(X5) WPLETE DATE
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Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MHL044-68	B. WING		F 08/1	₹ 5/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE	, , , , , , ,	
THE BAI	LSAM CENTER ADUL	TRECOVERY IIN	RLANE ROA			
IIIE BAI	I	WAYNES	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 CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 267	(6) other trea (f) When a SAIOP each direct care sta includes the followir (1) adolescer	rapy; rapy; revention; and tment methodologies. serves adolescent clients aff shall receive training that	V 267			
	failed to ensure that audited (Qualified F Specialist and the T nature of addiction,	view and interview the facility t 2 of 2 direct care staff Professional/Peer Support Therapist) were trained in the group therapy, family therapy, and other treatment				
	Qualified Profession revealed: -Hired 10/1/17No documented tra	of the personnel record for the nal/Peer Support Specialist aining in nature of addiction, ily therapy, relapse prevention, t methodologies.				
	Therapist revealed: -Hired 9/1/17.	of the personnel record for the aining in nature of addiction.				
	Interview on 8/15/18	8 with the Director revealed:				

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_	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMPI	
		MHL044-68	B. WING		R 08/1	₹ 5/2018
	PROVIDER OR SUPPLIER	T RECOVERY UN 91 TIMBE	DRESS, CITY, S RLANE ROA /ILLE, 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 SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
V 267	-Training departme requiredShe did not know i aware of the prografor all direct care st	ont tracked trainings that were If the training department was also specific trainings required aff. It is that some staff still lacked ut would ensure that the	V 267			
V 270	ratios that ensure the served in the facility (b) Staff with training provision of care to present at all times (c) The facility shall additional staff on supervision, treatment of the supervision of a shall be on call on a (e) Each direct care access at all times are qualified in the with whom the staff (f) Each direct care and have basic known and psychotropic meffects; mental retard developmental disarbehaviors; the naturand the withdrawal methodologies for a (g) Staff supervision.	all maintain staff to client he health and safety of clients of any and experience in the the needs of clients shall be when clients are in the facility. I have the capacity to bring ite to provide more intensive ent, or management in eds of individual clients. Of each client shall be under a physician, and a physician a 24-hour per day basis. The staff member shall have to qualified professionals who disability area(s) of the clients is working.	V 270			

Division of Health Service Regulation STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.		F	,
		MHL044-68	B. WING	 		5/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE BAI	SAM CENTER ADUL	I RECOVERY IIN	RLANE ROAVILLE, 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 270	Continued From pa	age 3	V 270			
	client's needs.					
	Based on record refailed to ensure that audited (The Clinic Assistant) were trated and psychotropic meffects, nature of a withdrawal syndrom methodologies for The findings are: Review on 8/14/18 Clinician revealed: -Hired 6/1/14No documented tr	et as evidenced by: eview and interview the facility at 2 of 4 direct care staff ian and Certified Medical ined in the mental illnesses nedications and their side ddiction and recovery, the ne and treatment adults and children in crisis. of the personnel record for the aining in the withdrawal chotropic medications and their				
	Review on 8/14/18 Certified Medical A -Hired 11/1/14.	of the personnel record for the ssistant revealed:				
	-No documented tr psychotropic medic nature of addiction	aining in mental illnesses and cations and their side effects, and recovery, the withdrawal tment methodologies for adults is.				
	-Training departme requiredShe did not know aware of the prografor all direct care standard was not aware.	e that some staff still lacked out would ensure that the				

Division of Health Service Regulation

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _____

(X3) DATE SURVEY COMPLETED

> R 08/15/2018

MHL044-68

B. WING ___

STREET ADDRESS, CITY, STATE, ZIP CODE 91 TIMBERI ANE ROAD

(X5) COMPLET DATE

Division of Health Service Regulation STATE FORM

NAME OF PROVIDER OR SUPPLIER