Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		A. BUILDING.				
	MHL054-125	B. WING		01/1	4/2019	
ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE			
D FACILITY			FORD ROAD			
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	_D BE	(X5) COMPLETE DATE	
INITIAL COMMENT	-s	V 000				
on January 14, 2019 substantiated (intak	9. The complaints were e #NC00146643,					
category: 10A NCA	.C 27G .1900, Psychiatric					
27G .0201 (A) (1-7)	Governing Body Policies	V 105				
POLICIES (a) The governing by facility or service show written policies for the context of the face o	ody responsible for each all develop and implement he following: anagement authority for the ility and services; asion; arge; ssments, including: a the assessment; and completing assessment. nagement, including: zed to document; ords; cords against loss, tampering, by unauthorized persons; cord accessibility to all times; and infidentiality of records. ch shall include: of the individual's presenting					
1 VOSTO OF V 1 VOSTO OF VOSTO	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS INITIAL COMMENT A complaint and foll on January 14, 2019 substantiated (intak NC00146799 & NC cited. This facility is licens category: 10A NCA Residential Treatme Adolescents. 27G .0201 (A) (1-7) 10A NCAC 27G .02 POLICIES (a) The governing be facility or service sh written policies for ti (1) delegation of mate operation of the fac (2) criteria for admis (3) criteria for disch (4) admission asses (A) who will perform (B) time frames for (C) client record mate (A) persons authoriz (B) transporting rec (C) safeguard of rec (B) transporting rec (C) sasurance of rec (C) assurance of rec (C) assurance of rec (D) assurance of rec (E) assurance of rec (E) assurance of rec (B) an assessment (B) an assessment (B) an assessment	ROVIDER OR SUPPLIER 2002 A & I KINSTON, SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS A complaint and follow up survey was completed on January 14, 2019. The complaints were substantiated (intake #NC00146643, NC00146799 & NC00147018). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1900, Psychiatric Residential Treatment for Children and Adolescents. 27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's	ROVIDER OR SUPPLIER ROVIDER OR SUPPLIER D FACILITY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A complaint and follow up survey was completed on January 14, 2019. The complaints were substantiated (intake #NC00146643, NC00146799 & NC00147018). Deficiencies were cited. 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(6) screenings, which shall include: (A) an assessment of whether or not the facility can provide services to address the individual's	MHL054-125 **ROVIDER OR SUPPLIER** **STREET ADDRESS, CITY, STATE, ZIP CODE** **2002 A & B SHACKLEFORD ROAD** **KINSTON, NC 28502 **SUMMARY STATEMENT OF DEFICIENCIES** (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) **NITIAL COMMENTS** A complaint and follow up survey was completed on January 14, 2019. The complaints were substantiated (intake #NC00146643, NC00146799 & NC00147018). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G, 1900, Psychiatric Residential Treatment for Children and Adolescents. 27G .0201 (A) (1-7) Governing Body Policies **10A NCAC 27G .0201 GOVERNING BODY** POLICIES** (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of whether or not the facility and provide services to address the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's presenting problem or need; (MHL054-125 B. WING	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					K3) DATE SURVEY COMPLETED	
		MHL054-125	B. WING		01/1	4/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
PINEWO	OD FACILITY		B SHACKLE NC 28502	FORD ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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 105	Continued From pa	ge 1	V 105				
	recommendations; (7) quality assurance activities, including: (A) composition and assurance and qua (B) written quality a improvement plan; (C) methods for more quality and approprincluding delineation utilization of services (D) professional or a requirement that a professionals and treatment/habilitation (G) review of staff quality determination made treatment/habilitation (G) review of all fatt were being served residential program (H) adoption of star and programmatic papplicable standard purpose, "applicable means a level of coreference to the promethods, and the discontinuous description of the professional professi	d activities of a quality lity improvement committee; ssurance and quality initoring and evaluating the liateness of client care, n of client outcomes and les; clinical supervision, including staff who are not qualified lirovide direct client services by a qualified professional in liproving client care; ualifications and a let to grant					

