

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL041-807</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 08/01/2018</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CENTER OF PROGRESSIVE STRIDES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2212 GLENSIDE DRIVE GREENSBORO, NC 27405</b>
--	--

(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	<p><b>INITIAL COMMENTS</b></p> <p>A complaint and follow-up survey was completed on 8/1/18. The complaint was unsubstantiated (Intake ID # NC00140940). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.</p>	V 000	<p><b>DHSR - Mental Health</b></p> <p><b>SEP 04 2018</b></p> <p><b>Lic. &amp; Cert. Section</b></p>	
V 118	<p><b>27G .0209 (C) Medication Requirements</b></p> <p><b>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</b></p> <p>(c) Medication administration:</p> <p>(1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs.</p> <p>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.</p> <p>(3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications.</p> <p>(4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following:</p> <p>(A) client's name;</p> <p>(B) name, strength, and quantity of the drug;</p> <p>(C) instructions for administering the drug;</p> <p>(D) date and time the drug is administered; and</p> <p>(E) name or initials of person administering the drug.</p> <p>(5) Client requests for medication changes or</p>	V 118	<p><i>Group Home QP and Director will monitor all changes.</i></p>	

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Makelle Wilson* TITLE *MSW QP* (X6) DATE *8/24/18*

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL041-807</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 08/01/2018</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CENTER OF PROGRESSIVE STRIDES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2212 GLENSIDE DRIVE GREENSBORO, NC 27405</b>
--	--

(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 118	<p>Continued From page 1</p> <p>checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.</p> <p>This Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure all medications administered to clients were recorded immediately following administration on each clients' MAR and failed to ensure medications were administered on the written order of a person authorized by law to prescribe drugs affecting 3 of 4 clients (#1, #2 and #3). The findings are:</p> <p>Review on 7/23/18 of client #1's record revealed: - Admission date: 4/19/18 - Age 16 - Diagnoses of Conduct Disorder, unspecified, Disruptive Mood Dysregulation Disorder and Attention Deficit Disorder with Hyperactivity, Impulsive</p> <p>Observation on 7/23/18 at approximately 10 am of client #1's medications revealed: - Bupropion HCL SR 150 mg (milligrams) 1 tab PO (by mouth) two times daily (8 am/8 pm) - Adderall XR 20 mg 1 capsule PO in the morning</p> <p>Review on 7/23/18 of client #1's July 2018 MAR revealed: - No staff initials on the following dates for Bupropion HCL SR 150 mg at 8 am: 7/1-7/2/18, 7/6-7/9/18, 7/16/18 and 7/21/18 - Bupropion HCL SR 150 mg at 8 pm: 7/1/18, 7/8/18, 7/14-7/15/18 and 7/20-7/21/18</p>	V 118	<p>V118 Effective Immediately</p> <ul style="list-style-type: none"> <li>- All medications will be written on each consumers MAR.</li> <li>- MAR will be signed after each medication administration.</li> <li>- QP will monitor Daily for staff initials</li> <li>- Medication orders will be kept for each medication prescribed.</li> </ul>	8/24/18
-------	---	-------	--	---------

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL041-807</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 08/01/2018</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CENTER OF PROGRESSIVE STRIDES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2212 GLENSIDE DRIVE GREENSBORO, NC 27405</b>
--	--

