Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		TED
		MHL041-187	B. WING		01/2	4/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE DINC	ED CENTED	213 EAST	BESSEMER A	VENUE		
THE KING	ER CENTER	GREENS	BORO, NC 2740	01		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICENCY)	D BE	(X5) COMPLETE DATE
V 000	V 000 INITIAL COMMENTS		V 000			
	An annual survey was completed on 1/24/20. Deficiencies were cited.					
	categories:	d for the following service				
		00 Outpatient Detoxification				
	for Substance Abuse	; and 00 Day Treatment Facilities				
		ubstance Abuse Disorders				
V 536	27E .0107 Client Rigl Int.	nts - Training on Alt to Rest.	V 536			
	10A NCAC 27E .0107	7 TRAINING ON				
	ALTERNATIVES TO INTERVENTIONS	RESTRICTIVE				
	(a) Facilities shall im	plement policies and				
		size the use of alternatives				
	to restrictive intervent					
		services to people with				
	employees, students	ding service providers,				
	demonstrate compete					
		communication skills and				
	•	eating an environment in				
		f imminent danger of abuse with disabilities or others or				
	property damage is p					
		s shall establish training				
		etencies, monitor for internal				
		onstrate they acted on data				
	gathered. (d) The training shall	be competency-based,				
	include measurable le					
		vritten and by observation of				
	behavior) on those of	ojectives and measurable				
		e passing or failing the				
	course.	training much be served to d				
	(e) Formal refresher	training must be completed	1			

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

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED	
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MHL041-187		B. WING		01/24/202	0	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		213 EAST	BESSEMER A	/ENUE		
THE RING	ER CENTER		BORO, NC 2740			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COM	X5) PLETE ATE
V 536	Continued From page	÷ 1	V 536			
	by each service proviannually).  (f) Content of the trai provider wishes to enthe Division of MH/DI Paragraph (g) of this (g) Staff shall demonfollowing core areas:  (1) knowledge apeople being served;  (2) recognizing behavior;  (3) recognizing external stressors that disabilities;  (4) strategies for relationships with performal stressors that disabilities;  (6) recognizing organizational factors disabilities;  (6) recognizing assisting in the persong decisions about their (7) skills in assesscalating behavior;  (8) communication disabilities which direct behaviors which are used (h) Service providers documentation of initiat least three years.  (1) Documentation	der periodically (minimum  ning that the service heloy must be approved by D/SAS pursuant to Rule. strate competence in the and understanding of the and interpreting human  the effect of internal and at may affect people with  or building positive sons with disabilities; cultural, environmental and that may affect people with  the importance of and n's involvement in making life; essing individual risk for  tion strategies for defusing tentially dangerous behavior; havioral supports (providing n disabilities to choose ly oppose or replace unsafe).				

Division of Health Service Regulation

(B)

when and where they attended; and

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Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL041-187	B. WING		01/24/2020	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE ZIP CODE	, , , , , , , , , , , , , , , , , , , ,	
TO THE OT 1	NOVIDEN ON OUR PEIER		BESSEMER A			
THE RING	ER CENTER		BORO, NC 2740			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 536	Continued From page		V 536			
	review/request this do (i) Instructor Qualificat Requirements: (1) Trainers sha by scoring 100% on to aimed at preventing, need for restrictive inf (2) Trainers sha by scoring a passing instructor training pro (3) The training competency-based, in objectives, measurable observation of behavi measurable methods failing the course. (4) The content service provider plans approved by the Divis to Subparagraph (i)(5) (5) Acceptable shall include but are r (A) understandi (B) methods fo course; (C) methods fo performance; and (D) documentat (6) Trainers sha teaching a training pr reducing and eliminat interventions at least review by the coach. (7) Trainers sha aimed at preventing,	n of MH/DD/SAS may occumentation at any time. ations and Training all demonstrate competence esting in a training program reducing and eliminating the terventions. all demonstrate competence grade on testing in an gram. It is shall be include measurable learning le testing (written and by sior) on those objectives and it to determine passing or it of the instructor training the is to employ shall be sion of MH/DD/SAS pursuant				

