STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
		A. BUILDING: _			
			D WING		С
		MHL041658	B. WING		04/07/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
MOVAIMED	E DI ACE	203 HAN	MOND DRIVE		
WYNMERE PLACE GREENSB			BORO, NC 2740	06	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PRÉFIX TAG	`	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	I
V 000	INITIAL COMMENTS		V 000		
	A complaint survey w The complaint was su #NC161913). Deficie				
	This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.				
	sister facilities will be B or C. Staff and/or c	entified in this report. The identified as sister facility A, lients will be identified using y and a numerical identifier.			
V 293	27G .1701 Residentia	al Tx. Child/Adol - Scope	V 293		
	children or adolescen free-standing residen intensive, active there interventions within a shall not be the prima who is not a client of (b) Staff secure mean awake during client shall be continuous a this Section. (c) The population seadolescents who have mental illness, emotion substance-related disco-occurring disorder disabilities. These chance the continuous are criteria for in (d) The children or are require the following:	treent staff secure facility for ts is one that is a stall facility that provides apeutic treatment and system of care approach. It in residence of an individual the facility. In staff are required to be seep hours and supervision is set forth in Rule .1704 of the erved shall be children or a primary diagnosis of oral disturbance or orders; and may also have including developmental wildren or adolescents shall inpatient psychiatric services.			
	(1) removal from	m home to a idential setting in order to			

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		MHL041658	B. WING		C 04/07/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
WYNMER	E DI ACE		OND DRIVE			
VV I IVIVILLIX	LILAGE	GREENSE	ORO, NC 2740	06		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
V 293	(e) Services shall be (1) include individed include individed include individed included incl	nd a staff secure setting. designed to: vidualized supervision and g; e occurrence of behaviors leficits; dty and deescalate out of uding frequent crisis without physical restraint; hild or adolescent in the e functioning in self-control, al and recreational skills; and child or adolescent in ded to step-down to a less etting. eatment staff secure facility	V 293			
	This Rule is not met Based on observatior interviews, the facility individualized supervi- living affecting 2 of 4 findings are:	n, record reviews and failed to provide sion and structure of daily				
Review on 4/2/2020 of client #1's record revealed: - Admission date: 3/2/2020;						

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DIVISION	n nealth Service Negu	ialion				
· , ,		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLET	TED
					С	
		MHL041658	B. WING	B. WING		12020
		WITILU41636			04/07	12020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		203 HAN	IMOND DRIVE			
WYNMER	E PLACE	GREENS	BORO, NC 274	06		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	I	COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
V 293	Continued From page	2	V 293			
	. •					
		t Disorder; Oppositional				
	Defiant Disorder; and					
	Hyperactivity Disorde	r (ADHD);				
	- Age: 16					
		ed 3/2/2020 that revealed a				
		nd aggressive behaviors				
		o his way, AWOL (absent				
		and alcohol use, property				
	damage, defies autho					
	extremely impulsive, assaultive verbally,					
	oppositional, defiance	e and anxiety.				
	Davison as 2/24/2022 of disast #01s as and					
	Review on 3/31/2020 of client #2's record					
	revealed:					
	- Admission date: 1/28/2019 - Diagnoses: ADHD; "Severe Stress"; and					
		Severe Stress; and				
	Adjustment Disorder;					
	- Age: 16	ad 1/20/2010 revealed a				
		ed 1/28/2019 revealed a				
	history of instigating of	ance, lying, blame-shifting,				
		ance, lying, blame-shilling, attempting to look under				
		. •				
	occupied bathroom st					
	animals, stealing, and					
	•	ring things on a regular				
	basis.					
	Review on 3/9/2020 o	of client #A-5's record				
	revealed:	or client #A-3 s record				
		7/2018 to the level II, sister				
	facility A;	7,2010 to the level ii, eleter				
		Spectrum Disorder; and				
	Intermittent Explosive					
	- Age: 17					
		ed 1/8/2019 that revealed a				
		communicate feelings and				
		skills, lacks appropriate				
		le peers, can be inflexible,				
		nerisms, over-talks his				
peers, inability to make and sustain friendships. "		1				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MI II TIDI E	CONSTRUCTION	(Y3) DATE S	IID\/EV
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		A. BUILDING: _				
						;
		MHL041658	B. WING		04/0	7/2020
NAME OF D	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZID CODE		
NAME OF PI	ROVIDER OR SUPPLIER		, ,	I E, ZIP CODE		
WYNMER	E PLACE		MOND DRIVE			
		GREENS	BORO, NC 2740	D6		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
TAG	REGOLATORI ORT	EGO IDENTIL PINO INI ORMATION)	TAG	DEFICIENCY)	WATE	
V 293	Continued From page	e 3	V 293			
	Risk/weaknesses· r	poor communication skills,				
		oing skills, impulsive, lacks				
	appropriate boundarie	-				
	appropriate boundant	5 5				
	Review on 4/2/2020 o	of client #C-6's record				
	revealed:					
		/2020 to the level II, sister				
	facility C;	, _ 0 _ 0				
	- Diagnoses: Adjustm	ent Disorder: Anxiety				
	Disorder; ADHD; and					
	Disorder;	Oppositional Bollant				
	- Age: 14					
	•	ed 2/3/2020 that revealed a				
		glect and domestic violence,				
		, dishonesty, talking back,				
	-	y, lying, temper tantrums,				
		e behaviors, depression,				
	• • •	elems, and use of marijuana				
	in a vape pen.	nems, and use of manjualia				
	iii a vape peii.					
	Observation at sister	facility A from approximately				
		on 3/5/2020 revealed:				
	- Client #1, client #2 a					
		sister facility A with only staff				
	#1 present to provide					
	·	•				
	 Staff #2 arrived at si approximately 12:07F 					
		cility A with clients #1 and #2				
		-				
	at approximately 12:0	oor ivi.				
	Interview on 3/31/202	20 with client #1 revealed:				
		to sister facilities at times in				
	order for facility staff t					
	medications, or to "ha					
		#1 had been at sister facility				
		ot enrolled in school yet;				
		ere taken to sister facility A at				
	approximately 8:30AN					
		y staff present with clients				
#1, #2 and #A-5 while at sister facility A.		1				

