Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 .	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
				A. BUILDING: _			
		MHL036-345		B. WING		11/0)2/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
COSBY C	OUNSELING & CONSUL	TING, PLLC		ON AVENUE , NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FL LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS			V 000			
	An annual survey was completed on 11/2/21. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential						
	Treatment Staff Secure for Children or Adolescents						
V 118	V 118 27G .0209 (C) Medication Requirements			V 118			
	10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administering the drug. (5) Client requests for medication changes or		n ribe / e / nurse, and tions. R) of e kept he				

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

(X6) DATE TITLE

Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		MHL036-345	B. WING		11	/02/2021
	ROVIDER OR SUPPLIER OUNSELING & CONSULT	170	EET ADDRESS, CITY, STA	TE, ZIP CODE		
	OUNSELING & CONSUL	GAS	STONIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From page	: 1	V 118			
	with a physician.					
	interviews, the facility medications were adrorder of a person authorized affecting 1 of 1. Review on 11/2/21 of admission date of 10-diagnoses of Attention Disorder and Opposition and Physicians' orders or physicians' orders orders or physicians' orders orders or physicians' orders o	iew, observations and failed to ensure ministered on the written norized by law to prescribe client(#1). The findings are: client #1's record revealed:	;			
	medications revealed -Clonidine 0.1mg 1-2 10/18/21;	:				
	,	ablets in the am dispensed				
	10/28/21 until present -Clonidine 0.1mg 1-2 administered from 10, -Adderall 20mg two to as administered from	at bed documented as /27-10/31 at 7pm; ablets in the am documented 10/28-11/1 at 7am.	d			
	Interview on 11/1/21 v	with client #1 revealed:	I			

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL036-345	B. WING		11	/02/2021
NAME OF PI	ROVIDER OR SUPPLIER		ET ADDRESS, CITY, STA	TE, ZIP CODE		
COSBY C	OUNSELING & CONSULT	TING. PLLC	MAXTON AVENUE ONIA, NC 28052			
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 118	-takes his medicines along them all in staff looked at bottles one in am and one in doing now; -gets medicines every Interview on 11/1/21 and one that the physimedications yet; -waiting on client #1 to management provide. Interview on 11/2/21 and Professional revealed the medicines are called one medication orders doing the medication orders doing the performance of the clients along the performance of the clients within seven days clients and point the clients and provides the performance of	Adderall and Clonidine; in the am but got here and and saw supposed to take pm so that is what he is a day like the bottle says. With the Licensee revealed: icians' orders for client #1's to be seen by medication r. With the Qualified it: eating the MARs, make sure led in and make sure clients on not have the initial ones; itered Plan) lists the clients' isis plans and create the so to have most accurate is medications; ents have a medication ment with a local provider; bintment before clients even	V 118			
V 131	G.S. 131E-256 (D2) H Verification	HCPR - Prior Employment	V 131			
	REGISTRY (d2) Before hiring hea health care facility or health care facility sha	alth care personnel into a service, every employer at a all access the Health Care and shall note each incident opriate business files.				

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Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) P

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILANC	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		COIVII LL	1120
		MHL036-345	B. WING		11/0	2/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
COSBY C	OUNSELING & CONSUL	TING. PLLC	TON AVENUE A, NC 28052			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 131	Continued From page	∋ 3	V 131			
	facility failed to ensur prior to hire for 2 of 3 Associate Profession Review on 11/2/21 of the AP was hired on accessed on 2/28/21, staff #1 was hired or accessed on 9/5/21. Interview on 11/1/21 sheen here for one yearwork all shifts; fill in for staff also; susually work 12pm-8 Interview on 11/1/21 sheen working here forwork 2nd shift 3pm-9 Interview on 11/2/21 shoot the initial HCPR	view and interviews, the e the HCPR was accessed staff(staff #1 and the al/AP). The findings are: personnel records revealed: 10/9/20 and the HCPR was in 9/3/21 and the HCPR was with the AP revealed: ear; spm. with staff #1 revealed: or 2 months; opm/3pm-11pm. with the Licensee revealed: on the AP; of moving documents from				
V 133	G.S. 122C-80 Crimin	al History Record Check	V 133			
	G.S. §122C-80 CRIM CHECK REQUIRED	IINAL HISTORY RECORD FOR CERTAIN				

