STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3)		
			5 14/11/0		R
		MHL060-739	B. WING		05/24/2019
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	
COMMUN	COMMUNITY TREATMENT ALTERNATIVES II 4901 RC				
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 000	INITIAL COMMENTS		V 000		
	completed on May 24 unsubstantiated (Intal Deficiencies were cite This facility is licensed category: 10A NCAC	ed. d for the following service 27G .1700 Residential			
	Treatment Staff Secu Adolescents.	re for Children or			
V 112	27G .0205 (C-D) Assessment/Treatme	nt/Habilitation Plan	V 112		
	PLAN  (c) The plan shall be assessment, and in plegally responsible per of admission for clien receive services beyond (d) The plan shall incomplete the plan shall incompose the projected date of achieved by provision projected date of achieved by strategies;  (3) staff responsible;  (4) a schedule for reannually in consultation responsible person of the projected date of achievement (b) written consent of the projected date of achievement (c) written consent of the projected date of achievement (d) written consent of the projected date of the	developed based on the artnership with the client or erson or both, within 30 days ts who are expected to and 30 days. Blude: I that are anticipated to be a of the service and a devement; I view of the plan at least on with the client or legally roboth; I to on or assessment of			

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

(X6) DATE TITLE

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:		COMP	LETED
		MHL060-739	B. WING			R <b>24/2019</b>
NAME OF PI	ROVIDER OR SUPPLIER	STRI	EET ADDRESS, CITY, STA	ATE, ZIP CODE		
COMMUN	ITY TREATMENT ALTER	MATIVES II	1 ROSENA DRIVE			
COMMON	III IREAIWENI ALIER	CHA	ARLOTTE, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
V 112	Continued From page	e 1	V 112			
	to develop and imple the needs of the clier (Clients #1, #2, and # Review on 4/29/19 of -Admission date 5/25 -Diagnoses of Post-T Attention Deficit Hype -7 years old; -History of "sexually in no specifics noted; -Treatment plan date strategies to address Review on 4/29/19 of -Admission date 6/29 -Diagnoses of Post-T Attention Deficit Hype Attachment Disorder; -11 years old; -History of sexual bel behaviors such as tal with boys, touching g tube of lip balm in a c -"Possible sexually in child in home in previ the current treatment -Treatment plan date strategies to address urinating or defecatin bedroom;	and record review, the facility ment strategies to address hts affecting 3 of 4 clients #3). The findings are:  If Client #1's record revealed: 5/18;  Traumatic Stress Disorder, eractivity Disorder;  Inappropriate behaviors" with d 3/7/19 did not include exexualized behaviors.  If Client #2's record revealed: 5/18;  Traumatic Stress Disorder, eractivity Disorder, Reactive 9/18;  Traumatic Stress Disorder, eractivity Disorder, eractivity Disorder, Reactive 9/18;  Traumatic Stress Disorder, eractivity Disorder, eracti	n d			
	Review on 4/29/19 of -Admission date 2/22	f Client #3's record revealed: 2/18;				

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STATE FORM 6899 JQ5I11 If continuation sheet 2 of 14

