STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPL			E SURVEY PLETED	
		MHL026-777	B. WING			R 13/2019
	PROVIDER OR SUPPLIER	2030 HOK	DRESS, CITY, ST KE LOOP ROA VILLE, NC 28	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC 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 000	INITIAL COMMENT	rs	V 000			
	on September 13, 2 This facility is licens	w up survey was completed 2019. Deficiencies were cited. sed for the following service AC 27G .1700 Residential cure for Children or				
V 114	27G .0207 Emerge	ncy Plans and Supplies	V 114			
	AND SUPPLIES (a) A written fire pla area-wide disaster shall be approved be authority. (b) The plan shall be and evacuation pro posted in the facility (c) Fire and disaster shall be held at least repeated for each sunder conditions the	r drills in a 24-hour facility st quarterly and shall be shift. Drills shall be conducted at simulate fire emergencies. all have basic first aid supplies				
	facility failed to hold quarterly on each s Interview on 9/12/19 (QP) stated: -The facility staffed -3 week day sh	et as evidenced by: views and interviews, the If fire and disaster drills at least hift. The findings are: If the Qualified Professional with the following shifts: ifts, Monday through Friday: 8 If pm; 10 pm - 8 am.				

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

(X6) DATE TITLE

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURV	
,	0. 00.11.120.10.1		A. BUILDING:			
		MHL026-777	B. WING		09/1	3/2019
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SUNLIG	HT BEHAVIOR CENTE	R	E LOOP RO			
		FAYETTE	VILLE, NC 2	28314		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / 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)	D BE	(X5) COMPLETE DATE
V 114	Continued From pa	ge 1	V 114			
	-2 week end shifts, Saturday and Sunday: 8 am - 8 pm; 8 pm - 8 am.					
	between 7/1/18 thro-Quarter 7/1/18 - 9/documented for the the week end, 8 pm - Quarter 10/1/18 - 3/documented for the week end, 8 pm - 8 - Quarter 1/1/19 - 3/documented for the Review on 9/13/19 documented betwe 2019 revealed: - Quarter 7/1/18 - 9/documented for the or the week end 8 shifts Quarter 10/1/18 - 3/documented for the pm - 10 pm shifts, c shift Quarter 1/1/19 - 3/documented for the week end 8 am - 8 - Quarter 4/1/19 - 6/documented for the week end 8 am - 8 - Quarter 4/1/19 - 6/documented for the shift. Interview on 9/13/19-She was not aware were required for all	12/31/18: No fire drills a week day 8 am - 2 pm, or the am shifts. 31/19: No fire drills a week day 2 pm - 10 pm shift. of the disaster drills en 7/1/18 through August 30/18: No disaster drills a week day 10 pm - 8 am shift, am - 8 pm and 8 pm - 8 am 12/31/18: No disaster drills a week day 8 am - 2 pm and 2 or the week end 8 pm - 8 am 31/19: No disaster drills a week day 8 am - 2 pm, or the pm; 8 pm - 8 am shifts. 30/19: No disaster drills a week day 8 am - 2 pm; 2 pm he week end 8 pm - 8 am 9 the QP stated: a that fire and disaster drills				

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Division of Health Service Regulation STATE FORM

5NO911 If continuation sheet 2 of 13

DIVISION	of Health Service Re	guiation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					_	
			D WING		F	
		MHL026-777	B. WING		09/1	3/2019
NAME OF I		CTDEET AD	DDECC CITY (STATE, ZIP CODE		
NAIVIE OF I	PROVIDER OR SUPPLIER		, ,	•		
SUNLIG	HT BEHAVIOR CENTE	R	E LOOP RO			
CONLIG	TI BEILIATION GENTE	FAYETTE	VILLE, NC 2	8314		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIES	PRIATE	DATE
				DEFICIENCY)		
\/ 118	Continued From pa	go 2	V 118			
V 110	Continued From pa	ge 2	V 110			
V 118	27G .0209 (C) Med	ication Requirements	V 118			
	10A NCAC 27G .02	POS MEDICATION				
	REQUIREMENTS	.00 MEDIOATION				
	(c) Medication adm	injetration:				
	. ,					
		non-prescription drugs shall ed to a client on the written				
	,					
	· ·	uthorized by law to prescribe				
	drugs.					
		all be self-administered by				
		uthorized in writing by the				
	client's physician.					
	(3) Medications, inc	cluding injections, shall be				
		y licensed persons, or by				
	unlicensed persons	trained by a registered nurse,				
		legally qualified person and				
		e and administer medications.				
		Iministration Record (MAR) of				
		red to each client must be kept				
		s administered shall be				
		ely after administration. The				
	MAR is to include the	le following.				
	(A) client's name;	and some Charlet the advance				
	, ,	and quantity of the drug;				
	· ,	administering the drug;				
		ne drug is administered; and				
	` '	of person administering the				
	drug.					
		for medication changes or				
	checks shall be rec	orded and kept with the MAR				
	file followed up by a	appointment or consultation				
	with a physician.					
	. ,					
	This Dula is not me	ot as avidanced by:				
	This Rule is not me					
		views and interviews, the				
	racility failed to adm	ninister medications as				