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Division of Health Service Regulation

Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		TE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COI	MPLETED
		MHL041-187	B. WING		(	1/24/2020
NAME OF D	ROVIDER OR SUPPLIER	CTDEET AL	DDRESS, CITY, STA	TE ZID CODE		
NAIVIE OF F	ROVIDER OR SUFFLIER					
THE RING	THE RINGER CENTER		T BESSEMER A\ BORO, NC 2740			
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(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 THE APPROPRIATE	(X5) COMPLETE DATE
V 536	Continued From page	<b>3</b>	V 536			
	instructor training at let (j) Service providers documentation of inition training for at least the (1) Docume (A) who particip outcomes (pass/fail); (B) when and verification (C) instructor's (2) The Division request and review the (k) Qualifications of (1) Coaches should require the course which is be (3) Coaches should remain the trainer instruction (I) Documentation should be a service facility failed to ensure least annually, in the restrictive intervention Director, Counselor a findings are:	shall maintain ial and refresher instructor ree years. entation shall include: eated in the training and the where attended; and name. In of MH/DD/SAS may his documentation any time. Coaches: hall meet all preparation liner. In hall teach at least three times eing coached. In hall demonstrate eletion of coaching or luction. In hall be the same preparation was evidenced by: ews and interviews, the estaff completed training at use of alternatives to the for 3 of 3 staff (Clinical and Nurse Practitioner). The				

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- Hire Date: 1996

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Division of Health Service Regulation

Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
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		MHL041-187	B. WING		01/2	4/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		213 FAST	BESSEMER AV	/ENLIE		
THE RING	ER CENTER		ORO, NC 2740			
		GREENSE	TORO, NC 2740			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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			+			
V 536	Continued From page	e 4	V 536			
	- Position: Clinical Di	rector				
		nentation of alternatives to				
	restrictive intervention					
		ation that documented				
	competence in the fol					
		erstanding of the people				
	being served;	5.5.ag 5. a.o p55p.5				
	•	erpreting human behavior;				
		ct of internal and external				
	0 0	fect people with disabilities;				
	_	ng positive relationships with				
	persons with disabiliti					
	- recognizing cultural,					
		that may affect people with				
	disabilities;					
	- recognizing the impo	ortance of and assisting in				
	the person's involvem	nent in making decisions				
	about their life;					
	- skills in assessing in	ndividual risk for escalating				
	behavior;					
		tegies for defusing and				
	de-escalating potentia	ally dangerous behavior; and				
		supports (providing means				
	for people with disabi	lities to choose activities				
	, , , ,	or replace behaviors which				
	are unsafe).					
		the Counselor's record				
	revealed:					
	- Hire Date: 1/2/20					
		nentation of alternatives to				
	restrictive intervention	_				
		ation that documented				
	competence in the fol	_				
	-	erstanding of the people				
	being served;	empoting human babasian				
		erpreting human behavior;				
		ct of internal and external				
		fect people with disabilities;				
	<ul> <li>strategies for building</li> </ul>	ig positive relationships with				

Division of Health Service Regulation

STATE FORM 6899 T00W11 If continuation sheet 5 of 12

Division of Health Service Regulation					
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED
		MHL041-187	B. WING		01/24/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STATE	E, ZIP CODE	
THE RING	GER CENTER		BESSEMER AVE BORO, NC 27401		
(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 APPROPF DEFICIENCY)	BE COMPLETE
V 536	persons with disabiliti - recognizing cultural, organizational factors disabilities; - recognizing the imported the person's involvem about their life; - skills in assessing in behavior; - communication strated e-escalating potential compositive behavioral for people with disability.	ies;	V 536		
	Review on 1/23/20 of the Nurse Practitioner's record revealed:  - Hire Date: 5/20/19  - There was no documentation of alternatives to restrictive interventions training.  - There was no attestation that documented competence in the following core areas:  - knowledge and understanding of the people being served;  - recognizing and interpreting human behavior;  - recognizing the effect of internal and external stressors that may affect people with disabilities;  - strategies for building positive relationships with persons with disabilities;  - recognizing cultural, and organizational factors that may affect people with disabilities;  - recognizing the importance of and assisting in the person's involvement in making decisions about their life;				