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DIVISION	n nealth Service Negu	lialion				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			-			
		MHL041658	B. WING		04/0	7/2020
			•			
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ATE, ZIP CODE		
		203 HAM	MOND DRIVE			
WYNMER	E PLACE	GREENS	BORO, NC 2740	06		
						I
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP		DATE
IAG		,	IAG	DEFICIENCY)		
V 293	Continued From page	e 4	V 293			
	Interview on 3/31/202	20 with client #2 revealed:				
	- Client #2 had stayed	d at sister facilities "a couple				
	1	Ve went over to [sister facility				
	A] usually"					
	_ =	#2 had been at sister facility				
		•				
		en suspended from school;				
		vere taken to sister facility A				
	at approximately 8:20AM that day;					
	- Staff #1 and #2 had been working at sister					
	facility A that morning;					
	- " Anytime a kid is	suspended, they make				
	them go sit at [sister t	facility A] or [sister facility B]				
	"	, , , , , , , , , , , , , , , , , , , ,				
	Interview on 4/1/2020) with client #A-5 revealed:				
		acilities were brought to				
	sister facility A occasi					
		acilities stayed at sister				
		an hour, maybe two"				
	- Client #A-5 thought	that clients from sister				
	facilities were brough	t to the facility when facility				
	_	ip items such as bread or if				
		ngs they needed to do;				
		sure why clients #1 and #2				
		A on 3/5/2020, or how long				
		A off 3/3/2020, of flow long				
	they had been there.					
) with client #C-6 revealed:				
	- On 3/5/2020, staff #	2 had taken him to a dentist				
	appointment.					
	Interview on 3/5/2020) with staff #1 revealed:				
		orking at the facility that				
		ents #1 and #2 to sister				
	_					
	_	ff #2 asked staff #1 to come				
		A-5 while staff #2 took client				
		ointment that morning;				
		given for why staffing was				
	not coordinated sepa	rately for the facility and				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND I EAR OF CONNECTION		A. BUILDING:		OOM! LETED		
				С		
	MHL041658		B. WING	04/07/2020		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE		
		203 HAMI	MOND DRIVE			
WYNMER	E PLACE		BORO, NC 27406	5		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	DN (X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	
V 293	Continued From page	5	V 293			
	sister facilities A and	C.				
	Further interview attempt with staff #1 on 3/31/2020 was unsuccessful due to no return call received from staff #1 prior to exit.					
	#2 revealed: - Staff #1's role was perfect dental and vision appropriated medications when the and general coordinate to each of the sister factorial coordinates are staff #1 occasionally worker to supervise coordinates and staff #1 occasionally worker to supervise coordinates and staff #1 occasionally worker to supervise coordinates are staff #1 occasionally worker to supervise coordinates with the staff #1 occasionally worker to supervise coordinates with the staff #1 occasionally worker to supervise coordinates with the staff #1 occasionally worker to supervise coordinates with the staff #1 occasionally worker to supervise coordinates with the staff #1 occasionally worker to supervise coordinates with the staff #1 occasionally worker to supervise coordinates with the staff #1 occasionally worker to supervise coordinates with the staff #1 occasionally worker to supervise coordinates with the staff #1 occasionally worker to supervise coordinates with the staff #1 occasionally worker to supervise coordinates with the staff #1 occasionally worker to supervise coordinates with the staff #1 occasionally worker to supervise coordinates with the staff #1 occasionally worker to supervise with the staff #1 occasionally worker with the	y filled in as a direct care lients when needed; 2 needed to take client #C-6 ent, so staff #1 stayed at the ients #1, #2, and #A-5;				
	- The Qualified Professional/Director (QP/D) was responsible for the staffing schedule. Interview on 4/7/2020 with the QP/D revealed:					
	so could not answer with clients from two countries. The QP/D made sur had staff scheduled a					
	therapy sessions; - There had been son may have contributed grouped together beto - There had not been	ne staffing shortages, which I to the reasons clients were ween the sister facilities; any behavioral issues when facilities were together.				
	intensive, active thera interventions for child	ren and adolescents whose nough to require removal				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL041658	B. WING			C 07/2020
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	ΓΕ, ZIP CODE	1 04/	0172020
WYNMER	E PLACE		MOND DRIVE BORO, NC 2740	6		
(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	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 293	staff-secure setting. T been designed to incl supervision and struc (#1 & #2) from the fac level 2 sister facility A supervise clients from	The services should have ude individualized ture. On 3/5/2020, 2 clients cility were dropped off at the with only 1 staff present to the two different facilities. The tres were made to provide and #2 at their own	V 293			

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