· · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED 02/28/2019	
		MHL036-332	B. WING			
ame of Pr	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
REEDOM			AY DRIVE IIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
V 000	INITIAL COMMENTS		V 000			
	An annual survey was 2019. Deficiencies w	s completed on February 28, ere cited.				
	category: 10A NCAC	d for the following service 27G .3100 Nonhospital n for Individuals who are				
V 119	27G .0209 (D) Medica	ation Requirements	V 119			
	guards against divers (2) Non-controlled su of by incineration, flus system, or by transfer destruction. A record shall be maintained b Documentation shall medication name, stru- date and method, the disposing of medicati witnessing destruction (3) Controlled substan accordance with the I Substances Act, G.S. subsequent amendm (4) Upon discharge of remainder of his or he disposed of promptly expected that the pat to the facility and in s	al: d non-prescription isposed of in a manner that ion or accidental ingestion. bstances shall be disposed shing into septic or sewer r to a local pharmacy for of the medication disposal y the program. specify the client's name, ength, quantity, disposal signature of the person on, and the person n. nces shall be disposed of in North Carolina Controlled 90, Article 5, including any				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
REEDON	Л		RAY DRIVE NIA, NC 28054			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET DATE
V 119	Continued From page	e 1	V 119			
	This Rule is not met	•				
	Based on interview, r observation, the facili	ity failed to ensure that all				
	expired medications	be disposed affecting 1 of 3				
	audited clients (Clien	t #2). The findings are:				
	Observation on 2/28/	19 at approximately 2:10pm				
	of Client #2's medica					
		40mg (elevated cholesterol				
	and triglyceride levels pharmacy label direc	s) dispensed 12/1/17 with tions to discard after				
	12/1/18;					
	-Bottle of Finasteride	5mg (urinary retention)				
	dispensed 12/14/17 v					
	directions to discard	after 12/1/18; tivitamins (supplement) with				
	expiration date of 8/2					
		f Client #2's record revealed:				
	-Admission date of 2/					
		Use Disorder, Alcohol Use Remission, Unspecified				
	Anxiety Disorder, Un					
		eficit Hyperactivity Disorder;				
	-	ated 2/24/19 for Simvastatin ng, and multivitamins.				
	Interview on 2/28/19 revealed:	with the Registered Nurse				
		e medication labels reveal				
	that the medications	•				
		re brought to the facility by #2 did not want to discard the				
	medications.					
		with the Office Administrator				
	revealed:		1			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL036-332	B. WING		02	2/28/2019
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, RAY DRIVE	, ZIP CODE		
FREEDOM	Λ		NIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
V 119	Continued From page	e 2	V 119			
	a client who presents with medications white	a policy on how to address to the facility for admission ch appear to have expired eplace the medications prior				
V 131	G.S. 131E-256 (D2) I Verification	HCPR - Prior Employment	V 131			
	REGISTRY (d2) Before hiring hea health care facility or health care facility sh Personnel Registry a	ALTH CARE PERSONNEL alth care personnel into a service, every employer at a all access the Health Care nd shall note each incident opriate business files.				
	failed to ensure that t registry be accessed prior to an offer of em	nd record review, the facility he health care personnel and the results documented ployment affecting 2 of 3 ions Coordinator and Office				
	record revealed: -Hire date of 10/23/18	f the Admission Coordinator's 3; el Registry Check completed				
	Review on 2/28/19 of record revealed: -Hire date of 8/8/18;	f the Office Administrator's				

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STATEMEN	of Health Service Regu T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-332	B. WING		02	/28/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
FREEDO	М		RAY DRIVE			
	1		NIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
V 131	Continued From page	e 3	V 131			
	-Healthcare Personne on 11/19/18.	el Registry Check completed				
	revealed:	-				
V 133	G.S. 122C-80 Crimin	al History Record Check	V 133			
	CHECK REQUIRED APPLICANTS FOR E (a) Definition As us "provider" applies to a program and any pro- developmental disabi- services that is licens Chapter. (b) Requirement Ar provider licensed und applicant to fill a posi- applicant to fill a posi- applicant to have an conditioned on conse criminal history record the applicant has bee less than five years, f is conditioned on con- criminal history record national criminal histor the applicant has bee five years or more, th on consent to a State check of the applicant employ an applicant of	EMPLOYMENT. ed in this section, the term an area authority/county vider of mental health, lity, and substance abuse able under Article 2 of this n offer of employment by a ler this Chapter to an tion that does not require the occupational license is ent to a State and national d check of the applicant. If en a resident of this State for then the offer of employment sent to a State and national d check of the applicant. The				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL036-332	B. WING	02	2/28/2019	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
FREEDOM	I		RAY DRIVE NIA, NC 28054			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C		(X5)
PREFIX TAG	(Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!) THE APPROPRIATE	COMPLET DATE
V 133	Continued From page	e 4	V 133			
	subsection. within five	e business days of making				
		of employment, a provider				
		at to the Department of				
	Justice under G.S. 11	•				
	criminal history record	d check required by this				
	section or shall submit a request to a private					
	entity to conduct a State criminal history record					
	check required by this	s section. Notwithstanding				
		Department of Justice shall				
		ational criminal history				
		ployment positions not				
	covered by Public Law 105-277 to the					
	Department of Health and Human Services,					
	Criminal Records Check Unit. Within five business days of receipt of the national criminal					
	-	-				
		the Department of Health				
		, Criminal Records Check				
		provider as to whether the may affect the employability				
		case shall the results of the				
	• •	bry record check be shared				
		oviders shall make available				
		tion that a criminal history				
		pleted on any staff covered				
		inty that has adopted an				
	•	nance and has access to				
		al Information data bank				
	may conduct on beha	alf of a provider a State				
	criminal history record	d check required by this				
	section without the pr	rovider having to submit a				
		ment of Justice. In such a				
		Il commence with the State				
		d check required by this				
	section within five bu	-				
		nployment by the provider.				