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behavior;

- communication strategies for defusing and

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY IPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE		
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THE RING	GER CENTER	GREENS	BORO, NC 27401			
(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 TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 536	Continued From page	÷ 6	V 536			
	- positive behavioral s for people with disabi which directly oppose are unsafe).	ally dangerous behavior; and supports (providing means lities to choose activities or replace behaviors which with the Licensee/Clinical				
	Director revealed:  - The staff (licensed a training in alternatives)  - The staff who were not have an attestation competence in the following served;  - recognizing and interpretations.	and unlicensed) did not have s to restrictive interventions. Licensed Professionals did on that documented				
	stressors that may aff - strategies for buildin persons with disabiliti - recognizing cultural,	fect people with disabilities; g positive relationships with es;				
	- recognizing the imported the person's involvement about their life; - skills in assessing in behavior; - communication strated e-escalating potential positive behavioral services for people with disability.	prtance of and assisting in ment in making decisions advisional risk for escalating stegies for defusing and ally dangerous behavior; and supports (providing means lities to choose activities a or replace behaviors which				
V 537	ITO	nts - Training in Sec Rest &	V 537			
	10A NCAC 27E .0108	B TRAINING IN				

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Division of Health Service Regulation

DIVISION	n nealth Service Negu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
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MHL041-187		B. WING	<del></del>	01/2	4/2020	
NAME OF D	ROVIDER OR SUPPLIER	STREET AS	DRESS, CITY, STA	TE ZID CODE		
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THE RING	ER CENTER		BESSEMER A			
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(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
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				DEFICIENCY)		
V 537	Continued From page	. 7	V 537			
V 331	Continued From page	÷ /	V 337			
	SECLUSION, PHYSI	CAL RESTRAINT AND				
	ISOLATION TIME-OU					
	(a) Seclusion physic	al restraint and isolation				
		loyed only by staff who have				
	been trained and hav					
		oper use of and alternatives				
		Facilities shall ensure that				
		ploy and terminate these				
	· ·	ned and have demonstrated				
	competence at least a	annually.				
	(b) Prior to providing	direct care to people with				
	disabilities whose trea	atment/habilitation plan				
		terventions, staff including				
	service providers, em					
	-	plete training in the use of				
		straint and isolation time-out				
		se interventions until the				
	training is completed	and competence is				
	demonstrated.					
		r taking this training is				
		etence by completion of				
	training in preventing,	, reducing and eliminating				
	the need for restrictive	e interventions.				
	(d) The training shall	be competency-based,				
	include measurable le	earning objectives,				
		vritten and by observation of				
	• •	ejectives and measurable				
		e passing or failing the				
	course.	padding of family the				
		training must be completed				
	•	der periodically (minimum				
	annually).					
	(f) Content of the trai					
		ploy must be approved by				
	the Division of MH/DI	-				
	Paragraph (g) of this	Rule.				
	(g) Acceptable trainir	ng programs shall include,				
	but are not limited to,					
		formation on alternatives to				

