T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	MHL054-159	B. WING		06/	24/2021
ROVIDER OR SUPPLIER					
OOD FACILITY			D ROAD		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE	(X5) COMPLET DATE
INITIAL COMMENT	rs	V 000			
2021. One complai #NC00178408) and unsubstantiated (in Deficiencies were c This facility is licens category: 10A NCA Residential Treatmo	nt was substantiated (intake d one complaint was take #NC00178249). cited. sed for the following service C 27G .1900 Psychiatric				
	/Supervision	V 110			
SUPERVISION OF (a) There shall be paraprofessionals. (b) Paraprofession associate profession professional as spe Subchapter. (c) Paraprofession knowledge, skills at population served. (d) At such time as employment system then qualified profe professionals shall (e) Competence sh exhibiting core skills (1) technical knowl (2) cultural awaren (3) analytical skills (4) decision-makin (5) interpersonal sh	PARAPROFESSIONALS no privileging requirements for als shall be supervised by an onal or by a qualified ecified in Rule .0104 of this als shall demonstrate and abilities required by the s a competency-based n is established by rulemaking ssionals and associate demonstrate competence. hall be demonstrated by s including: ledge; mess; ; g; kills;				
	TOF DEFICIENCIES DF CORRECTION  ROVIDER OR SUPPLIER  OOD FACILITY  SUMMARY STA (EACH DEFICIENC' REGULATORY OR L  INITIAL COMMENT  A complaint survey 2021. One complai #NC00178408) and unsubstantiated (in Deficiencies were of This facility is licens category: 10A NCA Residential Treatm Adolescents.  27G .0204 Training Paraprofessionals 10A NCAC 27G .02 SUPERVISION OF (a) There shall be paraprofessionals. (b) Paraprofession associate profession associate profesesion associate profession a	DF CORRECTION       IDENTIFICATION NUMBER:         MHL054-159         ROVIDER OR SUPPLIER       STREET A         OOD FACILITY       2002-G S         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         INITIAL COMMENTS         A complaint survey was completed on June 24, 2021. One complaint was substantiated (intake #NC00178408) and one complaint was unsubstantiated (intake #NC00178249).         Deficiencies were cited.         This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents.         27G .0204 Training/Supervision Paraprofessionals         10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter.         (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served.         (d) At such time as a competency-based employment system is established by rulemaking then qualified professionals and associate professionals shall demonstrate competence.         (e) Competence shall be demonstrate by exhibiting core skills including:         (1) technical knowledge;         (2) cultural awareness;         (3) analytical skills;         (4) decision-making;         (5) interpersonal skills; <td>TOF DEFICIENCIES DF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE A. BUILDING: DENTIFICATION NUMBER:         MHL054-159       B. WING</td> <td>ICP DEFICIENCIES       [X1] PROVIDERSUPPLIER(LIA IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: MHL054-159       [X2] MULTIPLE CONSTRUCTION A. BUILDING: </td> <td>TOP DEFICIENCIES       [X1] PROVIDERSUPPLIER/CLIM       (X2) MULTIPLE CONSTRUCTION       (X3) DATA         SPE CORRECTION       MHL054-159       B. WING       (X3) DATA         ROVIDER OR SUPPLIER       STREET ADDRESS. CITY. STATE, ZIP CODE       (X3) DATA         SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S CALLEFOR ROAD         SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION         RECULATORY OR LSC IDENTIFYING INFORMATION       PREFIX       CROSS-REFERENCES AND         SUMMARY STATEMENT OF DEFICIENCIES       ID       PREFIX       CROSS-REFERENCES AND         SUMMARY STATEMENT OF DEFICIENCIES       ID       PREFIX       CROSS-REFERENCES AND         NOTAL COMMENTS       V 000       V 000       PREFIX       CROSS-REFERENCES APPROPRIATE         INITIAL COMMENTS       V 000       V 000       CROSS-REFERENCES APPROPRIATE       DEFICIENCY         INITIAL COMMENTS       V 000       V 110       PREADULATION NUMBER       CROSS-REFERENCES APPROPRIATE         Catagory: 10A NCAC 27G. 1900 Psychiatric       Catagory: 10A NCAC 27G. 0204 COMPETENCIES AND       V 110       Praprofessionals         10A NCAC 27G. 0204 COMPETENCIES AND       V 110       Praprofessionals shall demonstrate competence for paraprofessionals.       V 110       Preprofessional shall be supervised by an associate professiona</td>	TOF DEFICIENCIES DF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE A. BUILDING: DENTIFICATION NUMBER:         MHL054-159       B. WING	ICP DEFICIENCIES       [X1] PROVIDERSUPPLIER(LIA IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: MHL054-159       [X2] MULTIPLE CONSTRUCTION A. BUILDING: 	TOP DEFICIENCIES       [X1] PROVIDERSUPPLIER/CLIM       (X2) MULTIPLE CONSTRUCTION       (X3) DATA         SPE CORRECTION       MHL054-159       B. WING       (X3) DATA         ROVIDER OR SUPPLIER       STREET ADDRESS. CITY. STATE, ZIP CODE       (X3) DATA         SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S CALLEFOR ROAD         SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION         RECULATORY OR LSC IDENTIFYING INFORMATION       PREFIX       CROSS-REFERENCES AND         SUMMARY STATEMENT OF DEFICIENCIES       ID       PREFIX       CROSS-REFERENCES AND         SUMMARY STATEMENT OF DEFICIENCIES       ID       PREFIX       CROSS-REFERENCES AND         NOTAL COMMENTS       V 000       V 000       PREFIX       CROSS-REFERENCES APPROPRIATE         INITIAL COMMENTS       V 000       V 000       CROSS-REFERENCES APPROPRIATE       DEFICIENCY         INITIAL COMMENTS       V 000       V 110       PREADULATION NUMBER       CROSS-REFERENCES APPROPRIATE         Catagory: 10A NCAC 27G. 1900 Psychiatric       Catagory: 10A NCAC 27G. 0204 COMPETENCIES AND       V 110       Praprofessionals         10A NCAC 27G. 0204 COMPETENCIES AND       V 110       Praprofessionals shall demonstrate competence for paraprofessionals.       V 110       Preprofessional shall be supervised by an associate professiona

STATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		MHL054-159	B. WING		06/	24/2021
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
MAPLEV	VOOD FACILITY	2002-G S	SHACKLEFOR			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
V 110	Continued From pa	ige 1	V 110			
	for the initiation of t	nent policies and procedures he individualized supervision ch paraprofessional.				
	one audited former (Former Staff (FS)	views and interviews, one of paraprofessional staff #1) failed to demonstrate ind abilities required by the				
	record revealed: - 11 year old male. - Admission date of - Diagnoses of Pos Adjustment Disorde Emotions and Cond	t Traumatic Stress Disorder, er with Disturbance of duct, Attention Deficit der and Learning Disorder.				
	revealed: - Date of hire: 04/2 - Position Description - Job Description si	on: Paraprofessional. igned 05/04/20. ies with all NOVA Behavioral				
	- He had recently ta community services	21 FC #2's Guardian stated: aken FC #2 home with s. m a staff member had given				

STATEMEN	of Health Service Re NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		MHL054-159	B. WING		06/	24/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
	VOOD FACILITY		HACKLEFORI	D ROAD		
	TOOD TAOLETT	KINSTON	I, NC 28502			-1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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 THE APPROPRIATE	(X5) COMPLETE DATE
V 110	Continued From pa	ge 2	V 110			
	food to his peers ar - He had addressed monthly meetings w	l concerns and issues at the				
	<ul> <li>She no longer wor</li> <li>She had shared her</li> <li>facility.</li> <li>The Director of Re</li> </ul>	21 and 06/24/21 FS #1 stated: ked at the facility. er food with clients at the esidential Services had spoken aring food with clients.				
	stated: - FS #1 had given f - FC #2 had told his from receiving food - FC #2 changed hi	21 the Qualified Professional bod to all clients in the past. Guardian he was excluded s story about events. rovide personal food to clients.				
	Director stated: - Staff should not sh - She had addresse #1.	21 the Residential Services hare food with the clients. Ind the sharing of food with FS written documentation was od sharing.				
V 315	27G .1902 Psych. F	Res. Tx. Facility - Staff	V 315			
	physician board-elig psychiatry or a gene experience in the tr adolescents with m (b) At all times, at I members shall be p or adolescents in ea	all be under the direction a gible or certified in child eral psychiatrist with eatment of children and ental illness. east two direct care staff present with every six children				

	of Health Service Re TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	or ookkeeniok	BERTH TO/THOM NOW BER.	A. BUILDING:			
		MHL054-159	B. WING		06/	24/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
MAPLEV	VOOD FACILITY		HACKLEFORI	D ROAD		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
V 315	Continued From pa	ige 3	V 315			
	responsibilities sep an acute medical u (d) A psychiatrist s consultation to revie or adolescent admi	ew medications with each child tted to the facility. Il provide 24 hour on-site				
	facility failed to ens	views and interviews, the ure at least 2 direct care staff every 6 children or adolescents				
	revealed: - 9 year old male. - Admission date of - Diagnoses of Pos	t Traumatic Stress Disorder nal Defiant Disorder and				
	record revealed: - 14 year old male. - Admission date of - Diagnoses of PTS Dysregulation Disor Hyperactivity Disord	D, Disruptive Mood rder and Attention Deficit				
	Review on 06/22/22 personnel record re - Date of hire: 04/22					

