Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ′ | (X2) MULTIPLE CONSTRUCTION | | |
|---|--|---|----------------------------|--|-------------|
| 74101 1244 | or dorate of the transfer of t | IDENTIFICATION TO A TOTAL OF THE PARTY. | A. BUILDING: | | COMPLETED |
| | | MHL011-339 | B. WING | | 09/06/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | STREET AD | DDRESS, CITY, STATE | E, ZIP CODE | |
| WOMEN A | AND CHILDREN FIRST | 12 TUPPE | ER ROAD REST, NC 28770 | | |
| (X4) ID | SLIMMARY ST | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | N (X5) |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE COMPLETE |
| V 000 | INITIAL COMMENTS | | V 000 | | |
| | An annual and follow- on 9/6/19. Deficienci | -up survey was completed es were cited. | | | |
| | - | d for the following service 27G .4300 Therapeutic | | | |
| V 118 | 27G .0209 (C) Medica | ation Requirements | V 118 | | |
| | only be administered order of a person autl drugs. (2) Medications shall clients only when autl client's physician. | 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 | | | |
| | (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: | | | | |
| | (A) client's name; (B) name, strength, a (C) instructions for ad (D) date and time the (E) name or initials of drug. (5) Client requests for checks shall be recor | nd quantity of the drug; | | | |

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|---------------------|---|-------------------------------|--|
| | | | A. BUILDING: _ | | | |
| | | MHL011-339 | B. WING | | 09/06/2019 | |
| NAME OF PI | ROVIDER OR SUPPLIER | STREET ADD | DRESS, CITY, STA | TE, ZIP CODE | | |
| WOMEN A | ND CHILDREN FIRST | 12 TUPPE | | | | |
| | | | EST, NC 28770 | | | |
| (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 118 | Continued From page | e 1 | V 118 | | | |
| | review the facility failed rugs were administed person authorized by only when authorized for 1 of 3 sampled clief findings are: Review on 9/4/19 of 0-an admission date of diagnoses of Major E Borderline Personality Cannabis Use-severe Use-severe, Cocaine Migraines. | n, interview, and record ed to ensure prescription red on the written order of a law and self-administered in writing by the physician ents (Client #1). The Client #1's record revealed: 6/28/19. Depression Disorder, by Disorder, Anxiety Disorder, ch, Methamphetamine Use-moderate, and | | | | |
| | a.m. of Client #1's me | ams (mg) - two tablets, 2 | | | | |
| | -Strattera - 80 mg - or -Sumatriptan - 50 mg headache, repeat in c -Propranolol - 20 mg | - 2 a day at start of | | | | |
| | nausea. | ery 6 hours as needed for | | | | |
| | -Ibuprofen - 400 mg --Essential Multi-Vitam-Docusate Sodium - 1 | • | | | | |
| | Review on 9/4/19 of 0 | • | | | | |

Division of Health Service Regulation

STATE FORM 6899 IZWN11 If continuation sheet 2 of 13

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CO | | | E SURVEY IPLETED | |
|--|--|---|---|---|--------------------------------|--------------------------|
| | | MHL011-339 | B. WING | | 0: | 9/06/2019 |
| | ROVIDER OR SUPPLIER | 12 TUPF | DDRESS, CITY, STATE PER ROAD REST, NC 28770 | , ZIP CODE | | |
| (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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| V 118 | 9/4/19 revealed: -the client initialed for was prescribed at the and 6/30/19Topamax - 50 mg - to-Amitriptyline - 100 m Review on 9/4/19 of 0 for 7/1/19 through 9/4 -Topamax - 50 mg - to was ordered 7/1/19Amitriptyline - 100 m ordered 7/1/19 and di-there were no physic when the client was a there were no physic self-administer until 8 Interview on 9/4/19 w the facility kept her medication room, how themthey handed her the and she dispensed w signed her MARthe staff observed he medicationsshe had been doing admission. Interview on 9/4/19 w Manager revealed: -she kept the clients medication roomwhen it was time for clients came to the m provided them their b | the two medications she time as taken on 6/29/19 wo tablets, 2 times a day. g - 1/2 tablet at bedtime. Client #1's physician orders //19 revealed: wo tablets, 2 times a day g - 1/2 tablet at bedtime was iscontinued 7/16/19. cian orders for June 2019 idmitted. cian orders for the client to //20/19. ith Client #1 revealed: nedications locked in the vever she self-administered basket with her medications hat she needed to take and er while she took her this process since the day of ith the Medication Case medications locked in the "Medication Calls" the edication room and she asket of medications. ministered their medications | V 118 | | | |

