| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL078-170 | A. BUILDING: _____ B. WING _____ | R 06/02/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHAPARRAL YOUTH SERVICES, LLC | 5973 MCLEOD DRIVE MAXTON, NC 28364 |

| (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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| V 000 | INITIAL COMMENTS<br><br>An annual, complaint, and follow up survey was completed on June 2, 2023. The complaint was substantiated (intake #NC00201738). Deficiencies were cited.<br><br>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.<br><br>This facility is licensed for 4 and currently has a census of 4. The survey sample consisted of an audit of 2 current clients and 1 discharged client. | V 000 | | |
| V 114 | 27G .0207 Emergency Plans and Supplies<br><br>10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES<br>(a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority.<br>(b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.<br>(c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies.<br>(d) Each facility shall have basic first aid supplies accessible for use.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interviews, the facility failed to have a fire and disaster drills held at least quarterly and repeated on each shift. The | V 114 | DHSR - Mental Health<br>JUN 21 2023<br>Lic. & Cert. Section | |

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| V 114 | Continued From page 1<br>findings are:<br><br>Interview on 6/1/23 Staff #3 stated:<br>-There were 3 shifts as follows:<br>-1st shift: 8am-4pm<br>-2nd shift: 4pm-12am<br>-3rd shift: 12am-8am<br><br>Review on 6/1/23 and 6/2/23 of the facility fire and disaster records from 4/1/22-3/31/23 revealed:<br>-Quarter 4/1/22-6/30/22:<br>-1st shift: Drills were documented on 4/7/22 at 8:01am and 5/30/22 at 3:01pm. Only one drill time was documented for each day, but both fire and disaster drills were marked on the report.<br>-2nd shift: Drill documented on 6/7/22 at 5:32pm. Only one drill time was documented, but both fire and disaster drills were marked on the report.<br>-3rd shift: No fire or disaster drills documented.<br>-Quarter 7/1/22-9/30/22:<br>-1st shift: Drills documented on 7/13/22 at 8:08am, 8/15/22 at 3:06 pm, and 9/15/22 at 10:08am. Only one drill time was documented for each day, but both fire and disaster drills were marked on the report.<br>-2nd shift: Drill documented on 8/25/22 at 6:25pm. Only one drill time was documented, but both fire and disaster drills were marked on the report.<br>-3rd shift: No disaster drill documented.<br>-Quarter 10/1/22-12/31/22:<br>-1st shift: No fire or disaster drills documented.<br>-2nd shift: No disaster drill documented.<br>-3rd shift: No disaster drill documented.<br>-Quarter 1/1/23-3/31/23:<br>-2nd shift: No disaster drill documented. | V 114 | | |

# Plan of Correction: Chaparral Youth Services LLC

## Plan of Correction

| Please complete all requested information and mail completed Plan of Correction form to: | In lieu of mailing the form, you may e-mail the completed electronic form to: |
|---|---|
| Mental Health Licensure and Certification Section<br>NC Division of Health Service Regulation<br>2718 Mail Service Center<br>Raleigh, NC 27699-2718 | |

| | | | |
|---|---|---|---|
| **Provider Name:** | **Chaparral Youth Services, LLC** | **Phone:** | **910-827-1169** |
| **Provider Contact Person for follow-up:** | **Sheree Sampson**<br>**Sheree Sampson** | **Fax:** | **910-593-3577** |
| | | **Email:** | **sheree1157@gmail.com** |
| **Address:** | 5973 McLeod Dr., Maxton NC 28364 | **Provider #** 6603911 | |

