topical Ointment was not transcribed on September's MAR.         Observation of client #2's medication locked box	V 118	CROSS-REFERENCED TO THE APPROPRIATE	COMPLET
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<ul> <li>-13 year old male.</li> <li>-Admitted on 4/15/21.</li> <li>-Diagnoses of Attention Deficient Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder.</li> <li>Review on 9/16/21-9/17/21 of client #2's signed physician orders revealed:</li> <li>-No order for Clindamycin Topical Ointment. (Acne)</li> <li>Review on 9/16/21 of client #2's MARs from Ju 1, 2021 to September 16, 2021 revealed:</li> <li>-Clindamycin Topical Ointment was not transcribed on September's MAR.</li> <li>Observation of client #2's medication locked box</li> </ul>			
<ul> <li>physician orders revealed:</li> <li>-No order for Clindamycin Topical Ointment. (Acne)</li> <li>Review on 9/16/21 of client #2's MARs from Ju 1, 2021 to September 16, 2021 revealed:</li> <li>-Clindamycin Topical Ointment was not transcribed on September's MAR.</li> <li>Observation of client #2's medication locked box</li> </ul>			
<ul> <li>1, 2021 to September 16, 2021 revealed:</li> <li>-Clindamycin Topical Ointment was not transcribed on September's MAR.</li> <li>Observation of client #2's medication locked be</li> </ul>	d		
	ıly		
-Clindamycin Topical Ointment available on ha for administration.	1:		
Interview on 9/16/21 client #2 stated he had received his medications daily.			
Finding #2 Review on 9/16/21-9/17/21 of client #3's record revealed: -13 year old male. -Admitted on 6/4/21. -Diagnoses of Disruptive Mood Dysregulation Disorder (DMDD), ADHD, combine type and P Traumatic Stress Disorder, unspecified.			
Review on 9/16/21-9/17/21 of client #3's signed physician orders dated 7/6/21 revealed: -Miralax 17 grams powder, daily as needed for constipation.			
Review on 9/16/21 of client #2's MARs from Ju	ıly		

NR0311

Division of Health Service Regulation           STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: MHL078-170		A. BUILDING:		COM	PLETED	
		B. WING			R <b>20/2021</b>	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	RAL YOUTH SERVIC	FSILC	LEOD DRIVE			
		MAXIO	I, NC 28364			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pa	ige 4	V 118			
	1, 2021 to September 16, 2021 revealed: -Miralax 17 grams was not transcribed on MARs for July, August or September.					
	Interview on 9/16/21 client #3 stated he had received his medications daily.					
	Finding #3 Review on 9/16/21-9/17/21 of client #4's record revealed: -16 year old male. -Admitted on 5/3/21. -Diagnoses of DMDD, Conduct Disorder,					
	physician orders re -5/25/21: Ibuprofen needed for mild pai -6/24/21: Omega 3 (Supplement) -8/21/21: Fluticasor sprays daily. (Allerg -9/14/21: Cetirizine	9/17/21 of client #4's signed vealed: 400 mg, 1 every 6 hours as n/headache. Fish Oil, at bedtime. he Propionate 50 mcg, 2 gies) HCL (Hydrochloride) 10 mg, Ilergies) : Guanfacine HCL 2				
	1, 2021 to Septemb -Guanfacine HCL 2 MAR for July. -Cetirizine HCL 10 Ibuprofen 400 mg v for July and August	e 50 mcg was not transcribed				
	Interview on 9/16/2 received his medica	1 client #4 stated he had ations daily.				

NR0311

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-170					(X3) DATE SURVEY COMPLETED R 09/20/2021	
		B. WING				
IAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
		5973 MC	LEOD DRIVE			
, HAPAR	RAL YOUTH SERVIC	ACTO	N, NC 28364			
(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 ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pa	age 5	V 118			
	-Client #2's Clindar ordered by phone -Client #2's Clindar been applied daily. -All clients had rece prescribed by phys -There were errors -She would ensure	e Professional stated: nycin Topical Ointment was nycin Topical Ointment had eived their medications as ician.				

NR0311

If continuation sheet 6 of 6