	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: B. WING		R 06/08/2021	
		MHL001-016				
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
IALL AV	ENUE FACILITY		L AVENUE GTON, NC 272	215		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ¹	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMEN	TS	V 000			
	completed on June substantiated (intal Deficiencies were This facility is licen categories: 10A NC Medical Detoxificat Substance Abusers Facility Based Cris Disability Groups a	sed for the following service CAC 27G .3100 Nonhospital tion for Individuals Who are s, 10A NCAC 27G .5000 is Service for Individuals of All and 10A NCAC 27G .5600E for Adults with Substance				
V 114	27G .0207 Emerge	ency Plans and Supplies	V 114			
	AND SUPPLIES (a) A written fire pla area-wide disaster shall be approved a uthority. (b) The plan shall be and evacuation pro- posted in the facilit (c) Fire and disaster shall be held at lea repeated for each s under conditions the	er drills in a 24-hour facility st quarterly and shall be shift. Drills shall be conducted nat simulate fire emergencies. all have basic first aid supplies				
	Based on record re facility failed to cor	et as evidenced by: eviews and interviews, the iduct fire and disaster drills nat simulate emergencies. The	•			

OR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE JRATORY DIF

ZPXI11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLI AND PLAN OF CORRECTION IDENTIFICATION NU		(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY COMPLETED	
	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED	
		MHL001-016	B. WING			R 08/2021
IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
		136 HAL	L AVENUE			
IALL AV	ENUE FACILITY	BURLING	GTON, NC 272	215		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF (EACH CORRECTIVE AC		(X5) COMPLE
PRÉFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO	THE APPROPRIATE	DATE
				DEFICIEN	JY)	
V 114	Continued From pa	age 1	V 114			
	findings are:					
	Review on 6/1/21 c	of the facility's fire drill log				
	revealed the follow					
	-3/31/21 2nd shift	-				
	-3/30/21 1st shift -1/29/21 3rd shift					
	-11/11/20 2nd shift					
	-9/22/20 3rd shift					
	-8/5/20 2nd shift					
	-6/1/20 1st shift					
	-6/1/20 3rd shift	rter of 2020 there were no fire				
	drills conducted for 1st and 3rd shifts.					
		rter of 2020 there was no fire				
	drill conducted for					
	drill conducted for	arter of 2020 there was no fire				
		of the facility's disaster drill log				
	revealed the follow -3/18/21 1st shift	ing:				
	-3/17/21 2nd shift					
		rter of 2021 there was no				
	disaster drill condu					
	U	rter of 2020 there were no ucted for 1st, 2nd and 3rd				
	shifts.					
		rter of 2020 there were no				
		ucted for 1st, 2nd and 3rd				
	shifts. During the 2nd gua	arter of 2020 there were no				
		ucted for 1st, 2nd and 3rd				
	shifts.					
	Interview with clien	t #2 on 6/3/21 revealed:				
		ility since July 2020.				
		re and disaster drills with them.				
	-He thought they di -He thought the dri	id fire drills once or twice.				

STATE FORM

ZPXI11

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION			
	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COM	COMPLETED	
		MHL001-016	B. WING			R 08/2021	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
		136 HAL	L AVENUE				
	ENUE FACILITY	BURLING	GTON, NC 272	215			
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLE DATE	
V 114	Continued From pa	age 2	V 114				
	-He lived at the fac	t #5 on 6/3/21 revealed: ility for about two months. ucted any fire and disaster					
	-Staff worked 3 sep -They had some re and the drills are no -He confirmed staff	Manager on 6/1/21 revealed: barate shifts at the facility. cent issues with staff turnover ot being done consistently. If failed to conduct fire and r conditions that simulate					
	confirmed: -Staff failed to cond	Clinical Director on 6/1/21 duct fire and disaster drills at simulate emergencies.					
V 542	27F .0105(a-c) Clie Funds	ent Rights - Client's Personal	V 542				
	typically provides re clients for more that (b) Each competer above the age of 1 encouraged to mai personal fund acco This shall include, I investment of funds (c) If funds are ma employee, manage in accordance with (1) assure to and withdraw more	es to any 24-hour facility which esidential services to individual on 30 days. Int adult client and each minor 6 shall be assisted and intain or invest his money in a ount other than at the facility. but need not be limited to, is in interest-bearing accounts. Inaged for a client by a facility ement of the funds shall occur policy and procedures that: the client the right to deposit	n				

