STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL046-038 02/04/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 415 EAST HOLLOMAN AVENUE REHOBOTH COUNSELING SERVICES AHOSKIE, NC 27910 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PRFFIX COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 000 INITIAL COMMENTS V 000 An annual survey was completed on February 4. 2020. Deficiencies were cited. This facility is licensed for the following service **DHSR** - Mental Health categories: 10A NCAC 27G .1400 Day Treatment for Children and Adolescents with Emotional or Behavioral Disturbances Lic. & Cert. Section 10A NCAC 27G .2200 Before/After School and Summer Developmental Day Services for Children with or at Risk for Developmental Delays, Developmental Disabilities, or Atypical Development 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program V 113 27G .0206 Client Records V 113 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date: (F) discharge date: (2) documentation of mental illness. developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone Division of Health Service Regulation

Division of Health Service Regulation

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

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING MHL046-038 02/04/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 415 EAST HOLLOMAN AVENUE REHOBOTH COUNSELING SERVICES AHOSKIE, NC 27910 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 113 Continued From page 1 V 113 number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain documentation of services provided and documentation of progress toward outcomes for 2 of 2 former clients (FC #1 and #2). The findings are: Review on 2/4/20 of records for FC #1 and FC #2 revealed: FC #1: - admission date: uncertain - diagnoses: Attention Deficit Hyperactivity Disorder (ADHD), combined type,

Division of Health Service Regulation

Reading Disorder (DO)

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Division	of Health Service Regu	ulation			. 0.4474111072
STATEMEN	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE SURVEY
Ensw.	OF CONTRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		14111 0 40 000	B. WING	£.	
		MHL046-038	B. WING		02/04/2020
NAME OF	PROVIDER OR SUPPLIER	STREET #	ADDRESS, CITY, STA	ATE, ZIP CODE	
REHOBO	OTH COUNSELING SERVI	CES	ST HOLLOMAN A	VENUE	
		AHOSKI	IE, NC 27910		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETE
V 113	Continued From page	2	V 113		
		t plan dated 10/9/19			4-4.20
	- no docume	entation of services provided			
	or progress toward ou	utcomes for FC #1 for			
		n by the day treatment			
	program FC #2:			The following action was take	en to
		date: uncertain		correct the deficiency V 113	27G.0206
		ADHD, Conduct DO		Client Records.	
		t plan dated 8/1/19	and the same of th	To correct the deficient area	a of
		ntation of services provided		practice.	a or
	or progress toward out	tcomes for FC #2 for		A checklist has been prepared	d hu tha
	activities provided him	by the day treatment		Program Coordinator to verify	1 by the
1	program	in the second se		riogram Coolumnator to verify	y that all
	Burlan an Interdemon			required information is mainta	ained in
	During an interview on	2/4/20, the Licensee		client records for each individ	
	reported: - she currently did	not have any clients in any		admitted to the facility. The co	
	of her programs	not have any chents in any		checklist will aid in ensuring	
		nded the program 4 time in		required data has been omitted	
*	October and Novembe	er. 2019	(0.00)	will be trained on how to use	this
	- FC #2 attended f	for approximately 2 months	Î	checklist and be made respons	sible for its
	in April and May, 2019		1	completion. The Quality Mana	ager will
		nded after they were	7	conduct regular reviews of rec	
	suspended from schoo		Mary III.	ensure that the facility is in ful	
	- she had not done	e any documentation on FC	9 44	compliance.	11
	#1 Of FC #2 Write in the	e day treatment program seeing both individuals in	The state of the s	•	1.6.1
	her private practice an	d writing notes about those	A. Nome and	Specifically, Clinicians and Quantum Professionals will maintain	uaiifiea
	meetings	1 Milling Hotes about those			
		e goals in her private		documentation of progress toward	
		ced in the day treatment		outcomes for every individual	admitted
	program			to the facility. This documenta	
		e documentation would be		be completed immediately after the	
	done when clients were	admitted again		service is provided. The Progra	
	A STATE OF THE STA		1	Coordinator and the Quality M	
		s - Training on Alt to Rest.	V 536	will monitor records at least m	onthly to
	Int.			be sure that all staff is in comp	
	1011010 075 0407		- Action to	oo sare mat an starr is in comp	Harice.
	10A NCAC 27E .0107	TRAINING ON			724

PRINTED: 02/05/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL046-038 02/04/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 415 EAST HOLLOMAN AVENUE REHOBOTH COUNSELING SERVICES AHOSKIE, NC 27910 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 536 Continued From page 3 V 536 ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers. employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) 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. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to

(2)

behavior: (3)

Paragraph (g) of this Rule.

following core areas:

people being served;

