Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-777	A. BUILDING: _____ B. WING _____	R 08/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNLIGHT BEHAVIOR CENTER	2030 HOKE LOOP ROAD FAYETTEVILLE, NC 28314

(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, complaint and follow up survey was completed on August 21, 2018. The complaint was unsubstantiated (Intake #NC00141574). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.	V 000	DHSR - Mental Health SEP 05 2018 Lic. & Cert. Section	
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged	V 132		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-777	A. BUILDING: _____ B. WING _____	R 08/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNLIGHT BEHAVIOR CENTER	2030 HOKE LOOP ROAD FAYETTEVILLE, NC 28314

(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 132	Continued From page 1 acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report an allegation of abuse to the Health Care Personnel Registry (HCPR). The findings are: Review on 08/21/18 of client #1's record revealed: -14 year old male. -Admission date of 05/16/18. -Diagnoses of Oppositional Defiant Disorder, Bipolar Disorder, Over weight, Asthma, Allergies, and Hypothyroidism. Review on 08/21/18 of the North Carolina Incident Response Improvement System report dated 07/23/18 revealed: "-[Client #1] became upset that staff would not allow him to stay up pass the set bedtime and refused to follow any directives given to him. These behaviors continued until the breakfast time. Staff prompted him to remain in his room until he de-escalated and could communicate	V 132		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-777	A. BUILDING: _____ B. WING _____	R 08/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNLIGHT BEHAVIOR CENTER	2030 HOKE LOOP ROAD FAYETTEVILLE, NC 28314

(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 132	Continued From page 2 properly. [Client #1] refused while utilizing profanity. He then attempted to push pass staff. [Client #1] refuse to accept or follow any directives and redirection given to him. Staff placed him in a therapeutic hold for less than 1 minute while the other staff processed with him. Staff remained in the room with him going over different ways to communicate in positive ways with [Client #1] He then de-escalated and apologized. No more incidents took place the rest of the day. -Walk off-Due to [Client #1] getting upset about his bedtime. He left off the facility grounds pushing past staff. Staff put him in a therapeutic hold for less than a minute and released him. He walked off the grounds and down the street. He was brought back by the authorities and went to bed without incident." During interview on 08/21/18 client #1 revealed: -He and staff #6 got into an argument. -He walked off from the facility. -Staff #6 was a cool guy. -He had hit staff #6 twice . -He walked off from the facility to a local store. -The police located him and he told the police staff #6 had pushed him. -Staff #6 had never hit him or hurt him. During interview on 08/21/18 staff #4 revealed: -Client #1 was verbally and physically aggressive with staff #6. -Client #1 was placed in a physical restraint. -Client #1 left the facility. -Client #1 alleged staff #6 had tackled him. -Staff #6 only put client #1 in a restraint. During interview on 08/21/18 staff #6 revealed: -2 or 3 weeks ago he had to put client #1 in a physical restraint.	V 132		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-777	A. BUILDING: _____ B. WING _____	R 08/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNLIGHT BEHAVIOR CENTER	2030 HOKE LOOP ROAD FAYETTEVILLE, NC 28314

(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 132	Continued From page 3 -Client #1 left the facility and was brought back to the facility by law enforcement. -He never tackled or pushed client #1. Review on 08/21/18 of facility records revealed no documentation the HCPR was notified of the 07/23/18 allegation staff #6 abused client #1. Interview on 08/21/18 the Qualified Professional revealed: -She understood the HCPR was required to be notified of all allegations -Client #1 told the authorities staff #6 had tackled him. -Client #1 later recanted his story and stated staff #6 had not done anything to him. -She did not think the HCPR had to be completed since client #1 recanted.	V 132	All allegations of abuse will be reported and documented to the HCPR (even if recanted) by the Administrator and/or Facility Manager.	10/20/18

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL026-777 (Y1)	A. Building B. Wing (Y2)	8/21/2018 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNLIGHT BEHAVIOR CENTER	2030 HOKE LOOP ROAD FAYETTEVILLE, NC 28314

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0108 Reg. # 27G .0202 (F-I) LSC	Correction Completed 08/21/2018	ID Prefix V0118 Reg. # 27G .0209 (C) LSC	Correction Completed 08/21/2018	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
			Emily Stanley, BSW	8/21/18
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/14/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

August 28, 2018

Rashad Rahmsan
Sunlight Behavior Center, Inc.
2030 Hoke Loop Road
Fayetteville, NC 28314

Re: Annual, Follow Up and Complaint Survey completed 08/21/18
Sunlight Behavior Center, 2030 Hoke Loop Road, Fayetteville, NC 28314
MHL # 026-777
E-mail Address: rachellvr@gmail.com
Intake #NC00141574

Dear Mr. Rahmaan:

Thank you for the cooperation and courtesy extended during the annual, follow up and complaint survey completed 08/21/18. The complaint was unsubstantiated.

As a result of the follow up survey, it was determined that all of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. An additional deficiency was cited during the survey.

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

- 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 10/20/18.

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.

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 Wendy Boone at 252-568-2744.

Sincerely,

Emily Stanley, BSW

Emily Stanley, BSW
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Keith Hughes
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: Rob Robinson, Director, Alliance Behavioral Health LME/MCO
Wes Knepper, Quality Management Director, Alliance Behavioral Health LME/MCO
Sarah Stroud, Director, Eastpointe LME/MCO
Jeanette Jordan-Huffam, Quality Management Director, Eastpointe LME/MCO
Victoria Whitt, Director, Sandhills Center LME/MCO
Mary Kidd, Quality Management Director, Sandhills Center LME/MCO
File