Division of Health Service Regulation STATE FORM

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		SURVEY PLETED	
		MHL054-125	B. WING		01/·	14/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
DINEWO	OD FACILITY	2002 A &	B SHACKLE	FORD ROAD		
FINEVVO	OD FACILITI	KINSTON	, NC 28502			
(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 SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 105	Continued From pa	ge 2	V 105			
	failed to develop and for adoption of stand federal requirement	et as evidenced by: view and interview, the facility d implement a written policy dards of practice related to ts for the reporting of events e of restraint or seclusion. The				
	findings are: Review on 1/9/19 of LME-MCO (Local Management Entity-Managed Care Organization) communication Bulletin J287, "Clarifying the Reporting Standards for Psychiatric Residential Treatment Facilities [PRTF]" dated 5/11/18 revealed: "As a reminder, Serious Occurrences are any event that result in Restraint or Seclusion, NC [North Carolina] 483.374 specifies that facilities must report each Serious Occurrence to both the State Medicaid agency (Division of Medical Assistance - DMA) DMA receives reports of Serious Occurrences via the Incident Response and Improvement System (IRIS) managed by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services "					
	DEATH RESPONS 11/1/17 revealed: "Upon learning of a consumer currently shall document the specified in this poli [Department of Hea Incident Response Level II/III DHHS In include: b) Restricti documentation is reintervention details	alth and Human Services] Improvement System (IRIS). cident and Death Report ve Intervention: additional equired on the restrictive				

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY	
		MHL054-125	B. WING		01/1	14/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PINEWO	OOD FACILITY		B SHACKLE , NC 28502	FORD ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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 105	that exceeds Licens an unauthorized pelicensed health profrestrictive interventiphysical or psycholodays " Review on 1/9/19 or INCIDENT REPOR revealed that it did restrictive intervention Review on 1/9/19 or Death or Serious Or policy, last revised "It is the policy of [Locurrence/Sentine Consumer or any siphysical condition of by [Licensee's] Primother qualified Med but shall not be limited but shall not be limited but shall not be limited bone fractures, subinjuries to internal or inflicted by another abuse, neglect or econsidered a Serious and documented as Death or Serious Or and documented in State rules " Review on 1/9/19 or Situations/Emerger policy effective 1/1/" Procedure: 1. No situation or ESS exinterventions as doc Centered Plan)	sure Rules is administered by rson, requires treatment by a fessional. Level III any on that results in permanent ogical impairment within 7 If the facility's "LEVEL I TING" policy effective 9/1/10 not address reporting of ons. If the facility's "Consumer occurrence/Sentinel Event" 11/1/17 revealed: icensee] to define a Serious el Event as the death of a ignificant impairment of the of a Consumer as determined hary Care Medical Director or ical Personnel. This includes, ted to, burns, lacerations, stantial hematomas, and organs, whether self-inflicted or person. Any allegation of exploitation shall also be us Occurrence and reported occordingly. Each Consumer occurrence shall be reported accordance with Federal and of the facility's "Imminent Risk accy Safety Situations (ESS)"	V 105			

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL054-125	B. WING		01/1	4/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PINEWO	OD FACILITY		B SHACKLE NC 28502	FORD ROAD		
(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 APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
V 105	Continued From para Prevention Institute: Review on 1/3/19 or revealed both recomprofile with "Crisis Felan Restrictive will be made to desuse of physical rest Intervention should risk of, or in the protype: Physical Rest use of physica	ge 4 I training " If client #7 & #8's records ds included Person Centered Prevention and Intervention Interventions: Every attempt escalate the crisis prior to the raint or seclusion. Restrictive be used when at imminent cess of injuring self or others. Traint: 1. Duration Limit: the traint will be immediately indication of Consumer risk ediately when the Consumer tt-risk behaviors, or when 10 d Type: Seclusion use of Seclusion will be tinued at any indication of stress, or immediately when so control over at-risk hour has elapsed " Perviews on 1/9/19, clients #7 by had been placed in hile at the facility and had ing placed in therapeutic of client #11's record revealed: admitted to the facility and Deficit Hyperactivity and Defiant Disorder, we Disorder, and Disruptive	V 105			