(g) Staff shall demonstrate competence in the

external stressors that may affect people with

knowledge and understanding of the

recognizing and interpreting human

recognizing the effect of internal and

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
		MHL046-038	B. WING		02/04/2020	
	ROVIDER OR SUPPLIER	CES 415 EAS	DDRESS, CITY, STATE T HOLLOMAN AVE E, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
	disabilities; (4) strategies for relationships with persity (5) recognizing organizational factors disabilities; (6) recognizing assisting in the person decisions about their lifty (7) skills in assees calating behavior; (8) communication and de-escalating pote and (9) positive behaviors which directly behaviors which directly behaviors which are under the service providers and (1) Service providers and (2) positive providers and (3) who participate outcomes (pass/fail); (8) when and who participate (2) The Division review/request this docuing instructor Qualification Requirements: (1) Trainers shall by scoring 100% on testianed at preventing, reneed for restrictive interection (2) Trainers shall by scoring a passing grinstructor training progrinstructor training progrinstructor training sinstructor training sin	r building positive ons with disabilities; cultural, environmental and that may affect people with the importance of and 's involvement in making fe; ssing individual risk for on strategies for defusing entially dangerous behavior; evioral supports (providing disabilities to choose oppose or replace isafe). Shall maintain and refresher training for on shall include: ded in the training and the ere they attended; and ame; of MH/DD/SAS may umentation at any time. ons and Training demonstrate competence ting in a training program ducing and eliminating the eventions. demonstrate competence ade on testing in an am.	V 536			

(X2) MULTIPLE CONSTRUCTION

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		MHL046-038	B. WING		0:	2/04/2020
REHOBO	ROVIDER OR SUPPLIER TH COUNSELING SERVICE	CES 415 EAS AHOSKII	DDRESS, CITY, STATE T HOLLOMAN AVE E, NC 27910			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
	objectives, measurable observation of behavior measurable methods failing the course. (4) The content service provider plans approved by the Divisito Subparagraph (i)(5) (5) Acceptable is shall include but are not (A) understandin (B) methods for course; (C) methods for performance; and (D) documentation (B) Trainers shall teaching a training proveducing and eliminating interventions at least or review by the coach. (7) Trainers shall aimed at preventing, respectively interventions at least or review by the coach. (7) Trainers shall aimed at preventing, respectively interventions at least or review by the coach. (8) Trainers shall aimed at preventing, respectively interventions at least or review by the coach. (9) Service providers shall instructor training at least three (1) Documentation of initial training for at least three (1) Documentation (A) who participate outcomes (pass/fail); (B) when and who instructor's national contents and review this (k) Qualifications of Co	e testing (written and by or) on those objectives and to determine passing or of the instructor training the to employ shall be on of MH/DD/SAS pursuant of this Rule. Instructor training programs of limited to presentation of: g the adult learner; teaching content of the evaluating trainee In procedures. I have coached experience gram aimed at preventing, and the need for restrictive ne time, with positive I teach a training program aducing and eliminating the riventions at least once I complete a refresher ast every two years. I and refresher instructor e years. I teating trained at preventing the restrictive near the every two years. I teach a training program and refresher instructor e years. I teating and the training and the ere attended; and ame. If MH/DD/SAS may documentation any time.	V 536			

Division of Health Service Regulation

Division	of Health Service Regu	lation			FORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED
		MHL046-038	B. WING		02/04/2020
	PROVIDER OR SUPPLIER	CES 415 EAS	ADDRESS, CITY, S ST HOLLOMAN IE, NC 27910	CONTRACTOR OF STATE O	02/04/2020
(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 APPROP DEFICIENCY)	D BE COMPLETE
V 536	requirements as a trai (2) Coaches sh the course which is be (3) Coaches sh competence by compl train-the-trainer instruct (I) Documentation sha as for trainers. This Rule is not met a Based on record review failed to ensure 2 of 2 #1) were trained in alte interventions. The find Review on 2/4/20 of per staff #1 hire date 1/4 no document alternatives to restrictive Licensee: hire date 11/4	all teach at least three times eing coached. all demonstrate letion of coaching or oction. all be the same preparation s evidenced by: w and interview, the facility staff (Licensee and staff ernatives to restrictive ling are: ersonnel records revealed:: //19 tation of training in re interventions 1/16 tation of training in e interventions 2/4/20, the Licensee elle finding a trainer in	V 536	The following action was take correct the deficiency V536 2. Client Rights – Training on Al Int. To correct this deficiency, the has secured training - Nonviole Intervention Flex - Human Ser staff are required to successful complete this training yearly. Additionally, records related to training including training certification. The Program Coordinator and the successful complete this training training certification.	this ificates quired. the
V 537	seclusions, restraints at 27E .0108 Client Rights ITO	nd time-outs. s - Training in Sec Rest &	V 537	Quality Manager will monitor a least monthly to be sure that all in compliance.	records at staff is

