STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-338	A. BUILDING: _____ B. WING _____	04/03/2018

DHSR - Mental Health
APR 20 2018
Lic. & Cert. Section

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARPE AND WILLIAMS #5	2042 TEMPLE STREET WINSTON SALEM, NC 27101

(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 An annual survey was completed on 4/3/18. A deficiency was cited. This facilitty is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Mental Illness.	V 000	we have updated our process to include a unsupervised Assessment form in their admission packet. please see attached unsupervised time Assessment tool. This Assessment tool will be utilized on current consumers and future new admissions. All current consumers will have this form completed within the next 30-60 days by Administrative team.	
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or	V 290		

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V 290	Continued From page 1 more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to document in the client's treatment plan that the client was capable of remaining in the home or community without supervision affecting 3 of 3 audited clients (#1, #2 and #3). The findings are: Review on 4/2/18 of client #1's record revealed: - An admission date of 1/7/18 - Diagnoses of Schizophrenia, Paranoid Type; ETOH Dependence, FSR (Full Sustained Remission); Cannabis Abuse and Seizure Disorder - A treatment plan dated 1/20/18 and completed by the facility's Qualified Professional (QP) documented client #1 could have up to five hours of unsupervised time in the community "in order to gain independence." - No documentation in client #1's treatment plan which reflected that client #1 was capable of being in the community without staff supervision	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-338	A. BUILDING: _____ B. WING _____	04/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 290	Continued From page 2 Review on 4/3/18 of client #2's record revealed: - An admission date of 1/10/18 - Diagnoses of Schizophrenia, Continuous; Onychomycosis; Hyperlipidemia; Constipation and Peripheral Vascular Disease - A treatment plan dated 1/20/18 and completed by the facility's QP which documented client #2 could have "unsupervised time for up to 6 hours specifically to go with his brothers in order to build his work skills..." - No documentation in client #2's treatment plan which reflected that client #2 was capable of being in the community without staff supervision Review on 4/3/18 of client #3's record revealed: - An admission date of 1/21/18 - Diagnoses of Schizoaffective D/O, Bipolar Type and Multiple Open Wounds without Complication - A treatment plan dated 1/20/18 and completed by the facility's QP documented client #3 could have "up to 4 hours unsupervised time in the community to be used for exercise with his health and cholesterol..." - No documentation in client #3's treatment plan which reflected that client #3 was capable of being in the community without staff supervision Interviews on 4/2/18 and on 4/3/18 with the House Attendant Supervisor revealed: - The QP responsible for completing an assessment of the client's capability of remaining in the home or community without staff supervision was no longer employed by the facility - It had been his understanding the required information regarding the clients' ability to have unsupervised time had been documented in the clients' treatment plans.	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 290	Continued From page 3 Interview on 4/3/18 with facility's Chief Financial Officer revealed: - The facility would ensure the required information regarding the clients' ability to have unsupervised time would be documented in the clients' treatment plans as soon as possible.	V 290		

DIVISION OF DEVELOPMENTAL DISABILITIES
UNSUPERVISED TIME ASSESSMENT

Individual's Name: _____ **MIS #** _____

Provider's Name: _____ **Skill Level** _____

Address: _____

Is the individual their own Guardian? Yes: ☐ No: ☐

Has the individual been determined to be in need of a guardian? Yes: ☐ No: ☐

Has a guardian been legally appointed? Yes: ☐ No: ☐

Guardian's name: _____ Date of appointment: _____

Does the individual wish to have unsupervised time at home? Yes: ☐ No: ☐

Does the individual wish to have unsupervised time in the community? Yes: ☐ No: ☐

Does the individual have any legal issue or criminal history that may negatively affect unsupervised time? Yes: ☐ No: ☐

Explain: _____

_____

_____

_____

_____

_____

_____

Unsupervised Time Assessment completed by: _____

Relationship to individual: _____

Date of Assessment : _____

6/20/03

Unsupervised Time in Community Care Homes
Work Group

Recommendations:

1. The IDT must determine what purpose the unsupervised time serves the individual.

It should be done to increase the independence of the individual and not for the convenience of the sponsor. The IDT must, as part of the assessment, review what restrictions in activities apply during the unsupervised time.

2. The consumer must express a desire for time alone.

3. The Skill Level of the individual must be considered. There will be no unsupervised time for a Level IIIB, or IV. The criteria for these levels indicate that 24 hour supervision in required. (See page 13 for Skill Level Criteria).

