IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	IDENTIFICATION NOMBER.		A. BUILDING:		
	MHL033-111	B. WING		01/	30/2020
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
E GENERATION IN C	HRISI		STREET, SUITE 15		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE	(X5) COMPLET DATE
INITIAL COMMEN	TS	V 000			
on 1/30/20. The co	mplaint was unsubstantiated				
This facility is licensed for the following service categories: 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program & 10A NCAC 27G .4500 Substance Abuse Comprehensive Outpatient Treatment Program					
27G .0201 (A) (1-7	) Governing Body Policies	V 105			
POLICIES (a) The governing & facility or service sh written policies for t (1) delegation of m operation of the fac (2) criteria for admi (3) criteria for disch (4) admission asse (A) who will perform (B) time frames for (5) client record ma (A) persons authori (B) transporting rec (C) safeguard of re defacement or use (D) assurance of re authorized users at (E) assurance of co (6) screenings, whi (A) an assessment problem or need; (B) an assessment	body responsible for each hall develop and implement the following: anagement authority for the cility and services; ission; harge; essments, including: n the assessment; and c completing assessment. anagement, including: ized to document; cords; cords against loss, tampering by unauthorized persons; ecord accessibility to t all times; and confidentiality of records. icch shall include: c of whether or not the facility	,			
	PROVIDER OR SUPPLIER E GENERATION IN C SUMMARY ST/ (EACH DEFICIENCI REGULATORY OR L INITIAL COMMENT An annual and com on 1/30/20. The co Intake #NC001597 This facility is licen categories: 10A NC Abuse Intensive Ou NCAC 27G .4500 S Comprehensive Ou 27G .0201 (A) (1-7 10A NCAC 27G .02 POLICIES (a) The governing I facility or service sl written policies for (1) delegation of m operation of the fac (2) criteria for disch (4) admission asse (A) who will perforr (B) time frames for (5) client record ma (A) persons author (B) transporting rec (C) safeguard of re defacement or use (D) assurance of ca (A) an assessment problem or need; (B) an assessment problem or need; (B) an assessment provide service	OF CORRECTION         IDENTIFICATION NUMBER:           MHL033-111         MHL033-111           PROVIDER OR SUPPLIER         STREET A           E GENERATION IN CHRIST         2109 SA           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         INITIAL COMMENTS           An annual and complaint survey was completed on 1/30/20. The complaint was unsubstantiated Intake #NC00159707. Deficiencies were cited.         This facility is licensed for the following service categories: 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program & 10A NCAC 27G .4500 Substance Abuse Comprehensive Outpatient Treatment Program           27G .0201 (A) (1-7) Governing Body Policies         10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for admission; (3) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of whether or not the facility can provide services to address the individual's	TO OF DEFICIENCIES OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE A. BUILDING: DENTIFICATION NUMBER:         MHL033-111       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, ST 2109 SAINT ANDREW ST TARBORO, NC 27886         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         INITIAL COMMENTS       V 000         An annual and complaint survey was completed on 1/30/20. The complaint was unsubstantiated Intake #NC00159707. Deficiencies were cited.       V 000         An annual and complaint survey was completed on 1/30/20. The complaint was unsubstantiated Intake #NC00159707. Deficiencies were cited.       V 000         An annual and complaint survey was completed on 1/30/20. The complaint was unsubstantiated Intake #NC00159707. Deficiencies were cited.       V 105         INKCAC 27G .4500 Substance Abuse Comprehensive Outpatient Program & 10A NCAC 27G .0201 GOVERNING BODY POLICIES       V 105         10A NCAC 27G .0201 GOVERNING BODY POLICIES       V 105         (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment, and (B) time frames for completing assessment, (5) client record management, including: (A) who will perform the assessment; and (B) transporting records; (C) safeguard of records	TO F DEFICIENCIES       (X1) PROVIDER/SUPPLIENCIAL       (X2) MULTIPLE CONSTRUCTION         OF CORRECTION       MHL033-111       B. WING	TO FO ENCRECIES       (X1) PROVIDERSUPPLIERCLAD       A BUILDING:       (X2) MULTIPLE CONSTRUCTION       (X3) DATA         OPCORRECTION       MHL033-111       B. WING       01/         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       01/         EGENERATION IN CHRIST       2109 SAINT ANDREW STREET, SUITE 15 TARBORO, NC 27885       PROVIDER'S PLAN OF CORRECTION (EACH OPERCIENCY WAS TEP RECEDED BY FULL REQUATORY OR LSC DENTIFYING INFORMATION)       PREEK TAG       PROVIDER'S PLAN OF CORRECTION (EACH OPERCIENCY WAS TEP RECEDED BY FULL REQUATORY OR LSC DENTIFYING INFORMATION)       PREEK TAG       PROVIDER'S PLAN OF CORRECTION (EACH OPERCIENCY WAS TEP RECEDED BY FULL REQUATORY OR LSC DENTIFYING INFORMATION)       PREEK TAG       PROVIDER'S PLAN OF CORRECTION (EACH OPERCIENCY WAS TEP RECEDED BY FULL REQUATORY OR LSC DENTIFYING INFORMATION)       PREEK TAG       PROVIDER'S PLAN OF CORRECTION (EACH OPERCIENCY WAS COMPLEX         INITIAL COMMENTS       V 000       An annual and complaint was unsubstantiated Intake #NC00159707. Deficiencies were cited.       PROVIDER'S PLAN OF CORRECTION (EACH OPERCIENCY AND THE ADDRESS)       PROVIDER'S PLAN OF CORRECTION (EACH OPERCIENCY AND THE ADDRESS OF CORRECTION (EACH OPERCIENCY ADDRESS ADDRESS)         27G. 0201 (A) (1-7) GOVERNING BODY POLICIES       V 105       IDA NCAC 27G. 4201 GOVERNING BODY POLICIES for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for discharge; (4) admission assessment, including: (A) mo will perform the assessment; and (B) transporting records; (5) clent record management, including; (

