STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						SURVEY	
		20190063		B. WING		08/2	28/2019
NAME OF I	PROVIDER OR SUPPLIER			DRESS, CITY, S Y DRIVE	STATE, ZIP CODE		
THE WIL	MINGTON TREATME	NT CENTER LLC		TON, NC 28	401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMEN	TS		V 000			
	An annual survey v 2019. Deficiencies	vas completed on Augus were cited.	st 28,				
	categories: 10A NO Medical Detoxificat Substance Abusers	sed for the following ser CAC 27G .3100 Nonhosp tion for Individuals who a s and 10A NCAC 27G .3 cilities for Individuals with Disorders.	oital are 5700				
V 114	27G .0207 Emerge	ency Plans and Supplies		V 114			
	AND SUPPLIES (a) A written fire play area-wide disaster shall be approved authority. (b) The plan shall be and evacuation proposted in the facility (c) Fire and disaster shall be held at leas repeated for each sunder conditions the street of the street	er drills in a 24-hour facil st quarterly and shall be shift. Drills shall be cond nat simulate fire emerger all have basic first aid su	and staff Ill be ity ucted ncies.				
	Based on record refailed to ensure disand repeated on earlier Review on 8/27/19 revealed:	et as evidenced by: eview and interview, the easter drills were held qu ach shift. The findings a of facility records for 20 isaster drills recorded be	arterly re: 19				

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		20190063	B. WING		08/2	8/2019
	PROVIDER OR SUPPLIER	NT CENTER LLC 2520 TRO		STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
V 114	January 2019 throu During interview on Services stated: -Two disaster drills September 2018 th -Concerns about th clients diagnosed w		V 114			
V 118	10A NCAC 27G .02 REQUIREMENTS (c) Medication adm (1) Prescription or ronly be administered order of a person a drugs. (2) Medications share clients only when a client's physician. (3) Medications, incommendation administered only bunlicensed persons pharmacist or other privileged to prepare (4) A Medication Administered only bunlicensed persons pharmacist or other privileged to prepare (4) A Medication Administered immediate MAR is to include the (A) client's name; (B) name, strength, (C) instructions for (D) date and time the	inistration: non-prescription drugs shall ad to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be by licensed persons, or by a trained by a registered nurse, a legally qualified person and the and administer medications. Iministration Record (MAR) of a death client must be kept a sadministered shall be thely after administration. The	V 118			

Division of Health Service Regulation

STATE FORM 92IM11 If continuation sheet 2 of 11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			SURVEY LETED
	20190063		B. WING		08/2	8/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE WIL	MINGTON TREATME	NT CENTER, LLC 2520 TRO WILMING	Y DRIVE TON, NC 28	401		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 118	Continued From page 2		V 118			
	checks shall be rec	for medication changes or corded and kept with the MAR appointment or consultation				
	facility failed to adm written order of a pl	views and interviews, the ninister medications on the hysician and failed to keep the cting two of five audited clients				
	revealed: - 22 year old female - Admission date of - Diagnoses of Opic	f 08/23/19. oid Use Disorder, Cocaine Use Use Disorder and Post				
	physician orders re 08/23/19 - Admit to: Opiate E - Tylenol (treats fev take 2 every 6 hour greater than 99.5 o - Tylenol 325 millign needed for tempera	Detoxification rer and pain) Extra Strength - rs as needed for temperature r pain. rams (mg) - 2 every 4 hours as ature greater than 99.5 or pain.				
	- "Pt (patient) pregr - "D/C (discontinue needed)"	nant.") admission order PRNS (as				