(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 118	<p>Continued From page 2</p> <ul style="list-style-type: none"> <li>- No staff initials on the following dates for Adderall XR 20 mg at 8 am: 7/1-7/2/18, 7/6/18, 7/8-7/9/18, 7/14/18 and 7/21-7/22/18</li> <li>- No evidence of a medication order for the medications listed on client #1's MAR</li> </ul> <p>Review on 7/23/18 of Client #2's record revealed:</p> <ul style="list-style-type: none"> <li>- Admission date: 1/5/18</li> <li>- Age: 16</li> <li>- Diagnosis: Adjustment Disorder with disturbance of conduct</li> </ul> <p>Observation on 7/23/18 at approximately 10:30 am of client #2's medications revealed:</p> <ul style="list-style-type: none"> <li>- Amphetamine Salts 30 mg 1 tab PO every day (8 am)</li> <li>- Bupropion HCL SR 150 mg 1 tab two times daily (8 am/8 pm)</li> <li>- ProAir HFA 90 mcg Inhaler 2 puffs every four hours as needed</li> <li>- Mucinex Sinus Max Severe Congestion Relief (over the counter) every four hours</li> </ul> <p>Review on 7/23/18 of client #2's June and July 2018 MARs revealed:</p> <ul style="list-style-type: none"> <li>- No staff initials on the following dates for the Amphetamine Salts at 8 am: 7/8/18 and 7/13-7/14/18</li> <li>- No staff initials on the following dates for Bupropion HCL SR 150 mg at 8 am: 7/7-7/8/18 and 7/13/18</li> <li>- No staff initials on the following dates for Bupropion HCL SR 150 mg at 8 pm: 6/25/18 and 7/14/18</li> <li>- No evidence of a medication order for the medications listed on client #2's MAR</li> </ul> <p>Review on 7/23/18 of Client #3's record revealed:</p> <ul style="list-style-type: none"> <li>- Admission date: 1/11/18</li> <li>- Age 16</li> </ul>	V 118	<p>V.118 medication refresher provided to all staff.</p> <p>Staff will not begin work before medication administration training</p>	
-------	--	-------	---	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL041-807</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 08/01/2018</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CENTER OF PROGRESSIVE STRIDES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2212 GLENSIDE DRIVE GREENSBORO, NC 27405</b>
--	--

(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 118	<p>Continued From page 3</p> <ul style="list-style-type: none"> <li>- Diagnoses: Post Traumatic Stress Disorder (PTSD), Disruptive Mood Dysregulation Disorder, Childhood Sexual Abuse Victim, Perpetrator (2015) and Conduct Disorder</li> </ul> <p>Observation on 7/23/18 at approximately 11:00 am of client #3's medications revealed:</p> <ul style="list-style-type: none"> <li>- Vyvanse 20 mg 1 capsule PO every day (8 am)</li> <li>- Bupropion HCL SR 150 mg 1 tab two times daily (8 am/8 pm)</li> </ul> <p>Review on 7/23/18 of client #3's July 2018 MAR revealed:</p> <ul style="list-style-type: none"> <li>- No staff initials on the following dates for the Vyvanse 20 mg at 8 am: 7/1-7/2/18 and 7/14/18</li> <li>- No staff initials on the following dates for Bupropion HCL SR 150 mg at 8 am: 7/1/18 and 7/7-7/8/18</li> <li>- No staff initials on the following dates for Bupropion HCL SR 150 mg at 8 pm: 7/1-7/2/18 and 7/14/18</li> <li>- No evidence of a medication order for the medications listed on client #3's MAR</li> </ul> <p>Interviews on with 7/23/18 with clients (#1, #2, #3) revealed:</p> <ul style="list-style-type: none"> <li>- Staff administered their medications to them each day as prescribed.</li> </ul> <p>Interview with the Qualified Professional (QP) revealed:</p> <ul style="list-style-type: none"> <li>- She had contacted each staff that worked on the dates with the missing documentation on the clients' (#1, #2 and #3) MARS and requested an explanation as to why staff had not documented that they had administered the client's medications to them</li> <li>- She had scheduled an in-service on medication administration for staff on 7/30/18</li> <li>- The medication orders for client #1's</li> </ul>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL041-807</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 08/01/2018</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CENTER OF PROGRESSIVE STRIDES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2212 GLENSIDE DRIVE GREENSBORO, NC 27405</b>
--	--