Division of Health Service Regulation

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Division of Health Service Regulation

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		LETED		
		MHL036-345	B. WING		11/	02/2021		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE				
00051/0		-W.O. D. J. O. 1701 MA	XTON AVENUE					
COSBY C	OUNSELING & CONSUL	GASTON	NIA, NC 28052					
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION	(X5)		
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO	O THE APPROPRIATE	COMPLETE DATE		
				DEFICIE	:NCY)			
V 133	Continued From page	e 4	V 133					
	ADDITIONALE FOR F	TAIDLOVAIENT						
	APPLICANTS FOR E							
		ed in this section, the term						
		an area authority/county						
	,	vider of mental health,						
	· ·	ility, and substance abuse sable under Article 2 of this						
	Chapter.	sable under Afticle 2 of this						
	•	n offer of employment by a						
	provider licensed under this Chapter to an applicant to fill a position that does not require the							
		occupational license is						
	••	ent to a State and national						
		d check of the applicant. If						
		en a resident of this State for						
		then the offer of employment						
	-	sent to a State and national						
		d check of the applicant. The						
	_	ory record check shall						
		e applicant's fingerprints. If						
		en a resident of this State for						
	five years or more, th	nen the offer is conditioned						
	on consent to a State	e criminal history record						
	check of the applican	it. A provider shall not						
		who refuses to consent to a						
	criminal history recor	d check required by this						
	•	herwise provided in this						
		e business days of making						
		of employment, a provider						
		st to the Department of						
		14-19.10 to conduct a						
		d check required by this						
		nit a request to a private						
	1	tate criminal history record						
		s section. Notwithstanding						
		Department of Justice shall						
		national criminal history						
		ployment positions not						
	covered by Public La							
	Department of Healtr	n and Human Services,						

Division of Health Service Regulation

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Division of	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
		MHL036-345	B. WING		11/02/2021
					11/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STF	REET ADDRESS, CITY, STA	ATE, ZIP CODE	
COSBY C	OUNSELING & CONSUL	TING PLIC	1 MAXTON AVENUE		
000010	CONCELING & CONCOL	GA	STONIA, NC 28052		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	
TAG	NEGOLATORI ORT	LOO IDEIVIII TIIVO IIVI ONIMATION)	TAG	DEFICIENCY)	TOME
V 133	Continued From page	e 5	V 133		
	Criminal Records Che	eck Unit Within five			
		eipt of the national criminal			
		the Department of Health			
		, Criminal Records Check			
		rovider as to whether the			
		may affect the employability	,		
		case shall the results of th			
		ory record check be shared			
		viders shall make available			
	upon request verificat	tion that a criminal history			
	check has been comp	oleted on any staff covered			
	by this section. A cou	nty that has adopted an			
	appropriate local ordi	nance and has access to			
	the Division of Crimin	al Information data bank			
	may conduct on beha	ılf of a provider a State			
	1	d check required by this			
		ovider having to submit a			
		ment of Justice. In such a			
		I commence with the State			
	_	d check required by this			
	section within five bus				
		nployment by the provider.			
	_	ormation received by the			
		al and may not be disclosed			
		nt as provided in subsection)		
	(c) of this section. For				
		"private entity" means a			
	business regularly en				
	records obtained from	d checks utilizing public			
		licant's criminal history			
		one or more convictions of			
		e provider shall consider all			
		s in determining whether to	l l		
	hire the applicant:	o in dotomining whomen to			
	_ · · · · · · · · · · · · · · · · · · ·	ousness of the crime.			
	(2) The date of the cri				
	` '	rson at the time of the			

Division of Health Service Regulation

conviction.