		formation received by the				
		al and may not be disclosed,				
		nt as provided in subsection				
	(c) of this section. For	r nurnases at this				1

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STATEMENT OF D AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		MHL036-332	B. WING		00/00/0040		
NAME OF PROVID	ER OR SUPPLIER	I	B. WING 02/28/201				
FREEDOM		GASTO	NIA, NC 28054				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 133 Coi	ntinued From page	e 5	V 133				
sub bus crim rec (c) rec a re of t hire (1) (2) (3) cor (4) cor (5) the fille (6) reh per (7) a re sha liste If th cor the sha liste to t to t (0) rec (1) (2) (3) cor (4) cor (5) the fille (6) reh (1) (2) (3) cor (4) cor (5) the fille (6) reh (1) (2) (3) cor (4) cor (5) the fille (6) reh (7) cor (7) c	esection, the term inness regularly en ninal history record ords obtained from Action If an app ord check reveals elevant offense, th he following factor a the applicant: The level and seri The date of the pe viction. The circumstance mission of the cri The age of the pe viction. The circumstance mission of the cri The nexus betwee person and the jo d. The prison, jail, pr abilitation, and err son since the date the subsequent of elevant offense. e fact of conviction all not be a bar to e e factors shall be the provider disqua isideration of the r vider may disclose criminal history re he disqualification he criminal history plicant. Limited Immunity. employee of a prov nplies with this ser I liability for: The failure of the	"private entity" means a logaged in conducting d checks utilizing public in a State agency. licant's criminal history one or more convictions of e provider shall consider all rs in determining whether to ousness of the crime. ime. rson at the time of the s surrounding the me, if known. en the criminal conduct of b duties of the position to be					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		MHL036-332	B. WING			0/28/2040
	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE		02	2/28/2019
FREEDOM	Л		NIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
V 133	Continued From page 6		V 133			
	(2) Failure to check a criminal offenses if th history record check i compliance with this s (e) Relevant Offense "relevant offense" me federal criminal histori indictment of a crime, felony, that bears up have responsibility fo persons needing mer disabilities, or substa crimes include the cri any of the following A General Statutes: Art Issuing Monetary Sut Endangering Execution Article 6, Homicide; A Sex Offenses; Article Kidnapping and Abdu Injury or Damage by Incendiary Device or and Other Housebrea Other Burnings; Article Robbery; Article 18, E False Pretenses and Obtaining Property of Fraudulent Use of Cri Article 19B, Financial Act; Article 20, Fraud 26, Offenses Against Decency; Article 37, Office; Article 35, Office	A - As used in this section, ans a county, state, or by of conviction or pending whether a misdemeanor or on an individual's fitness to r the safety and well-being of natal health, developmental nce abuse services. These minal offenses set forth in articles of Chapter 14 of the icle 5, Counterfeiting and ostitutes; Article 5A, we and Legislative Officers; article 7A, Rape and Other 8, Assaults; Article 10, action; Article 13, Malicious Use of Explosive or Material; Article 14, Burglary akings; Article 15, Arson and le 16, Larceny; Article 17, Embezzlement; Article 19, Cheats; Article 19A, * Services by False or edit Device or Other Means; Transaction Card Crime s; Article 21, Forgery; Article Public Morality and , Adult Establishments; n; Article 28, Perjury; Article I, Misconduct in Public enses Against the Public tiots and Civil Disorders; of Minors; Article 40,				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	A. BUILDING:		E SURVEY PLETED
		MHL036-332	B. WING		02	/28/2019
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
FREEDOM	n		RAY DRIVE NIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
V 133	Continued From page 7		V 133			
	Crime. These crimes sale of drugs in violat Controlled Substance 90 of the General Sta offenses such as sale violation of G.S. 18B- impaired in violation of G.S. 20-138.5. (f) Penalty for Furnish applicant for employin supplies, or otherwise an employment applic criminal history record shall be guilty of a Cla (g) Conditional Employ employ an applicant of obtaining the results of check regarding the a following requirement (1) The provider shall prior to obtaining the criminal history record subsection (b) of this fingerprint cards as re (2) The provider shall criminal history record business days after th conditional employme 2001-155, s. 1; 2004-	of G.S. 20-138.1 through ning False Information Any nent who willfully furnishes, e gives false information on cation that is the basis for a d check under this section ass A1 misdemeanor. byment A provider may conditionally prior to of a criminal history record applicant if both of the ts are met: not employ an applicant applicant's consent for d check as required in section or the completed equired in G.S. 114-19.10. I submit the request for a d check not later than five ne individual begins				
		nd record review, the facility criminal background checks				

STATEMEN	of Health Service Regu T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMF	SURVEY PLETED
		MHL036-332	B. WING		02	/28/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
FREEDOM	л		RAY DRIVE NIA, NC 28054			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	F CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETE
V 133	Continued From page	e 8	V 133			
	employment affecting (Admissions Coordina Administrator). The f	ator and Office				
	Review on 2/28/19 of record revealed: -Hire date of 10/23/18 -Criminal background 11/20/18.					