Division of Health Service Regulation

STATE FORM 6899 IZWN11 If continuation sheet 3 of 13

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CO | ONSTRUCTION | | E SURVEY PLETED | |
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| | | MHL011-339 | B. WING | | 09 | /06/2019 |
| | ROVIDER OR SUPPLIER | 12 TUPF | ADDRESS, CITY, STATE, PER ROAD REST, NC 28770 | ZIP CODE | | |
| (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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| V 118 | Public Safety (DPS)she had her medicat her physician orders very they always attempted DPS on admission, he problemthe earliest they could was 7/1/19the first signed self-acclient #1 was 8/20/19 | ed from the Department of ions, but DPS did not send with them. ed to obtain the orders from owever this was an on-going d get the client to a clinic dministration order for other to a re-cited deficiency | V 118 | | | |
| V 119 | guards against divers (2) Non-controlled sul of by incineration, flus system, or by transfer destruction. A record shall be maintained b Documentation shall medication name, stre date and method, the disposing of medicati witnessing destruction (3) Controlled substan accordance with the N Substances Act, G.S. subsequent amendme (4) Upon discharge of | al: d non-prescription isposed of in a manner that ion or accidental ingestion. bestances shall be disposed shing into septic or sewer to a local pharmacy for of the medication disposal y the program. specify the client's name, ength, quantity, disposal signature of the person on, and the person n. nces shall be disposed of in North Carolina Controlled 90, Article 5, including any | V 119 | | | |

Division of Health Service Regulation

STATE FORM 6899 IZWN11 If continuation sheet 4 of 13

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|---|---|-------------------------------|--|
| | | MHL011-339 | B. WING | | 09/06/2019 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | DRESS, CITY, STA | TE, ZIP CODE | | |
| WOMEN A | AND CHILDREN FIRST | 12 TUPPEI RIDGECRE | R ROAD EST, NC 28770 | | | |
| (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 APPROP DEFICIENCY) | BE COMPLETE | |
| V 119 | disposed of promptly expected that the pat to the facility and in s | unless it is reasonably ient or resident shall return uch case, the remaining be held for more than 30 ie date of discharge. | V 119 | | | |
| | Based on observation staff failed to dispose medications in a man | and interview the facility | | | | |
| | a.m. and 12:00 p.m. r -the door to the staff of -as knocked, staff car into the office that wa -an intern came into the she had any Tums. | office was closed. me from behind and walked s unlocked. he office and asked staff if ocked left hand side of her tained numerous | | | | |
| | of the staff desk draw -expired OTC medica -Diabetic Tussin - 1/2 -Mylanta Gas - chewa -Adult gummies - Fiba -Centrum Daily Vitam | tions: 018 able - 1/2018 er - 4/2019 in - 6/2019 r - 4 mg - 11/2018, 2/2019, 19. | | | | |