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	OF DEFICIENCIES	(X1) PROVIDER/S		(X2) MULTIPLE CONSTRUCTION			SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATI	ON NUMBER:	A. BUILDING: _		COMPL	ETED
		MHL036-	345	B. WING		11/0	2/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
COSBY C	OUNCELING & CONCUL	TING BLIG	1701 MAXT	ON AVENUE			
COSBTC	OUNSELING & CONSUL	TING, PLLC	GASTONIA	, NC 28052			
(X4) ID	SUMMARY ST	ATEMENT OF DEFIC	CIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX		Y MUST BE PRECEI		PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING IN	IFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
					,		
V 133	Continued From page	∍ 6		V 133			
	(4) The circumstance	e eurroundina tl	he				
	commission of the cri						
	(5) The nexus between		conduct of				
	the person and the jo						
	filled.						
	(6) The prison, jail, pr	obation, parole	,				
	rehabilitation, and em						
	person since the date	the crime was	committed.				
	(7) The subsequent of	ommission by t	he person of				
	a relevant offense.						
	The fact of conviction	of a relevant o	ffense alone				
	shall not be a bar to e						
	listed factors shall be						
	If the provider disqua						
	consideration of the r						
	provider may disclose						
	the criminal history re						
	to the disqualification						
	of the criminal history	record check to	o tne				
	applicant.	A providor on	d an afficar				
	(d) Limited Immunity. or employee of a prov						
	complies with this sec						
	civil liability for:	Stion shall be in	indic nom				
	(1) The failure of the	provider to emn	lov an				
	individual on the basi						
	the criminal history re		•				
	(2) Failure to check a						
	criminal offenses if th						
	history record check i	s requested an	d received in				
	compliance with this						
	(e) Relevant Offense.						
	"relevant offense" me	•					
	federal criminal histor						
	indictment of a crime,						
	felony, that bears upo						
	have responsibility fo	•	•				
	persons needing mer						
	disabilities, or substa	nce abuse serv	ices. These				

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Division of	of Health Service Regu	lation	<u>, </u>			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		MHL036-345	B. WING		11/02/2021	
			I		11/02/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREE	ET ADDRESS, CITY, STA	TE, ZIP CODE		
COSBY C	OUNSELING & CONSUL	TING PLIC	MAXTON AVENUE			
000010	CONCELING & CONCOL	GAS1	TONIA, NC 28052			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		
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 DEFICIENCY)	NATE DATE	
				,		
V 133	Continued From page	e 7	V 133			
	orimos includo the ori	minal offenses set forth in				
		rticles of Chapter 14 of the				
	_	icle 5, Counterfeiting and				
	Issuing Monetary Sub	•				
		ve and Legislative Officers;				
		article 7A, Rape and Other				
		8, Assaults; Article 10,				
		iction; Article 13, Malicious				
	Injury or Damage by					
		Material; Article 14, Burglary				
		akings; Article 15, Arson and				
		le 16, Larceny; Article 17,				
	_	Embezzlement; Article 19,				
	False Pretenses and					
		Services by False or				
		edit Device or Other Means;				
		Transaction Card Crime				
		s; Article 21, Forgery; Article				
	26, Offenses Against					
		, Adult Establishments;				
	_	n; Article 28, Perjury; Article				
		, Misconduct in Public				
		enses Against the Public				
		tiots and Civil Disorders;				
	Article 39, Protection					
	Protection of the Fam	•				
		cle 60, Computer-Related				
	· ·	also include possession or				
		ion of the North Carolina				
	_	es Act, Article 5 of Chapter				
		itutes, and alcohol-related				
		e to underage persons in				
	violation of G.S. 18B-	.				
		of G.S. 20-138.1 through				
	G.S. 20-138.5.	_				
	(f) Penalty for Furnish	ning False Information Any				
		nent who willfully furnishes,				

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supplies, or otherwise gives false information on an employment application that is the basis for a

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DIVISION	or rieditii Service Negu	ıatıon			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		MILL 000 045	B. WING		44/00/0004
		MHL036-345	1 2		11/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE	
		1701 MAX	TON AVENUE		
COSBY C	OUNSELING & CONSUL	TING. PLLC	A, NC 28052		
		GASTONIA	4, NC 20032	T.	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	
IAG			IAG	DEFICIENCY)	
V 133	Continued From page	8	V 133		
	criminal history record	d check under this section			
	shall be guilty of a Cla				
		yment A provider may			
	employ an applicant of				
		of a criminal history record			
	_	-			
	check regarding the a				
	following requirement				
		not employ an applicant			
		applicant's consent for			
	1	d check as required in			
	` ,	section or the completed			
	fingerprint cards as re	equired in G.S. 114-19.10.			
	(2) The provider shall	submit the request for a			
	criminal history record	d check not later than five			
	business days after th	ne individual begins			
	conditional employme	ent. (2000-154, s. 4;			
	2001-155, s. 1; 2004-	124, ss. 10.19D(c), (h);			
	2005-4, ss. 1, 2, 3, 4,	. , . ,			
	, , , , ,	, ,			
	This Rule is not met	as sylidanood by:			
		•			
		iew and interviews, the			
	_	e a criminal records check			
		d within five business days of			
	making the conditions	al offer of employment for 1			
	of 3 staff(the Associate	te Professional/AP). The			
	findings are:				
	Review on 11/2/21 of	personnel records revealed			
		10/9/20 and the criminal			
	records check was re				
		•			
	Interview on 11/1/21 v	with the AP revealed:			
	-been here for one ye				
	-work all shifts;	•			