	Review on 2/28/19 of record revealed: -Hire date of 8/8/18; -Criminal background 11/19/18.	f the Office Administrator's I check completed on				
	revealed:	•				
V 536	27E .0107 Client Rig Int.	hts - Training on Alt to Rest.	V 536			
	to restrictive intervent (b) Prior to providing disabilities, staff inclu employees, students demonstrate compete completing training in other strategies for cr which the likelihood c	RESTRICTIVE plement policies and size the use of alternatives tions. services to people with iding service providers, or volunteers, shall				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			MUL 036.332 B. WING			
		MHL036-332			02	2/28/2019
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, RAY DRIVE	, ZIP CODE		
FREEDON	1		NIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 536	Continued From page	e 9	V 536			
	based on state comp compliance and demi gathered. (d) The training shall include measurable for measurable testing (w behavior) on those of methods to determine course. (e) Formal refresher by each service provi annually). (f) Content of the trai provider wishes to en the Division of MH/DI Paragraph (g) of this (g) Staff shall demor following core areas: (1) knowledge people being served; (2) recognizing behavior; (3) recognizing external stressors that disabilities; (4) strategies for relationships with per (5) recognizing organizational factors disabilities; (6) recognizing assisting in the person decisions about their (7) skills in ass escalating behavior; (8) communications and the service (1) science and the service (1) science and the service (1) science and the service (2) recognizing organizational factors (3) recognizing assisting in the person decisions about their (3) science and the service (3) recognizing assisting in the person decisions about their (3) science and the service (3) recognizing assisting in the person decisions about their (3) communications and the service (3) recognizing	s shall establish training etencies, monitor for internal onstrate they acted on data be competency-based, earning objectives, written and by observation of bjectives and measurable e passing or failing the training must be completed ider periodically (minimum ining that the service nploy must be approved by D/SAS pursuant to Rule. nstrate competence in the and understanding of the g and interpreting human g the effect of internal and at may affect people with or building positive rsons with disabilities; g cultural, environmental and s that may affect people with g the importance of and on's involvement in making				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:			
		MHL036-332	B. WING		02	2/28/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
REEDON	1		RAY DRIVE NIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLE DATE
	by scoring a passing instructor training pro- (3) The trainin competency-based, objectives, measural observation of behave measurable methods failing the course. (4) The conter service provider plan approved by the Divi- to Subparagraph (i)((5) Acceptable shall include but are (A) understand	grade on testing in an ogram. g shall be include measurable learning ble testing (written and by vior) on those objectives and s to determine passing or at of the instructor training the his to employ shall be ision of MH/DD/SAS pursuant				

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMF	SURVEY
		MHL036-332	B. WING		02	/28/2019
IAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
REEDON	Λ		RAY DRIVE NIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
V 536	Continued From page	e 11	V 536			
	 performance; and (D) documentation (G) Trainers shiteaching a training preducing and elimination interventions at least review by the coach. (7) Trainers shitead at preventing, need for restrictive in annually. (8) Trainers shiteat at preventing at least the course providers documentation of inition training for at least the shift trai	ial and refresher instructor ree years. entation shall include: bated in the training and the where attended; and name. n of MH/DD/SAS may his documentation any time. Coaches: hall meet all preparation hiner. hall teach at least three times eing coached. hall demonstrate bletion of coaching or				

1089 >	A. BUILDING: B. WING T ADDRESS, CITY, STATE CRAY DRIVE ONIA, NC 28054 ID PREFIX TAG V 536	E, ZIP CODE PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	F CORRECTION CTION SHOULD BE D THE APPROPRIATE	/28/2019 /28/2019