4. Skill Levels I, II and III will be considered for unsupervised time:

   a. When an Assessment has been completed with the consumer that reviews unsupervised time, both in the home and on the property, as well as in the community. Assessment is to be completed by Division staff with input from residential provider and the individual. Additional input may be obtained from day program, behaviorist, nurse, family members etc. as needed.

   b. When the complete IDT has reviewed the assessment, weighed the risks versus the benefits, and is in agreement that the unsupervised time is appropriate. The IDT must include the consumer, sponsor, case manager, guardian, family (if there is no family or appointed guardian, the Case Management Supervisor would review and sign off on the recommendation. A behaviorist, day program, psychologist or nurse should be included when applicable. If an IDT cannot reach agreement, a referral to the DDD Human Rights Committee is to be initiated. The Case Management Supervisor and County Administrator will receive a copy of the referral.

   c. When the sponsor can demonstrate that they have a back-up plan should the consumer need to contact someone for assistance during the unsupervised time.

   d. All Skill Level III requests will be reviewed by IDT, Regional Administrator, and DDD Human Rights Committee.

5. Unsupervised time must be addressed in the IHP and documented. The Unsupervised Time Assessment must be reviewed and re-approved on at least an annual basis or as circumstances change.

6. One consumer cannot be left to supervise another consumer.

7. Each individual, if appropriate, in a home must have an assessment. Group assessments are not allowed.

Assessment Scale: (3)- Yes (Please provide brief explanation of all "yes" responses)
(2)- No
(1)- Not Applicable
If the individual exhibits any of the first 5 issues, independent unsupervised time should not be approved.

Assessment-(Part 1)- Medical/Behavioral Needs

Does the consumer currently have, or have a history of any of the following that could preclude them from having unsupervised time?

1. PICA 3 ☐ 2 ☐ 1 ☐

2. Uncontrolled Seizure Disorder 3 ☐ 2 ☐ 1 ☐

3. Fire Setting Behavior 3 ☐ 2 ☐ 1 ☐

4. Dementia 3 ☐ 2 ☐ 1 ☐

5. Elopment 3 ☐ 2 ☐ 1 ☐

6. Diabetes 3 ☐ 2 ☐ 1 ☐

7. Hearing/Visual Impairment

8. Medication 3 ☐ 2 ☐ 1 ☐

Name of med : time administered: AM ☐ PM ☐
Name of med : time administered: AM ☐ PM ☐
Name of med : time administered: AM ☐ PM ☐
Name of med : time administered: AM ☐ PM ☐
Name of med : time administered: AM ☐ PM ☐

Does the individual self-medicate? Yes: ☐ No: ☐
Date of self-medication assessment: _____

9. Choking/Swallowing Problems 3 ☐ 2 ☐ 1 ☐

Assessment-(Part 1)- Cont.

10. Mobility Issues 3 ☐ 2 ☐ 1 ☐

11. Hypertension 3 ☐ 2 ☐ 1 ☐

12. Self-Injurious Behaviors 3 ☐ 2 ☐ 1 ☐

13. Agoraphobia (Abnormal Fear of Open Spaces) 3 ☐ 2 ☐ 1 ☐

14. Oppositional Behaviors 3 ☐ 2 ☐ 1 ☐

15. Non-compliant Behaviors 3 ☐ 2 ☐ 1 ☐

16. Tendency of forgetfulness 3 ☐ 2 ☐ 1 ☐

17. Legal Constraints (Court Ordered Suspension, etc.) 3 ☐ 2 ☐ 1 ☐

18. Other 3 ☐ 2 ☐ 1 ☐

If you answered yes to any of the above, the Regional Nurse, Behaviorist, and/or psychologist must review and agree that these medical/behavioral issues will not affect the consumer negatively during unsupervised time, before any unsupervised time is approved.

Throughout this assessment, the following scale should be used: ***Assessment Scale:***

(3)- Independent (2) - Semi- Independent

(1) - Dependent (*)-Individual must demonstrate skill

If the individual is not able to independently complete the first 9 areas, independent unsupervised time should not be approved in this area.

Assessment-(Part 2)- In-Home Emergency Skills

*1. Can the individual communicate his/her first and last name, address, and telephone number?

3 ☐ 2 ☐ 1 ☐

*2. Can the individual use the telephone to request help with or without adaptive equipment?

3 ☐ 2 ☐ 1 ☐

*3. Does the individual know how to lock/unlock the doors to his/her home?