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-fill in for staff also;

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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		
		MHL036-345		B. WING		11	/02/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, STATE	E, ZIP CODE		
000DV 0	OUNCELING & CONCU	TING BLIG	1701 MAX	KTON AVENUE			
COSBYC	OUNSELING & CONSUL	IING, PLLC	GASTON	IA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENC BY MUST BE PRECEDED LSC IDENTIFYING INFOR	BY FULL	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 133	Continued From pag	e 9		V 133			
	-usually work 12pm-8pm.						
	Interview on 11/2/21 -lost the initial HCPR -was in the process one electronic medic another.	on the AP; of moving documen	ts from				
V 367	27G .0604 Incident F	Reporting Requirem	ents	V 367			
	identification informa (2) client identi (3) type of inci (4) description (5) status of th cause of the incident	REMENTS FOR B PROVIDERS B providers shall repept deaths, that ocole services or while providers premises a deaths involving the rendered any servincident to the LME atchment area where the within 72 hours of the incident. The remprovided by the remay be submitted or encrypted electronal include the following fication information dent; of incident; e effort to determining and duals or authorities	cur during e the or level III e clients rice within re port shall d via mail, onic owing e the notified				

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1701 MAXTON AVENUE		OF CORRECTION	NCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
1701 MAXTON AVENUE			MHL036-345	B. WING		11/02/2021	
COSPY COUNSELING & CONSULTING BLLC 1701 MAXTON AVENUE	NAME OF PROVIDE	PROVIDER OR SUPPLIER	SUPPLIER STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
COSBY COUNSELING & CONSULTING, PLLC GASTONIA, NC 28052	COSBY COUNS	OUNSELING & CONSU	G & CONSULTING. PLLC				
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	PREFIX	(EACH DEFICIENC	ACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMP	PLETE
shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 2EC .0300 and 10A NCAC 2TE. O104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident;	shall repo day (1) infor error (2) requ unav (c) (3) (d) (of all Men Substantial beconstructed Heal By the Inclusion (1) definition (2)	shall submit an upda report recipients by to day whenever: (1) the provided information provided erroneous, misleadir (2) the provided required on the incided unavailable. (c) Category A and I upon request by the obtained regarding to (1) hospital resinformation; (2) reports by (3) the provided (d) Category A and I of all level III inciden Mental Health, Deve Substance Abuse Sebecoming aware of the providers shall send incidents involving a Health Service Regulated becoming aware of the client death within secon restraint, the provimmediately, as required. 0300 and 10A NCAM (e) Category A and report quarterly to the catchment area when The report shall be septimed by the Secretary via include summary information of a level III (2) restrictive in the second of a level III (2) restrictive in the second of a level III (2) restrictive in the second of a level III (2) restrictive in the second of a level III (2) restrictive in the second of a level III (2) restrictive in the second of a level III (2) restrictive in the second of a level III (2) restrictive in the second of a level III (2) restrictive in the second of a level III (2) restrictive in the second of a level III (2) restrictive in the second of a level III (2) restrictive in the second of a level III (2) restrictive in the second of a level III (2) restrictive in the second of a level III (2) restrictive in the second of a level III (2) restrictive in the second of a level III (3) restrictive in the second of a level III (4) restrictive in the second of a level III (4) restrictive in the second of a level III (4) restrictive in the second of a level III (4) restrictive in the second of a level III (4) restrictive in the second of a level III (4) restrictive in the second of a level III (4) restrictive in the second of a level III (4) restrictive in the second of a level III (4) restrictive in the second of a level III (4) restrictive in the second of a level III (4) restrictive in the second of a level III (4) restrictive in the second of a level III (omit an updated report to all required cipients by the end of the next business never: the provider has reason to believe that on provided in the report may be as, misleading or otherwise unreliable; or the provider obtains information on the incident form that was previously ble. gory A and B providers shall submit, quest by the LME, other information regarding the incident, including: hospital records including confidential on; reports by other authorities; and the provider's response to the incident. Group A and B providers shall send a copy all lincident reports to the Division of dealth, Developmental Disabilities and conce Abuse Services within 72 hours of graware of the incident. Category A as shall send a copy of all level III as involving a client death to the Division of ervice Regulation within 72 hours of graware of the incident. In cases of an ath within seven days of use of seclusion int, the provider shall report the death telly, as required by 10A NCAC 26C and 10A NCAC 27E .0104(e)(18). Group A and B providers shall send a parterly to the LME responsible for the int area where services are provided. For shall be submitted on a form provided decretary via electronic means and shall summary information as follows: medication errors that do not meet the information for the lincident; restrictive interventions that do not meet	V 367			