Division of Health Service Regulation

STATE FORM 6899 IZWN11 If continuation sheet 5 of 13

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--|---|--|--------------------------------------|---|-------------|
| | | MHL011-339 | B. WING | | 09/06/2019 |
| | | | | | 09/06/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | DDRESS, CITY, STAT ER ROAD | E, ZIP CODE | |
| WOMEN A | AND CHILDREN FIRST | | REST, NC 28770 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLETE |
| V 119 | Continued From page | 5 | V 119 | | |
| | Interviews on 9/4/19 a Staff #2 revealed: -they were unaware of being expired. | and 9/5/19 with Staff #1 and f the OTC medications h all of them and ensure | | | |
| V 120 | 27G .0209 (E) Medica | ation Requirements | V 120 | | |
| | and 86 degrees Fahre (B) in a refrigerator, if degrees and 46 degre refrigerator is used fo shall be kept in a sepa or container; (C) separately for each (D) separately for exte (E) in a secure manne for a client to self-med (2) Each facility that in controlled substances registered under the N | e: Il be stored: ed cabinet in a clean, d room between 59 degrees enheit; required, between 36 ees Fahrenheit. If the r food items, medications erate, locked compartment th client; ernal and internal use; er if approved by a physician dicate. naintains stocks of e shall be currently North Carolina Controlled 90, Article 5, including any | | | |
| | failed to ensure non-p | as evidenced by: and interview the facility rescription medications rely locked cabinet. The | | | |

Division of Health Service Regulation

STATE FORM 6899 IZWN11 If continuation sheet 6 of 13

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|----------------------------|--|-------------------------------|------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: _ | A. BUILDING: | | LETED |
| | | | | | | |
| | | MHL011-339 | B. WING | | 09 | /06/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STAT | FE, ZIP CODE | | |
| WOMEN / | AND CHILDREN FIRST | 12 TUPP | ER ROAD | | | |
| VVOIVIEN | AND CHILDREN FIRST | RIDGEC | REST, NC 28770 | | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN O | | (X5) |
| PREFIX TAG | , | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | THE APPROPRIATE | COMPLETE DATE |
| V 120 | Continued From page | e 6 | V 120 | | | |
| | Observation on 9/4/1 | 9 at approximately 11:00 | | | | |
| | a.m. and 12:00 p.m. i | | | | | |
| | -the door to the staff | | | | | |
| | | me from behind and walked | | | | |
| | into the office that wa | | | | | |
| | | the office and asked staff if | | | | |
| | she had any Tums. | | | | | |
| | -staff opened the unio | ocked left hand side of her | | | | |
| | desk drawer that con | tained numerous | | | | |
| | over-the-counter (OT | C) medications. | | | | |
| | Observation on 9/4/1 | 9 at approximately 3:50 p.m. | | | | |
| | of the staff desk draw | | | | | |
| | -approximately 33 OT | ΓC medications in the top | | | | |
| | drawer. | | | | | |
| | | ΓC medications in the bottom | | | | |
| | drawer. | | | | | |
| | -OTCs included: | | | | | |
| | -Diabetic Tussin | | | | | |
| | -Mylanta Gas -Adult gummies - Fibe | 0.5 | | | | |
| | -Centrum Daily Vitam | | | | | |
| | -Narcan - nasal spray | | | | | |
| | -Vitamin B12 | Thig X & boxes | | | | |
| | -CoQ10 - gummies | | | | | |
| | -Tums | | | | | |
| | -Cold and Flu Relief | | | | | |
| | -Dramamine | | | | | |
| | -Dulcolax | | | | | |
| | -Mucinex DM | | | | | |
| | -Tylenol | | | | | |
| | -Aspirin | | | | | |
| | -Alkaseltzer Heartbur | 'n | | | | |
| | -Airborne | ositorios | | | | |
| | -Hemorrhoidal Suppo -Hydrogen Peroxide. | ositories | | | | |
| | -i iyulogeli Feloxide. | | | | | |
| | | and 9/5/19 with Staff #1 and | | | | |
| | Staff #2 revealed: | | | | | |
| | -they were unaware (| OTC medications needed to | | | | |