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL060-739	B. WING		0:	R 5/24/2019
NAME OF	PROVIDER OR SUPPLIER	STREE	ET ADDRESS, CITY, STATE	E, ZIP CODE		
сомми	NITY TREATMENT ALTER	RNATIVES II	ROSENA DRIVE			
		CHAF	RLOTTE, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 112	-Diagnoses of Post-Major Depressive Di Disruptive Disorder, -13 years old; -History of "sexual a -Treatment plan date strategies to address urinating or defecatin bedroom; Interview on 4/29/19 -Had no personal be bedroom because sl -In order to earn her back in her bedroom room for "month or v long. It "has been to urinated in her room Interview on 4/29/19 -Furniture had been because of her beha -Personal items have bedroom because sl items.  Interview on 4/24/19 Manager/Program M -All personal items a been moved into the behaviors. Client #1 property destruction. history of urinating of belongings. Client # masturbating with her -Could not identify w to take to earn back -Could not identify is	Traumatic Stress Disorder, sorder, Unspecified Impulse Control Disorder; cting out;" ed 3/14/19 did not include a sexualized behaviors or ing on personal items in her with Client #2 revealed: dongings or furniture in her he had urinated on it; belongings and furniture in, she cannot urinate in her weeks" but is not sure how wo weeks" since she last with Client #3 revealed: removed from her bedroom wiors; a been removed from her he masturbates with the with the House lanager revealed: and furniture storage had a living room due to client and #4 has a history of Clients #2 and #3 had a r defecating on their is has a history of er personal items. The head of their items in their bedrooms;	V 112			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R	
		MHL060-739	B. WING		05/24	/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
COMMUN	ITY TREATMENT ALTER	NATIVES II 4901 ROSE	ENA DRIVE TE, NC 28227			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID ID	PROVIDER'S PLAN OF CORRECTION	ı I	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETE DATE
V 112	Continued From page	: 3	V 112			
	conjunction with the L	e revealed: t plans are updated in icensed Professional's input ent needs and treatment				
V 118 27G .0209 (C) Medication Requirements		V 118				
	only be administered order of a person authoriugs.  (2) Medications shall clients only when authorient's physician.  (3) Medications, incluadministered only by unlicensed persons trepharmacist or other leprivileged to prepare (4) A Medication Admall drugs administered current. Medications a recorded immediately MAR is to include the (A) client's name;  (B) name, strength, and (C) instructions for add (D) date and time the (E) name or initials of drug.  (5) Client requests for checks shall be recorded.	stration: n-prescription drugs shall to a client on the written norized by law to prescribe be self-administered by norized in writing by the ding injections, shall be licensed persons, or by ained by a registered nurse, egally qualified person and and administer medications. inistration Record (MAR) of d to each client must be kept administered shall be after administration. The following:				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL060-739	B. WING		R <b>05/24/2019</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
COMMUNITY TREATMENT ALTERNATIVES II			ENA DRIVE TE, NC 28227			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
V 118	Continued From page with a physician.	÷ 4	V 118			
	failed to maintain curred	nd record review, the facility				
	Review on 4/29/19 of Client #1's record revealed: -Admission date 5/25/18; -Diagnoses of Post-Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder; -7 years old; -Physician's order dated 3/26/19 for Ivermectin 0.5% topical lotion #117 grams "apply externally to the affected area one time - leave on hair for 10 minutes - wash hair thoroughly after application." -March, 2019 MAR did not include the use of Ivermectin.					
	-Had lice in her hair "special shampoo.  Interview on 4/29/19 Manager/Program Ma-Was not aware that the					
	Interview on 5/24/19 Professional/Licensed	· · · · · · · · · · · · · · · · · · ·				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL			(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN C	OF CORRECTION	IDENTIFICATIO	N NUMBER:	A. BUILDING:			COMPLETED	
							R	
		MHL060-7	39	B. WING			/24/2019	
NAME OF P	ROVIDER OR SUPPLIER	_	STREET AND	RESS, CITY, STA	TE ZIP CODE			
TWAINE OF TH	KOVIDER OR GOL LEEK		4901 ROSE		TE, ZII OODE			
COMMUN	ITY TREATMENT ALTER	NATIVES II		ΓE, NC 28227				
(V4) ID	SLIMMARY ST.	ATEMENT OF DEFICIE		1	PROVIDER'S PLAN OF C	ORRECTION	(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDE LSC IDENTIFYING INF	D BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
V 298	Continued From page 5		V 298					
V 298	27G .1706 Residential Tx. Child/Adol - Operations		V 298					
	10A NCAC 27G .170		-					
	<ul><li>(a) Each facility shall of 12 children and ad</li></ul>		han a total					
	(b) Family members		•					
	persons shall be involved in development of plans in order to assure a smooth transition to a less restrictive setting.  (c) The residential treatment staff secure facility							
	shall coordinate with to ensure that the chi							
	met as identified in th							
	the treatment plan. Nable to attend school;							
	coordinate services a		•					
	alternative learning prijob placement.	rograms, day trea	atment, or a					
	(d) Psychiatric consuneeded for each child		vailable as					
	<ul><li>(e) If an adolescent h receiving treatment in</li></ul>		•					
	for six months or until	I the end of the s						
	year, whichever is lor (f) Each child or adol	•	entitled to					
	age-appropriate person	onal belongings i	unless such					
	entitlement is counter plan.	r-indicated in the	treatment					
	(g) Each facility shall	operate 24 hour	s per day,					
	seven days per week	, and each day o	f the year.					
	This Rule is not met Based on interview, r							