3 ☐ 2 ☐ 1 ☐

4. During the past 12 months, did the individual consistently evacuate independently during scheduled fire drills (including at least 1 overnight)?

3 ☐ 2 ☐ 1 ☐

*5. Does the individual know where all exits are located in case of emergency?

3 ☐ 2 ☐ 1 ☐

6. If the individual must evacuate due to an emergency, does he/she know not to go back into the home unless police/fire dept. say it is safe to return?

3 ☐ 2 ☐ 1 ☐

*7. Can the individual identify a designated safe place to go if he/she must leave the home in an emergency?

3 ☐ 2 ☐ 1 ☐

*8. Is the individual able to locate and utilize emergency numbers in the home?

3 ☐ 2 ☐ 1 ☐

*9. Can the individual explain when to dial 9-1-1? 3 ☐ 2 ☐ 1 ☐

*10. Can the individual tell time? 3 ☐ 2 ☐ 1 ☐

Comments: _____

11. Does the individual maintain a key to the home? 3 ☐ 2 ☐ 1 ☐

12. Can the individual safely operate household appliances? 3 ☐ 2 ☐ 1 ☐

Specify which appliances: _____

_____

13. Can the individual safely prepare a meal? 3 ☐ 2 ☐ 1 ☐

Assessment-(Part 2)- Cont.

*14. Does the individual know where to find emergency flashlight and how to operate it?

3 ☐ 2 ☐ 1 ☐

15. Does the individual know how to care for a minor injury (ie. cut)?

3 ☐ 2 ☐ 1 ☐

16. Does the individual know what to do if he/she has a major injury (ie. gash)?

3 ☐ 2 ☐ 1 ☐

17. Does the individual know what to do in an emergency if the telephone does not work?

3 ☐ 2 ☐ 1 ☐

Demonstrations of In-Home Emergency Skills:

1. Time Telling: Date of Demo _____

☐ Individual completed task independently
☐ Individual completed task w/verbal prompts
☐ Individual completed task w/physical assistance
☐ Task not completed

2. Communicate Name, Address, Telephone #: Date of Demo _____

☐ Individual completed task independently
☐ Individual completed task w/verbal prompts
☐ Individual completed task w/physical assistance
☐ Task not completed

3. Telephone Use: Date of Demo _____

☐ Individual completed task independently
☐ Individual completed task w/verbal prompts
☐ Individual completed task w/physical assistance
☐ Task not completed

4a. Lock/Unlock Doors: Date of Demo _____

☐ Individual completed task independently
☐ Individual completed task w/verbal prompts
☐ Individual completed task w/physical assistance
☐ Task not completed

Assessment-(Part 2)- Demonstrations Cont.

5. State and Demonstrate Designated Safe Place: Date of Demo _____

- ☐ Individual completed task independently
- ☐ Individual completed task w/verbal prompts
- ☐ Individual completed task w/physical assistance
- ☐ Task not completed

6. Locate/Read Emergency Numbers: Date of Demo _____

- ☐ Individual completed task independently
- ☐ Individual completed task w/verbal prompts
- ☐ Individual completed task w/physical assistance
- ☐ Task not completed

7. State when to Dial 9-1-1: Date of Demo _____

- ☐ Individual completed task independently
- ☐ Individual completed task w/verbal prompts
- ☐ Individual completed task w/physical assistance
- ☐ Task not completed

8. Operate Flashlights: Date of Demo _____

- ☐ Individual completed task independently
- ☐ Individual completed task w/verbal prompts
- ☐ Individual completed task w/physical assistance
- ☐ Task not completed

Assessment Scale: **(3)-Independent** **(1)-Dependent**
(2)-Semi-Independent **(*)-Individual must demonstrate skill**

If the individual is not able to independently complete the first 7 areas, independent unsupervised time should not be approved.

Assessment-(Part 3)-Community Safety/Awareness Skills

*1. Can the individual explain what to do if he/she gets lost in the community? 3 ☐ 2 ☐ 1 ☐

*2. Does the individual cross streets safely at the crosswalk? 3 ☐ 2 ☐ 1 ☐

*3 Can the individual utilize a phone to call for help or use a public pay phone? 3 ☐ 2 ☐ 1 ☐

*4. Can the individual explain what to do if he/she became sick while in the community? 3 ☐ 2 ☐ 1 ☐

*6. Can the individual list who to ask for help (in the community) if he/she is unable to reach their sponsor? 3 ☐ 2 ☐ 1 ☐