STATEMEN	of Health Service Re NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		MHL054-159	B. WING		06/2	24/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
MAPLEV	WOOD FACILITY		HACKLEFOR N, NC 28502	D ROAD		
(X4) ID		TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
V 315	Continued From pa	ge 4	V 315			
	- Position Description - Job Description si	on: Paraprofessional. gned 05/04/20.				
	investigation dated	1 of a facility internal 06/07/21 revealed "Actions make effort to increase ke hours"				
	for approximately 6 - He recalled an all #1.	d and had lived at the facility				
	- He recalled the al against FC #1. - One staff usually clients.	21 client #14 stated: legation client #7 made worked in each pod or 3 e allegation there was one staf	f			
	against FC #1. - She had 6 clients - There were usual 6 clients.	rked at the facility. the allegation client #7 made the entire weekend. ly at least 2 staff working with by inappropriate behavior				
vision of H	stated: - Client #7 made ar - The incident date	21 the Program Director n allegation against FC #1. was identified as 05/15/21. ne staff for 6 clients on that				

Division of Health Service Regulation STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		MHL054-159	B. WING		06//	24/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
MAPLEV	VOOD FACILITY		HACKLEFORI N, NC 28502	DROAD		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF (	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
V 315	Continued From pa	ige 5	V 315			
	- She was aware th clients. - There had been d	e rule required 2 staff for 6 ifficulty hiring staff.				
V 364	G.S. 122C- 62 Add Facilities	litional Rights in 24 Hour	V 364			
	Facilities. (a) In addition to the 122C-51 through G who is receiving tre 24-hour facility keel (1) Send and receind access to writing massistance when ne (2) Contact and co and at no cost to the physicians, and privi- developmental disar professionals of his (3) Contact and co there is a client adve The rights specified restricted by the face exercise these right (b) Except as prov- of this section, each treatment or habilitat times keeps the rig (1) Make and receind calls. All long distart the client at the time collect to the received (2) Receive visitors a.m. and 9:00 p.m. hours daily, two hours (3) the time the time the client at the time collect to the received (3) Receive visitors a.m. and 9:00 p.m.	ve sealed mail and have aterial, postage, and staff ecessary; insult with, at his own expense e facility, legal counsel, private vate mental health, abilities, or substance abuse a choice; and insult with a client advocate if vocate. d in this subsection may not be cility and each adult client may ts at all reasonable times. ided in subsections (e) and (h) in adult client who is receiving ation in a 24-hour facility at all ht to: ive confidential telephone ince calls shall be paid for by e of making the call or made				

2BSJ11

If continuation sheet 6 of 11

Division	of Health Service Re	gulation	1			APPROVED
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		MHL054-159	B. WING		06/	24/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
MAPLEW	VOOD FACILITY		HACKLEFORI , NC 28502	D ROAD		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (	CORRECTION	(X5)
PRÉFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETE DATE
V 364	Continued From pa	ge 6	V 364			
	supervision with ind upon the consent of (4) Make visits outs unless: a. Commitment pr the result of the clievident crime, include assault with a dead respondent was four insanity or incapable b. The client was four committed to the far committed to the far several times a week (5) Be out of doors facilities and equipt several times a week (6) Except as prohi- personal clothing ar client is being held for proceed pursuant to (7) Participate in ref (8) Keep and spen- own money; (9) Retain a driver's prohibited by Chapt and (10) Have access to his private use. (c) In addition to th 122C-51 through G	side the custody of the facility roceedings were initiated as int's being charged with a ling a crime involving an ly weapon, and the and not guilty by reason of e of proceeding; voluntarily admitted or cility while under order of prrectional facility of the rrection of the Department of ing held to determine capacity t to G.S. 15A-1002; expressly authorize visits d by the existence of the ed by this subdivision; daily and have access to ment for physical exercise ek; ibited by law, keep and use and possessions, unless the to determine capacity to o G.S. 15A-1002;				

	of Health Service Re TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		MHL054-159	B. WING		06/	24/2021
AME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
		2002-G S	HACKLEFOR	D ROAD		
IAPLEV	VOOD FACILITY	KINSTON	N, NC 28502			
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE	(X5) COMPLET DATE
TAG	REGULATORTORE		TAG	DEFICIENC		57.112
V 364	Continued From pa	ge 7	V 364			
	who is receiving tre	atment or habilitation in a				
		the right to have access to				
		ision and guidance. In				
		ninor's status as a developing				
		individual, the minor shall be provided				
	opportunities to enable him to mature physically,					
	emotionally, intellec					
		v of the physical, emotional,				
	and intellectual immaturity of the minor, the 24-hour facility shall provide appropriate					
	structure, supervision and control consistent with					
	the rights given to the minor pursuant to this Part.					
	The facility shall also, where practical, make					
	5	o ensure that each minor				
		ment apart and separate from				
		the treatment needs of the				
	minor client dictate	otherwise.				
	Each minor client w	ho is receiving treatment or				
	habilitation from a 2	24-hour facility has the right to:				
	(1) Communicate a	and consult with his parents or				
	guardian or the age custody of him;	ency or individual having legal				
		nsult with, at his own expense				
		responsible person and at no				
		egal counsel, private				
		mental health, developmental				
		tance abuse professionals, of				
		sponsible person's choice; and				
	there is a client adv	nsult with a client advocate, if				
		l in this subsection may not be				
		cility and each minor client				
		rights at all reasonable times.				
		ided in subsections (e) and (h)				
		n minor client who is receiving				
		ation in a 24-hour facility has				
	the right to:					
		ive telephone calls. All long				
		be paid for by the client at the				
	1	· ·	ii			1