| Finding | Corrective Action Steps | Responsible Party | Time Line |
|---|---|---|---|
| **V114 Fire/Disaster Drills** :This Rule is not met as evidenced by:<br>Based on record review and interviews, the facility failed to have a fire and disaster drills held at least quarterly and repeated on each shift | Fire and disaster drills will be held at least quarterly on each shift. Additionally, all staff will be included in practicing fire and disaster drills.<br><br>Residential Mgr will cover new policy in supervision this month: Emergency drills will be held by the 10th of each month on each shift. All staff will be required to participate in and conduct the drills by the 10th of each month. | Fred McCallum, QP<br>Johnny K. Sampson PP<br><br>Johnny Sampson, PP will be assigned duties as SAFETY OFFICER and will monitor Drill Reports quarterly to ensure that all staff are participating and that drills occur on each shift at least quarterly.<br>Fred McCallum, QP will cover in supervision. | Implementation Date: 6/30/2023<br><br>Projected Completion Date: Ongoing |
| **V118 MARS:** This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to administer medications as ordered by the physician, and maintain a current/accurate MAR with medications recorded immediately after administration, affecting 2 of 2 audited current clients (#1, #3) and 1 of 1 former client (FC#5). | Medication Administration Records (MAR's) have been revised to include time-specific administration to ensure PRN's are administered/accounted for appropriately and will give a specific time in case of late administrations. The QP/AP will review MAR's daily to double check them for accuracy in transcription, administration and orders. Training to ensure that no client will receive any medication without a specific Dr's order. Previous OTC form is now discontinued for administration of any medication. A copy of RX from the pharmacy or a copy of Dr's note prescribing the medication will be used to document order to administer. | Sheree Sampson LCMHC LCAS-A/AP-Residential Mgr<br>Fred McCallum, QP will review MAR's with Johnny Sampson, PP daily to ensure accuracy. | Implementation Date: 6/02/2023<br><br>Projected Completion Date: 6/05/2023 & Ongoing |

| | | | |
|---|---|---|---|
| | | | |
| **V300 Unplanned Discharge**: This Rule is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure a service planning meeting was held within five business days of an emergency discharge affecting 1 of 1 former clients (FC#5). | Policy & Procedure will be updated to add: A service planning meeting will be held within five business days of an emergency discharge of any client. | Sheree Sampson LCMHC<br>LCAS-A/AP-Residential Mgr | Implementation Date:<br>6/02/2023<br>Projected Completion Date:<br>6/30/2023 |
| **V366 Restrictive Interventions:** This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to report incidents as required by the rule. | Supervision by Residential Mgr will include clarification on what constitutes a restrictive intervention and how it is reported. Staff will be educated on importance of documenting the intervention within 24 hrs and reported to all personnel. A log will be produced for documenting restrictive interventions to include IRIS info. Policy & Procedure to be amended to include more thorough documentation. | Sheree Sampson LCMHC<br>LCAS-A/AP-Residential Mgr | Implementation Date:<br>6/05/2023<br>Projected Completion Date:<br>7/15/2023/Ongoing |
| **V367 V521 V524 V525 Restrictive Interventions:** This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to report incidents as required by the rule. | Residential Mgr will ensure that (according to log) all Critical Incidents will be reported through IRIS within 72 hrs. Training will be provided to QP so at least two staff have knowledge of these reporting requirements. Debriefing of the Critical Incident will occur within 5 days of the incident with both group home staff & legally responsible person. Policy & Procedure to be reviewed to ensure reflection of these procedures. | Sheree Sampson LCMHC<br>LCAS-A/AP-Residential Mgr<br>Fred McCallum, QP | Implementation Date:<br>6/05/2023<br>Projected Completion Date:<br>7/15/2023/Ongoing |

Sheree Sampson LCMHC LCAS-A/AP
6/16/2023

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

**ROY COOPER** • Governor
**KODY H. KINSLEY** • Secretary
**MARK PAYNE** • Director, Division of Health Service Regulation

June 8, 2023

Sheree Sampson
Chaparral Youth Services, LLC
16 Stanley St.
Pembroke, NC 28372

Re: Annual, Follow Up, and Complaint Survey completed June 2, 2023
Chaparral Youth Services, LLC, 5973 McLeod Road, Maxton, NC 28364
MHL # 078-170
E-mail Address: sheree1157@gmail.com
Intake #NC00201738

Dear Ms. Sampson:

Thank you for the cooperation and courtesy extended during the annual, follow up, and complaint survey completed June 2, 2023. The complaint was substantiated.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

**Type of Deficiencies Found**

- Re-cited standard level deficiencies.
- All other tags cited are standard level deficiencies.

**Time Frames for Compliance**

- Re-cited standard level deficiencies must be ***corrected*** within 30 days from the exit of the survey, which is 7/2/23.
- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is 8/1/23.

**What to include in the Plan of Correction**

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Gloria Locklear at 910-214-0350.

Sincerely,

Betty Godwin, RN, MSN
Nurse Consultant 1
Mental Health Licensure &
Certification Section

Ryan Meredith
Facility Compliance Consultant 1
Mental Health Licensure &
Certification Section

Cc: Joy Futrell, CEO, Trillium Health Resources LME/MCO
Fonda Gonzales, Director of Quality Management, Trillium Health Resources LME/MCO
Pam Pridgen, Administrative Supervisor