Division of Health Service Regulation

STATE FORM 6899 IZWN11 If continuation sheet 7 of 13

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|---|---|--|---------------------|---|----------|------------------------|
| | | | 7 50 5 | | | |
| | | MHL011-339 | B. WING | | 09/06/20 | 19 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | DRESS, CITY, STA | TE, ZIP CODE | | |
| WOMEN / | AND CHILDREN FIRST | 12 TUPPEI | R ROAD | | | |
| WONLINA | AND CHIEDREN HINST | RIDGECRE | ST, NC 28770 | | | |
| (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 SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE CO | (X5) MPLETE DATE |
| V 120 | Continued From page | e 7 | V 120 | | | |
| | be in a locked cabine -they were going to go medications and dispo- -they had a top cabino | t. o through all of the ose of the expired ones. et to the hutch of the desk v to be locked where they | | | | |
| V 364 | G.S. 122C- 62 Additi Facilities | onal Rights in 24 Hour | V 364 | | | |
| | 122C-51 through G.S who is receiving treat 24-hour facility keeps (1) Send and receive access to writing mate assistance when need (2) Contact and consand at no cost to the physicians, and private developmental disability professionals of his classification of the rights specified in restricted by the facilities exercise these rights (b) Except as provide of this section, each attreatment or habilitatity times keeps the right (1) Make and received calls. All long distance the client at the time of collect to the receiving (2) Receive visitors is | rights enumerated in G.S 122C-61, each adult client ment or habilitation in a the right to: e sealed mail and have erial, postage, and staff essary; sult with, at his own expense facility, legal counsel, private te mental health, lities, or substance abuse hoice; and sult with a client advocate if eate. In this subsection may not be try and each adult client may at all reasonable times. I the didt client who is receiving on in a 24-hour facility at all to: I confidential telephone erights and the call or made | | | | |

Division of Health Service Regulation

STATE FORM 6899 IZWN11 If continuation sheet 8 of 13

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---------------------|---|-------------------------------|--------------------------|
| | | | 7 50.25 | | | |
| | | MHL011-339 | B. WING | | 09/0 | 6/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | TE, ZIP CODE | | |
| WOMEN A | AND CHILDREN FIRST | 12 TUPPE | R ROAD | | | |
| | 1 | RIDGECR | REST, NC 28770 | | | |
| (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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETE DATE |
| V 364 | Continued From page | e 8 | V 364 | | | |
| V 304 | hours daily, two hours p.m.; however visiting over therapies; (3) Communicate ar supervision with indivupon the consent of t (4) Make visits outsi unless: a. Commitment pro the result of the client violent crime, includir assault with a deadly respondent was founinsanity or incapable b. The client was vocommitted to the facil commitment to a corr Division of Adult Corr Public Safety; or c. The client is beint to proceed pursuant to a court order may expotherwise prohibited conditions prescribed (5) Be out of doors of facilities and equipmes several times a week (6) Except as prohib personal clothing and client is being held to proceed pursuant to (7) Participate in reli (8) Keep and spend own money; (9) Retain a driver's prohibited by Chapter and | s of which shall be after 6:00 g shall not take precedence and meet under appropriate riduals of his own choice he individuals; de the custody of the facility ceedings were initiated as it's being charged with a angle a crime involving an weapon, and the don't guilty by reason of of proceeding; coluntarily admitted or lity while under order of ectional facility of the ection of the Department of angle held to determine capacity for G.S. 15A-1002; pressly authorize visits by the existence of the liby this subdivision; daily and have access to ent for physical exercise; itted by law, keep and use I possessions, unless the determine capacity to G.S. 15A-1002; | V 304 | | | |