Division	of Health Service Re	aulation			FORM	APPROVED
STATEMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING:				E SURVEY PLETED	
		MHL054-159	B. WING		06/	24/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	VOOD FACILITY	2002-G SI	HACKLEFOR	D ROAD		
		KINSTON	, NC 28502			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 364	Continued From pa	ge 8	V 364			
	time of making the receiving party; (2) Send and receiving materials, power when necessary; (3) Under appropriativisitors between the p.m. for a period of hours of which shall visiting shall not take therapies; (4) Receive special training in accordant (5) Be out of doors recreation, and physical basis in accordance (6) Except as prohipersonal clothing ar appropriate supervi held to determine car G.S. 15A-1002; (7) Participate in ref (8) Have access to the safekeeping of (9) Have access to of his own money; a (10)Retain a driver's prohibited by Chapt (e) No right enume of this section may by the qualified prof formulation of the car plan. A written state client's record that i for the restriction. T reasonable and relation habilitation needs. A period not to exceed	call or made collect to the ve mail and have access to ostage, and staff assistance ate supervision, receive a hours of 8:00 a.m. and 9:00 at least six hours daily, two I be after 6:00 p.m.; however a precedence over school or I education and vocational ace with federal and State law; daily and participate in play, sical exercise on a regular a with his needs; ibited by law, keep and use and possessions under sion, unless the client is being apacity to proceed pursuant to eligious worship; individual storage space for personal belongings; and spend a reasonable sum				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		MHL054-159	B. WING		06/24/2021	
	PROVIDER OR SUPPLIER		DRESS, CITY, ST		00/	24/2021
APLEV	VOOD FACILITY	KINSTON	I, NC 28502			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
V 364	Continued From pa	ge 9	V 364			
	Each evaluation of a documented in the rights may be renew statement entered be the client's record the renewal of the restriction of the restriction of the restriction of a restriction of right the client shall, us be notified of the restriction of a restricti	estriction may be removed. a restriction shall be client's record. Restrictions on wed only by a written by the qualified professional in nat states the reason for the iction. In the case of an adult been adjudicated incompetent, an initial restriction or renewal ghts, an individual designated upon the consent of the client, striction and of the reason for ninor client or an incompetent ally responsible person shall instance of an initial restriction riction of rights and of the eation of the designated responsible person shall be ing in the client's record.				
	failed to ensure clie consult with parents individual having leg one former clients (	and record review, the facility ints could communicate and s or guardian or the agency or gal custody affecting one of FC #2)). The findings are:				
	<ul> <li>11 year old male.</li> <li>Admission date of</li> <li>Diagnoses of Posi</li> <li>Adjustment Disorde</li> <li>Emotions and Cond</li> </ul>	I of FC #2's record revealed: 12/16/20. t Traumatic Stress Disorder, er with Disturbance of duct, Attention Deficit der and Learning Disorder.				

STATE FORM

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		MHL054-159	– B. WING		06/	24/2021
NAME OF I	PROVIDER OR SUPPLIER		REET ADDRESS, CITY, STATE, ZIP CODE			
MAPLEV	VOOD FACILITY	2002-G S	HACKLEFORI			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / 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 THE APPROPRIATE	(X5) COMPLET DATE
V 364	Continued From pa	ige 10	V 364			
	- Date of discharge	06/17/21.				
	personnel record re - Date of hire: 04/2 - Position Description - Job Description si	7/20. on: Paraprofessional. gned 05/04/20. ies with all NOVA Behavioral				
	- He had recently ta community services - He had a staff dis was talking to FC # - FC #2 was talking discontinued the ca - FC #2 had the rigi staff at the facility.	connected the phone while he 2. about staff and they II. ht to speak with him regarding d concerns and issues at the				
	<ul> <li>She no longer wo</li> <li>She was told clier</li> <li>if they were talking</li> <li>She asked again</li> </ul>	t phone calls could be ended				
	stated: - Staff are suppose about peers while r	iscontinue client phone calls				