7. Can the individual identify the ladies/men's room? 3 ☐ 2 ☐ 1 ☐

*8. Does the individual or access link know how to use public transportation? 3 ☐ 2 ☐ 1 ☐

9. Does the individual know how to call and pay for a cab? 3 ☐ 2 ☐ 1 ☐

*10. Can the individual explain what to do if he/she lost their keys? 3 ☐ 2 ☐ 1 ☐

Demonstrations of Community Safety/Awareness Skills:

1. Explain what to do if lost in community: Date of Demo _____

☐ Individual completed task independently
☐ Individual completed task w/verbal prompts
☐ Individual completed task w/physical assistance
☐ Task not completed

2. Cross streets safely: Date of Demo _____

☐ Individual completed task independently
☐ Individual completed task w/verbal prompts
☐ Individual completed task w/physical assistance
☐ Task not completed

Assessment-(Part 3)- Demonstrations Cont.

3. Use of Public Transportation: Date of Demo _____

- ☐ Individual completed task independently
- ☐ Individual completed task w/verbal prompts
- ☐ Individual completed task w/physical assistance
- ☐ Task not completed

4. Explain what to do if sick in the community: Date of Demo _____

- ☐ Individual completed task independently
- ☐ Individual completed task w/verbal prompts
- ☐ Individual completed task w/physical assistance
- ☐ Task not completed

5. Explain what to do if transportation does not come: Date of Demo _____

- ☐ Individual completed task independently
- ☐ Individual completed task w/verbal prompts
- ☐ Individual completed task w/physical assistance
- ☐ Task not completed

6. List who to ask for help in the community: Date of Demo _____

- ☐ Individual completed task independently
- ☐ Individual completed task w/verbal prompts
- ☐ Individual completed task w/physical assistance
- ☐ Task not completed

7. Explain what to do if keys are lost while in the community: Date of Demo _____

- ☐ Individual completed task independently
- ☐ Individual completed task w/verbal prompts
- ☐ Individual completed task w/physical assistance
- ☐ Task not completed

Assessment- (Part 4)-General Discussion Questions

1. What should the individual carry with him/her when out in the community?

2. What would the individual do if a stranger asks for money or tries to steal something from him/her?

3. Does the individual know what to do if a stranger knocks on the door?

4. Can the individual explain the dangers of accepting rides, hitchhiking or accepting money from strangers?

5. Does the individual display appropriate interaction in the community? If no, explain

6. Can the individual say "NO" in a situation he/she is uncomfortable with? Explain.

7. Has the individual spent time alone at their current home or at a previous living arrangement (including when they lived with their family)? If yes, explain

8. Has the individual ever spent time alone in the community? When? How long?

Assessment -(Part 4)-Cont.

9. What are the agreed upon guidelines for having friends over without the caregiver present?

10. Has the individual had an IHP goal involving being in community with supervision? If yes, what did the goal state?

11. How long did the individual work on their community goal?

12. If unsupervised time is approved at home, what area(s) would that include (ie. front porch, backyard, entire property, to the mailbox, to the curb, driveway etc.)?

13. If unsupervised time is approved in the community, what area(s) would that include (ie. friend's house, library, local stores, park, transportation services, etc.)

14. Are there any ambulation issues that would impact on unsupervised time? If yes, explain

15. If another individual, who has unsupervised time, will be present, are the individuals willing/able to stay home alone with each other? If no, explain

16. Are there any restrictions/limitations that should be considered for this individual?

LEVELS OF SUPERVISION

Independent means the individual:

a. Doesn't need 24 hours supervision
b. Is capable of performing tasks without direction
c. Exercises personal responsibility
d. Is able to safely and purposely follow routines
e. Has demonstrated an acceptable standard of social behavior
f. Is self-directed
g. Has no medical or behavioral conditions that place him/her at risk
h. Consistently follows rules and regulations
i. Can avoid exploitation and environmental hazards

Semi-Independent means the individual:

a. May not need 24 hour supervision at all times but may need intermittent supervision or checks
b. Can accomplish most tasks, but may be inconsistent or need additional training or direction
c. Usually doesn't exhibit dangerous behaviors
d. May require reminders or prompts
e. Has no medical or behavioral conditions that might place him/her at risk

Dependent means the individual:

a. Requires 24 hour supervision
b. Cannot complete most tasks without direction or assistance
c. Cannot safely and purposefully follow routines; is not self directed
d. May have demonstrated unacceptable social behaviors
e. May have medical or behavioral conditions that place him/her at risk
f. Cannot follow rules and regulations
g. Is not aware of environmental hazards and cannot protect himself/herself from exploitation

