STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         MHL0411254         NAME OF PROVIDER OR SUPPLIER       STREET			A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MU 0444254				
		ADDRESS, CITY, STATE	, ZIP CODE	08	08/23/2024	
HERS PL	ACE		/ER HILLS DRIVE SBORO, NC 27410			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT 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	ACTION SHOULD BE COMP TO THE APPROPRIATE DA	
∨ 000	INITIAL COMMENTS An annual survey was completed on August 23, 2024. Deficiencies were cited.		V 000			
	This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents.					
	census of 2. The sur	ed for 4 and has a current vey sample consisted of ents and 1 former client.				
V 114	27G .0207 Emergene	cy Plans and Supplies	V 114			
	AND SUPPLIES (a) Each facility shall and a disaster plan a these plans available to the county emerge request. The plans sh procedures and route (b) The plans shall be and evacuation proce posted in the facility. (c) Fire and disaster shall be held at least repeated for each sh	ency services agencies upon hall include evacuation es. e made available to all staff edures and routes shall be drills in a 24-hour facility quarterly and shall be ift. eted under conditions that response to fire				
ision of U.S.	Ith Service Regulation					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0411254			(X2) MULTIPLE CO		E SURVEY PLETED	
			A. BUILDING:			
		B. WING		30	08/23/2024	
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
CHERS PL	LACE		/ER HILLS DRIVE SBORO, NC 27410			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT 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	ACTION SHOULD BE COMPL TO THE APPROPRIATE DAT	
V 114	Continued From pag	e 1	V 114			
	This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure fire and disaster drills were conducted once per shift per quarter. The findings are:					
	to 8/19/24 revealed: -First client was adm 2023 -11/2/23 8am -11/2/23 6pm -No documentation a December 2023 -1/9/24 2:45am -2/8/24 8:30am -2/8/24 6:01pm	's fire drill logs from 11/2/23 itted the 13 th day of October a fire drill was conducted in				
	March 2024	a fire drill was conducted in a fire drill was conducted in				
	-8/19/24 9:16am Attempted review on drills revealed no doo conducted once per	8/22/24 and 8/23/24 disaster cumentation the drills were shift per quarter. with clients #2 and #3				
	revealed: -Had no participated					
	Interview on 8/22/24 revealed:	with Qualified Professional				

STATE FORM

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0411254				(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:		
		B. WING		08/23/2024		
IAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
HERS P	LACE		SBORO, NC 27410			
(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 TO DEFICIEN	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLET DATE
V 114	Continued From page 2		V 114			
		depends. But we try to do n all three shifts. I have not er drills."				
	Interview on 8/23/24 with the Owner/Licensee revealed: -"My first client came in October 2023." -Had only one client in December 2023, March 2024 and April 2024. -"I will be creating a form for the disaster drills (identical to the fire drill form) to start using."					
V 131	G.S. 131E-256 (D2) I Verification	HCPR - Prior Employment	V 131			
	REGISTRY (d2) Before hiring hea health care facility or health care facility sh Personnel Registry a	ALTH CARE PERSONNEL alth care personnel into a service, every employer at a all access the Health Care nd shall note each incident opriate business files.				
	facility failed to acces hire for 3 of 3 audited	ews and interview, the is the HCPR registry prior to I staff (#1, the Qualified d the Owner/Licensee				
	Review on 8/23/24 of -A hire date of 6/16/2 -A job description of F					

U8BW11

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		MHL0411254	B. WING		08	3/23/2024
AME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
HERS PL	ACE		VER HILLS DRIVE SBORO, NC 27410			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	ACTION SHOULD BE COMPL TO THE APPROPRIATE DAT	
V 131	Continued From page 3		V 131			
	-The HCPR was accessed on 8/23/24					
	Review on 8/23/24 of the QP's record revealed: -A hire date of 7/28/24 -A job description of QP -The HCPR was accessed on 8/7/24 Review on 8/23/24 of the O/L's record revealed:Date of Hire: -A hire date of 6/14/22 -A job description of Owner -The HCPR was accessed on 6/28/23					
	-Was not aware the H accessed prior to hire	with the O/L revealed: HCPR checks were to be e. r ensuring the HCPR checks				

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