(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 118	Continued From page 4  medications were sent to the pharmacy electronically and no written copy of the order had been provided to the facility - She would attempt to get copies of the medication orders from the pharmacy and place them in the clients' records; however, no medication orders were available for review prior to the end of the survey	V 118		
V 293	27G .1701 Residential Tx. Child/Adol - Scope  10A NCAC 27G .1701 SCOPE (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility. (b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to a community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting. (e) Services shall be designed to: (1) include individualized supervision and structure of daily living;	V 293	<p>V293</p> <p>Effective Immediately</p> <p>- Two staff will be scheduled for each shift</p> <p>- Only clients w/ DEP intervention for one staff transport will be transported by one staff, all other clients will be transported by two staff.</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL041-807</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 08/01/2018</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CENTER OF PROGRESSIVE STRIDES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2212 GLENSIDE DRIVE GREENSBORO, NC 27405</b>
--	--

(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 293	<p>Continued From page 5</p> <p>(2) minimize the occurrence of behaviors related to functional deficits;</p> <p>(3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint;</p> <p>(4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and</p> <p>(5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting.</p> <p>(f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care.</p> <p> </p> <p>This Rule is not met as evidenced by: Based on records review and interviews the facility failed to provide care and services within the scope of the program for 4 of 4 clients (Client #1, #2, #3 and #4). The findings are:</p> <p> </p> <p>Cross Reference: 10A NCAC 27G .1704 Minimum Staffing Requirements (V296). Based on observations, interviews and records review the facility failed to ensure the minimum staffing requirements for 4 of 4 clients (Client #1, #2, #3 and #4).</p> <p> </p> <p>Review on 8/1/18 of the facility's plan of protection, dated 8/1/18 and written by the</p>	V 293		
-------	--	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL041-807</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 08/01/2018</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CENTER OF PROGRESSIVE STRIDES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2212 GLENSIDE DRIVE GREENSBORO, NC 27405</b>
--	--

(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 293	<p>Continued From page 6</p> <p>Qualified Professional (QP) revealed: What immediate action will the facility take to ensure the safety of the consumer's in your care? - "Placing 2 staff at the summer camp for the remainder of the summer camp (ends 8/9/18). Revise PCP (Person Centered Plan) to reflect client's ability to have one single staff to transport to and from while in the community, daily activities and appts. (Appointments) Retraining staff to rule of code 10a NCAC 27G -1704 (Minimum staffing regulation)" Describe your plans to make sure the above happens. - "(QP) we have retrained staff of the rule of code for minimum staffing. Staff will be placed at the summer camps starting immediately, QP will enforce 2 staff at level 3 group home as well as QP(QI and QA) will enter all necessary documentation that supports clients being able to be transported in cars with a single staff member. QI&amp;QA will have PCP revised during monthly CFT's (Child and Family Team Meetings) which are 8/1, 8/6, and 8/7."</p> <p>The Center of Progressive Strides is a Residential Treatment Staff Secure facility which served clients (#1, #2, #3 and #4) who ranged in age from 13 to 16 years old and had diagnoses of Attention Deficit Disorder, Combined Type; Disruptive Mood Dysregulation Disorder; Adjustment Disorder with Disturbance of Conduct; Post Traumatic Stress Disorder; Childhood Sexual Abuse - Victim and Perpetrator; Conduct Disorder and Attention Deficit Disorder with Hyperactivity. The clients had behaviors that included but were not limited to the following: defiance, being disrespectful towards adults, physically aggressive towards family members and peers, destroying property, larceny and inappropriate sexual conduct. Based on their</p>	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL041-807</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 08/01/2018</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CENTER OF PROGRESSIVE STRIDES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2212 GLENSIDE DRIVE GREENSBORO, NC 27405</b>
--	--