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Division of Health Service Regulation STATE FORM

5NO911 If continuation sheet 3 of 13

l	IDENTIFICATION NUMBER:	A. BUILDING:			
		A. BUILDING:		COMPLETED	
		D WING	D. WING		₹
MHL026-777		B. WING		09/1	3/2019
PPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CENTE	R				
		VILLE, NC 2			
ICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE DATE
om pa	ge 3	V 118			
8 Continued From page 3 ordered by the physician and maintain current MARs affecting 2 of 3 clients audited (clients #3 and #4). The findings are:					
led: male a nclude de, mode ention nbined tal Distance 7/26/19 dtime. cumen 7/26/19 order w 6/28/19 epression 7/26/19	dmitted 6/4/19. d Major Depressive Disorder, derate; Autism Spectrum Deficit Hyperactive Disorder type; Intellectual ability, mild. 19 for Guanfacine ER 2 mg (milligrams) twice daily. 19 for Guanfacine ER 2 mg, 3 atted to clarify if the Guanfacine was to be discontinued when as written. 19 for Trazodone 150 mg at on) 19 for Trazodone 150 mg,				
6/28/1 mg at itability 7/26/1 ne. 7/26/1 s at be 8/29/1 s at be 6/18/1 ce daily	19 for Risperidone 1 mg for 7 bedtime. (Mental/mood associated with autistic 19 to increase Risperidone to 3 19 for Desmopressin 0.2 mg, dtime. (Night time bed wetting 19 for Desmopressin 0.2 mg, dtime. 19 for Hydrocortisone 2.5% at to the affected area for 14				
THE MATING TO THE MET WELL TO THE MET OF TH	rom participation participatio	TARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL PRY OR LSC IDENTIFYING INFORMATION) From page 3 The physician and maintain current ting 2 of 3 clients audited (clients #3 e findings are: 1/12/19 and 9/13/19 of client #4's aled: male admitted 6/4/19. included Major Depressive Disorder, de, moderate; Autism Spectrum tention Deficit Hyperactive Disorder mbined type; Intellectual tial Disability, mild. 1/12/6/19 for Guanfacine ER elease) 2 mg (milligrams) twice daily. 1/12/19 was to be discontinued when order was written. 1/12/6/19 for Trazodone 150 mg at expression) 1/12/6/19 for Trazodone 150 mg, 2 tablets at bedtime. 1/12/6/19 for Risperidone 1 mg for 7 mg at bedtime. (Mental/mood ritability associated with autistic 1/12/6/19 for Desmopressin 0.2 mg, 2 at bedtime. (Night time bed wetting 1/12/6/19 for Desmopressin 0.2 mg, 2 at bedtime. (Night time bed wetting 1/12/6/19 for Desmopressin 0.2 mg, 2 at bedtime. (Night time bed wetting 1/12/6/19 for Desmopressin 0.2 mg, 2 at bedtime. (Night time bed wetting 1/12/6/19 for Desmopressin 0.2 mg, 2 at bedtime. (Night time bed wetting 1/12/6/19 for Desmopressin 0.2 mg, 2 at bedtime. (Night time bed wetting 2/12/6/19 for Desmopressin 0.2 mg, 2 at bedtime. (Night time bed wetting 2/13/13/19 for Hydrocortisone 2.5% 2/13/19 for Hydroc	TARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL TAG. TOM page 3 The physician and maintain current sing 2 of 3 clients audited (clients #3 e findings are: 1/12/19 and 9/13/19 of client #4's aled: male admitted 6/4/19. included Major Depressive Disorder, de, moderate; Autism Spectrum stention Deficit Hyperactive Disorder mbined type; Intellectual stal Disability, mild. dr/26/19 for Guanfacine ER elease) 2 mg (milligrams) twice daily. 