MHL034-379 B. WING 04/26/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 04/26/20 INSPIRATIONZ, LLC CUATRO 2427 PATRIA STREET WINSTON-SALEM, NC 27127 VINSTON-SALEM, NC 27127 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CO		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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NERRATIONZ, LLC CUATRO 247 PATRIA STREET WINSTON-SALEM, NC 27127 OMID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MAY BE PRECEDED BY FULL (EACH DEFICIENCY MAY BE PRECEDED BY FULL RECULATORY OR LSC DENTIFYING INFORMATION) PREFIX TAG PROVIDENS PLAN OF CORRECTION (EACH DEFICIENCY) 00 V 000 INITIAL COMMENTS V 000 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 00 V 001 INITIAL COMMENTS V 000 A an annual survey was completed on 4/26/2019. A deficiency was cited. V 100 Init facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children and Adolescents. V 112 V 112 Z7G .0205 (C-D) Assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. V 112 (i) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible. Initian the service and a projected date of achievement; (i) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (i) staff responsible; (i) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (i) basis for evaluation or assessment of outcome achievement; and (i) written consent or agreement by the client or responsible person or both; Initian staff secure or both; (i) client staffing My such consent could not be						02	/26/2019
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		MHL034-379	B. WING			1/26/2019
NAME OF P	ROVIDER OR SUPPLIER	1	ADDRESS, CITY, STATE		02	4/20/2019
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INSPIRAT	IONZ, LLC CUATRO		N-SALEM, NC 271	27		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
V 112	Continued From pag	e 1	V 112			
	facility failed to devel on the assessment a (#3). The findings ar Review on 4/26/2019 revealed: - Admission date: 2/2 - Diagnoses: Major D recurrent, severe wit Post Traumatic Stres - Age: 15 - An admission asses noted a history of rer abuse and self-harm non-compliance with - A "Physician Discha 3/22/2019 from the m residential treatment history of suicidal stati including running aw agitation and aggres weeks prior to admis 2/14/2019), and usin - A treatment plan ini 2/21/2019, with a rev goals of: 1) "[Client #3] will trating group home" 2) "[Client #3] will ince evidenced by) refrair isolating herself whe anxiety or past traum of worry and sadness	iews and interviews, the lop the treatment plan based diffecting 1 of 3 audited clients re: 0 of client #3's record 28/2019 Depressive Disorder, hout psychotic features; and as Disorder (PTSD); ssment dated 2/28/2019 that moval from home due to ing behaviors and medications and rules; arge Summary" dated eferring psychiatric facility (PRTF) that noted a atements, risky behaviors ay, sexualized behaviors, sive behavior within the two esion (admitted to PRTF on g marijuana with friends; itially developed on view date of 3/21/2019 listed insition to Inspirationz level III crease coping skills AEB (as ning from closing down and n she gets overwhelmed by na, decreasing general level s, and increasing her ability nose around her what she is				

Division of Health Service Regulation STATE FORM

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:			
		MHL034-379	B. WING		04	/26/2019
IAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
NSPIRAT	IONZ, LLC CUATRO		TRIA STREET IN-SALEM, NC 271	27		
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V 112	Continued From page	e 2	V 112			
	comply with rules wit disrespectful behavio as evidenced by refra outbursts and using p 4) "[Client #3] will get and rest each night b of inappropriate beha assigned sleep area documentation and s 5) "[Client #3] will par and/or respite, in an contacts and develop family and/or respite communication and v treatment team appro - There were no treat #3's history of suicida sexualized behaviors or running away; - The interventions lis were identical from g	or towards authority figures aining from emotional positive coping skills." t a healthy mount of sleep by not exhibiting any incidents aviors and remaining in as evidenced by shift note taff's report after bedtime." rticipate in therapeutic leave effort to improve social o positive relationships with providers through ongoing visitations with guardian and oval." tment goals related to client al statements, self-harm, s, medication non-compliance sted in the treatment plan oal to goal and specified " ne Staff will:" rather than				
	 Her treatment goals to do," have "positive" Interview on 4/26/20² Facility clients migh on a board posted or 					
	entire house. Interview on 4/26/20 Professional (AP) rev - The treatment plan and client #3's Guard	was written by a therapist				

STATE FORM

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL034-379	B. WING		04	/26/2019
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NSPIRAT	IONZ, LLC CUATRO		TRIA STREET N-SALEM, NC 271	27		
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V 112	Continued From page	e 3	V 112			
	ideation, self-harm, s non-compliance with (absent without leave not locate any;	medications, and AWOL e) behaviors, the AP could ted basic strategies that staff				
	Professional (QP) rev - "The [Home Provide 3's] admission to Insp and wrote the current (PCP). - Prior to [Client # 3's had been stable for m days). The treatment self-injurious behavior	with the Director/Qualified vealed: er] (provider prior to [Client # oirationz Cuatro) developed t Person Centered Plan e] admission (2/28/19) she nore than thirty day (30 team will not address the ors or elopement issues with she has not presented those				
	into the plan (PCP) th	n will not allow us to put goals nat she hasn't shown a ssumption is she has gotten				
	- [Client #3] has beer with us (Inspirationz -I asked about adding self-injurious and elo Provider] said she ad either behavior) and	. ,				
	meeting was March t the [Home Provider] [Client #3] working or	d and Family Team (CFT) wenty first (3/21/19). Again developed goals they want n. r] is still servicing and will				
	develop her PCP goa - We would have wro intervention for self-ir	als until we are servicing her. te it with strategies of njurious behaviors and issues that are in her				

Division of Health Service Regu STATE FORM

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			SURVEY PLETED
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ISPIRATI	ONZ, LLC CUATRO		TRIA STREET DN-SALEM, NC 2712	27		
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V 112	Continued From pag	e 4	V 112			
	can add an addendu	ical Assessment (CCA). We m to the PCP with strategies njurious and elopement				