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL046-038	B. WING		02/	04/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE		
REHOBO	TH COUNSELING SERVI	CES 415 EAST AHOSKIE,	HOLLOMAN NC 27910	AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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	(X5) COMPLETE DATE
	10A NCAC 27E .0108 SECLUSION, PHYSIC ISOLATION TIME-OU (a) Seclusion, physicatime-out may be employed time-out may be employed time-out may be employed to these procedures. Staff authorized to emprocedures are retrain competence at least a (b) Prior to providing disabilities whose treatincludes restrictive interestrictive interestrictive providers, emprovedures shall comploseclusion, physical restraining is completed at demonstrated. (c) A pre-requisite for the demonstrating competence at least and shall not use these training in preventing, in the need for restrictive (d) The training shall be include measurable least measurable testing (which is to determine provided to determine provided to determine provided to determine provided annually). (f) Content of the training provider plans to employ the Division of MH/DD/S Paragraph (g) of this Richard in the provided the provide	TRAINING IN CAL RESTRAINT AND T al restraint and isolation oyed only by staff who have demonstrated oper use of and alternatives Facilities shall ensure that oloy and terminate these ed and have demonstrated nnually. irrect care to people with tment/habilitation plan erventions, staff including oloyees, students or ete training in the use of straint and isolation time-out e interventions until the nd competence is taking this training is ence by completion of reducing and eliminating interventions. e competency-based, arning objectives, itten and by observation of ectives and measurable bassing or failing the anining must be completed er periodically (minimum mg that the service by must be approved by SAS pursuant to ule. programs shall include,	V 537			

Division of Health Service Regulation

STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	MHL046-038	B. WING		02	02/04/2020	
NAME OF PROVIDER OR SUPP	LIER ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE		141	
DEHODOTH COUNCEL IN	41 41	I5 EAST HOLLOMAN	AVENUE			
REHOBOTH COUNSELING	3 SEKVICES	HOSKIE, NC 27910				
PREFIX (EACH D	IMARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
the use of resi (2) guid (understanding others); (3) emp rights and digric concepts of les incremental st (4) strate of restrictive in (5) the use of restrictive interventions wassessment and psychological suse of restrainment restrictive inter (6) prohit (7) debrit importance and (8) docutly (h) Service prodocumentation at least three y (1) Docutly (A) who poutcomes (pasted) (B) where (C) instructor Q Requirements: (1) Trained by scoring 1000 aimed at prevented for restrictive intervented for restrictive. (2) Trained	esher information on alternatives to trictive interventions; elines on when to intervene g imminent danger to self and hasis on safety and respect for the nity of all persons involved (using ast restrictive interventions and eps in an intervention); egies for the safe implementation terventions; use of emergency safety which include continuous and monitoring of the physical and well-being of the client and the safe throughout the duration of the vention; bited procedures; efing strategies, including their d purpose; and mentation methods/procedures. viders shall maintain of initial and refresher training for ears. mentation shall include: participated in the training and the	ie ie				

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PRINTED: 02/05/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING MHL046-038 02/04/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 415 EAST HOLLOMAN AVENUE REHOBOTH COUNSELING SERVICES AHOSKIE, NC 27910 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) Continued From page 9 V 537 V 537 teaching the use of seclusion, physical restraint and isolation time-out. 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. 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. Trainers shall be retrained at least (7)annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule.

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(8)

CPR.

coach. (10)

annually. (11)

Trainers shall be currently trained in

in teaching the use of restrictive interventions at least two times with a positive review by the

use of restrictive interventions at least once

instructor training at least every two years.

Trainers shall have coached experience

Trainers shall teach a program on the

Trainers shall complete a refresher

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	0 0	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL046-038	B. WING		02/04/2020
REHOBO	ROVIDER OR SUPPLIER TH COUNSELING SERVIO	CES 415 EAS	DDRESS, CITY, STAT T HOLLOMAN AV E, NC 27910		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES 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 COMPLETE
V 537	(k) Service providers documentation of initial training for at least thre (1) Documentation (A) who participal outcome (pass/fail); (B) when and who instructor's recomplete (2) The Division review/request this document (1) Qualifications of Company (2) Coaches share times, the course which	shall maintain al and refresher instructor ee years. ion shall include: ated in the training and the here they attended; and name. of MH/DD/SAS may cumentation at any time. baches: all meet all preparation ner. all teach at least three h is being coached. all demonstrate etion of coaching or tion. all be the same	V 537		
	failed to ensure 2 of 2 s #1) were trained in sec and isolation time-out. Review on 2/4/20 of pe - staff #1 - hire date 1/4, - no document seclusion, physical rest - Licensee: - hire date 11/ - no document	v and interview, the facility staff (Licensee and staff lusion, physical restraint The finding are: rsonnel records revealed:: //19 tation of training in raint and isolation time-out			
	seciusion, physical resti	raint and isolation time-out			

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The state of the s	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		MHL046-038	B. WING		02	/04/2020
	PROVIDER OR SUPPLIER TH COUNSELING SERVIO	CES 415 EA	ADDRESS, CITY, STATE ST HOLLOMAN AVE (IE, NC 27910			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 537	During an interview or reported they had trou Seclusion, physical re	n 2/4/20, the Licensee uble finding a trainer in	V 537			

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