(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 293	<p>Continued From page 7</p> <p>diagnoses and history of behaviors, these clients required continuous supervision, behavioral intervention and a high level of support to meet their needs.</p> <p>Staff (#1 and #2) worked the 12 am until 8:00 am shift. On the morning of 7/23/18, staff #1 transported client #1 to a licensed day program and client #4 to his summer program. Staff #2 transported clients (#2 and #3) to a summer program held at a local church. The clients' treatment plans did not reflect the ability for any of these clients to be transported to their programs with only one staff present. Clients (#2, #3 and #4) were transported by staff to their summer programs between 7:45 am and 8 am each day and picked up from their programs between the hours of 5 pm and 5:45 pm each day. Leaving clients in settings without staff present who were familiar with their diagnoses/behaviors and a knowledge of their individualized treatment needs was detrimental to the health and safety of these clients.</p> <p>This deficiency constitutes a Type B rule violation. If the violation is not corrected within 45 days, an administrative penalty of \$200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.</p>	V 293		
V 296	<p>27G .1704 Residential Tx. Child/Adol - Min. Staffing</p> <p>10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times.</p>	V 296	<p>V. 296 Effective Immediately Two staff will be scheduled to work on all shifts.  - Staff will monitor consumers at summer camp until camp ends</p>	



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL041-807</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 08/01/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>CENTER OF PROGRESSIVE STRIDES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2212 GLENSIDE DRIVE GREENSBORO, NC 27405</b>		
(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 296	Continued From page 8  (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan.	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL041-807</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 08/01/2018</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CENTER OF PROGRESSIVE STRIDES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2212 GLENSIDE DRIVE GREENSBORO, NC 27405</b>
--	--

(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 296	<p>Continued From page 9</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and records review the facility failed to ensure the minimum staffing requirements for 4 of 4 clients (Client#1, #2, #3 and #4): The findings are:</p> <p>Review on 7/23/18 of Client #1's record revealed: - Admission date: 4/19/18 - Age: 16 - Diagnosis: Conduct Disorder unspecified; Disruptive Mood Dysregulation Disorder; Attention Deficit Disorder with hyperactivity - Admission Assessment dated 4/19/18 " ...fighting in school, does not know how to express self, triggers are people yelling, fighting, someone pointing the blame at him (Client #1). Five placements in Psychiatric Residential Treatment Facilities (PRTF) and wilderness camp and mental health behavioral unit. Receives Behavioral Health Counseling to process triggers that impact school participation." - Person Centered Plan (PCP) dated 3/14/18 Goals: teach effective coping skills, teach problem solving and communication skills, utilize cognitive behavioral therapy, comply with directives, decrease excessive talk and distractibility in school setting, decrease legal and law enforcement involvement. - Further review of client #1's record failed to document Client #1's ability to be transported by one facility staff.</p> <p>Review on 7/23/18 of Client #2's record revealed: - Admission date: 1/5/18 - Age: 16 - Diagnosis: Adjustment Disorder with disturbance of conduct</p>	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL041-807</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 08/01/2018</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CENTER OF PROGRESSIVE STRIDES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2212 GLENSIDE DRIVE GREENSBORO, NC 27405</b>
--	--

(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 296	<p>Continued From page 10</p> <ul style="list-style-type: none"> <li>- Admission Assessment dated 1/5/18 " ... misdemeanor larceny 12/8/17, verbal threats and assaultive, needs self-care"</li> <li>- PCP dated 1/10/18 goals: "demonstrate increased interpersonal effectiveness to self-advocate, increase ability to engage in healthy relationship and will display the ability to accept feedback though emotional regulation ... and participate in specific activities on a daily, maintaining a healthy lifestyle and learn skills necessary to function independently in the community by participating in the [summer enrichment program] ..."</li> <li>- Crisis Plan revealed: How to best support me(Client #2) allow [Client#2] to isolate himself in a quiet place area or go to his room, can allow to go outside and play basketball ..."</li> <li>- Further review of Client #2's record failed to document Client #2's ability to be transported by one facility staff.</li> </ul> <p>Review on 7/23/18 of Client #3's record revealed:</p> <ul style="list-style-type: none"> <li>- Admission date: 1/11/18</li> <li>-Age 16</li> <li>- Diagnoses: Post Traumatic Stress Disorder (PTSD); Disruptive Mood Dysregulation Disorder; Childhood sexual abuse Victim and perpetrator 2015; Conduct Disorder</li> <li>- Admission Assessment dated 1/11/18 ..."Physical altercation with [family member] - placed in detention, [family member] was not cooperative with allowing [Client #3] to receive certain services. [Client #3] was then placed in foster care and then placed in a PRTF ..."</li> <li>- Reported family history of drug addiction, homelessness, alcoholism and mental health disorders. Client #3 is currently in the custody of family and children services.</li> <li>- PCP dated 4/2/18 revealed: How to best support me: "I do not like anyone yelling at me. I</li> </ul>	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL041-807</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 08/01/2018</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CENTER OF PROGRESSIVE STRIDES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2212 GLENSIDE DRIVE GREENSBORO, NC 27405</b>
--	--