STATEMEN	of Health Service Re T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		MHL033-111	B. WING		01/30/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
POSITIVI	E GENERATION IN C	HRISI	NT ANDREW 3 O, NC 27886	STREET, SUITE 15		
(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 ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 105	activities, including: (A) composition and assurance and qua (B) written quality a improvement plan; (C) methods for more quality and appropri- including delineatio utilization of service (D) professional or a requirement that professionals and p shall be supervised that area of service (E) strategies for im (F) review of staff of determination made treatment/habilitatio (G) review of all fat were being served residential program (H) adoption of star and programmatic applicable standard purpose, "applicabl means a level of cor reference to the pro- methods, and the d	ce and quality improvement d activities of a quality lity improvement committee; assurance and quality ponitoring and evaluating the riateness of client care, on of client outcomes and es; clinical supervision, including staff who are not qualified provide direct client services d by a qualified professional in e; nproving client care; qualifications and a e to grant	V 105			
ision of He	This Rule is not me ealth Service Regulation	et as evidenced by:				

STATEMEN	of Health Service Re TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		BENTI IOATION NOMBER.	A. BUILDING:		01/30/2020	
	MHL033-111					
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
POSITIV	E GENERATION IN C	HRIST	INT ANDREW S O, NC 27886	STREET, SUITE 15		
(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	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
V 105	Continued From pa	age 2	V 105			
		the facility failed to develop & ntive policy. The findings are:				
	<ul> <li>has attended the alcohol use</li> <li>\$25.00 gift card attendance</li> <li>if a person attendance</li> <li>if a person attendance</li> <li>purchased food</li> <li>sometimes will with the gift card</li> <li>During interview on</li> <li>received \$25.0</li> <li>purchased item</li> <li>During interview on</li> <li>gift card was gift card was gif</li></ul>	d with the gift card purchase alcohol & cigarettes 1/30/20 client #2 reported: 0 gift card for attendance ns for the grandchildren 1/30/20 client #3 reported: iven for attendance				
	- rarely purchase	rogram due to alcohol use ed alcohol with the gift card n 1/30/20 staff #1 reported:				
	<ul> <li>clients are not</li> <li>tobacco with the gift</li> <li>she was not av</li> </ul>	given for attendance allowed to purchase alcohol or ft card vare of any clients who lcohol or tobacco with gift card				
	reported:	1/30/20 the Licensee				
	admission about th - \$25.00 gift card participation, attend - if staff found ou	Iked with the clients upon e incentive program d was given weekly for dance to program ut alcohol was purchased with				
vision of L	the gift card, the cli gift cards ealth Service Regulation	ent would no longer receive				

Division of Health Service Regulation STATE FORM

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If continuation sheet 3 of 7