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED		
		20190063		B. WING		08/	28/2019
	PROVIDER OR SUPPLIER	NT CENTER, LLC	2520 TRO		STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	Review on 08/28/18 MAR revealed the f - "Tylenol 1 gm PO - Staff initials to ind administered on 08 discontinue order. Interview on 08/27/ - She found out she admitted to the faci - The facility doctor medications She received her Finding #2 Review on 8/28/19 - 24 year old female - Admission date of - Diagnoses of: Bip Traumatic Stress D Disorder, Opioid Us Assisted Therapy, Moderate, Angina, or Anxiolytic withdra Disturbance, Sedat Disorder-Severe ar Review on 8/28/19 revealed: 8/24/19 - Multivitamin (used tablet daily for 7 da - Thiamine (used to 100mg (milligram) - Phenobarbital (us tablet twice daily Phenobarbital 90r - Vraylar (used to tr capsule at bedtime	9 of client #2's Augustollowing transcribed (by mouth) every 8 licate the Tylenol was /25/19 after the phys 19 client #2 stated: e was pregnant where lity. had changed some medications as ordered; f 8/24/19. olar II Disorder; Postisorder; Unspecified se Disorder on Medications as ordered; Unspecified se Disorder on Medications as ordered; Unspecified se Disorder on Medications, Sedative, awal-without Perceptive, Hypnotic or Anxold Herpes. of signed physician of to treat vitamin defitys. The prevent B1 deficient at the prevent B	entry: hours prn." sician a she was of her ered. I revealed: I Anxiety cation er Hypnotic tual ielytic use orders acciency) - 1 acy) or 7 days. 120mg - 1 ily5mg - 1	V 118			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED		
		20190063		B. WING		08/	28/2019
	PROVIDER OR SUPPLIER	NT CENTER, LLC	2520 TRC		TATE, ZIP CODE	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	tablet three times d - Vistaril (used to tro three times daily for - Losartan (used to 50mg- 1 tablet daily - Doxepin (used to capsule at bedtime 8/25/19 - Seroquel (used to 1 tablet at bedtime Robaxtin (used as tablet three times d 8/26/19 - Melatonin (used to bedtime. Review on 8/28/19 - Melatonin (used to bedtime. Review on 8/28/19 - Multivitamin 8/28/ - Robaxtin 8/28/19 - Thiamine 8/28/19 - Thiamine 8/28/19 - Phenobarbital 120 - Phenobarbital 90r - Vraylar 8/27/19 - Neurontin 8/25/19 - Vistaril 8/28/19 at - Losartan 8/28/19 - Doxepin 8/27/19 - Seroquel 400mg 8 Interview on 8/27/11 received some of h Interview on 8/28/19 (RN) #2 stated:	aily for 10 days. eat anxiety) 950mg - r 10 days. treat high blood pres r. treat depression) 50 treat schizophrenia s a muscle relaxer) 7 aily for 7 days. treat insomnia) 6m of Client # 8's Augus e following blanks: 19. at 8am. cmg on 8/27/19 at 9p mg on 8/28/19 at 8am eat 9pm. 8am.	ssure) mg - 1) 400mg - 50mg - 1 g- 1 tab at st 2019 mm. n.	V 118			

Division of Health Service Regulation

STATE FORM 92IM11 If continuation sheet 5 of 11

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			SURVEY LETED	
			A. BOILBING.				
		20190063	B. WING		08/2	8/2019	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
THE WIL	MINGTON TREATME	NT CENTER LLC	DY DRIVE STON, NC 28	401			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
V 118	medicine because and the blanks should administered. She had not signed have signed the Madministered. She did not have a discontinue the Serence and the se	they did not have it. d not be in the MAR. If her medicine for 8/28/19, but the MAR yet. She should AR when the medications were a physician's order to roquel 400mg. signed the MAR when the administered. 9 with the Director of Nursing g Seroquel was discontinued a copy of the physicians order 400mg Seroquel. if Client #8 had received the ad blanks in the MAR, but she enobarbital. administered the she checked. be any blanks in the MAR. not administered client #2's 9 after the physican had 18/24/19. 10 accurately document estration and to keep the MAR be determined if client #8 eations as ordered by the					
V 220	10A NCAC 27G .31 (a) Monitoring Clie written policy that re (1) procedure	nts. Each facility shall have a	V 220				

Division of Health Service Regulation

STATE FORM 92IM11 If continuation sheet 6 of 11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		20190063	B. WING		08/2	8/2019
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE WIL	MINGTON TREATME	NT CENTER, LLC 2520 TRO WILMING	Y DRIVE TON, NC 28	401		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 220	the first 72 hours or and (2) procedure recording each clie and temperature at first 24 hours and a thereafter. (b) Discharge Plan Treatment/Rehability discharging the clied discharge plan for a client who has come	f the detoxification process; es for monitoring and nt's pulse rate, blood pressure least every four hours for the at least three times daily uning And Referral To tation Facility. Before ent, the facility shall complete a each client and refer each upleted detoxification to an ential treatment/rehabilitation	V 220			
	Based on record refacility failed to more blood pressure and four hours for the fix audited current clies are: Finding #1: Review on 08/28/19 revealed: - 22 year old female: - Admission date of Diagnoses of Opin Disorder, Tobacco Traumatic Stress Diagnoses were refor the first 24 hour	f 08/23/19. oid Use Disorder, Cocaine Use Use Disorder and Post Disorder. not completed every four hours s as required.				
		9 of client #2's digitally signed lated 08/23/19 revealed:				