(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 296	<p>Continued From page 11</p> <p>need to talk to calm me down. I like to walk to calm down, listen to music." What is not working for me: "group home not working. I don't know." Keeping Client #3 away from others if he feels disrespected in group home.</p> <p>Goals: follow rules and expectations, participate actively in therapy as indicated and take medications and participate in activities specific activities on a daily, maintaining a healthy lifestyle and learn skills necessary to function independently in the community by participating in the [summer enrichment program] ..."</p> <p>- Crisis Plan revealed: How to best support me (Client #3) " Leave me alone when I'm upset, do not yell at him when addressing behaviors, allow to play a game, allow him to spend time in his room while keeping eyes on him until he deescalates or calms down ..."</p> <p>- Further review of Client #3's record failed to document Client #3's ability to be transported by one facility staff.</p> <p>Review on 7/23/18 of Client #3's Clinical Re-Evaluation Sexual Harm Summary and Conclusion revealed: ..." [Client #3] has a complex history of recurrent exposures to variety of victimizing experiences within the context of intermittent neglect, physical abuse, chaos, intergenerational violence, sexualized living environments and a compromised parent with documented mental health/substance abuse challenges. [Client #3's] 'fractured' relationship with his mother and the "trauma" of past abuses and the "grief" associated with his [family member's] suicide attempt and her subsequent incapacitation have clearly depleted his coping skills and emotional reserves.</p> <p>- [Client #3's ] rating on the Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II) point to</p>	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL041-807</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 08/01/2018</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CENTER OF PROGRESSIVE STRIDES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2212 GLENSIDE DRIVE GREENSBORO, NC 27405</b>
--	--

(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 296	<p>Continued From page 12</p> <p>moderate to moderate-high risk factors that are associated with conduct issues, of which inappropriate sexual behavior was one element. -Overall, [Client #3's] rating on the J-SOAP-II underscore risk factors that are primarily associated with conduct issues. His 2015 sexual offense appears to have been reflective of poor judgment/decision making as well as one element on a continuum of conduct problems ...</p> <p>- ...risk factors are associated with [Client #3's] history of sexual victimization (at age 10 [Client #3] reported 'my foster father inserted a rubber tool into my bottom') and partial presence of sexual preoccupation ... It should be noted that [Client #3's] offense occurred in 2015 and involved "fondling of a young female child on two reported occasions." [Client #3's] impulsive/antisocial behavior scale factors include caregiver inconsistency, anger problems, moderate school behavior issues, history of conduct and behaviors resulting in DJJ involvement, and exposure to family violence /physical assault</p> <p>- On 4/25/17 [Client #3] was admitted into the [area PRTF] for sex specific treatment. He was discharged 1/11/18 at which point he was placed into Center of Progressive Strides. On 1/29/18 [Client #3's] juvenile probation was terminated. His adjustment appears to be stable at this time.</p> <p>- [Client #3] completed the sex specific treatment program at [PRTF] on 1/11/18. He reportedly completed treatment goals associated with psychoeducational regarding sexual matters, self-regulation and coping skills"</p> <p>Review on 7/23/18 of Client #3's Safety Plan dated 3/26/1018 revealed:</p> <p>- "Supervision responsibilities: [Client #3] will be supervised by Center of Progressive Strides staff or legal guardian. [Client #3] will be</p>	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL041-807</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 08/01/2018</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CENTER OF PROGRESSIVE STRIDES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2212 GLENSIDE DRIVE GREENSBORO, NC 27405</b>
--	--

