

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-204	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/07/2020
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NAME OF PROVIDER OR SUPPLIER SOUTHEASTERN BEHAVIORAL HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3575 LACKEY STREET LUMBERTON, NC 28359
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 000	<p>INITIAL COMMENTS</p> <p>During survey at sister facility, it was revealed an emergency relocation occurred two years ago at this location with no notification to Division of Health Service Regulation. A deficiency was cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G .1100 Partial Hospitalization For Individuals Who Are Acutely Mentally Ill, 10A NCAC 27G .1200 Psychosocial Rehabilitation Facilities for Individuals With Severe and Persistent Mental Illness, and 10A NCAC 27G .1400 Day Treatment for Children and Adolescents with Emotional or Behavioral Disturbances.</p>	V 000		
V 114	<p>27G .0207 Emergency Plans and Supplies</p> <p>10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES</p> <p>(a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority.</p> <p>(b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.</p> <p>(c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies.</p> <p>(d) Each facility shall have basic first aid supplies accessible for use.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interview, the</p>	V 114	<p>Southeastern Behavioral Healthcare Services, LLC will review current emergency/disaster plan to ensure that all criteria required by the NCDHHS are noted and implemented as follows:</p> <p>(a) written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority.</p> <p>(b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.</p> <p>(c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies.</p> <p>(d) Each facility shall have basic first aid supplies accessible for use.</p> <p>Southeastern Behavioral Healthcare Services, LLC shall adhere to all policies on reporting provider change(s) of the facility due to an emergency/disaster.</p>	03/25/2020

Division of Health Service Regulation

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

TITLE

(X6) DATE

Kelli Mullen VP of Operations 02/18/2020

STATE FORM

6899

ZTD011

If continuation sheet 1 of 2

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER SOUTHEASTERN BEHAVIORAL HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3575 LACKEY STREET LUMBERTON, NC 28359		
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V 114	Continued From page 1 facility failed to implement a written disaster plan as required. The findings are: Review on 2/7/2020 of the facility client list revealed 16 clients had attended a Sister Facility Psychosocial Rehabilitation (PSR) program, located in a neighboring town, during the prior year. Interview on 2/7/2020 the Vice President of Administration stated: -There was an emergency relocation of the clients to the Sister Facility PSR due to facility damages caused by the hurricane in the fall of 2018. -The clients were not admitted to the Sister Facility PSR. -The clients were integrated with the Sister Facility PSR clients for services during this relocation. -The clients had returned to the facility the prior week. -The facility had notified the Managed Care Organization when the emergency relocation was done. -He was not aware of the requirements to notify the Division of Health Service Regulation of any emergency relocation.	V 114	Southeastern Behavioral Healthcare Services LLC will notify NCDHHS and MCO's of any provider/facility changes that occur due to an emergency/disaster within a 24 hr period. Kelli McLean VP of Operations, will review its emergency/disaster plan quarterly to ensure that we are current with implementing emergency/disaster plan. Kelli McLean, VP of Operations, will conduct emergency/disaster preparedness training annually or as needed to all agency staff.	



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

February 18, 2020

Kelli McLean
Southeastern Behavioral Healthcare Services, Inc.
P.O. Box 1004
Lumberton, NC 28359-1004

Re: Licensure Survey completed February 7, 2020
Southeastern Behavioral Healthcare Services, LLC, 3575 Lackey Street,
Lumberton, NC 28359
MHL # 078-204
E-mail Address: kmcleang@sebhs.net

Dear Ms. McLean:

Thank you for the cooperation and courtesy extended during the licensure survey completed February 7, 2020.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- The tag cited is a standard level deficiency.

Time Frames for Compliance

- Standard level deficiency must be **corrected** within 60 days from the exit of the survey, which is April 7, 2020.

What to include in the Plan of Correction

- Indicate what measures will be put in place to **correct** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to **prevent** the problem from occurring again.

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603
MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718
www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

- Indicate **who will monitor** the situation to ensure it will not occur again.
- Indicate **how often** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. **Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.**

Send the original completed form to our office at the following address within 10 days of receipt of this letter.


Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Gloria Locklear at 910-214-0350.

Sincerely,



Betty Godwin, RN, MSN
Nurse Consultant
Mental Health Licensure & Certification Section



Ryan Meredith, MSW
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: DHSRreports@eastpointe.net
_DHSR_Letters@sandhillscenter.org
Pam Pridgen, Administrative Assistant