

507

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL054-126	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/08/2020
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NAME OF PROVIDER OR SUPPLIER OAKWOOD FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504
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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	INITIAL COMMENTS A complaint survey was completed on June 8, 2020. One complaint was substantiated (Intake #NC161929), one complaint was unsubstantiated (intake #NC00162848), A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents.	V 000	DHSR-Mental Health JUN 24 2020 Lic. & Cert. Section	
V 318	130 .0102 HCPR - 24 Hour Reporting 10A NCAC 130 .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). This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to report an allegation of abuse to the Health Care Personnel Registry (HCPR) within 24 hours of learning about the allegation. The findings are: Review on 4/30/20 of client #4's record revealed: - 14 year old male admitted 6/08/18. - Diagnoses included Disruptive Mood Dysregulation Disorder, Attention Deficit	V 318		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Kimberly Manning, RN, Program Director
STATE FORM 6899 UFOT11 TITLE _____ (X6) DATE *06/16/2020*

Appendix 1-B: Plan of Correction Form

Plan of Correction

Please complete all requested information and email completed Plan of Correction form to:

Plans.Of.Correction@dhhs.nc.gov

Provider Name:	Oakwood Facility	Phone:	252-233-0491 ext. 1201
Provider Contact Person for follow-up:	Kimberly Manning, RN Director of PRTF Services	Fax:	252-233-0495
Survey completed:	6-8-2020	Email:	kmanning@novaprtf.com
Intake Number:	NC00161929 & NC00162848		
Address:	2002 D & E Shackelford Road, Kinston, NC 28504		Provider # MHL054-126

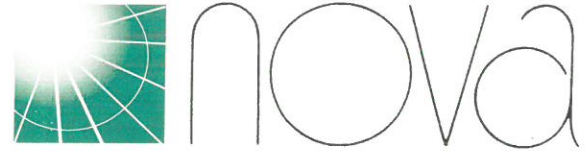
Finding	Corrective Action Steps	Responsible Party	Time Line
<p>V 318 130 .0102 HCPR – 24 Hour Reporting</p> <p>10A NCAC 130 .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL</p>	<p>As stated in the internal inquiry summary related to the allegation of abuse, corrective action was taken as follows:</p> <ul style="list-style-type: none"> -Staff #1 was reprimanded and placed on disciplinary probation for the incompetency and neglect of duties (neglected to report allegation of abuse). He was also reassigned to an alternate work location away from Consumer #4. - Staff #2 plus another involved staff were reassigned to an alternate location with explicit instructions to avoid contact with Consumer #4. They were reprimanded and placed on disciplinary probation for the incompetency and neglect of duties (neglected to report allegation of abuse). -All involved staff received additional training related to reporting procedures, therapeutic interventions, and behavior management practices. -Additionally, All Paraprofessional received coaching logs reinforcing: <ul style="list-style-type: none"> • reporting procedures for alleged abuse, neglect, and exploitation, • staff placement during mealtimes for supervision of consumers, and 	<p>Kimberly Manning, RN Director of PRTF Services</p>	<p>Implementation Date: 1/6/20</p> <hr/> <p>Projected Completion Date: 1/24/20</p>

	<ul style="list-style-type: none">• therapeutic communication / relationships (avoiding the use of profanity) <p>Proactive corrective measures were immediately taken between 01/6/20 and completed by 01/24/20.</p> <p>Daily, the Facility Supervisors shall monitor staff for compliance which will be evidenced by immediate follow through of allegations of abuse, neglect and exploitation of consumers, in accordance to policy and regulations.</p>		
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DHSR-Mental Health

JUN 18 2020

Lic. & Cert. Section



BEHAVIORAL HEALTHCARE CORPORATION

... lighting the way to new beginnings

June 17, 2020

via Certified Mail: 7015 1660 0000 1428 6968

Connie Anderson Facility Compliance Consultant I
Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, North Carolina 27699-2718

Re: Compliant Survey, completed 6/8/2020
Oakwood Facility, 2002-D/E Shackleford Road Kinston, NC 28504
MHL# 054-126

Dear Ms. Anderson,

Attached you will find the plan of correction associated with your correspondence dated 6/10/2020 along with the statement of deficiencies from the survey completed 6/8/2020.

Should anything else be needed, please don't hesitate to contact me.

Sincerely,

A handwritten signature in black ink that reads "Kimberly Manning, RN".

Kimberly R. Manning, RN
Director of PRTF Services
NOVA Behavioral Healthcare

Attachments: Signed and dated first page of the state form
Plan of Correction: Oakwood