1/12/6/19 for Guanfacine ER 2 mg, 3 ditime. Social stal bedtime. In the continued when order was written. In 6/28/19 for Trazodone 150 mg, 2 tablets at bedtime. In the continued with autistic stal precision of the continued with autistic stal precision. In the continued with autistic stal precision of the continued with autistic stal precision. In the continued with autistic stal precision of the continued with autistic stal precision. In the continued with autistic stal precision of the continued with autistic stal precision. In the continued with autistic stal precision of the continued with autistic stal precision. In the continued with autistic stal precision of the continued with autistic stal precision. In the continued with autistic stal precision of the continued with autistic stal precision. In the continued with autistic stal precision of the continued with autistic stal precision. In the continued with autistic stal precision of the continued with autistic stal precision. In the continued with autistic stal precision of the continued with autistic stal precision of the continued with autistic stall precision of the continued with autist	CENTER 2030 HOKE LOOP ROAD FAYETTEVILLE, NC 28314 IARY STATEMENT OF DEFICIENCIES INCIDENCIES OF THE APPROVIDER'S PLAN OF CORRECTIFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTIFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTIFY ACTION SHOULD RY OR LSC IDENTIFYING INFORMATION) Tom page 3 The physician and maintain current ing 2 of 3 clients audited (clients #3 e findings are: 1/12/19 and 9/13/19 of client #4's siled: male admitted 6/4/19. included Major Depressive Disorder, de, moderate; Autism Spectrum tention Deficit Hyperactive Disorder mbined type; Intellectual tital Disability, mild. 1/12/6/19 for Guanfacine ER 2 mg, 3 ditime. pourmented to clarify if the Guanfacine Prize Please) 2 mg (milligrams) twice daily. 18/29/19 for Guanfacine ER 2 mg, 3 ditime. pourmented to clarify if the Guanfacine Prize Please) 2 mg (milligrams) twice daily. 18/29/19 for Trazodone 150 mg, 2 tablets at bedtime. 18/28/19 for Risperidone 1 mg for 7 mg at bedtime. (Mental/mood iffability associated with autistic discontinued with autistic discontinued with autistic discontinued wetting in 1/26/19 for Desmopressin 0.2 mg, s at bedtime. (Night time bed wetting discontinued discontinued disco	CENTER 2030 HOKE LOOP ROAD FAYETTEVILLE, NC 28314 MAY STATEMENT OF DETICIENCIES FICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION) TAG PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TOM page 3 V 118 The physician and maintain current sing 2 of 3 clients audited (clients #3 e findings are: V12/19 and 9/13/19 of client #4's elied: male admitted 6/4/19. included Major Depressive Disorder, de, moderate; Autism Spectrum tention Deficit Hyperactive Disorder mibined type; Intellectual tial Disability, mild. 31/2/6/19 for Guanfacine ER elease) 2 mg (milligrams) twice daily. 31/2/6/19 for Guanfacine ER 2 mg, 3 dtime. cocumented to clarify if the Guanfacine 77/26/19 was to be discontinued when order was written. 31/2/8/19 for Trazodone 150 mg, 31/2/8/19 for Trazodone 150 mg, 31/2/8/19 for Trazodone 150 mg, 31/2/8/19 for Risperidone 1 mg for 7 mg at bedtime. 31/2/8/19 for Desmopressin 0.2 mg, 32 at bedtime. 33/2/9/19 for Desmopressin 0.2 mg, 34/2/9/19 for Desmopressin 0.2 mg, 35 at bedtime. 36/3/19 for Phydrocortisone 2.5% 36 ce daily to the affected area for 14 200ditions, reduces the swelling,