Division of Health Service Regulation

STATE FORM 6899 IZWN11 If continuation sheet 9 of 13

Division of Health Service Regulation

| DIVISION | of Health Service Regu | liation | | | |
|------------|---------------------------|----------------------------------|----------------------------|---|------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY |
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLETED |
| | | | | _ | |
| | | MHI 044 220 | B. WING | | 00/06/2040 |
| | | MHL011-339 | | | 09/06/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, STA | TE, ZIP CODE | |
| WOMEN A | ND CHILDREN FIRST | 12 TUPPI | R ROAD | | |
| VVOIVIEN | IND CHILDREN FIRST | RIDGECF | REST, NC 28770 | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | V (X5) |
| PREFIX | • | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD | BE COMPLETE |
| TAG | REGULATORY OR I | LSC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | RIATE DATE |
| | | | | DEI IGIENGT) | |
| V 364 | Continued From page | e 9 | V 364 | | |
| | (c) In addition to the | rights enumerated in G.S. | | | |
| | 122C-51 through G.S | | | | |
| | • | S. 122C-61, each minor client | | | |
| | • | ment or habilitation in a | | | |
| | • | ne right to have access to | | | |
| | proper adult supervis | - | | | |
| | | nor's status as a developing | | | |
| | individual, the minor s | | | | |
| | | le him to mature physically, | | | |
| | emotionally, intellectu | | | | |
| | | of the physical, emotional, | | | |
| | • | turity of the minor, the | | | |
| | 24-hour facility shall p | • | | | |
| | | and control consistent with | | | |
| | • | e minor pursuant to this Part. | | | |
| | | , where practical, make | | | |
| | | ensure that each minor | | | |
| | | ent apart and separate from | | | |
| | | ne treatment needs of the | | | |
| | minor client dictate of | therwise. | | | |
| | Each minor client who | o is receiving treatment or | | | |
| | | -hour facility has the right to: | | | |
| | (1) Communicate an | nd consult with his parents or | | | |
| | guardian or the agend | cy or individual having legal | | | |
| | custody of him; | | | | |
| | (2) Contact and cons | sult with, at his own expense | | | |
| | or that of his legally re | esponsible person and at no | | | |
| | cost to the facility, leg | | | | |
| | physicians, private m | ental health, developmental | | | |
| | disabilities, or substan | nce abuse professionals, of | | | |
| | | onsible person's choice; and | | | |
| | (3) Contact and cons | sult with a client advocate, if | | | |
| | there is a client advoc | cate. | | | |
| | The rights specified in | n this subsection may not be | | | |
| | restricted by the facili | ty and each minor client | | | |
| | may exercise these ri | ights at all reasonable times. | | | |
| | (d) Except as provid | ed in subsections (e) and (h) | | | |
| | of this section, each r | minor client who is receiving | | | |
| | treatment or habilitati | on in a 24-hour facility has | | | |

