STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING		(	
		MHL054-126	D. WING	· · · · · · · · · · · · · · · · · · ·	06/0	8/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
OAKWOOD FACILITY  2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	-S	V 000			
	2020. One complai #NC161929), one c (intake #NC001628 This facility is licens	was completed on June 8, int was substantiated (Intake complaint was unsubstantiated 48), A deficiency was cited.  sed for the following service at 27G .1900 Psychiatric ent for Children and				
V 318	130 .0102 HCPR -	24 Hour Reporting	V 318			
	10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g).					
	facility failed to report the Health Care Perwithin 24 hours of leteral The findings are:  Review on 4/30/20 - 14 year old male are Diagnoses included.	views and interviews the ort an allegation of abuse to rsonnel Registry (HCPR) earning about the allegation.  of client #4's record revealed: admitted 6/08/18.				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

DIVISION	Of Fleatill Service IN	guiation					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL054-126	B. WING			8/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
OAKWO	OAKWOOD FACILITY  2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504						
040.15	CUMMADY CTA			DDOVIDEDIC DI ANI OF CODDECTION		()(5)	
(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 SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 318	Continued From pa	ge 1	V 318				
		der, Conduct Disorder, ntellectual/Developmental					
	Abuse, Neglect, or revealed: - "Date and Time of approximately 1640 Alleged Incident: [O on the date of 12/30 he was in behaviors right arm by [former verbalized this to hi On the date of 1/8/2 investigating social the staff that bit him and Time of Provide aware of allegation: pm) Date and ti reported to the Prog 1500 (3:00 pm) (Department of Soc Services) Report: ( Date and Time of 01/07/20 @ 1335 (2 - Client #4 made the time of the allegarem meeting on 1 Review on 4/30/20 Inquiry/Investigation former staff #1 and - "Date of this reporalleged incident: 12 was in the restraint	e allegation of abuse to staff at ged incident on 12/30/19 and tion during a Child/Family /06/20.  of "Confidential a Statement" completed by dated 1/08/20 revealed: t: 1-8-20; Date & Time of /30/19 at 4:30 pm while he [client #4] say's stop bitting ng is bitting you "					

6899

Division of Health Service Regulation STATE FORM

UFOT11 If continuation sheet 2 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL054-126	B. WING			C <b>08/2020</b>	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
OAKWOOD FACILITY  2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
V 318	former staff #2 and - "Date of this repor alleged incident: 12 say he was bitting of claimed he right arr Review on 4/30/20 Personnel Registry revealed: - Two reports comp signed 1/10/20, one #1 and one report re - "Date submitted 1 - " Incident Date pm) "  During interview on stated: - He was assigned Licensee's campus - Client #4 was com restrained using a telli- - "He said I bit him, - "He said it after we - He thought a co-we to the Residential Selection - "I should've report I will report it myselection."  During interview on stated: - He no longer work reassigned to anoth campus in January by client #4 Client #4 made the time of a physical research.	a Statement" completed by dated 1/06/20 revealed: t: 1/6/2020; Date & Time of /30/19 at 4:40 pm He did during the time of the wrap, he in was bitting."  of documentation Health Care 5-Working Day Reports  leted by the Program Director, ereport regarding former staff egarding former staff #2. ///20 " e: 12/30/19 Time 16:40 (4:40)  5/28/20 former staff #1  to another facility on the hout "filled in that one day." hobative toward staff and was herapeutic wrap. but I didn't. No one bit him." e let him go." //orker reported the allegation dervices Supervisor. ded it to the supervisor myself. If next time."  5/28/20 former staff #2  seed in the facility; he was her facility on the Licensee's due to an allegation of abuse at the	V 318				

Division of Health Service Regulation

STATE FORM 6899 UFOT11 If continuation sheet 3 of 4

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:				
		MHL054-126	B. WING		06/0	)8/2020
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00.0	0.2020
				FORD ROAD		
OAKWO	OD FACILITY	KINSTON	NC 28504			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 318	Continued From pa	ge 3	V 318			
	received additional allegations of abuse	training in the reporting of e, neglect, and exploitation.				
	stated she understo	6/08/20 the Program Director ood the requirement to report e, neglect and exploitation to rsonnel Registry.				

Division of Health Service Regulation

STATE FORM 6899 UFOT11 If continuation sheet 4 of 4