PRINTED: 06/11/2019 FORM APPROVED

Division of	of Health Service Regu	Ilation					1 014	IN THOULD
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIE) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		MHL076-104		B. WING			05/3	31/2019
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	RECEIVED		
STEPS FOR CHANGE BEHAVIORAL HEALTH CARE 103 SOUTH RAMSEUR,			H BRADY STREET By DHSR - Mental Health Lic. & Cert. S			Section at 7:44 am, Jul 18, 2019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		' FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE COMP			(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and comp on May 31, 2019. Th substantiated (Intake Deficiencies were cite This facility is license category: 10A NCAC Abuse Intensive Outp 27G .4401 Sub. Abus 10A NCAC 27G .440 (a) A substance abu program (SAIOP) is o individual and group services that are pro- designed to assist ac primary substance-re recovery and learn sl maintenance. (b) Treatment suppo or specifically design disabilities, co-occurr mental illness or devo	laint survey was com e complaint was #NC00149837). ed. d for the following se 27G .4400 Substance patient Program. se Intensive Outpt - S 1 SCOPE se intensive outpatient addiction treatment a vided in an outpatient lults or adolescents w elated diagnosis to be kills for recovery rt activities may be a ed for persons with p ing disorders includir	pleted prvice ce Scope nt uctured ind t setting vith a egin dapted hysical	V 000 V 266	Water w the towr the restribuilding Substa for all s within g Substa	DEFICIENCY) was fixed on 5/15/20 on the clients were ab room on the other sid	19 by le to use de of the e Outpar ated e is	5/15/19 e e
	incorporate communi(5)life skills;(6)crisis contir(7)disease mail(8)service coordination	Il have a structured p llowing services: ounseling; seling; seling; or relapse prevention ty and social support ngency planning; inagement; rdination activities; a I assays to identify re drug screens).	nogram, a, which s; nd ecent			TITLE		(X6) DATE

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL076-104			. ,	E CONSTRUCTION (X3	(X3) DATE SURVEY COMPLETED	
		B. WING		05/31/2019		
	ROVIDER OR SUPPLIER	AL HEALTH CARE	DDRESS, CITY, ST TH BRADY STF IR, NC 27316			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
V 266	Continued From page	e 1	V 266			
	failed to provide inform operating a structured	as evidenced by: nd observation, the facility mation to assure they were d Substance Abuse Intensive SAIOP) program. The		Please review original floor pla it is the main group room. It is set up in a manner clients have refreshment and drinks in of leaving the facility area.	can	
	During an observation on 5/15/19 at approximately 11am revealed: Two people (male /female) sitting in a breakroom area in the facility alone. [Licensee] identified them as SAIOP clients, however; no other staff was with them at the time. Interview with the Licensee on 5/15/19 revealed: When asked by surveyor for the names of clients to complete the Client Census Form and if she could provide staff and client records for the survey the Licensee replied: "I don't know how many clients we are serving in our program. I think we have two or three active clients." - The Licensee stated that she was meeting with the LME/MCO and that she would continue the survey after she was finish them.			Licensee was just returning fro medical after 6 weeks leave bu LCAS-A. Licensee staffed with Lead LC/ and CSAC to assure Quality Management was is	t is a	
				compliance. Licensee was distracted by mu visits. In the future licensee will request for MCO to reschedule a different time.		
	office of the facility, the again if she could pro- for review. The License records and returned	mately 35 minutes in a back ne Licensee was asked ovide staff and client records see went to look for the approximately 30 minutes I stated, "We just had an				

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL076-104			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED 05/31/2019	
		B. WING				
	ROVIDER OR SUPPLIER	AL HEALTH CARE	DDRESS, CITY, ST/ ITH BRADY STR JR, NC 27316			
(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 HE APPROPRIATE	(X5) COMPLETE DATE
V 266	audit and I don't know to contact my QP (Qu where the records and Approximately 30 min called. The Licensee client or staff names documentation for the Outpatient Program.	w where my files are. I need ualified Professional) to see e." nutes later the QP had not was unable to provide any or files, nor any other e Substance Abuse Intensive g on. I'm currently going ree and I thought this had	V 266	Licensee will assure refiled after audit pro		5/15/201

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