(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 296	<p>Continued From page 13</p> <p>supervised in accordance with stipulation of this Safety Plan, especially at the group home, community and by school staff. [Client #3] will be supervised by competent staff who are aware of his Safety Plan.</p> <ul style="list-style-type: none"> <li>- Supervision is to be provided by an adult who is aware of [Client #3]'s sexual offending history. This individual must be approved by therapist and must abide by the conditions of this pan at all times. [Client #3] will remain within eyesight of authorized adults at all times when around children younger than 13 years -old. An adult will be aware of [Client #3's] whereabouts at all times ..."</li> </ul> <p>Review on 7/23/18 of Client #4's record revealed:</p> <ul style="list-style-type: none"> <li>- Admission date: 6/19/18</li> <li>- Age: 13</li> <li>- Diagnoses: Attention Deficit Combined and Disruptive Mood Dysregulation Disorder</li> <li>- Admission Assessment Dated 6/19/18 revealed: "significant defiance, verbal aggression, slamming things around and banging on windows. Defiance and no ability to control impulses ..."</li> <li>- PCP dated 5/23/18 and revised 6/19/18 revealed: "demonstrates patterns of disrespectful and disruptive behaviors towards adults, laughs at inappropriate times, frequent anger outbursts that consist of pushing, hitting and punching, slapping and destroying property.</li> <li>- Consistently engages in physical altercation with his peers. Starts fights with others being disruptive and destroying property and being very impulsive. Goals: follow level III placement rules, demonstrate improved decision -making skills, and decrease his disrespect for authority as evidenced by increasing his ability to follow direction, participate in medication evaluations and individual and family therapy ... "</li> </ul>	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL041-807</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 08/01/2018</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CENTER OF PROGRESSIVE STRIDES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2212 GLENSIDE DRIVE GREENSBORO, NC 27405</b>
--	--

(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 296	<p>Continued From page 14</p> <ul style="list-style-type: none"> <li>- Further review of Client #4's record failed to document Client #4's ability to be transported by one facility staff.</li> </ul> <p>Review on 7/24/18 of Staff #1's record revealed:</p> <ul style="list-style-type: none"> <li>- Hire date: 10-2-17</li> <li>- Job Description: Paraprofessional (PP)</li> </ul> <p>Review on 7/26/18 of Staff #2's record revealed:</p> <ul style="list-style-type: none"> <li>- Hire date: 8/1/17</li> <li>- Job Description: Paraprofessional</li> </ul> <p>Observations on 7/23/18 at approximately 8:15 am revealed:</p> <ul style="list-style-type: none"> <li>- One staff (Staff #1) was present in the group home with two clients (Client #1 and Client #4).</li> </ul> <p>Interview on 7/21/18 with Staff #1 revealed:</p> <ul style="list-style-type: none"> <li>- Staff #2 left with Clients #2 and #3 to transport them to their summer program.</li> <li>- Staff # 1 reported that he transported Client #1 and Client #4 to their summer program. (Client #1 attends a licensed day treatment program)</li> <li>- Staff #1 worked from 12:00 am midnight with Staff #2 and they get off work at 8:00 am and after the clients are transported to their summer programs.</li> <li>- Staff #1 needed to get the clients to their programs and that the Qualified Professional (QP) was on her way to group home to assist surveyors.</li> </ul> <p>Interview on 7/24/18 with Client #1 revealed:</p> <ul style="list-style-type: none"> <li>- He attended a day program 7:45 am until 5:00 pm (Licensed by the Division of Health Services Regulation Licensure and Certification)</li> <li>- Staff drops off Client #1 and then drops off Client #4 at a summer recreation program</li> </ul> <p>Interview on 7/24/18 with Client #2 revealed:</p>	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL041-807</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 08/01/2018</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CENTER OF PROGRESSIVE STRIDES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2212 GLENSIDE DRIVE GREENSBORO, NC 27405</b>
--	--