	of Health Service Re	egulation				
		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	MHL033-111		B. WING	B. WING		30/2020
AME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
οοειτιν	E GENERATION IN CH	2109 SAI	NT ANDREW S	STREET, SUITE 15		
00111	E GENERATION IN CI	TARBOR	O, NC 27886			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / 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) COMPLETI DATE
V 105	Continued From pa	ge 3	V 105			
		ent a policy that explained the entive program & what could /ith the gift cards				
V 267	27G .4402 Sub. Ab	use Intensive Outpt- Staff	V 267			
	Licensed Clinical Ac Certified Clinical Su minimum of 50% of operation. (b) When a SAIOP shall be at least one the requirements of set forth in 10A NC/ 12 or fewer adult cli (c) When a SAIOP there shall be at lea meets the requirem Professional as set (18) for every 6 or f (d) Each SAIOP sh care staff present in the following areas: (1) alcohol an symptoms; and (2) symptoms due to alcoholism a (e) Each direct care education that inclu (1) understan addiction; (2) the withdr (3) group the (4) family the (5) relapse pn (6) other trea	hall be under the direction of a ddictions Specialist or a upervisor who is on site a f the hours the program is in P serves adult clients there e direct care staff who meets f a Qualified Professional as AC 27G .0104 (18) for every ients. If serves adolescent clients ast one direct care staff who hents of a Qualified forth in 10A NCAC 27G .0104 (18) for every adolescent clients. If a qualified forth in 10A NCAC 27G .0104 (18) for every ients. If a qualified forth in 10A NCAC 27G .0104 (18) for every adolescent clients. If a qualified forth in 10A NCAC 27G .0104 (18) for every adolescent clients. If a qualified forth in 10A NCAC 27G .0104 (18) for every adolescent clients. If a qualified forth in the program who is trained in the program who is t	n -			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
		MHL033-111		B. WING		01/30/2020	
AME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, ST	DDRESS, CITY, STATE, ZIP CODE			
OSITIV	E GENERATION IN C	109 S		STREET, SUITE 15			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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	(X5) COMPLE DATE	
V 267	Continued From pa	ige 4	V 267				
	includes the followi (1) adolescer	aff shall receive training that ng: nt development; and ic techniques for adolescents	5.				
	interview the facility Professional (QP) f clients. The finding	ion, record review and / failed to have a Qualified for every 12 or fewer adult s are: /17/20 revealed no sign in ar	nd				
	Observation on 1/1 following: - surveyor obser - there were 14 of - clients walked bathroom & outside - surveyor was u clients attended (44	7/20 at 11:22am revealed the ved one staff in the classroor clients up & down the hall from the e nsure which program those					
		1/30/20 staff #1 reported: show on 1/17/20					
	reported: - there were sev program	1/30/20 the Licensee eral QP's that worked at the e why there was only 1 QP in					

STATE FORM

TATEMEN	of Health Service Re T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		MHL033-111	B. WING		0.4/00/0000	
					01/	30/2020
	PROVIDER OR SUPPLIER	2109 SA	DDRESS, CITY, ST INT ANDREW \$	STREET, SUITE 15		
OSITIVI	E GENERATION IN C	HRISI	RO, NC 27886			
(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'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 267	Continued From pa	age 5	V 267			
	the classroom with - a sign in/out sh implemented	14 clients leet for the clients were				
V 281	27G .4502 Sub. Ab	use Comp. Outpt. Tx Staff	V 281			
	Licensed Clinical A Certified Clinical Su minimum of 90% of operation. (b) For each SACC direct care staff wh Qualified Professio 27G .0104 (18) for (c) Each SACOT si care staff present in the following areas (1) alcohol an symptoms; and (2) symptoms; due to alcoholism at (d) Each direct care education that incluin (1) understare addiction; (2) the withdin (3) group the (4) family the (5) relapse p	hall be under the direction of a ddictions Specialist or a upervisor who is on site a f the hours the program is in OT there shall be at least one o meets the requirements of a nal as set forth in 10A NCAC every 10 or fewer clients. shall have at least one direct in the program who is trained in the program who is trained in the dother drug withdrawal s of secondary complications and drug addiction. The staff shall receive continuing udes the following: anding of the nature of trawal syndrome; trapy;	1			
	This Rule is not me ealth Service Regulation	et as evidenced by:				

Division of Health Service Regulation						
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL033-111	B. WING		01/3	0/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
POSITIV	E GENERATION IN CI		IT ANDREW D, NC 27886	STREET, SUITE 15		
(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 SHOUL) CROSS-REFERENCED TO THE APPROINDEFICIENCY)	D BE	(X5) COMPLETE DATE
V 281	Continued From pa	ge 6	V 281			
	Based on observation interview the facility Professional (QP) f clients. The findings Record review on 1 out sheet for the cli Observation on 1/1 following: - surveyor observertion - there were 14 c - clients walked of bathroom & outside - surveyor unsurvertion attended (4400/450 - both programs	on, record review and r failed to have a Qualified or every 10 or fewer adult s are: /17/20 revealed no sign in and ents 7/20 at 11:28am revealed the ved one staff in the classroom clients in the classroom down the hall, from the e which program those clients 00/) are in the same building				
Division of H	reported: - there were seve program - she was unsure the classroom	1/30/20 the Licensee eral QP's that worked at the e why there was only 1 QP in eet for the clients were				