Division of Health Service Regulation

STATE FORM 5899 5NO911 If continuation sheet 4 of 13

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		R	
		MHL026-777	B. WING			3/2019
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SUNLIGHT BEHAVIOR CENTER		-R	E LOOP RO VILLE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 118	Continued From page 4		V 118			
	Review on 9/13/19 of client #4's June 2019 MARs revealed no documentation Hydrocortisone 2.5% ointment had been administered twice daily to the affected area.					
	Review on 9/13/19 of client #4's July 2019 MARs revealed: -Trazodone 150 mg, 1 tablet at bedtime was documented 7/1/19 - 7/31/19. (Should have increased to 2 tablets at bedtime on 7/26/19)Transcribed order read, "Risperidone 1 mg take 1 tablet at bedtime for 7 days, then begin 2 mg bedtime dose." Medication documented from 7/2/19 - 7/28/19 without documentation when the client received 1 mg or 2 mg at bedtime. Dosage should have increased to 3 mg at bedtime on 7/26/19.					
	Review on 9/13/19 of client #4's August 2019 MARs revealed: -Desmopressin 0.2 mg, 3 tablets at bedtime was documented 8/29/19 - 8/30/19. (Should have reduced to 2 tablets at bedtime on 8/29/19)					
	MARs revealed: -Guanfacine ER 2 i am and 7 pm, from -Guanfacine ER 2 i 7 am from 9/12/19 -Guanfacine ER 6 i from 9/1/19 - 9/12/2	mg documented once daily at - 9/13/19. mg documented daily at 7 pm 19. mg, 3 tablets at bedtime was				
	Finding #2: Review on 9/12/19 record revealed: -13 year old male a	and 9/13/19 of client #3's dmitted 8/23/19.				

Division of Health Service Regulation

STATE FORM 5899 5NO911 If continuation sheet 5 of 13

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						SURVEY LETED
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		MHL026-777	B. WING		09/1	3/2019
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SUNLIGI	HT BEHAVIOR CENTE	-R	(E LOOP RO VILLE, NC 2			
(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)	_D BE	(X5) COMPLETE DATE
V 118	/ 118 Continued From page 5		V 118			
V 110	-Diagnoses include allergiesOrder dated 8/20/7 (Allergies) -Order dated 8/12/7 morning for moodOrder dated 9/4/18 8 hours as needed -Order dated 9/4/18 daily for eczema. Review on 9/13/19 September 2019 M-Loratadine 10 mg administered 8/30/7-Sertraline 100 mg at 7 am had not be administered on 9/7-Hydroxyzine 25 mg administered daily as administered at documentation clie itchingNo transcription for and no documentation daministered 9/4/19 Interview on 9/13/1 (GHM) stated: -The pharmacy used days a weekClient #4's physicia reauthorization for his last dose on hall-He (GHM) had call	d ADHD, and seasonal 19 for Loratadine 10 mg daily. 19 for Sertraline 100 mg in the 9 for Hydroxyzine 25 mg every for itching. 9 for Aquaphor or vaseline of client #3's August and ARs revealed: daily was not documented as 19, or 9/1/19 - 9/4/19. scheduled to be administered en documented as 13/19. g had been transcribed to be at 7 pm, and was documented 7 pm 9/5/19 - 9/12/19. No nt requested or complained of ar Aquaphor or vaseline daily tion this had been 9 - 9/13/19. 9 the Group Home Manager and by all clients was open 7 an had not done the Risperdal. Client #4 had taken	V 116			
	continued on the 7	believe client #4 had been pm dose of Guanfacine 4 mg mg that was ordered 8/29/19.				

Division of Health Service Regulation

STATE FORM 5899 5NO911 If continuation sheet 6 of 13

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:						DATE SURVEY COMPLETED	
			A. BUILDING.		R		
		MHL026-777	B. WING			3/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE			
SUNLIGH	IT BEHAVIOR CENTE	·R	E LOOP RO VILLE, NC 2				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 118	(Desmopressin) do Topamax. (Used fo off-label to treat a v Interview on 9/13/1 stated: -Client #3 was seer and diagnosed to h orders were not leg surveyor, she (QP) clarification the ord Vaseline daily and s skinThe facility had de site and a jar of vas-After discussion w called client #4's ph the Guanfacine ord until the following T pharmacy. The phorder dated 8/29/19 Since the physician the recommendation 8/29/19 order, and clarification could b -The facility would for recommendation for orders. Due to the failure to medication administration administration administration of the service of the	an had decreased the DDAVP se because he started him on a seizures and sometimes wide range of mood disorders.) 9 the Qualified Professional on 9/4/19 by his physician ave eczema. The handwritten ible. After discussion with the ocalled and received ers were for Aquaphor or soap & detergent for sensitive stergent for se	V 118				
V 133	G.S. 122C-80 Crim	inal History Record Check	V 133				
	G.S. §122C-80 CR CHECK REQUIRE	IMINAL HISTORY RECORD D FOR CERTAIN					

