STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-101 NAME OF PROVIDER OR SUPPLIER STREET			(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
		raddress, city, state, zip code		11/12/2020		
	COUDER OR SUPPLIER					
RESH ST	ART-BOUNDARY HOU	ISE	RTH MARTIN LUTHI URY, NC 28144	ER RING AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE
V 000	INITIAL COMMENT	S	V 000			
	12, 2020. The com (Intake #NC001709	was completed on November olaint was unsubstantiated 13). A deficiency was cited.				
		ed for the following service C 27G .1700 Residential ure for Children or				
V 296	27G .1704 Resident Staffing	tial Tx. Child/Adol - Min.	V 296			
	telephone or page.	04 MINIMUM STAFFING essional shall be available by A direct care staff shall be cility within 30 minutes at all				
	required when child present and awake	umber of direct care staff ren or adolescents are is as follows: care staff shall be present for				
	one, two, three or for (2) three direct for five, six, seven of adolescents; and	our children or adolescents; ct care staff shall be present r eight children or				
	nine, ten, eleven or adolescents.	care staff shall be present for twelve children or umber of direct care staff				
	follows: (1) two direct	escent sleep hours is as care staff shall be present				
	children or adolesce (2) two direct	rake for one through four ents; care staff shall be present vake for five through eight				
	children or adolesce					

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-101			A. BUILDING:		(X3) DATE SURVEY COMPLETED 11/12/2020	
		MHL080-101				
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
RESH ST	ART-BOUNDARY HOUS	SE	TH MARTIN LUTHI JRY, NC 28144	ER KING AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES XY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	CTION SHOULD BE COMPL O THE APPROPRIATE DAT	
V 296	Continued From page 1		V 296			
	 asleep for nine, ten, adolescents. (d) In addition to the care staff set forth in Rule, more direct can the facility based on individual needs as a plan. (e) Each facility shal supervision of childre are away from the facility for the facility for the facility shall supervision for the facility facility for the facility for the facility facility for the facility facility for the facility facility facility for the facility facilit	a awake and the third may be eleven or twelve children or minimum number of direct Paragraphs (a)-(c) of this re staff shall be required in the child or adolescent's specified in the treatment If be responsible for ensuring en or adolescents when they cility in accordance with the individual strengths and the treatment plan.				
	failed to ensure mining staff for up to four ad Observation on 11/9/ am revealed: -Director was the onl Clients #1 and #3. Interview on 11/9/20	as evidenced by: and record review, the facility mum staffing ratios of two lolescents. The findings are: /20 at approximately 10:30 y staff in the faiclity with with the Director revealed: d just left the facility to take				
	Client #2 to take a st admission exam. Interview on 11/12/20	andardized college 0 with the President revealed: a client to school and did thers to COVID;				

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL080-101	B. WING		11	/12/2020
AME OF PR	OVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
RESH ST/	ART-BOUNDARY HO	USE	RTH MARTIN LUTHI URY, NC 28144	ER KING AVENUE		
(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) COMPLE DATE

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