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	, , ,	(X3) DATE SURVEY COMPLETED	
		MHL060-739	B. WING	B. WING		
NAME OF P	ROVIDER OR SUPPLIER		EET ADDRESS, CITY, STAT	E. ZIP CODE	1 00	5/24/2019
		490	1 ROSENA DRIVE			
COMMUN	ITY TREATMENT ALTER	NATIVES II CHA	ARLOTTE, NC 28227			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 298	Continued From page	e 6	V 298			
	child or adolescent to belongings unless su indicated in the treatr	ty failed to provide each age-appropriate personal ch entitlement is counter nent plan affecting 4 of 4 #3, and #4). The findings				
	Observation on 4/24/19 at approximately 2:50pm of the facility revealed:  -The only item in Client #1, #2, #3, and #4's bedroom was a double bed;  -All client personal belongings were in the living room.  Review on 4/29/19 of Client #1's record revealed:  -Admission date 5/25/18;  -Diagnoses of Post-Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder;  -7 years old;  -No documentation in the treatment plan to indicate that the possession of personal items is counter indicated.					
	-Admission date 6/29 -Diagnoses of Post-T Attention Deficit Hype Attachment Disorder; -11 years old; -No documentation in	raumatic Stress Disorder, eractivity Disorder, Reactive				
	-Admission date 2/22 -Diagnoses of Post-T Major Depressive Dis Disruptive Disorder, I -13 years old;	raumatic Stress Disorder,	:			

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STATE FORM 6899 JQ5I11 If continuation sheet 7 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	1 ' '	(X3) DATE SURVEY COMPLETED	
			P WING	B WING		R	
		MHL060-739	B. WING		05	/24/2019	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA SENA DRIVE	TE, ZIP CODE			
COMMUN	ITY TREATMENT ALTER	NATIVES II	TTE, NC 28227				
(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	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 298	Continued From page	e 7	V 298				
	indicate that the poss counter indicated.	ession of personal items is					
	-Admission date of 8/ -Diagnoses of Attention Disorder, Post-Traum -9 years old; -No documentation in indicate that the poss counter indicated.	on Deficit Hyperactivity natic Stress Disorder; the treatment plan to session of personal items is					
		with Client #1 revealed: er bedroom because "I don't					
	-Had no personal belo bedroom because sho -In order to earn her b back in her bedroom, room for "month or we	with Client #2 revealed: ongings or furniture in her e had urinated on it; belongings and furniture she cannot urinate in her eeks" but is not sure how o weeks" since she last					
	-Furniture had been r because of her behav -Personal items have	with Client #3 revealed: emoved from her bedroom viors; been removed from her e masturbates with the					
	been moved into the behaviors. Client #1	anager revealed:  nd furniture storage had  living room due to client  and #4 has a history of  Clients #2 and #3 had a					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL060-739		B. WING		R <b>05/24/2019</b>
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
COMMUN	ITY TREATMENT ALTER	NATIVES II	4901 ROSI	ENA DRIVE		
	THE THE THE TEN		CHARLOT	TE, NC 28227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM,	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
V 298	Continued From page	e 8		V 298		
	belongings. Client #3 masturbating with her -Could not identify who to take to earn back the -Could not identify is incorporated to remove from the bedrooms.	r personal items. nat steps the clients r heir items in their bed the treatment plan val of the personal ite	drooms;			
	Interview on 5/23/19 or Professional/Licenseer-Will ensure treatment conjunction with the L to accurate reflect clies trategies as soon as	e revealed: It plans are updated i icensed Professiona ent needs and treatm	ıl's input			
V 736	27G .0303(c) Facility	and Grounds Mainte	nance	V 736		
	10A NCAC 27G .0303 EXTERIOR REQUIRI (c) Each facility and it maintained in a safe, manner and shall be odor.	EMENTS is grounds shall be clean, attractive and	•			
	This Rule is not met Based on interview at was not maintained ir orderly manner affect #2, #3, and #4). The Observation on 4/24/revealed: -Missing floor tile in C-Bathroom cabinet in Client #1's bedroom; -Broken window blind	nd observation, the far a clean, attractive a ing 4 of 4 clients (Clifindings are:  19 at approximately 2 client #1's bedroom; disrepair and chippe	ents #1, 2:50pm d in			