Division of Health Service Regulation

STATE FORM 5899 5NO911 If continuation sheet 7 of 13

DIVISION	of Health Service Re	egulation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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		MUI 026 777	B. WING		F 00/4	
		MHL026-777			09/1	3/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		2030 HO	KE LOOP RO	AD		
SUNLIGH	HT BEHAVIOR CENTE	-R	VILLE, NC 2			
(V4) ID	QUIMMADV QTA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTI	ON	(VE)
(X4) ID PREFIX		/ MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
V 133	Continued From pa	ige 7	V 133			
	•					
	APPLICANTS FOR					
	` ,	used in this section, the term				
		o an area authority/county				
		rovider of mental health,				
		ibility, and substance abuse				
		nsable under Article 2 of this				
	Chapter.					
		An offer of employment by a				
		nder this Chapter to an				
		sition that does not require the				
		n occupational license is				
	conditioned on con-	sent to a State and national				
	criminal history rec	ord check of the applicant. If				
	the applicant has b	een a resident of this State for				
	less than five years	, then the offer of employment				
	is conditioned on co	onsent to a State and national				
	criminal history rec	ord check of the applicant. The				
	national criminal his	story record check shall				
		the applicant's fingerprints. If				
		een a resident of this State for				
	five years or more,	then the offer is conditioned				
		ite criminal history record				
		ant. A provider shall not				
		it who refuses to consent to a				
		ord check required by this				
	,	otherwise provided in this				
		ive business days of making				
		r of employment, a provider				
		est to the Department of				
		114-19.10 to conduct a				
		ord check required by this				
		mit a request to a private				
		State criminal history record				
		his section. Notwithstanding				
		Department of Justice shall				
		f national criminal history				
		employment positions not				
	covered by Public L					
		Ith and Human Services,				
	Department of Hea	iui anu muman Services,				

DIVISION	Of Fleatill Service IN					1
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
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		MHL026-777	B. WING		09/1	3/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		2030 HOK	E LOOP RO	ΔD		
SUNLIGHT REHAVIOR CENTER		VILLE, NC 2				
	T		VILLE, NC 2			I
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF		COMPLETE DATE
IAG	TREGOLITION ON E		IAG	DEFICIENCY)	140412	
V 133	Continued From pa	ge 8	V 133			
	Criminal Booards C	Check Unit. Within five				
		eceipt of the national criminal				
		n, the Department of Health				
		es, Criminal Records Check				
		provider as to whether the				
		d may affect the employability				
		no case shall the results of the				
		story record check be shared				
	with the provider. Providers shall make available					
	upon request verification that a criminal history					
	check has been cor	mpleted on any staff covered				
	by this section. A co	ounty that has adopted an				
	appropriate local or	dinance and has access to				
	the Division of Crim	ninal Information data bank				
	may conduct on be	half of a provider a State				
		ord check required by this				
		provider having to submit a				
		artment of Justice. In such a				
		all commence with the State				
		ord check required by this				
		business days of the				
		employment by the provider.				
		nformation received by the				
		itial and may not be disclosed,				
		ant as provided in subsection				
	(c) of this section. F	•				
		n "private entity" means a				
		engaged in conducting				
		ord checks utilizing public				
	records obtained fro					
		oplicant's criminal history				
		Is one or more convictions of				
		the provider shall consider all				
		ors in determining whether to				
	hire the applicant:					
		eriousness of the crime.				
	(2) The date of the					
	(3) The age of the p	person at the time of the				
	conviction.					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					R	
		MHL026-777	B. WING		09/1	3/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SUNLIGI	HT BEHAVIOR CENTE	R	E LOOP RO			
		FAYETTE	VILLE, NC 2	8314		T
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 133	Continued From pa	ge 9	V 133			
	(4) The circumstanc commission of the (5) The nexus between the person and the filled. (6) The prison, jail, rehabilitation, and experson since the day (7) The subsequental relevant offense. The fact of convictions shall not be a bar to listed factors shall lift the provider disquence of the criminal history to the disqualification of the criminal history to the disqualification of the criminal history to the disqualification of the criminal history (1) The failure of the criminal history (2) Failure to check criminal offenses if history record check criminal history record check criminal offenses if history record check criminal history record check c	ces surrounding the crime, if known. The en the criminal conduct of job duties of the position to be probation, parole, employment records of the ate the crime was committed. It commission by the person of the employment; however, the provider of the individual. It is an employee's criminal the employee's criminal the employee's criminal the provider of the employee's criminal the employee's criminal the provider of the employee's criminal the employee's criminal the provider of the employee's criminal the employ				

