STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-348	B. WING		04/29/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
OUNG E	XPRESSIONS		LUDA DRIVE NIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMENTS	6	V 000			
	An annual survey wa 2022. Deficiencies v	as completed on April 29, vere cited.				
		ed for the following service C 27G .1700 Residential ure for Children or				
		ed for 4 and has a census of le consisted of audits of 3				
V 118	27G .0209 (C) Medic	cation Requirements	V 118			
	<ul> <li>only be administered order of a person audrugs.</li> <li>(2) Medications shall clients only when auclient's physician.</li> <li>(3) Medications, incluadinistered only by unlicensed persons to pharmacist or other I privileged to prepare (4) A Medication Admall drugs administered current. Medications recorded immediatel MAR is to include the (A) client's name;</li> <li>(B) name, strength, a (C) instructions for a (D) date and time the</li> </ul>	histration: on-prescription drugs shall I to a client on the written thorized by law to prescribe I be self-administered by thorized in writing by the uding injections, shall be v licensed persons, or by trained by a registered nurse, legally qualified person and e and administer medications. ninistration Record (MAR) of ed to each client must be kept administered shall be y after administration. The				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-348			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
		B. WING	04	04/29/2022		
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
YOUNG E	XPRESSIONS		LUDA DRIVE IIA, NC 28054			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	F CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLET
V 118	drug. (5) Client requests for checks shall be recor	e 1 r medication changes or ded and kept with the MAR pointment or consultation	V 118			
	failed to ensure MAR	as evidenced by: nd record review, the facility s were kept current affecting (Client #2). The findings				
	record revealed: -Admitted 12/19/21; -Diagnosed with Atter Disorder, Post-Traum Oppositional Defiant I -17 years old; -Physician's order dat (allergies) 10mg (milli and Quetiapine (antip -Physician's order dat (sleep) 10mg 1 tab at -February, 2022 MAR noted for administration	Disorder; ted 12/10/21 for Montelukast gram) 1 tab (tablet) daily sychotic) 400mg 1 tab daily; ted 4/12/22 for Melatonin				
	-March, 2022 MAR re for administration of C on 3/1/22;	evealed no signature noted Quetiapine 400mg 1 tab daily ealed no dosage for the				

		Ilation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			(X3) DATE SURVEY COMPLETED	
		MHL036-348			04/29/2022		
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
	XPRESSIONS	2325 SA	LUDA DRIVE				
		GASTO	NIA, NC 28054				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETE DATE	
V 118	Continued From page	e 2	V 118				
	-All medications were Client #2; -Was an oversight the current with signature medication; -Was an oversight the was not listed on the	with the Director revealed: a dministered correctly to at the MARs were not kept es for administration of each at the dosage of Melatonin April, 2022 MAR; s are kept current in the					
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing		V 296				
	telephone or page. A able to reach the faci times. (b) The minimum nu required when childre present and awake is (1) two direct of one, two, three or fou (2) three direct for five, six, seven or adolescents; and (3) four direct of nine, ten, eleven or to adolescents. (c) The minimum nu during child or adoles follows: (1) two direct of and one shall be awa children or adolescent (2) two direct of	asional shall be available by A direct care staff shall be lity within 30 minutes at all mber of direct care staff en or adolescents are as follows: are staff shall be present for ir children or adolescents; care staff shall be present eight children or care staff shall be present for welve children or mber of direct care staff scent sleep hours is as are staff shall be present are staff shall be present scare staff shall be present					

Division of Health Service Regulation STATE FORM

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STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         MHL036-348         NAME OF PROVIDER OR SUPPLIER       STREET AI			NUMBER: A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MUI 026 348				
		ADDRESS, CITY, STATE,	ZIP CODE	04	/29/2022	
	XPRESSIONS		LUDA DRIVE			
	AFRESSIONS	GASTO	NIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 296	Continued From page	e 3	V 296			
V 296	<ul> <li>Continued From page 3</li> <li>children or adolescents; and <ul> <li>(3) three direct care staff shall be present</li> <li>of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents.</li> <li>(d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan.</li> <li>(e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan.</li> </ul> </li> </ul>					
	failed to ensure a mir for up to four clients. Review on 4/27/22 at	nd record review, the facility nimum of two staff present				
	record revealed: -Admitted 8/17/21; -Diagnosed with Pos Disruptive Mood Dys -15 years old.	t-Traumatic Stress Disorder, regulation Disorder;				
	record revealed: -Admitted 12/19/21;	nd 4/28/22 of Client #2's ntion Deficit Hyperactivity				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MUI 026 249	B. WING			
	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	. ZIP CODE	02	1/29/2022
	XPRESSIONS	2325 SA	LUDA DRIVE IIA, NC 28054	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLET DATE
V 296	Continued From page	e 4	V 296			
	Oppositional Defiant -17 years old.	Disorder;				
	record revealed: -Admitted 8/25/21; -Diagnosed with Atten Disorder, Post-Traum Depressive Disorder, Specified Neurodeve -16 years old. Interviews on 4/27/22 revealed: -Sometimes there is of facility; -Only one staff memb on 4/27/22 because t to leave early. Interview on 4/27/22 revealed: -Was only alone with prior to bringing the c	2 with Clients #1, #2, and #3 only one staff member at the per (Director) was working the second staff member had and 4/28/22 with the Director the clients for a few minutes clients to their day treatment be second staff member				