STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-176	A. BUILDING: ______ B. WING ______	R 10/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNES GROUP HOMES LLC	2201 RILEY ROAD KINSTON, NC 28504

(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 follow up survey was completed on October 12, 2020. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	{V 000}	DHSR - Mental Health [illegible] 2020 Lic. & Cert. Section	
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including:	V 105	QP did not state that he did not know the street address of the office building. QP stated that he did not know the street address by memory and that he would text that information to the surveyor, which he did. The text message is saved from the QP's phone for verification purposes of the disclosure of the office address. The administrator will request a duplicate office key to the main office complex door from the building owner for QP to have access of staff/client records in the event the administrator is out of town or unavailable by November 15th, 2020. No monitoring is necessary. Our facility "Infection Control/Coronavirus Policy 2020" has been updated and revised to include that all visitors are required to wear face masks to enter the facility at all times. A visitor's log will be utilized to ensure compliance. The updated/ revised Infection Control/Coronavirus Policy 2020 will be reviewed with all staff and clients by the QP during the QP's monthly monitoring by November 15th, 2020. Also, the residential director will monitor the facility weekly to ensure that all staff are wearing face masks and are following policy and procedure by November 15th, 2020. Staff #1 and Staff #2 were given verbal warnings for not wearing face masks as required by Infection Control/Coronavirus Policy 2020.	11/15/2020 11/15/2020 11/15/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION
	MHL054-176	A. BUILDING: ______ B. WING ______

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNES GROUP HOMES LLC	2201 RILEY ROAD KINSTON, NC 28504

(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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)
V 105	Continued From page 1 (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field; This Rule is not met as evidenced by: Based on record review, observations, and interviews the Licensee failed to (1) ensure	V 105	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-176	A. BUILDING: ______ B. WING ______	R 10/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNES GROUP HOMES LLC	2201 RILEY ROAD KINSTON, NC 28504

(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 follow up survey was completed on October 12, 2020. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	{V 000}	DHSR - Mental Health [stamp date illegible] 2020 Lic. & Cert. Section	
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including:	V 105	QP did not state that he did not know the street address of the office building. QP stated that he did not know the street address by memory and that he would text that information to the surveyor, which he did. The text message is saved from the QP's phone for verification purposes of the disclosure of the office address. The administrator will request a duplicate office key to the main office complex door from the building owner for QP to have access of staff/client records in the event the administrator is out of town or unavailable by November 15th, 2020. No monitoring is necessary. Our facility "Infection Control/Coronavirus Policy 2020" has been updated and revised to include that all visitors are required to wear face masks to enter the facility at all times. A visitor's log will be utilized to ensure compliance. The updated/ revised Infection Control/Coronavirus Policy 2020 will be reviewed with all staff and clients by the QP during the QP's monthly monitoring by November 15th, 2020. Also, the residential director will monitor the facility weekly to ensure that all staff are wearing face masks and are following policy and procedure by November 15th, 2020. Staff #1 and Staff #2 were given verbal warnings for not wearing face masks as required by Infection Control/Coronavirus Policy 2020.	11/15/2020 11/15/2020 11/15/2020

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE 10/21/2020

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-176	A. BUILDING: ______ B. WING ______	R 10/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNES GROUP HOMES LLC	2201 RILEY ROAD KINSTON, NC 28504

(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 105	Continued From page 1 (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field; This Rule is not met as evidenced by: Based on record review, observations, and interviews the Licensee failed to (1) ensure	V 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL054-176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED R 10/12/2020

NAME OF PROVIDER OR SUPPLIER: **BARNES GROUP HOMES LLC**

STREET ADDRESS, CITY, STATE, ZIP CODE: **2201 RILEY ROAD KINSTON, NC 28504**

(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 105	Continued From page 2 delegation of authority for the operation of the facility and services and (2) develop and implement adoption of standards that assure operation and programmatic performance meeting applicable standards of practice amidst the COVID-19 (Coronavirus Disease 2019) pandemic. The findings are: Finding (1): During interviews on 10/05/20 and 10/09/20 the Qualified Professional (QP) stated: - Staff records were maintained at the Licensee's office. - The office building was locked due to the pandemic. - He did not have access to the records because he did not have a key to the office; he would have to get the key from the - Administrator who was out of town. - He did not know the street address of the office building. Finding (2): Review on 10/07/20 of the Licensee's "Infection Control/Coronavirus Policy 2020" revealed: - "Policy: . . . All staff must wear a mask at all times while on the premises." - "Barnes GROUP Home will: . . . Ensure that face masks are available . . . Screen and triage everyone entering the home for signs and symptoms of COVID-19 . . . " - No requirement of the use of personal protective equipment, such as face masks, for facility visitors. Observations on 10/05/20 revealed: - At approximately 9:50 am staff #1 was not wearing a face mask and did not make an effort to "screen and triage" the surveyor. - 4 clients were present at facility; none were	V 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-176	A. BUILDING: ______ B. WING ______	R 10/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNES GROUP HOMES LLC	2201 RILEY ROAD KINSTON, NC 28504