JPPLIER STREE 1089 J GAST SUMMARY STATEMENT OF DEFICIENCIES H DEFICIENCY MUST BE PRECEDED BY FULL JLATORY OR LSC IDENTIFYING INFORMATION) From page 12 is not met as evidenced by: nterview and record review, the facility sure that all staff were trained in s to Restrictive Intervention prior to ervices affecting 1 of 3 audited staff is Coordinator). The findings are: 2/28/19 of the Admission Coordinator's ealed: of 10/23/18; g in Alternatives to Restrictive n. n 2/28/19 with the Office Administrator ssion Coordinator was scheduled to raining in Alternatives to Restrictive	T ADDRESS, CITY, STATE (RAY DRIVE ONIA, NC 28054 ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO	F CORRECTION CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET
1089 2 GAST SUMMARY STATEMENT OF DEFICIENCIES H DEFICIENCY MUST BE PRECEDED BY FULL ILATORY OR LSC IDENTIFYING INFORMATION) From page 12 is not met as evidenced by: nterview and record review, the facility sure that all staff were trained in s to Restrictive Intervention prior to ervices affecting 1 of 3 audited staff is Coordinator). The findings are: 2/28/19 of the Admission Coordinator's ealed: of 10/23/18; g in Alternatives to Restrictive n. n 2/28/19 with the Office Administrator ssion Coordinator was scheduled to raining in Alternatives to Restrictive	CRAY DRIVE ONIA, NC 28054	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE	COMPLET
GAST SUMMARY STATEMENT OF DEFICIENCIES H DEFICIENCY MUST BE PRECEDED BY FULL JLATORY OR LSC IDENTIFYING INFORMATION) From page 12 is not met as evidenced by: nterview and record review, the facility sure that all staff were trained in s to Restrictive Intervention prior to ervices affecting 1 of 3 audited staff is Coordinator). The findings are: 2/28/19 of the Admission Coordinator's ealed: of 10/23/18; g in Alternatives to Restrictive n. n 2/28/19 with the Office Administrator ssion Coordinator was scheduled to raining in Alternatives to Restrictive	ONIA, NC 28054	(EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE	COMPLET
SUMMARY STATEMENT OF DEFICIENCIES H DEFICIENCY MUST BE PRECEDED BY FULL ILATORY OR LSC IDENTIFYING INFORMATION) From page 12 is not met as evidenced by: Interview and record review, the facility sure that all staff were trained in is to Restrictive Intervention prior to ervices affecting 1 of 3 audited staff is Coordinator). The findings are: 2/28/19 of the Admission Coordinator's ealed: of 10/23/18; g in Alternatives to Restrictive n. n 2/28/19 with the Office Administrator ssion Coordinator was scheduled to raining in Alternatives to Restrictive	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE	COMPLET
From page 12 is not met as evidenced by: nterview and record review, the facility sure that all staff were trained in s to Restrictive Intervention prior to ervices affecting 1 of 3 audited staff is Coordinator). The findings are: 2/28/19 of the Admission Coordinator's ealed: of 10/23/18; g in Alternatives to Restrictive n. n 2/28/19 with the Office Administrator ssion Coordinator was scheduled to raining in Alternatives to Restrictive	TAG	CROSS-REFERENCED TO	THE APPROPRIATE	
is not met as evidenced by: Interview and record review, the facility sure that all staff were trained in is to Restrictive Intervention prior to ervices affecting 1 of 3 audited staff is Coordinator). The findings are: 2/28/19 of the Admission Coordinator's ealed: of 10/23/18; g in Alternatives to Restrictive n. In 2/28/19 with the Office Administrator assion Coordinator was scheduled to raining in Alternatives to Restrictive	V 536			
nterview and record review, the facility sure that all staff were trained in s to Restrictive Intervention prior to ervices affecting 1 of 3 audited staff is Coordinator). The findings are: 2/28/19 of the Admission Coordinator's ealed: of 10/23/18; g in Alternatives to Restrictive n. n 2/28/19 with the Office Administrator ssion Coordinator was scheduled to raining in Alternatives to Restrictive				
ssion Coordinator was scheduled to aining in Alternatives to Restrictive				
alize the Admissions Coordinator be trained in Alternatives to Restrictive in prior to starting work due to his int contact; e all staff receive training in s to Restrictive Intervention prior to ervices to clients.				
	nt contact; e all staff receive training in s to Restrictive Intervention prior to	nt contact; e all staff receive training in s to Restrictive Intervention prior to	nt contact; e all staff receive training in s to Restrictive Intervention prior to	at contact; e all staff receive training in s to Restrictive Intervention prior to