| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|--|---|--|--|
| mhl046-015 | | D 14/11/0 | | | | |
| mhl046-015 | | B. WING | B. WING | | 01/30/2020 | |
| ROVIDER OR SUPPLIER | STREE | TADDRESS, CITY, | STATE, ZIP CODE | | | |
| ALTH SEDVICES D | CANOKE CHOW, 144-C | COMMUNITY C | OLLEGE ROAD | | | |
| ALI II SERVICES - R | AHOS | KIE, NC 27910 | | | | |
| (EACH DEFICIENCY | / MUST BE PRECEDED BY FULL | ID PREFIX TAG | (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE | |
| INITIAL COMMENT | гs | V 000 | | | | |
| | | | | | | |
| category: 10A NCA | C 27G.5000 Facility Based | | | | | |
| 27G .0604 Incident | Reporting Requirements | V 367 | | | | |
| 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. | | III sail, | | | | |
| | ROVIDER OR SUPPLIER ALTH SERVICES - R SUMMARY STA (EACH DEFICIENCY REGULATORY OR L INITIAL COMMENT An annual and follo on 1/30/20. A defici This facility is licens category: 10A NCA Crisis Service for In Groups. 27G .0604 Incident 10A NCAC 27G .06 REPORTING REQ CATEGORY A AND (a) Category A and level II incidents, ex the provision of billa consumer is on the incidents and level to whom the provid 90 days prior to the responsible for the services are provid becoming aware of be submitted on a f Secretary. The rep in person, facsimile means. The report information: (1) reporting identification inform (2) client iden (3) type of inc (4) description (5) status of incure of cause of the inciden (6) other indir or responding. (b) Category A and (c) Category A and (d) Category A and (d) Category A and (e) Category A and (f) Category A an | MhI046-015 ROVIDER OR SUPPLIER ALTH SERVICES - ROANOKE CHOW SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS An annual and follow up survey was completed on 1/30/20. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G.5000 Facility Based Crisis Service for Individuals of All Disability Groups. 27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur durit the provision of billable services or while the consumer is on the providers premises or level incidents and level II deaths involving the client to whom the provider rendered any service with 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report she submitted on a form provided by the Secretary. The report may be submitted via main person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain and the provider of the pro | MINITIAL COMMENTS An annual and follow up survey was completed on 1/30/20. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G.5000 Facility Based Crisis Service for Individuals of All Disability Groups. 27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY AAND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the provider premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and other individuals or authorities notified | ROVIDER OR SUPPLIER ALTH SERVICES - ROANOKE CHOW: SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) An annual and follow up survey was completed on 1/30/20. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G.5000 Facility Based Crisis Service for Individuals of All Disability Groups. 27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents, except deaths, that occur during the provision of billable services or while the consumer is on the provider spremises or level III incidents and level II deaths involving the clients to whom the provider mere and where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident, and (6) other individuals or authorities notified or responding. (6) Category A and B providers shall explain any | TOWNITION NUMBER: MINIO MINIO MINIO MINIO | |

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) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|---|---------------------|--|--------------------------------|--------------------------|
| | | mhl046-015 | | B. WING | | 01/: | 30/2020 |
| NAME OF I | PROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| PORT H | EALTH SERVICES - R | OANOKE CHOW! | | | OLLEGE ROAD | | |
| | | | | , NC 27910 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE IE APPROPRIATE | (X5) COMPLETE DATE |
| | report recipients by day whenever: | ated report to all req the end of the next b ler has reason to beli | ousiness | V 367 | | | |
| | information provide erroneous, mislead (2) the provid required on the inci unavailable. | d in the report may b ing or otherwise unre ler obtains informatio dent form that was p | e eliable; or n reviously | | | | |
| | (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and | | | | | | |
| | | | | | | | |
| | Substance Abuse S becoming aware of providers shall send | Services within 72 how the incident. Catego d a copy of all level II a client death to the I | urs of ory A I | | | | |
| | Health Service Reg becoming aware of client death within s or restraint, the pro immediately, as red | ulation within 72 hou the incident. In case seven days of use of vider shall report the juired by 10A NCAC | rs of es of seclusion death 26C | | | | |
| | (e) Category A and report quarterly to the catchment area wh | AC 27E .0104(e)(18). B providers shall se he LME responsible ere services are prov submitted on a form | nd a for the vided. | | | | |
| | by the Secretary via include summary in (1) medicatio definition of a level (2) restrictive | a electronic means an formation as follows n errors that do not r II or level III incident; interventions that do evel II or level III incid | nd shall eneet the | | | | |

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | D | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--|--|---|--|--|-----------------------------------|--------------------------|
| | | mhl046-015 | B. WING | | 01/3 | 30/2020 |
| | PROVIDER OR SUPPLIER EALTH SERVICES - R | OANOKE CHOW! | REET ADDRESS, CITY, 4-C COMMUNITY (HOSKIE, NC 27910 | COLLEGE ROAD | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULI SC IDENTIFYING INFORMATION | | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| V 367 | (4) seizures of the possession of a (5) the total r incidents that occur (6) a statement been no reportable incidents have occur meet any of the crit | of a client or his living and client property or property of level II and levered; and ent indicating that there hincidents whenever not arred during the quarter the eria as set forth in Paragule and Subparagraphs | erty in rel III nave that graphs | | | |
| | failed to ensure Lev to the Incident Res System (IRIS) or th (LME) within 72 hor | view and interview the factorial II incidents were repositionse and Improvement e Local Management Erurs of becoming aware coudited former clients (FC) | orted t t ortity of the | | | |
| | revealed: -Admitted on 12/04 -Diagnosis of Subs Review on 1/29/20 revealed: -Incident report con -FC#1 reported tho -"Personal items re be used to harm se -FC#1 reported his: -Emergency Medica -FC #1 taken to Ho | tance Abuse Disorder. of the facility incident repulated by staff 12/04/19 ughts of self harm by ha moved from room that coulf. " tory of self harm to staff al Services (EMS) were | nging. ould | | | |

Division of Health Service Regulation

STATE FORM 6899 IJV211 If continuation sheet 3 of 4

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|---------------------|--|--------------------------------|--------------------------|--|
| | | mhl046-015 | B. WING | | 01/3 | 30/2020 | |
| | NAME OF PROVIDER OR SUPPLIER PORT HEALTH SERVICES - ROANOKE CHOW/ AHOSKIE, NC 27910 STREET ADDRESS, CITY, STATE, ZIP CODE 144-C COMMUNITY COLLEGE ROAD AHOSKIE, NC 27910 | | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 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 367 | revealed: -Admitted on 11/15/ -Diagnosis of Substance Review on 1/29/20 preparation policy reporting pain is concepted: -Incident report consumption of the provided increased respirationsEMS was called an incidents considered increased respirationsClient returned backets of the procedures in placeEMS was called an incident returned backets and increasedFamily Nurse Prackets in EMS is called an incident returned backetsFamily Nurse Prackets in EMS is called an incident returned backetsFamily Nurse Prackets in EMS is called an incident returned backets. | tance Abuse Disorder. of the facility's prevention and evealed: ious/agitated in distress and nsidered a level II incident. of the facility incident reports inpleted by staff 11/15/19. of chest pain and exhibited ons. In a client was taken to hospital. with the Program Supervisor any Level II incident reports to ed Level 1 since no one was eat was not followed through." See to prevent self harm. In a client was taken to the ock to the program after being the state of the control of the decision on the control of the decision on the state of the decision of the state of th | V 367 | | | | |

Division of Health Service Regulation STATE FORM