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Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
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NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
	213 EAS			/FNIIF		
THE RING	ER CENTER		BORO, NC 2740			
			DONO, NO 2740			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(* 15)	
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iAO		,	170	DEFICIENCY)		
V 537	Continued From page	∈ 8	V 537			
	the use of restrictive i	inton (antions:				
	the use of restrictive i					
	` '	on when to intervene				
	, -	nent danger to self and				
	others);					
		n safety and respect for the				
		all persons involved (using				
	•	trictive interventions and				
	incremental steps in a	•				
	(4) strategies for	or the safe implementation				
	of restrictive intervent					
	(5) the use of e	emergency safety				
	interventions which in	nclude continuous				
	assessment and mon	nitoring of the physical and				
	psychological well-be	ing of the client and the safe				
	use of restraint through	ghout the duration of the				
	restrictive intervention	n;				
	(6) prohibited p	procedures;				
		trategies, including their				
	importance and purpo					
	(8) documentat	tion methods/procedures.				
	(h) Service providers	shall maintain				
	. ,	ial and refresher training for				
	at least three years.	Ç				
	•	tion shall include:				
		pated in the training and the				
	outcomes (pass/fail);	<b>5</b>				
	**	vhere they attended; and				
	(C) instructor's					
		n of MH/DD/SAS may				
		ocumentation at any time.				
	(i) Instructor Qualification					
	Requirements:	auon and maining				
	•	all demonstrate competence				
		esting in a training program				
		reducing and eliminating the				
	need for restrictive in					
		all demonstrate competence				
	by scoring 100% on t	esting in a training program				

Division of Health Service Regulation

teaching the use of seclusion, physical restraint

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Division of Health Service Regulation

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COM	PLETED
D. WING	
MHL041-187 B. WING 0	/24/2020
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
THE RINGER CENTER 213 EAST BESSEMER AVENUE	
GREENSBORO, NC 27401	
(X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 537 Continued From page 9 V 537	
and isolation time-out.	
(3) Trainers shall demonstrate competence	
by scoring a passing grade on testing in an	
instructor training program.	
(4) The training shall be	
competency-based, include measurable learning	
objectives, measurable testing (written and by	
observation of behavior) on those objectives and	
measurable methods to determine passing or	
failing the course.	
(5) The content of the instructor training the	
service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant	
to Subparagraph (j)(6) of this Rule.	
(6) Acceptable instructor training programs	
shall include, but not be limited to, presentation	
of:	
(A) understanding the adult learner;	
(B) methods for teaching content of the	
course;	
(C) evaluation of trainee performance; and	
(D) documentation procedures.	
(7) Trainers shall be retrained at least	
annually and demonstrate competence in the use	
of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this	
Rule.	
(8) Trainers shall be currently trained in	
CPR.	
(9) Trainers shall have coached experience	
in teaching the use of restrictive interventions at	
least two times with a positive review by the	
coach.	
(10) Trainers shall teach a program on the	
use of restrictive interventions at least once	
annually.	
(11) Trainers shall complete a refresher	
instructor training at least every two years.  (k) Service providers shall maintain	

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL041-187	B. WING		01/2	4/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	-		
THE RING	ER CENTER	213 EAS	T BESSEMER A	/ENUE			
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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 537	V 537 Continued From page 10		V 537				
	training for at least the (1) Documenta (A) who particip outcome (pass/fail); (B) when and w (C) instructor's (2) The Division review/request this do (I) Qualifications of C (1) Coaches sh requirements as a tra (2) Coaches sh times, the course whi	tion shall include: ated in the training and the where they attended; and name. n of MH/DD/SAS may ocumentation at any time. oaches: all meet all preparation iner. all teach at least three ch is being coached. all demonstrate letion of coaching or ction. hall be the same					
	This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure staff completed training in restrictive interventions for 3 of 3 staff (Clinical Director, Counselor and Nurse Practitioner). The findings are:  Review on 1/23/20 of the Licensee/Clinical Director's record revealed: - Hire Date: 1996 - Position: Clinical Director - There was no documentation of restrictive interventions training.  Review on 1/23/20 of the Counselor's record revealed:						

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- Hire Date: 1/2/20

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		SURVEY LETED	
		MHL041-187	B. WING		01/	24/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
THE RING	SER CENTER		T BESSEMER AV BORO, NC 2740			
(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 ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 537	- There was no docur interventions training.  Review on 1/23/20 of record revealed: - Hire Date: 5/20/19 - There was no docur interventions training.  Interview on 1/24/20 of Director revealed: - The program did not	the Nurse Practitioner's  mentation of restrictive  mentation of restrictive  with the Licensee/Clinical t allow the use of restraints.  the Program's Restraint  tten policy to address	V 537			

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