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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	
		MIII 020 245	B. WING		4.	1/00/0004
		MHL036-345			11	1/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
COSBY C	OUNSELING & CONSUL	TING. PLLC	IAXTON AVENUE ONIA, NC 28052			
(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 AC' CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 367	(3) searches of (4) seizures of the possession of a c (5) the total nul incidents that occurre (6) a statement been no reportable in incidents have occurr meet any of the criter	f a client or his living area; client property or property in lient; mber of level II and level III ad; and t indicating that there have cidents whenever no red during the quarter that is as set forth in Paragraphs e and Subparagraphs (1) ragraph.	V 367			
	Based on records rev facility failed to ensur incidents to the LME catchment area when within 72 hours of bed incident. The findings Interview on 11/1/21 v-only had one incident #3(FC#3); -FC#3 got aggressive his room; -did not do a restraint	view and interviews, the e to report all level II responsible for the e services are provided coming aware of the e are: with staff #1 revealed: at involving former client e and had to escort him to but had to call police; erbal threats and being with the Associate ealed: v times;				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-345	B. WING		11/02/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE		
COSBY C	OUNSELING & CONSULT	TING. PLLC	AXTON AVENUE			
	OUN MAN DV OT		NIA, NC 28052			
(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 CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE	
V 367	Continued From page	ntinued From page 12				
	-called police on FC#3 due to aggression.					
	station on his own; -second time FC#2 ra did not return; -FC#3 had behaviors; -had to call police on -last time the police w policemen and EMS(I Services) personnel to a stretcher; -FC#3 went to inpatie Review on 11/1/21 of Improvement System	ealed: imes; back; hen he went to the police in, went to the hospital and FC#3; ere called, took several Emergency Medical o get FC#3 to the ground on				
	-have no incident reportant all of her incident	with the Licensee revealed: orts; t reports when she moved electronic medical records				
V 736	27G .0303(c) Facility and Grounds Maintenance		V 736			
		EMENTS				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED					
			A. BUILDING: _								
		MHL036-345	B. WING		11/	02/2021					
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE							
1701 MAXTON AVENUE											
COSBY COUNSELING & CONSULTING, PLLC GASTONIA, NC 28052											
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)					
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACT	ION SHOULD BE	COMPLETE					
TAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			CROSS-REFERENCED TO T DEFICIENC		DATE					
V 736	Continued From page 13		V 736								
	This Rule is not met as evidenced by: Based on observations and interviews, the facility										
	was not maintained in a safe, clean, attractive and orderly manner. The findings are:										
	and orderly mainter. The initialities are.										
	Observations on 11/1/21 at 3:13pm revealed:										
		nroom counter loose from									
	wall and pulled out;										
	-window over couch on left side of living room										
	double paned, inner panes were intact, outside upper pane cracked and broken, lower outside pane intact, screen over outside window panes, no glass on ground outside, glass not accessible from outside.										
		with staff #1 revealed:									
	 -think the broken window is from a rock thrown at the window from mowing yard; -no clients broke any windows; -no clients have cutting issues or self-injurious 										
	behaviors.										
	Interview on 11/1/21 with the Licensee revealed:										
-did not notice the broken window in the living											
	room;										
-just saw it today; -first time noticed it;											
	-don't know who broke it;										
		any self-harm, cutting issues									
	or history of self-injuri										
	,										

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