COMMUNITY SERVICES
SKILL LEVEL CRITERIA

Skill Level I	Skill Level II	Skill Level III
HEALTH		
1. Requires routine medical attention. May need to take daily medications.	1. Requires periodic non routine medical attention , resulting in medical appointments occurring more than twice a month.	1. Has a serious chronic medical condition which requires ongoing medical intervention.
2. May have a seizure condition which is generally controlled by medications.	2. Has a severe seizure condition which is partially controlled by medication.	2. Has a disabling seizure Condition which is poorly controlled by medication.
MOBILITY		
1. Independently mobile with or without assistive devices.	1. Needs occasional physical assistance with mobility and/or transfers with or without assistive devices.	1. Requires full time physical assistance with transfers and mobility.
SELF-CARE		
1. May need daily skill training or minimal physical assistance in areas of self-care.	1. With the individual participating, requires constant hands on physical assistance in all areas of self-care.	1. Due to the individual's inability to participate, requires all self-care tasks to be completed by the provider.
2. Independent or toileted by routine.	2. Needs physical assistance for incontinence occurring minimally twice a week.	2. Is incontinent and/or requires full physical assistance in toileting.
BEHAVIOR		
1. There may be some behavioral outbursts and/or difficulty in making adjustments.	1. Has periodic episodes of challenging behavior to the extent that it interferes with adjustment to home, day and community programming.	1. Exhibits severe challenging behaviors on an ongoing basis.

To determine the Skill Level of an individual, the PRT will use the above criteria. If an individual meets any one of the above criteria in Skill Level II or III, that will be the assigned skill level. If an individual meets three or more of Skill Level II criteria, he or she will be assigned Skill Level III. In the Northern Region if an individual meets three or more of Skill Level III criteria, he or she will be assigned Skill Level III B.

IDT Review of Unsupervised Time Assessment

_____ Has been assessed for unsupervised time by
(Client Name) members of the IDT listed below.

The IDT met on _____ and recommends
(Date))

_____	Is capable of having independent unsupervised time in the home.	
☐	Attached is a written plan, documenting amount of hours, per day, of approved unsupervised time, including any restrictions or conditions.	
_____	Is capable of having independent unsupervised time in the community.	
☐	Attached is a written plan, documenting amount of hours, per day, of approved unsupervised time, including any restrictions or conditions.	
_____	Is capable of unsupervised time with monitoring. (Sponsor/back-up will be on premises.)	
☐	Attached is a written plan, documenting amount of unsupervised time, time intervals for monitoring and any restrictions or conditions	
_____	Requires additional training and is **not** capable of un-supervised time.	
_____	Case Manager will refer to the DDD Human Rights Committee.	

IDT Membership

Agree Yes	Agree No	Print Name	Title	Signature

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

MARK PAYNE
DIRECTOR

April 10, 2018

Kesha Spaulding, Agency Director
Sharpe and Williams
8011 Northpoint Blvd, Ste. 102
Winston-Salem, NC 27106

Re: Annual Survey completed April 3, 2018
Sharpe and Williams #5, 2042 Temple Street, Winston-Salem, NC 27101
MHL # 034-338
E-mail Address: kspaulding@sharpeandwilliams.org
fnorthern@sharpeandwilliams.org

Dear Ms. Spaulding:

Thank you for the cooperation and courtesy extended during the annual survey completed April 3, 2018.

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

- The tag cited is a standard level deficiency.

Time Frames for Compliance

- Standard level deficiency must be ***corrected*** within 60 days from the exit of the survey, which is June 2, 2018.

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.***

MENTAL HEALTH LICENSURE & CERTIFICATION SECTION
WWW.NCDHHS.GOV
TEL 919-855-3795 • FAX 919-715-8078
LOCATION: 1800 UMSTEAD DRIVE •WILLIAMS BUILDING • RALEIGH, NC 27603
MAILING ADDRESS: 2718 MAIL SERVICE CENTER • RALEIGH, NC 27699-2718
AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

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 Barbara Perdue at 336-861-6283.

Sincerely,

Debra M. Branton, MSW
Facility Survey Consultant I
Mental Health Licensure & Certification Section

Cc: Trey Sutten, Interim Director, Cardinal Innovations LME/MCO
Onika Wilson, Quality Management Director, Cardinal Innovations LME/MCO
Victoria Whitt, Director, Sandhills Center LME/MCO
Carol Robertson, Quality Management Director, Sandhills Center LME/MCO
File