

SC7

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL054-159</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MAPLEWOOD FACILITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2002-G SHACKLEFORD ROAD KINSTON, NC 28502</b>
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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
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V 000	<b>INITIAL COMMENTS</b>  A complaint survey was completed on June 8, 2020. The complaint was unsubstantiated (Intake #NC00164516). 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		
V 318	<b>130 .0102 HCPR - 24 Hour Reporting</b>  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 5/13/20 of the North Carolina Incident Response Improvement System revealed no Level III incident reports by the facility regarding former client #22 between 3/01/20 and 3/30/20.	V 318	<b>DHSR-Mental Health</b>  <b>JUN 24 2020</b>  <b>Lic. &amp; Cert. Section</b>	

Division of Health Service Regulation

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

*Kimberly Manning, RN, Program Director*

TITLE

(X6) DATE

06-17-2020

**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

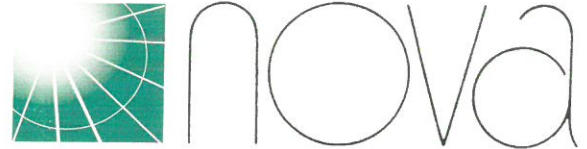
<b>Provider Name:</b>	Maplewood Facility	<b>Phone:</b>	252-233-0491 ext. 1201
<b>Provider Contact Person for follow-up:</b>	Kimberly Manning, RN Director of PRTF Services	<b>Fax:</b>	252-233-0495
<b>Survey completed:</b>	6-8-2020	<b>Email:</b>	kmanning@novaprtf.com
<b>Intake Number:</b>	NC00164516		
<b>Address:</b>	2002 G Shackleford Road, Kinston, NC 28504		<b>Provider #</b> MHL054-159

<b>Finding</b>	<b>Corrective Action Steps</b>	<b>Responsible Party</b>	<b>Time Line</b>
<b>V 318</b> 130 .0102 HCPR – 24 Hour Reporting  10A NCAC 130 .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL	The facility shall issue to all staff, a coaching log that reinforces policy and reporting procedures for alleged abuse, neglect and exploitation. Facility Supervisors shall monitor staff for compliance daily. Compliance will be evidenced by immediate follow through of allegations of abuse, neglect and exploitation of consumers, in accordance to policy and regulations.	Kimberly Manning, RN Director of PRTF Services	<b>Implementation Date:</b> 6/17/20  <b>Projected Completion Date:</b> 8/7/20

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 6944**

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  
Maplewood Facility, 2002-G Shackleford Road Kinston, NC 28504  
MHL# 054-159

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 R. 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: Maplewood