Division of Health Service Regulation

Review on 1/3/19 of the North Carolina Incident

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL054-125	B. WING		01/1	4/2019	
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE			
PINEWO	OD FACILITY		B SHACKLE , NC 28502	FORD ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
V 105	Response Improven no Level II incident that resulted in clier or 12/10/18. During interview on had been placed in but none recently, a peers being placed During interview on Services stated the ongoing communicatives of restrictive intrequirements for rethe use of restraint outlined in LME-MC J287 and corresport They were awaiting requirements.	ment System (IRIS) revealed reports regarding the events at #11's restraint on 11/20/18 1/9/19 client #11 stated he therapeutic holds, or "wraps", and he had witnessed his in therapeutic holds. 1/9/19 the Director of PRTF Executive Director was in ation with officials from the dealth regarding the planned derventions and the porting events that result in or seclusion in PRTF's as CO Communication Bulletin ading federal requirements. clarification of the	V 105				
V 366	10A NCAC 27G .06 RESPONSE REQUID CATEGORY A AND (a) Category A and implement written presponse to level I, shall require the proful attending of individuals involving (2) determining (3)	JIREMENTS FOR B PROVIDERS B providers shall develop and policies governing their II or III incidents. The policies povider to respond by: to the health and safety needs	V 366				

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STATE FORM 5899 ZWRW11 If continuation sheet 6 of 14

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	MHL054-125	B. WING		01/1	4/2019
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PINEWOOD FACILITY		B SHACKLE NC 28502	FORD ROAD		
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
to prevent similar in specified timeframe (5) assigning for implementation preventive measure (6) adhering set forth in G.S. 75, 42 CFR Parts 2 and 164; and (7) maintaining Subparagraphs (a) (b) In addition to the Paragraph (a) of the shall address incide regulations in 42 Cl (c) In addition to the Paragraph (a) of the providers, excluding develop and implementation that the provider is or while the provider is or while the client is The policies shall response to a while the client is The policies shall response to a while the client is the policies shall response to a while the client is the policies shall response to a while the client is the policies shall response to a while the client is the policies shall response to a while the client is the policies shall response to a while the client is the policies shall response to a while the client is the policies shall response to a while the client is the policies shall response to a while the client is the policies shall response to a while the provider is the policies of the provider is the provider in the provider in the provider is the provider in	exceed 45 days; ag and implementing measures ncidents according to provider es not to exceed 45 days; a person(s) to be responsible of the corrections and	V 366			

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STATE FORM 5699 ZWRW11 If continuation sheet 7 of 14

l l	A. DUILDING.		(X3) DATE SURVEY COMPLETED	
MHL054-125	B. WING		01/1	4/2019
NAME OF PROVIDER OR SUPPLIER STREET	ADDRESS, CITY, S	STATE, ZIP CODE		
PINEWOOD FACILITY	. & B SHACKLE ON, NC 28502	FORD ROAD		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
v 366 Continued From page 7 services at the time of the incident. The internareview team shall complete all of the activities a follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fawithin five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibilite for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department;	act act act act act act act act			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		SURVEY PLETED	
		MHL054-125	B. WING		01/	14/2019
	PROVIDER OR SUPPLIER OD FACILITY	2002 A &		STATE, ZIP CODE FORD ROAD		
(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 SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 366	(E) the client' applicable; and	ge 8 s legal guardian, as authorities required by law.	V 366			
	facility failed to doc Il incidents. The find Review on 1/9/19 of Management Entity communication Bul Reporting Standard Treatment Facilities revealed: "As a reminder, See event that result in [North Carolina] 483 must report each S State Medicaid age Assistance - DMA) Serious Occurrence and Improvement S Division of Mental H Disabilities and Sub Review on 1/9/19 of DEATH RESPONS 11/1/17 revealed: "Upon learning of a consumer currently shall document the specified in this poli	views and interviews the ument their response to level dings are: If LME-MCO (LocalManaged Care Organization) letin J287, "Clarifying the is for Psychiatric Residential is [PRTF]" dated 5/11/18 Tious Occurrences are any Restraint or Seclusion, NC 3.374 specifies that facilities erious Occurrence to both the incy (Division of Medical DMA receives reports of es via the Incident Response system (IRIS) managed by the Health, Developmental estance Abuse Services " If the facility's "INCIDENT AND E SYSTEM" policy last revised Level II/III incident involving a receiving services, [Licensee] event within the time frames				