ZPXI11

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
					R	
		MHL001-016	B. WING			08/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
HALL AV	ENUE FACILITY		L AVENUE GTON, NC 272	215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 542	Continued From pa	ige 3	V 542			
	 funds in a personal fund account; (3) provide for the receipt of deposits made by friends, relatives or others; (4) provide for the keeping of adequate financial records on all transactions affecting funds on deposit in personal fund account; (5) assure that a client's personal funds will be kept separate from any operating funds of the facility; (6) provide for the deduction from a personal fund account payment for treatment or habilitation services when authorized by the client or legally responsible person upon or subsequent to admission of the client; (7) provide for the issuance of receipts to persons depositing or withdrawing funds; and (8) provide the client with a quarterly accounting of his personal fund account. 		t			
	Based on record re facility failed to kee separate from any of nine current clier	, , , , , , , , , , , , , , , , , , ,				
	-Admission date of	hol Use Disorder and				
	Review of facility re revealed:	ecords on 6/1/21 and 6/3/21				
	Procedures include financial agreemen	m fees/fee payments- ed (1) Upon admission, ts are made with each client o ses are collected based on	f			

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			A. BUILDING:		1	
					R	
			B. WING		06/08/2021	
IALL AV	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
	ENUE FACILITY	136 HALL BURLING	AVENUE TON, NC 27	215		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO		(X5) COMPLET
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)		DATE
V 542	Continued From pa	ge 4	V 542			
		ment to pay. A three-part				
		he client receives the original, companies the collection to				
		the third copy stays in the				
		acility Manager posts clients'				
		permanent receipts left in the permanent receipts left in the permanent and a				
	copy of the deposit	is kept in the deposit book in				
		fice. (4) A monthly bank ed and reconciled by the				
	Accountant"	ed and reconclied by the				
		The "Financial Agreement" signed by each client upon admission had the following:				
	30% of Salary/Income to be paid while in					
	treatment. I underst					
		ity/unemployment income I will baying RTSA (Residential				
		s of Alamance) 30% of my				
		#2 dated 3/17/21-The ucted \$420.00 from client #2's				
	stimulus check.					
		t #2 on 6/3/21 revealed:				
		ility since July 2020. hitted he was told the facility				
	would take a 30% s	service fee.				
		o give 30% to the facility aid or got any other money.				
		% covers expenses				
	associated with the	facility.				
		s money, he got the \$600 and facility 30% of those stimulus				
	checks.					
	Interview with the C	Clinical Director on 6/1/21				
	revealed:	ts are informed those must pase				
sion of He	ealth Service Regulation	ts are informed they must pay				<u> </u>

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	MHL001-016		B. WING			R 08/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	TATE, ZIP CODE		
		136 HALL	AVENUE			
HALL AV	ENUE FACILITY	BURLING	TON, NC 272	215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
V 542	a 30% service fee. -The clients sign and in about 30% of any expenses associate -This service fee com- program, the Certifit the finances for the -The 30% service fee money, if a client re- -She thought 1 or 2 receive their stimulue -Some of the clients getting stimulus mo- clients who said the -Staff had given the order to look into th -She was not sure i eligible for stimulus -Most of the clients check. Interview with the C revealed: -She thought they ha ago with the clients about taking the 30 stimulus checks if th -Client #2 was the com- stimulus check as from client #2's \$14 -The 30% service feestimulus check this around \$420. -They did not collecom- from any of the clients -She confirmed the	a agreement when they come y monies being collected for ed with the program. overs the operating cost of the fed Public Accountant handle program. ee did include the stimulus aceived a stimulus check. of the residential clients did us checks. s had complained about not oney, these are the same ey never worked or filed taxes. em access to the computer in is issue. f all of the clients were even checks. never received a stimulus clinical Director on 6/8/21 had a meeting a few months . They talked with the clients % service fee from their hey received one. only client who received a ar as she knew. collected the 30% service fee 400.00 check. ee was deducted from his year, she thought it was ct any stimulus money last year	V 542	DEFICIENC		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		- (X3) DATE SURVEY COMPLETED		
		MHL001-016	B. WING			R 06/08/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
	ENUE FACILITY		AVENUE STON, NC 272	215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
V 542	Continued From pa	age 6	V 542				
	revealed: -The facility did coll clients if they work money. -The clients were a stimulus money the -The 30% service f of operational experi- facility. -Most of the clients eligible for the stim -He thought only or stimulus money wh -He confirmed the stim	ee generally covers any type enses associated with the did not receive or were not					