Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL026-989	B. WING		11/0	8/2024
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THOMPS	SON CHILD & FAMILY	FOCUS-SALLY H	Y HILL CIRC VILLE, NC  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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	-S	V 000			
	An annual survey w 2024. Deficiencies	vas completed on November 8, were cited.				
		sed for the following service C 27G .1700 Residential cure for Children or				
		sed for 6 and has a current urvey sample consisted of clients.				
V 114	27G .0207 Emerger	ncy Plans and Supplies	V 114			
	10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes. (b) The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (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 the facility's response to fire emergencies. (d) Each facility shall have a first aid kit accessible for use.					

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

TITLE (X6) DATE

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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		
		MHL026-989	B. WING		11/0	8/2024
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•	
THOMPS	SON CHILD & FAMILY	' FOCUS-SALLY H	Y HILL CIRC VILLE, NC 2			
(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 APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 114	Continued From pa	age 1	V 114			
	Based on record refacility failed to ensheld at least quarter. The findings are:  Review on 11/7/24 and disaster Drills Involved the 4th Quarter of 2000 -No disaster drill he Quarter of 2024 (All -No fire or disaster.	drill held on 2nd shift during 2023 (October - December). drill held on 2nd shift during 2024 (January - March). eld on 1st shift during the 2nd				
	Interview on 11/7/24 client #2 stated: -Fire drills are held monthlyShe had not participated in a disaster drill.					
	Interview on 11/7/2 -She had not partic since admission.	4 client #3 stated: sipated in a fire or disaster drill				
	Interview on 11/7/2 -Fire drills were hel -She was unsure a	ld monthly.				
		4 staff #3 stated: dule for fire and disaster drills. were held monthly.				
	stated: -1st shift - 7am - 7p -The facility held a	4 the Program Supervisor om and 2nd shift 7pm - 7am. fire drill once monthly. disaster drill each month or				

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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		
			A. BOILDING.			
		MHL026-989	B. WING		11/0	8/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THOMPS	SON CHILD & FAMILY	' FOCUS-SALLY H	Y HILL CIRC VILLE, NC 2			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECT	ON	(X5)
PREFIX TAG	·	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
V 118	27G .0209 (C) Med	lication Requirements	V 118			
	only be administered order of a person and drugs.  (2) Medications shad clients only when a client's physician.  (3) Medications, incompliation administered only build unlicensed persons pharmacist or othe privileged to prepare (4) A Medication Adall drugs administered order to the privileged to prepare (4) A Medication Adall drugs administered order to the privileged to prepare (4) A Medication Adall drugs administered order to the privileged to prepare (4) A Medication Adall drugs administered immediate (A) client's name; (B) name, strength (C) instructions for (D) date and time to (E) name or initials drug.  (5) Client requests checks shall be recorded.	ninistration: non-prescription drugs shall ed to a client on the written nuthorized by law to prescribe all be self-administered by nuthorized in writing by the cluding injections, shall be by licensed persons, or by se trained by a registered nurse, re legally qualified person and re and administer medications. dministration Record (MAR) of red to each client must be kept as administered shall be ely after administration. The				
	This Rule is not m	et as evidenced by:				

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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		
		MHL026-989		B. WING		11/0	08/2024
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THOMPS	ON CHILD & FAMILY	POCHS-SALLY H		Y HILL CIRC VILLE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F .SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From pa	age 3		V 118			
	interviews, the facil medications on the and failed to keep t	eviews, observations a lity failed to administer written order of a phy the MARs current affected ared clients (#2, #3). Th	sician cting				
	-17 year old female -Admitted 9/11/24. -Diagnoses of Post acute, Autistic Disc Intellectual Disabili -No documentation	t Traumatic Stress Dis order and Unspecified	order order				
	Review on 11/7/24 of client #2's MARs from September 11, 2024 - November 7, 2024 revealed: -Melatonin 10 mg was administered on 11/6/24						
	of client #2's medic -Melatonin 10 mg v	vas an over the counte ler box was empty and	er.				
	Interview on 11/7/2 -She received her in-		onsite.				
	-12 year old female -Admitted on 7/24/2 -Diagnoses of Atter	24. ntion-deficit hyperactiv type and Post-trauma	ity				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	·	COMPLETED	
		B. WING		44/00/0004	
		MHL026-989	D. WING		11/08/2024
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
THOMPS	ON CHILD & FAMILY	FOCUS-SALLY H	LLY HILL CIRC EVILLE, NC 2		
(V4) ID	QUIMMADV QTA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	N (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE COMPLETE
V 118	Continued From pa	ge 4	V 118		
	of client #3's medical-Vitafusion Melaton mg available for additional medical interview on 11/7/24-She took Vyvanseashe received her management of the view of 11/8/24-Client #2 was presson was told by the docherself.  -There was no self-#2.  -Client #2 lost the Vishe was prescribedal -Client #2 receivedal -She was in the promedication adminisal physician orders all physician orders all physician orders with her.  -He was unsure who clients.  -He understood all administered on a vishe edd to any client with administered on a vished with administered on a vished with a medical to any client	in 10 mg and Allergy Relief 2 ministration.  4 client #3 stated: daily. nedications daily.  4 the Nurse stated: cribed the Ventolin Inhaler artor she could administer it administration order for client /entolin Inhaler shortly after I. an over the counter Melatonicess of in servicing all staff of tration. nce 9/27/24 and had not see	5 nd t n. n		

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