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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		
			A. BOILDING.		R	
		MHL060-739	B. WING		05/24/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
COMMUN	ITY TREATMENT ALTER	NATIVES II	ENA DRIVE			
	OLUMBA DV OT		TE, NC 28227			
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 736	Continued From page	9	V 736			
	-Missing floor tile in Client #2's bedroom; -Fresh unpainted sheetrock patches in Client #3's bedroom.  Interview on 4/24/19 with the House Manager/Program Manager revealed: -The maintenance man comes regularly to the facility to make necessary repairs.					
	Interview on 4/29/19 v Manager/Program Ma -Client #2's blinds are					
	-The patches in the w	with Client #3 revealed: alls were caused by Client s "when my (Client #3's)				
	Interview on 5/24/19 v Professional/Licensee -Will ensure the neces immediately.					
	This deficiency consti	tutes a re-cited deficiency d within 30 days.				
V 750	27G .0304(b)(3) Main Water Systems	tenance of Elec., Mech., &	V 750			
	EQUIPMENT (b) Safety: Each facil constructed and equipensures the physical visitors.	oped in a manner that safety of clients, staff and nechanical and water				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		MHL060-739	B. WING		R <b>05/24/2019</b>		
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE			
COMMUN	ITY TREATMENT ALTER	NATIVES II	SENA DRIVE OTTE, NC 28227				
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
V 750	Continued From page 10		V 750				
	failed to maintain med operational manner a (Clients #1, #2, #3, ar Observation on 4/29/1-Smoke detector alarm Observation on 5/1/15-Smoke detector beep Interview on 4/29/19 Manager/Program Ma-The smoke detector battery alert this morn	and observation, the facility chanical systems in an effecting 4 of 4 clients and #4). The findings are:  19 at 1:30pm revealed: In beeping low battery alert.  2 at 9:00am revealed: Ding low battery alert.  with the House					
	Interview on 5/23/19 v Professional/Licensee -The battery should h immediately; -Will ensure all batter	anager revealed: an has still not replaced the ry. with the Qualified e revealed: ave been replaced					
V 774	smoke detectors.  27G .0304(d)(7) Minir	num Furnishings	V 774				
	EQUIPMENT (d) Indoor space requiprior to October 1, 19	FACILITY DESIGN AND irements: Facilities licensed 88 shall satisfy the minimum ements in effect at that					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
7.1.12 1 2.1.1	5. GOTH LEGITOR		A. BUILDING:				
		MHL060-739	B. WING			R <b>24/2019</b>	
NAME OF P	ROVIDER OR SUPPLIER	STRE	EET ADDRESS, CITY, STA	ATE, ZIP CODE			
COMMUN	ITY TREATMENT ALTER	NATIVES II	ROSENA DRIVE RLOTTE, NC 28227				
(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 TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
V 774	residential facilities lid 1988 shall meet the f requirements: (7) Minimum furnishir include a separate be	se provided in these Rules, censed after October 1, following indoor space angs for client bedrooms shalled, bedding, pillow, bedside personal belongings for	V 774				
	furnishing of bedside personal belongings of (Clients #1, #2, #3, and Observation on 4/24/ of the facility revealed -The only item in Clie bedroom was a doub	record review, and atty failed to ensure minimum table and storage for affecting 4 of 4 clients and #4). The findings are:  19 at approximately 2:50pm d: ant #1, #2, #3, and #4's le bed.					
	-Admission date 5/25 -Diagnoses of Post-T Attention Deficit Hype -7 years old.  Review on 4/29/19 of -Admission date 6/29 -Diagnoses of Post-T Attention Deficit Hype Attachment Disorder; -11 years old.	raumatic Stress Disorder, eractivity Disorder; f Client #2's record revealed: 1/18; fraumatic Stress Disorder, eractivity Disorder, Reactive					
	Review on 4/29/19 of -Admission date 2/22	f Client #3's record revealed: //18;					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
			B. WING			R	
		MHL060-739	B. WIIVO		05	05/24/2019	
NAME OF P	ROVIDER OR SUPPLIER	STRE	EET ADDRESS, CITY, STAT	E, ZIP CODE			
COMMUN	ITY TREATMENT ALTER	NATIVES II	1 ROSENA DRIVE				
		CHA	ARLOTTE, NC 28227				
(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 AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 774	Continued From page 12		V 774				
	Major Depressive Dis	raumatic Stress Disorder, corder, Unspecified mpulse Control Disorder;					
	-Admission date of 8/	on Deficit Hyperactivity					
		with Client #1 revealed: r bedroom because "I don't					
	-Had no personal belo bedroom because sho -In order to earn her b back in her bedroom, room for "month or we	with Client #2 revealed: ongings or furniture in her e had urinated on it; belongings and furniture she cannot urinate in her eeks" but is not sure how o weeks" since she last					
		with Client #3 revealed: emoved from her bedroom viors.					
	been moved into the behaviors. Client #1 property destruction. history of urinating or belongings. Client #3 masturbating with her-Could not identify who	anager revealed: and furniture storage had living room due to client and #4 has a history of Clients #2 and #3 had a defecating on their has a history of r personal items. at steps the clients needed heir items in their bedrooms.	;				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED							
701012701	or connection	IDENTIFICATION	THOMBEN.	A. BUILDING: _									
		MHL060-73	9	B. WING		05/2	4/2019						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE													
COMMUNITY TREATMENT ALTERNATIVES II CHARLOTTE, NC 28227													
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE						
V 774	Continued From page incorporated to remote from the bedrooms.  Interview on 5/23/19 Professional/Licensed-Will ensure treatment conjunction with the Lito accurate reflect clies strategies as soon as	wal of the personal with the Qualified e revealed: It plans are update icensed Profession the reds and treaters.	ed in onal's input	V 774									

Division of Health Service Regulation

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