DIVISION	of Health Service Re	guiation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					F	
		MHL026-777	B. WING			3/2019
		WITLUZO-777			09/1	3/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		2030 HOR	E LOOP RO	AD		
SUNLIGI	HT BEHAVIOR CENTE	R	VILLE, NC 2			
	OUR MAA DV OTA		· ·			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
1/ /00	0 " 1-	40	1/ 400			
V 133	Continued From pa	ge 10	V 133			
	crimes include the	criminal offenses set forth in				
		Articles of Chapter 14 of the				
		Article 5, Counterfeiting and				
		ubstitutes; Article 5A,				
		itive and Legislative Officers;				
		Article 7A, Rape and Other				
		ele 8, Assaults; Article 10,				
		duction; Article 13, Malicious				
		y Use of Explosive or				
		or Material; Article 14, Burglary				
		eakings; Article 15, Arson and				
		icle 16, Larceny; Article 17,				
		, Embezzlement; Article 19,				
		id Cheats; Article 19A,				
		or Services by False or				
		Credit Device or Other Means;				
		ial Transaction Card Crime				
		uds; Article 21, Forgery; Article				
		st Public Morality and				
		A, Adult Establishments;				
		ion; Article 28, Perjury; Article				
		31, Misconduct in Public				
	, ,	Offenses Against the Public				
		Riots and Civil Disorders;				
	· · · · · · · · · · · · · · · · · · ·	on of Minors; Article 40,				
	,	amily; Article 59, Public				
		ticle 60, Computer-Related				
		es also include possession or				
		• • • • • • • • • • • • • • • • • • •				
		ation of the North Carolina ces Act, Article 5 of Chapter				
		Statutes, and alcohol-related				
		ale to underage persons in				
		B-302 or driving while				
		n of G.S. 20-138.1 through				
	G.S. 20-138.5.	obing Edge Information Assu				
		shing False Information Any				
		yment who willfully furnishes,				
		ise gives false information on				
	an employment app	olication that is the basis for a				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					F	{
		MHL026-777	B. WING			3/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SUNLIGHT BEHAVIOR CENTER			(E LOOP RO VILLE, NC 2			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
V 133	criminal history receshall be guilty of a (g) Conditional Empemploy an applicant obtaining the result check regarding the following requirement (1) The provider shippior to obtaining the criminal history recesubsection (b) of the fingerprint cards as (2) The provider shippion conditional employing 2001-155, s. 1; 200	ord check under this section Class A1 misdemeanor. Dloyment A provider may t conditionally prior to s of a criminal history record a applicant if both of the	V 133			
	This Rule is not met as evidenced by: Based on record review and interview, the facility failed to make an offer of employment conditioned on consent to a national criminal history record check to include a check of the applicant's fingerprints affecting 1 of 1 audited staff (Staff #6) who had lived out of state within 5 years of hire. The findings are: Review on 9/13/19 of Staff #6's record revealed: -Paraprofessional hired 5/10/19Application documented employment from September 2016 to October 2018 in another stateState criminal background check dated 5/2/19No documentation of a national criminal record					

Division of Health Service Regulation STATE FORM

FORM 5NO911 If continuation sheet 12 of 13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
MHL026-777		MHL026-777	B. WING		R 09/13/2019		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2030 HOKE LOOP ROAD FAYETTEVILLE, NC 28314							
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
V 133	check to include fin Interview on 9/13/19 stated: -She would follow u record check to incl -She would put a pr this was done for all		V 133				

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