Division of Health Service Regulation

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DIVISION	of Health Service Re	guiation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		MHL054-125	B. WING		01/1	4/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AN	DRESS CITY S	STATE, ZIP CODE		
10 10 1	TO VIBER OR OUT FIER			FORD ROAD		
PINEWO	OD FACILITY		, NC 28502	I OND NOAD		
()(4) ID	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION)NI	(VE)
(X4) ID PREFIX		/ MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				DEI ICIENCT)		
V 366	Continued From pa	ige 9	V 366			
	Incident Response	Improvement System (IRIS)				
	Incident Response Improvement System (IRIS). Level II/III DHHS Incident and Death Report					
		ve Intervention: additional				
		equired on the restrictive				
	intervention details					
		ned use or any planned use sure Rules is administered by				
		rson, requires treatment by a				
		fessional. Level III any				
	restrictive intervent	ion that results in permanent				
		ogical impairment within 7				
	days"					
		f the facility's "LEVEL I				
		TING" policy effective 9/1/10 not address reporting of				
	restrictive intervent					
		f the facility's "Consumer				
		ccurrence/Sentinel Event"				
	policy, last revised	icensee] to define a Serious				
		el Event as the death of a				
		ignificant impairment of the				
	, ,	of a Consumer as determined				
		nary Care Medical Director or				
	-	ical Personnel. This includes, ited to, burns, lacerations,				
		estantial hematomas, and				
		organs, whether self-inflicted or				
		person. Any allegation of				
	abuse, neglect or e	xploitation shall also be				
		us Occurrence and reported				
		ccordingly. Each Consumer				
ı		ccurrence shall be reported accordance with Federal and				
	State rules "	accordance with rederal and				
		f the facility's "Imminent Risk				
	Situations/Emerger	ncy Safety Situations (ESS)"				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			X3) DATE SURVEY COMPLETED	
		MHL054-125	B. WING		01/	14/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PINEWO	OOD FACILITY		B SHACKLE , NC 28502	FORD ROAD		
(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 SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 366	situation or ESS exinterventions as doc Centered Plan) [North Carolina Intervention Institute] Review on 1/3/19 or - 13 year old male at 11/13/18 Diagnoses include psychosis, Attention Disorder, Opposition Intermittent Explosis Mood Dysregulation - "Order for Emerge" Physical Restraint" Review on 1/3/19 or Response Improven that resulted in clier or 12/10/18. During interview on had been placed in but none recently, a peers being placed During interview on Services stated the ongoing communication of Mental Frequirements for rethe use of restraint outlined in LME-MC	16 revealed: When an imminent risk ists staff should implement cumented in the PCP (Person and consistent with NCI rventions] and CPI [Crisis] training " If client #11's record revealed: admitted to the facility ad Bipolar Disorder with a Deficit Hyperactivity nal Defiant Disorder, we Disorder, and Disruptive a Disorder. Incy Safety Interventions" for adated 11/20/18 and 12/10/18. If the North Carolina Incident ment System (IRIS) revealed reports regarding the events at #11's restraint on 11/20/18 1/9/19 client #11 stated he therapeutic holds, or "wraps", and he had witnessed his in therapeutic holds. 1/9/19 the Director of PRTF Executive Director was in action with officials from the dealth regarding the porting events that result in or seclusion in PRTF's as a co Communication Bulletin ading federal requirements.	V 366			