Division of Health Service Regulation

STATE FORM 6899 IZWN11 If continuation sheet 10 of 13

Division of Health Service Regulation

| DIVISION | n Health Service Regu | ialion | | | | |
|-------------------|--------------------------|---------------------------------|----------------------------|---------------------------------|------------------|------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | |
| AND PLAN C | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLE | TED |
| | | | | | | |
| | | MIII 044 220 | B WING | B. WING | | 0/0040 |
| | | MHL011-339 | 1 = | | ı 09/0 | 6/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | TE, ZIP CODE | | |
| | | 12 TUPPE | R ROAD | | | |
| WOMEN A | ND CHILDREN FIRST | RIDGECR | EST, NC 28770 |) | | |
| 040.15 | SLIMMADV ST | ATEMENT OF DEFICIENCIES | | PROVIDER'S PLAN OF CORRECTION | N | 0/5) |
| (X4) ID PREFIX | | Y MUST BE PRECEDED BY FULL | ID PREFIX | (EACH CORRECTIVE ACTION SHOULD | | (X5) COMPLETE |
| TAG | , | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPR | | DATE |
| | | | | DEFICIENCY) | | |
| V 364 | Continued From page | 2.10 | V 364 | | | |
| V 004 | Continued i form page | 5 10 | * 004 | | | |
| | the right to: | | | | | |
| | (1) Make and receive | e telephone calls. All long | | | | |
| | distance calls shall be | e paid for by the client at the | | | | |
| | time of making the ca | II or made collect to the | | | | |
| | receiving party; | | | | | |
| | (2) Send and receive | e mail and have access to | | | | |
| | writing materials, pos | tage, and staff assistance | | | | |
| | when necessary; | | | | | |
| | (3) Under appropriat | te supervision, receive | | | | |
| | visitors between the h | nours of 8:00 a.m. and 9:00 | | | | |
| | p.m. for a period of at | least six hours daily, two | | | | |
| | | pe after 6:00 p.m.; however | | | | |
| | | precedence over school or | | | | |
| | therapies; | • | | | | |
| | | education and vocational | | | | |
| | | e with federal and State law; | | | | |
| | • | daily and participate in play, | | | | |
| | | cal exercise on a regular | | | | |
| | basis in accordance v | | | | | |
| | | ited by law, keep and use | | | | |
| | personal clothing and | | | | | |
| | | on, unless the client is being | | | | |
| | | pacity to proceed pursuant to | | | | |
| | G.S. 15A-1002; | and the process parameters | | | | |
| | (7) Participate in reli | aious worship: | | | | |
| | ' ' | ndividual storage space for | | | | |
| | the safekeeping of pe | - · | | | | |
| | | and spend a reasonable sum | | | | |
| | of his own money; an | | | | | |
| | • | license, unless otherwise | | | | |
| | • • | 20 of the General Statutes. | | | | |
| | • • • | ated in subsections (b) or (d) | | | | |
| | · · | e limited or restricted except | | | | |
| | | ssional responsible for the | | | | |
| | | ent's treatment or habilitation | | | | |
| | | | | | | |
| | • | nent shall be placed in the | | | | |
| | | dicates the detailed reason | | | | |
| | for the restriction. The | | | | | |
| | reasonable and relate | ed to the client's treatment or | 1 | | | |

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| Division of | of Health Service Regu | lation | | | |
|--------------------------|--|--|---------------------------------|---|-------------------------------|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: _ | CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | MHL011-339 | B. WING | | 09/06/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STA | ΓΕ, ZIP CODE | |
| MOMENIA | ND CHILL DDEN FIDOT | 12 TUPP | ER ROAD | | |
| WOMEN A | IND CHILDREN FIRST | RIDGEC | REST, NC 28770 | | |
| (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 APPROPI DEFICIENCY) | BE COMPLETE |
| V 364 | Continued From page | ÷ 11 | V 364 | | |
| | habilitation needs. A reperiod not to exceed a each restriction shall qualified professional at which time the rest Each evaluation of a redocumented in the cli rights may be renewed statement entered by the client's record that renewal of the restrict client who has not be in each instance of ar of a restriction of right by the client shall, upobe notified of the restrict. In the case of a min adult client, the legally be notified of each instance of a restriction of renewal of a restriction of renew | restriction is effective for a 30 days. An evaluation of be conducted by the at least every seven days, riction may be removed. restriction shall be ent's record. Restrictions on d only by a written the qualified professional in t states the reason for the cion. In the case of an adult en adjudicated incompetent, in initial restriction or renewal is, an individual designated on the consent of the client, riction and of the reason for nor client or an incompetent or responsible person shall stance of an initial restriction etion of rights and of the | | | |
| | failed to ensure client right to make and rec | ew and interviews the facility s were able to exercise the eive telephone calls ed clients (Clients #1 and | | | |
| | | he undated "Preppie sidents will receive one 5 on arrival to inform family | | | |

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you are here and safe..."

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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 | |
|---|--|---|--|--|---|-------------------------------|--|
| | | MHL011-339 | B. WING | | 09 |)/06/2019 | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12 TUPPER ROAD RIDGECREST, NC 28770 | | | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE COMP | | (X5) COMPLETE DATE | |
| V 364 | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | V 364 | | RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE | | |

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