Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
MHL078-319		B. WING		08/	08/18/2021		
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
RIVERBEND RESIDENTIAL SERVICES #2 527 FAIR BLUFF ROAD ORRUM, NC 28369							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	ΓS		V 000			
	on August 18, 2021 unsubstantiated (in deficiency was cited		s ). A				
		sed for the following AC 27G .1700 Resid cure for Children or					
V 296	27G .1704 Residen Staffing	tial Tx. Child/Adol -	Min.	V 296			
	REQUIREMENTS (a) A qualified profit telephone or page. able to reach the fatimes. (b) The minimum required when child present and awake (1) two direct one, two, three or for (2) three direct for five, six, seven adolescents; and (3) four direct nine, ten, eleven or adolescents. (c) The minimum research	care staff shall be pour children or adole of care staff shall be or eight children or tare staff shall be twelve children or number of direct care	ailable by shall be tes at all e staff are present for excents; e present for present for excents; e present for excents.				
	follows: (1) two direct and one shall be av children or adolesce (2) two direct	escent sleep hours care staff shall be provided the staff shall be provided to the staff shall be provided to the staff sha	oresent n four oresent				
	children or adolesco		=				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE SURVEY COMPLETED	
		MHL078-319	B. WING		08/	18/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE			
RIVERBEND RESIDENTIAL SERVICES #2 527 FAIR BLUFF ROAD ORRUM, NC 28369							
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
V 296	(3) three directions of which two shall be asleep for nine, ternadolescents. (d) In addition to the care staff set forth Rule, more direction the facility based of individual needs as plan. (e) Each facility should supervision of child are away from the child or adolescent	ect care staff shall be present be awake and the third may be an eleven or twelve children or the minimum number of direct in Paragraphs (a)-(c) of this care staff shall be required in the child or adolescent's aspecified in the treatment shall be responsible for ensuring the or adolescents when they facility in accordance with the is individual strengths and in the treatment plan.					
	Based on record reinterviews the faciliminimum number of The findings are:  Review on 08/18/2 revealed; - 16 year old male Admission date o - Diagnoses of Displication of	f 03/22/21. ruptive Mood Dysregulation Conduct Disorder, Attention y Disorder (ADHD)-Combined pectrum Disorder.  1 of client #2's record					

| - 15 year old male. Division of Health Service Regulation Division of Health Service Regulation

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED			
		MHL078-319		B. WING		08/	18/2021	
	NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  527 FAIR BLUFF ROAD  ORRUM, NC 28369							
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 296	- Admission date of - DMDD, ADHD-Co Developmental Disa Observation on 08/10:20am revealed: - Client #1 and clier the Associate Profe (HM) The AP/HM was the facility.  Interview on 08/18/2 - She was currently with client #1 and c - Staff #8 had gone coming back to the - She thought the scovid She understood 2 facility when at least facility.  Interview on 08/18/2 - There should be 2 at the facility.	in 09/21/20. Imbined Type, Mild Introduct Disorce 18/21 at approximately Int #2 were at the facility Int #2. Into the AP/HM stated: Int #2. Into the store and would facility. It is the facility It is the facility was waive It is the facility was waive It is the Licensee stated	der.  by with lanager at the acility do be to the the diach shift	V 296				

Division of Health Service Regulation STATE FORM