(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 105	Continued From page 3 wearing face masks. - At approximately 10:20 am staff #2 entered the facility and was not wearing a face mask. - Neither staff #1 nor staff #2 put on a face mask during the surveyor's on-site visit. During interview on 10/08/20 client #2 stated staff "don't wear masks at all." During interview on 10/08/20 client #3 stated facility staff did not wear face masks when on duty. During interview on 10/05/20 staff #1 stated: - There had been no visitors to the facility in "the last two months. No one can come in here." - 5 facility clients attended "school" from approximately 8:30 am - 3:00 pm during the week; client #2 did not attend school. - 3 of the clients present at the facility at the time of the survey lived in "the other group home." - Staff from the sister facility had a doctor's appointment and "dropped them off" until she finished with her appointment. - All the clients were tested for COVID-19 by their primary care providers with negative results. - No staff were symptomatic of COVID-19 to her knowledge. - The facility was her only place of employment. During interview on 10/08/20 staff #2 stated: - Management had instructed group home staff to wash their hands frequently and to "wear masks and check temperatures before anyone comes in the door." - "I have my mask on all the time." - She was not wearing a mask the morning of 10/05/20 because "I wasn't really coming in. She (staff #1) called me about something and I stopped in."	V 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-176	A. BUILDING: ______ B. WING ______	R 10/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNES GROUP HOMES LLC	2201 RILEY ROAD KINSTON, NC 28504

(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 105	Continued From page 4 - No one had symptoms of COVID-19 to her knowledge. During interview on 10/09/20 the QP stated staff were required to wear face masks when in the facility.	V 105		
{V 289}	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which	V 289	All staff will be informed that they are not permitted to provide to an unlicensed service at the facility to any visiting client by October 21st, 2020. Staff will be informed that any clients that visit the facility must have a designated staff at all times during the client's visit by October 21st, 2020. The residential director will monitor the facility weekly and review the visitor's log to ensure compliance.	10/21/2020 10/21/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-176	A. BUILDING: ______ B. WING ______	R 10/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNES GROUP HOMES LLC	2201 RILEY ROAD KINSTON, NC 28504

(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 289}	Continued From page 5 serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7) (A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1) (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e) (1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL). This Rule is not met as evidenced by: Based on record review, observation and interviews the facility failed to meet license scope by providing an unlicensed service at the facility to 3 of 3 unidentified clients (#10, #11, #12). The findings are:	{V 289}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-176	A. BUILDING: ______ B. WING ______	R 10/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNES GROUP HOMES LLC	2201 RILEY ROAD KINSTON, NC 28504

(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 289}	Continued From page 6 Review on 10/05/20 and 10/06/20 of the Client Census Form completed by staff #1 and the QP revealed 6 "current" clients and 1 former client listed. Observations on 10/05/20 revealed 2 clients outside and 2 clients and staff #1 inside the facility. During interview on 10/05/20 client #2 introduced himself and stated he was leaving the group home soon to get his own place. During interview on 10/05/20 unidentified client #12 introduced himself and stated he did not live at the facility. During interview on 10/05/20 staff #1 stated: - 5 facility clients attended "school" from approximately 8:30 am - 3:00 pm during the week; client #2 did not attend school. - 3 of the clients present at the facility at the time of the survey lived in "the other group home." - Staff #1 provided the names of 2 of the unidentified clients (#10 and #11). - She did not know unidentified client #12's name as he was "the new guy." - Staff from the "other group home" had a doctor's appointment and "dropped them off" until she finished with her appointment. - The facility was her only place of employment. During interviews on 10/06/20 and 10/09/20 the QP stated: - All the facility clients attended school during the week. - Unidentified clients #10, #11, and #12 lived in the Licensee's Family Care home. - Staff #1 worked at the Family Care home also, so it was okay for her to provide supervision for	{V 289}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-176	A. BUILDING: ______ B. WING ______	R 10/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNES GROUP HOMES LLC	**2201 RILEY ROAD KINSTON, NC 28504**

(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 289}	Continued From page 7 the family care home clients at the facility. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	{V 289}		

To: NC Dept of Health & Human Services (919) 715-8078

Atten: Connie Anderson

From: Barnes Group Home

DHSR - Mental Health

OCT 3 0 2020

Lic. & Cert. Section

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

October 15, 2020

DHSR - Mental Health
OCT 30 2020
Lic. & Cert. Section

Carrie Dudley, Owner/Director
Barnes Group Homes LLC
PO Box 2503
Kinston, NC 28502

Re: Follow Up Survey completed 10/12/20
Barnes Group Homes LLC, 2201 Riley Road, Kinston, NC 28504
MHL # 054-176
E-mail Address: carrieblessed@yahoo.com

Dear Ms. Dudley:

Thank you for the cooperation and courtesy extended during the follow up survey completed October 12, 2020.

As a result of the follow up survey, it was determined that some of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- Re-cited standard level deficiency.
- Other tag cited is a standard level deficiency.

Time Frames for Compliance

- Re-cited standard level deficiency must be ***corrected*** within 30 days from the exit of the survey, which is November 11, 2020.
- Standard level deficiency must be ***corrected*** within 60 days from the exit of the survey, which is December 11, 2020.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Gloria Locklear, South Coastal Team Leader, at 910-214-0350.

Sincerely,

Connie Anderson
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc:
Pam Pridgen, Administrative Assistant