(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 296	<p>Continued From page 15</p> <ul style="list-style-type: none"> <li>- He attended "camp" Monday thru Friday from 7:30 am until 5 pm</li> <li>- Staff drop him and his housemate (Client #3) at the camp each morning and pick them up at approximately 4:45 pm</li> <li>- No staff from the group home remain at the camp with them</li> <li>- He had been attending camp since 6/28/18 or 6/29/18</li> </ul> <p>Interview on 7/24/18 with Client #3 revealed:</p> <ul style="list-style-type: none"> <li>- He attended "camp" Monday thru Friday from 7:30 am until 5 pm</li> <li>- Camp was located at [a local city church]</li> <li>- He began attending camp on 6/27/18</li> <li>- The campers were divided into different groups based on their grade in school (elementary, middle and high school)</li> <li>- There were approximately six staff who worked at the camp (no staff were from the group home) with five to twelve participants in each group.</li> <li>- There were five participants in his group</li> <li>- "It's a drug free summer camp."</li> <li>- Staff drop him and his housemate at the camp each morning and pick them up at approximately 4:45 pm</li> </ul> <p>Interview on 7/24/18 with Client #4 revealed:</p> <ul style="list-style-type: none"> <li>- "I always come here (local area summer recreation program).</li> <li>- Just one (1) staff brings me here. Sometimes [Staff # 1] and sometimes [Staff #2].</li> <li>- They don't work alone they just bring me here alone.</li> <li>- I just got placed at the group home (6/19/18).</li> <li>- There isn't any group home staff here. They don't come here just at the group home.</li> <li>- Someone will pick me up at six (6:00 pm) or just a little before six."</li> </ul>	V 296		



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL041-807</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 08/01/2018</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CENTER OF PROGRESSIVE STRIDES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2212 GLENSIDE DRIVE GREENSBORO, NC 27405</b>
--	--

(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 296	<p>Continued From page 16</p> <p>Interview on 7/24/18 with summer program camp Staff for Client #2 and Client #3 revealed;</p> <ul style="list-style-type: none"> <li>- "The summer program gives kids a chance to continue to learn through the summer months.</li> <li>- We will help with math, writing and reading.</li> <li>- The kids attend from all over the city and other group homes as well.</li> <li>- We provide activities within the community.</li> <li>- We can provide breakfast and lunch.</li> <li>- Provides a direction for kids to make better decisions and stay off drugs, stay out of trouble.</li> <li>- A Licensed Professional is off site but available during the summer program if any of the kids should need him.</li> <li>- The group home staff will drop off [Client #2] and [Client #3] around eight (8:00) am and return to pick them up at around five, five forty five (5 to 5:45 pm).</li> <li>- I'm only aware of what was on the child's (Client #2 and #3's) applications."</li> </ul> <p>Interview on 7/23/18 with Client #3's Psychologist revealed:</p> <ul style="list-style-type: none"> <li>- "[Client #3] was a client of their program (PRTF) prior to his admission to Center of Progressive Strides."</li> <li>- Client #3 had completed his sex specific treatment due to his behaviors in 2015 and was re-evaluated by the psychologist in March 2018. It was determined the focus of his treatment would now be to address boundaries, self-regulation and his physical aggressive behaviors.</li> <li>- "It is concerning that if [Client #3] could be in the summer camp program for eight (8) hours daily with no staff supervision. Why is he (Client #3) in a level III group home that requires constant supervision?</li> <li>- Also during the summer camp, if he should require assistance, who could he go to for assistance, especially, if the staff at the camp is</li> </ul>	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL041-807</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 08/01/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>CENTER OF PROGRESSIVE STRIDES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2212 GLENSIDE DRIVE GREENSBORO, NC 27405</b>		
(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 296	Continued From page 17  not aware of his history/needs. - [Client #3] had a safety plan (developed in March 2018) to address - supervision needs, safety and monitoring. - [QP] (QP for COPS) was given a copy of the [Client #3's] re-evaluation and a safety plan for future reference. - I have no concerns regarding [Client #3] and the possibility of him re-offending but based on his safety plan, anyone supervising [Client #3] would have to be aware of his history and his supervision needs - [Client #3] needs contact with individuals outside of the facility but there needs to be consistency and security across all settings."  Interview on 7/23/18 with Client #3's Therapist revealed: - "I was made aware of his (Client #3's) attendance at the camp by talking with [Client #3]. - No I was not made aware of the program (summer camp program) by the QP - if so, I would have asked questions about who would be supervising [Client #3] and what the requirements of the program were and other specifics of the program. - My primary concern would be the length of time the [Client #3] is at the program."  Interview on 7/31/18 with the Licensed Professional (LP) for Center of Progressive Strides revealed: - "I was not part of the decision making process to send the clients to the summer camp. - I was made aware of the camp via Center of Progressive Stride's [QP]. - I had heard of the camp before and had seen the flyer for the camp. - I know that it is not a licensed facility. - I understand the camp has a licensed	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL041-807</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 08/01/2018</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CENTER OF PROGRESSIVE STRIDES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2212 GLENSIDE DRIVE GREENSBORO, NC 27405</b>
--	--