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TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
	MIII 054 405	B WING		04/4	4/0040
	MHL054-125	B. WING		01/1	4/2019
ROVIDER OR SUPPLIER					
DD FACILITY			FORD ROAD		
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(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	_D BE	(X5) COMPLETE DATE
Continued From pa	ge 11	V 366			
27G .0604 Incident	Reporting Requirements	V 367			
REPORTING REQUENTING AND (a) Category A and level II incidents, exthe provision of bills consumer is on the incidents and level to whom the provide 90 days prior to the responsible for the services are provide becoming aware of be submitted on a factorial Secretary. The reprin person, facsimile means. The report information: (1) reporting identification inform (2) client ider (3) type of ind (4) descriptio (5) status of the cause of the incider (6) other indivor responding. (b) Category A and missing or incomples shall submit an upder recipients by	UIREMENTS FOR B PROVIDERS B providers shall report all acept deaths, that occur during able services or while the providers premises or level III II deaths involving the clients er rendered any service within incident to the LME catchment area where ed within 72 hours of the incident. The report shall orm provided by the ort may be submitted via mail, or encrypted electronic shall include the following provider contact and action; attification information; cident; and or incident; the effort to determine the not; and or inciders shall explain any ete information. The provider lated report to all required				
	ROVIDER OR SUPPLIER DD FACILITY SUMMARY STA (EACH DEFICIENCY REGULATORY OR LETTE CONTINUED FROM PARTICIPATION OF LETTE CONTINUED FROM PARTICIPAT	MHL054-125 ROVIDER OR SUPPLIER STREET AD 2002 A & KINSTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 This deficiency constitutes a re-cited deficiency and must be corrected within 30 days. 27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the provider premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:	MHL054-125 ROVIDER OR SUPPLIER STREET ADDRESS, CITY, S 2002 A & B SHACKLE KINSTON, NC 28502 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 V 366 This deficiency constitutes a re-cited deficiency and must be corrected within 30 days. 27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. 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The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:	ROVIDER OR SUPPLIER ROVIDER OR SUPPLIER ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2002 A & B SHACKLEFORD ROAD KINSTON, NC 25502 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCE OT THE APPRO DEFICIENCY COntinued From page 11 V 366 This deficiency constitutes a re-cited deficiency and must be corrected within 30 days. 27G .0604 Incident Reporting Requirements V 367 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY AAND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider endered any service within 90 days prior to the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information; (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:	MHL054-125 MHL054-125 ROWIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2002 A & B SHACKLEFORD ROAD KINSTON, NC 28502 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY PLL) REGULATORY OR LSC DENTIFYING INFORMATION) Continued From page 11 This deficiency constitutes a re-cited deficiency and must be corrected within 30 days. 27G. 0604 Incident Reporting Requirements 10A NCAC 27G. 0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facisimle or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident, and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED							
		MHL054-125	B. WING		01/1	4/2019						
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE								
PINEWOOD FACILITY 2002 A & B SHACKLEFORD ROAD												
PINEWOOD FACILITY KINSTON, NC 28502												
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE							
V 367	information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of		V 367									
	Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III											
	incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death											
	immediately, as red .0300 and 10A NCA (e) Category A and	puired by 10A NCAC 26C AC 27E .0104(e)(18). B providers shall send a the LME responsible for the										
	catchment area wh The report shall be by the Secretary via	ere services are provided. submitted on a form provided a electronic means and shall										
	(1) medicatio definition of a level	formation as follows: n errors that do not meet the II or level III incident; interventions that do not meet										
	the definition of a let (3) searches (4) seizures (4) the possession of a	evel II or level III incident; of a client or his living area; of client property or property in a client; number of level II and level III										

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED					
		MHL054-125	B. WING		01/1	14/2019				
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE						
PINEWOOD FACILITY 2002 A & B SHACKLEFORD ROAD KINSTON, NC 28502										
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE						
V 367	Continued From paincidents that occur (6) a statemed been no reportable incidents have occumeet any of the crit (a) and (d) of this R through (4) of this F This Rule is not me Based on record refacility failed to comon the form provide required. The findin Refer to tag v366 for During interview on Services stated the ongoing communication Division of Mental Frequirements for rethe use of restraint	ge 13 red; and ent indicating that there have incidents whenever no arred during the quarter that eria as set forth in Paragraphs ule and Subparagraphs (1) Paragraph. et as evidenced by: views and interviews the explete Level II incident reports d by the Secretary as gs are: or specific details. 1/9/19 the Director of PRTF Executive Director was in ation with officials from the	TAG V 367		COPRIATE	DATE				
	They were awaiting requirements.									
	This deficiency conand must be correct	stitutes a re-cited deficiency ted within 30 days.								

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