Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
712 . 271	0. 0020		A. BUILDING:		R	
		MHL036-357	B. WING			₹ 25/2023
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
COSBY	COSBY COUNSELING & CONSULTING, PLLC 1351 HARGROVE AVENUE GASTONIA, 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMEN	TS	V 000			
	completed on Octo was substantiated Deficiencies were of This facility is licenscategory: 10A NCA	int and follow up survey was ober 25, 2023. The complaint (intake #NC00207941). cited. sed for the following service AC 27G .1700 Residential ecure for Children or				
	Adolescents.					
		sed for 4 and currently has a urvey sample consisted of ents.				
V 118	27G .0209 (C) Med	dication Requirements	V 118			
	only be administered order of a person and drugs. (2) Medications shad clients only when a client's physician. (3) Medications, included and administered only builties and persons pharmacist or othe privileged to prepare (4) A Medication Acall drugs administed current. Medication recorded immediat MAR is to include the (A) client's name; (B) name, strength	ninistration: non-prescription drugs shall ed to a client on the written authorized by law to prescribe all be self-administered by authorized in writing by the cluding injections, shall be by licensed persons, or by as trained by a registered nurse or legally qualified person and are and administer medications dministration Record (MAR) of ared to each client must be kep as administered shall be all gets after administration. The				

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

TITLE (X6) DATE

Division of Health Service Regulation

	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) PROVIDER/SUPPLIER/CLIA (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE (X7) MULTIPL			X3) DATE SURVEY COMPLETED		
		MHL036-357	B. WING		l l	R 25/2023
	PROVIDER OR SUPPLIER COUNSELING & CON	SULTING, PLLC	DDRESS, CITY, S'RGROVE AVE	NUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
V 118	(E) name or initials drug. (5) Client requests checks shall be rec	ne drug is administered; and of person administering the for medication changes or corded and kept with the MAR appointment or consultation	V 118			
	failed to ensure sta medication adminis pharmacist or other affecting 1 of 3 aud are:	et as evidenced by: view and interview, the facility ff had been trained in stration by a registered nurse, r legally qualified person ited staff (#1). The findings				
	-A hire date of 10/1	6/23. 10/16/23 which reflected Staff ining in medication				
	-Licensee provided training. -Did not know if Lic pharmacist or regis	23 with Staff #1 revealed: medication administration ensee was a licensed tered nurse. ered medication on 3 shifts.				
	-Trained as a medication -Thought medication qualified her to teach	23 with the Licensee revealed: cation technician on 3/20/23. on technician certification ch medication administration. said any person trained by a				

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
71101211	or contraction	BERTH IOMER MONBER	A. BUILDING:				
		MHL036-357	B. WING			R 25/2023	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
COSBV	COUNSELING & CON	SULTING BLIC 1351 HAR	GROVE AVE	NUE			
СОЗВТ	COUNSELING & CON	GASTONI	2				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
V 118	Continued From pa	ge 2	V 118				
	licensed nurse could teach medication administration." -"I misinterpreted the rule." -"I've only trained [Staff #1]."						
V 296	27G .1704 Residen Staffing	tial Tx. Child/Adol - Min.	V 296				
	REQUIREMENTS (a) A qualified profitelephone or page. able to reach the fatimes. (b) The minimum required when child present and awake (1) two direct one, two, three or fo (2) three direct for five, six, seven of adolescents; and (3) four direct nine, ten, eleven or adolescents. (c) The minimum reduring child or adolescents. (c) The minimum reduring child or adolescents. (1) two direct and one shall be averaged the children or adolescents. (2) two direct and both shall be averaged three directs.	care staff shall be present for our children or adolescents; ct care staff shall be present or eight children or to care staff shall be present for twelve children or twelve children or twelve children or twelve children or twelve staff escent sleep hours is as care staff shall be present wake for one through four eents; care staff shall be present wake for five through eight					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL036-357	B. WING			R 25/2023
	PROVIDER OR SUPPLIER	SULTING PLIC 1351 HA	DDRESS, CITY, S RGROVE AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 296	care staff set forth in Rule, more direct countries the facility based or individual needs as plan. (e) Each facility should supervision of child are away from the finding of adolescent.	in Paragraphs (a)-(c) of this are staff shall be required in the child or adolescent's specified in the treatment all be responsible for ensuring tren or adolescents when they facility in accordance with the sindividual strengths and in the treatment plan.				
	failed to ensure mir findings are: Observation on 10/2 pm revealed: -Staff #4 and a Clie facilityStaff #4 and Client approximately 30 m Review on 10/23/23 revealed: -Date of Admission -Age 10Diagnoses of Atter Disorder and Disrup Disorder.	ion and interviews the facility nimum staffing ratio. The 23/23 at approximately 1:30 ant #4 were present in the #4 were alone for ninutes. 3 of Client #4's record				

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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	
					F	
		MHL036-357	B. WING		10/2	5/2023
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
COSBY	COUNSELING & CON	SHITING PLIC	GROVE AVE A, NC 2805			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 296	Continued From pa	ge 4	V 296			
	-Sometimes only or	ne staff there.				
		23 with Client #3 revealed: 's here with us (clients)"				
	Professional reveal -Worked 3rd shift"I work alone some -"I am not sure wha to be, one or two." -Licensee was resp	etimes" It the staffing ratio is supposed consible for scheduling staff. 23 with the Licensee revealed:				
	-No incidentsOnly one staff schoolshortageOnly once or twice	eduled per shift due to staff				

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