(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 296	<p>Continued From page 18</p> <p>professional available to assist the clients if necessary and consents had been signed which would allow her and the camp LP to communicate if necessary regarding [Client #2] and [Client #3]."</p> <ul style="list-style-type: none"> <li>- Is aware of who the camp LP is. "He is an LCAS (Licensed Clinical Addiction Specialist).</li> <li>- I'm not sure if the camp is offering what would be considered 'treatment' but rather learning opportunities, outings, etc."</li> <li>- Not sure exactly what information the QP had shared with the Director of the program regarding Client #3's supervision needs</li> <li>- "I know that the camp attendees are separated by age into groups and that [Client #3] is in a group of children of the same age</li> <li>- I have no concerns about the length of time the clients are spending at the camp.</li> <li>- The number of hours are similar to the number of hours in a typical school day."</li> </ul> <p>Interview on 7/24/18 with the QP revealed:</p> <ul style="list-style-type: none"> <li>- "I visit the summer program that [Client #2] and [Client #3] are in daily.</li> </ul> <p>The LP they have is off site but would be available in the event he may be needed by anyone of the children in there.</p> <ul style="list-style-type: none"> <li>- We held Child and Family Team (CFT) meeting's for each client and discussed the summer programs and who (clients) would go where.</li> <li>- The local management entity [LME/MCO] was slow getting authorization on [Client #1] for the 1400 program.</li> <li>- When he (Client #1) was authorized the [guardian] then decided she didn't want him in that program because of one of the other clients in the same program. The [guardian] didn't want [Client #1] sitting around and they found the rec center he attended. He was there less than a month.</li> </ul>	V 296		
-------	--	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL041-807</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 08/01/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>CENTER OF PROGRESSIVE STRIDES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2212 GLENSIDE DRIVE GREENSBORO, NC 27405</b>		
(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 296	Continued From page 19  - Our staff does not attend the programs because there is staff in the programs. - The staff (summer camp and rec center) are trained. With the summer camp program for [Client #2 and Client #3] there is a LP available if needed. - Our therapists spoke with the program therapist (summer camp program's LP) with regards to the needs of [Client#2] and [Client #3]."  This deficiency is cross referenced into 10A NCAC 27G .1701 SCOPE (V293) for a Type B rule violation and must be corrected within 45 days.	V 296		