Division of Health Service Regulation

STATE FORM 92IM11 If continuation sheet 7 of 11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED		
		20190063		B. WING		08/	28/2019
	PROVIDER OR SUPPLIER MINGTON TREATME	NT CENTER, LLC	2520 TRC		STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 220	- "Admit To: Opiate - "If admitted to Def (three times daily) a indicated." Review on 08/28/19 vital signs from 08/2 - 08/23/19 at 7:19p - 08/24/19 at 8:29a - 08/24/19 at 3:48p - 08/24/19 at 10:47 Interview on 08/27/ - She was admitted - She found out she admitted Staff checked her as needed. Finding #2: Review on 08/28/19 revealed: - 24 year old female - Admission date of - Diagnoses of: Bip Traumatic Stress D Disorder, Opioid Us Assisted Therapy, Moderate, Angina, or Anxiolytic withdra Disturbance, Sedat Disorder-Severe ar Review on 08/28/19 admission orders d - "Admit To: Inpatie Detox Benzo"	Detox (Detoxification tox location, vital signand PRN (as needed 23/19 thru 08/24/19 m. m. m. m. pm. 19 client #2 stated: I to the facility on 08/2 was pregnant after vital signs 3 times a post of client #8's recorded as Disorder; Unspecified as Disorder; Unspecified as Disorder on Medic Tobacco use Disorder Migraines, Sedative, awal-without Perceptive, Hypnotic or Anxind Herpes. 20 of client #8's digital ated 8/24/19 revealed ated 8/	ned TID) as nented revealed: 23/19. she was day and d Anxiety cation er Hypnotic ual elytic use ly signed d: Inpatient	V 220			

Division of Health Service Regulation

STATE FORM 92IM11 If continuation sheet 8 of 11

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		20190063	B. WING		08/2	8/2019
	PROVIDER OR SUPPLIER	NT CENTER LLC 2520 TRO		STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
V 220	Review on 08/28/19 vital signs from 08/2 - 08/24/19 at 2:36pr - 08/25/19 at 7:05ar - 08/25/19 at 4:07pr - 08/25/19 at 10:30pr - 08/28/11 stated: - She was admitted at 10 - She checked clier and as needed. Interview on 08/27/10 - He had worked at 10 - The vital signs for times a day at appr - 7pm. Interview on 08/28/15 stated: - Clients admitted to had vital signs take hours. - Clients admitted for signs checked 3 times - She would speak - 08/25/19 at 12:43pr - 08/25/19 at 10:30pr - 08/28/15 at 10	O of client #8's documented 24/19 thru 08/25/19 revealed: m. am. m. m. om 19 client #8 stated: to the facility on 08/24/19. aperature during admission. 19 Certified Nursing Assistant at the facility for 9 years. at vitals signs 3 times a day 19 Registered Nurse I stated: the facility for 2 years clients were taken at least 3 oximately 7am, 3, pm and 19 the Director of Nursing the facility for Alcohol Detox on every 4 hours for the first 24 or Opiate Detox had vitals hes a day and as needed. with the doctor to ensure vital very 4 hours for the first 24	V 220			
V 752	, , , ,	ot Water Temperatures	V 752			
	EQUIPMENT					

6899

Division of Health Service Regulation STATE FORM

92IM11 If continuation sheet 9 of 11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		SURVEY PLETED		
		20190063	B. WING		08/	08/28/2019	
	PROVIDER OR SUPPLIER	NT CENTER LLC 2520 TRO	DRESS, CITY, ST	,			
		WILMING	TON, NC 284	01			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
V 752	(b) Safety: Each faconstructed and eqensures the physical visitors. (4) In areas described and eqensures the physical visitors. (4) In areas described and exposed to hot water water shall be main degrees Fahrenheit. This Rule is not medessed on observation water temperatures 100-116 degrees Facilients were exposed are:	cility shall be designed, uipped in a manner that all safety of clients, staff and of the facility where clients are er, the temperature of the tained between 100-116 t. Let as evidenced by: on and interview, the facility were not maintained between ahrenheit in areas where ed to hot water. The findings	V 752				
	11:00am revealed: -Room #102 water Fahrenheit in the ba- Room #105 water Fahrenheit in the ba- Fahrenheit in the sa- Room #109 water Fahrenheit in the ba- Room #112 water Fahrenheit in the ba- Room #212 water Fahrenheit in the ba- Room #214 water Fahrenheit in the ba- Room #215 water Fahrenheit in the ba- Room #216 water Fahrenheit in the ba- Room #211 water Fahrenheit in the ba- Room #210 water	temperature read 118 degrees athroom sink and 122 degrees nower. temperature read 118 degrees athroom sink and 118 degrees nower. temperature read 80 degrees athroom sink. temperature read 80 degrees athroom sink. temperature read 82 degrees athroom sink. temperature read 82 degrees athroom sink. temperature read 80 degrees athroom sink.					

Division of Health Service Regulation

		SUPPLIER/CLIA TION NUMBER:		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER THE WILMINGTON TREATMENT CENTER, LLC STREET ADDRESS, CITY, STATE, ZIP CODE 2520 TROY DRIVE WILMINGTON, NC 28401 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 752 Continued From page 10 V 752	2019006	3	B. WING		08/:	28/2019
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 752 Continued From page 10 PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 752		2520 TR	OY DRIVE		•	
	PRÉFIX (EACH DEFICIENCY MUST BE PRECI	CIENCIES EDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	I SHOULD BE	(X5) COMPLETE DATE
	1 0		V 752			

6899

Division of Health Service Regulation STATE FORM