PRINTED: 06/30/2019 FORM APPROVED

Division of Health Service Regulation

` '		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:			X3) DATE SURVEY COMPLETED	
			_		С			
		MHL092-685		B. WING		06/28/20	19	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE				
NEW BEG	INNINGS HEALTH CARE	PHASE III	3501 NEPT	UNE DRIVE				
			RALEIGH,	NC 27604				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FI SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE CO	(X5) DMPLETE DATE	
V 000	INITIAL COMMENTS			V 000				
	complaint was unsub #NC00152838). A de This facility is license	ficiency was cited. d for the following serv 27G .1700 Residential	rice					
V 296	27G .1704 Residentia Staffing	al Tx. Child/Adol - Min.		V 296				
	telephone or page. A able to reach the facilitimes. (b) The minimum nurrequired when childred present and awake is (1) two direct cone, two, three or four (2) three direct for five, six, seven or adolescents; and (3) four direct conine, ten, eleven or two adolescents. (c) The minimum nurreduring child or adolescents. (c) The minimum nurreduring child or adolescents. (d) two direct coning and one shall be away children or adolescent.	sional shall be available direct care staff shall ity within 30 minutes a mber of direct care staff or adolescents are as follows: are staff shall be preserved to care staff shall be preserved to children or adolescer care staff shall be preserved to children or managed to the control of the care staff shall be preserved to the control of the care staff shall be preserved to the care shall be preserv	le by be t all ff ent for nts; seent ent for					

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

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
					С	
		MHL092-685	B. WING		06	5/28/2019
NAME OF P	ROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, STA	TE, ZIP CODE		
NEW BEG	INNINGS HEALTH CARE	PHASE III	NEPTUNE DRIVE			
	OLIMANA DV OT		IGH, NC 27604	DDOWDEDIO DI AN O	E CORRECTION	
(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) COMPLETE DATE
V 296	asleep for nine, ten, e adolescents. (d) In addition to the care staff set forth in I Rule, more direct care the facility based on tindividual needs as splan. (e) Each facility shall supervision of childre are away from the facility shall specified in the facility shall supervision of childre are away from the facility shall specified in the facility shall supervision of childre are away from the facility shall specified in the facility specified in the fa	awake and the third may be eleven or twelve children or minimum number of direct Paragraphs (a)-(c) of this e staff shall be required in the child or adolescent's pecified in the treatment be responsible for ensuring n or adolescents when they cility in accordance with the individual strengths and	V 296			
	governing body failed care staff members we children or adolescen (#1-#4). The findings During an interview of Professional (AP) indicurrent census was 4 Review on 6/6/19 of the Service Regulation's of Residential Treatment or Adolescents reveal 1.1704 Minimum Staffin	ew and interviews, the to ensure at least two direct were present with every four ts effecting 4 of 4 clients are: n 6/13/19, the Associate icated their License and clients. the Division of Health Rules related to 1700 t Staff Secure For Children led: "10A NCAC 27G ng(The minimum number quired when children or				

Division of Health Service Regulation

STATE FORM 6899 066T11 If continuation sheet 2 of 5

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
						С	
		MHL092-685		B. WING		06	/28/2019
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
NEW DEC	CINNINGS HEALTH CADE	DUACE III	3501 NEPTU	JNE DRIVE			
NEW BEG	SINNINGS HEALTH CARE	: PRASE III	RALEIGH, N	IC 27604			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 296	Continued From page	e 2		V 296			
	one, two, three or fou (c) The minimum nu during child or adoles follows: (1) two direct c	are staff shall be present children or adolescer mber of direct care state cent sleep hours is as are staff shall be present one - four children or	nts aff ent and				
	submitted by the AP f revealed: - Monday thru Fr schedule between 3:0 morning. As allowed scheduled between 8 the clients were in sci - Saturday and S from 8:00am - 8:00pn staff were scheduled except for: - June 3; 1 s "4p-12a" (single cove - June 4; 1 s "4p-10p" (single cove	sunday, the schedule wan and 8:00pm - 8:00ar on each of these shifts staff "3p-10p" and 2nd rage 10p-12a) staff "3p-12a" and 2nd rage 10p-12a) staff "4p-12p" and 2n	f on next taff nen vas m - 2 s s staff				
	June, 2019 submitted revealed: - June 10th, 17th scheduled 4:00pm-12 4:00pm-10:00pm whi coverage from 10:00p - June 1st - 1 sta - June 2nd - 1 sta staff 8:00am-8:00pm	ff scheduled 8:00am-8 aff 8:00am-12:00pm ar (single from 12pm-8pn taff 4:00pm-10:00pm a	person single 3:00pm nd 2nd n)				

Division of Health Service Regulation

STATE FORM 6899 066T11 If continuation sheet 3 of 5

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER		. ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL092-685	B. WING		06	C 5/ 28/2019
NAME OF P	ROVIDER OR SUPPLIER		TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
_		3	501 NEPTUNE DRIVE	,		
NEW BEG	SINNINGS HEALTH CAR	E PHASE III	RALEIGH, NC 27604			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
	V 296 Continued From page 3 10pm-12am) - June 13 - 1 staff 4:00pm-9:00pm and a 2nd staff 4:00pm - ? (undecipherable) - June 21st - 1 staff 12:00am-8:00am During interviews between 6/6/19 and 6/20/19, 3 anonymous staff reported they had worked single shifts both on the weekend and during the week. Anonymous staff reported the handwritten schedule was the "working copy" given to the house managers. During an interview on 6/20/19, the Qualified Professional identified as the house manager of this program reported she was given a computer printed copy of the schedule to use and the AP was the person who updated the schedule and found relief staff as needed. During a phone interview on 6/12/19 at 10:40pm		3 gle k. of er			
	During an interview of as the 2nd staff person when there we cannot be staff person and the saw another staff person when there we be staff person when the st	on 6/13/19, the staff identification on duty on 6/12/19 the facility at 10:00pm but son coming into the house on 6/7/19, the Associate di: nsible for doing scheduling	ried t e			

Division of Health Service Regulation

STATE FORM 6899 066T11 If continuation sheet 4 of 5

PRINTED: 06/30/2019 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-685			(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING						
		B. WING							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NEW BEGINNINGS HEALTH CARE PHASE III ASSOL NEPTUNE DRIVE RALEIGH, NC 27604									
(X4) ID PREFIX TAG	X4) ID SUMMARY STATEMENT OF DEFICIENCIES REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE			
V 296	reported: - on 6/12/19 there between 10:00pm and staff person was in th	n 6/28/19, the Licensee e was a 2nd staff person on d 12:00am. She stated this e driveway and the staff	V 296						
	know she was there in they were neve staffed and she could staff schedule and a r and paychecks there were curre	spoke to at 10:40pm didn't in the parking lot/driveway in single staffed or under prove it by showing the record of their time cards ently disgruntled staff on							
	weekend - stated she thou be asking questions v	ght this surveyor seemed to which made the staff very seated and directed to get a							

Division of Health Service Regulation

STATE FORM 6899 066T11 If continuation sheet 5 of 5