ND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL078-212	B. WING 09/29/2		r. 29/2021	
IAME OF F	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	E, ZIP CODE		
IU-IMAG	E		N STREET RINGS, NC 2837	7		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF C		(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	COMPLET DATE
V 000	INITIAL COMMENT	S	V 000			
	completed on Septe complaint was unsu #NC00180696). De This facility is licens categories:10A NC/ Abuse Intensive Ou NCAC 27G .4500 S	ficiencies were cited. sed for the following service AC 27G .4400 Substance itpatient Program and 10A				
V 112	27G .0205 (C-D) Assessment/Treatn	nent/Habilitation Plan	V 112			
	PLAN	LITATION OR SERVICE				
	assessment, and in legally responsible of admission for clie receive services be (d) The plan shall i (1) client outcome(	nclude: s) that are anticipated to be				
	<ul><li>projected date of ac</li><li>(2) strategies;</li><li>(3) staff responsible</li><li>(4) a schedule for a</li></ul>	e; eview of the plan at least				
	responsible person (5) basis for evalua outcome achievem	ation or assessment of ent; and				
	responsible party, c	or agreement by the client or or a written statement by the y such consent could not be				

TITLE

Division	of Health Service Re	egulation			FORM	APPROVED
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		MHL078-212	B. WING			R 2 <b>9/2021</b>
NAME OF						
NU-IMAG	GE		N STREET			
			RINGS, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 112	Continued From pa	ge 1	V 112			
	failed to develop a t	view and interview, the facility treatment plan within 30 days e of three current audited				
	revealed: - 40 year old male. - Admission date of - Diagnoses of Adju Depressed Mood, C Disorder-Moderate, Disorder-Moderate Disorder-Mild.	Istment Disorder with Cannabis Use , Alcohol Use and Cocaine Use :linical Assessment dated				
	one month ago.	21 client #4 stated: to the facility approximately ces Monday thru Friday from				
	stated: - Client #4 did not h - Client #4 was rece - She understood a	21 the Qualified Professional have a current treatment plan. ently approved for services. Il clients needed to have a in 30 days of admission to the				

I	PLETED R 29/2021
CS PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE	29/2021 (X5) COMPLET
ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE	COMPLET
ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE	COMPLET
ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE	COMPLET
ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE	COMPLET

Division of Health Service Regulation STATE FORM

N9XU11

If continuation sheet 3 of 9

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING:			
	MHL078-212		B. WING		R <b>29/2021</b>
AME OF PROVIDER OR SUPPLIEF	R STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
NU-IMAGE		N STREET			
		RINGS, NC 28			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
V 280 Continued From p	age 3	V 280			
following: (1) reduction substances or con (2) the under (3) developm and necessary life (4) education (5) vocation by reducing substa employment; (6) social ar (7) improver (8) the negative substance abuse;	n in use and abuse of attinued abstinence; erstanding of addictive disease; ment of social support network style changes; nal skills; al skills leading to work activity ance abuse as a barrier to and interpersonal skills; d family functioning; and d commitment to recovery and				
Based on record r facility failed to en- scope of a substan outpatient treatme	net as evidenced by: eviews and interview, the sure it operated within the nce abuse comprehensive nt (SACOT) program for one of s (Former Client (FC) #14).				
<ul> <li>- 57 year old fema</li> <li>- Admission date of</li> <li>- Diagnoses of Co</li> </ul>	of 11/09/20. caine Use Disorder, Cannabis it Traumatic Stress Disorder sive Disorder.				
Summary revealed - Admitted 11/09/2 - Discharged 08/3	0.				

STATE FORM

N9XU11

If continuation sheet 4 of 9

STATEMEN	of Health Service Re NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		MHL078-212	B. WING			R <b>29/2021</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
NU-IMAC	ĴF		STREET			
	5L	RED SPR	INGS, NC 28	377		
(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 ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 280	Continued From pa	ge 4	V 280			
	intensive outpatient - Referred to: "Disc stepped down to ou - "Narrative Dischar charged from SACC Review on 09/29/21 for September 2022 - FC #14 received s program on 09/06/2 09/22/21 and 09/23 Interview on 09/28/2 SACOT group state - FC #14 had been for the month of Se - FC #14 had attend 09/27/21.	harged from SACOT and tipatient therapy/SAIOP." 'ge Summary: [FC #14] was DT to a lower level of care." I of FC #14's progress notes 1 revealed: services in the SACOT 21, 09/14/21, 09/15/21, /21. 21 the Facility Facilitator of the ed: attending the SACOT group ptember 2021. ded the SACOT program on admitted to the hospital and				
	- SAIOP was not cu - The program had to operate the SAIC - She understood o	21 the Licensee stated: irrently offered at the program. to have at least three clients OP. nly clients assessed to require volved in that program.				
V 282	27G .4503 Sub. Ab Operations	use Comp. Outpt. Tx	V 282			
	from the client's res (b) Each SACOT s minimum of 20 hou (c) Each SACOT s	operate in a setting separate idence. hall provide services a				

Division of Health Service Regulation STATE FORM

N9XU11

If continuation sheet 5 of 9

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: B. WING			
		MHL078-212				R <b>29/2021</b>
AME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
NU-IMAG	E					
			INGS, NC 28			
(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 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
V 282	Continued From pa	ge 5	V 282			
	<ul> <li>(d) Each SACOT s program of services and intensities spece plan.</li> <li>(e) Group counseli program services a</li> <li>(f) Each SACOT sl written policies to c their clients on a face basis 24 hours a da shall include at a m to face emergency</li> <li>(g) Psychiatric con needed.</li> <li>(h) Before discharge a discharge plan ar completed services</li> </ul>	ays between offered services. hall provide a structured is in the amounts, frequencies cified in each client's treatment ing shall be provided each day re offered. hall develop and implement arry out crisis response for ce to face and telephonic ay, seven days a week, which inimum the capacity for face response within two hours. sultation shall be available as ge, the program shall complete and refer each client who has to the level of treatment or ecified in the treatment plan.				
	ensure a discharge client prior to being including a referral specified in the disc	et as evidenced by: view, the facility failed to plan was completed for each discharged from the program, to the level of treatment charge plan for two of three ner Client (FC) #14 and #15).				
	Review on 09/28/2 <sup>2</sup> - 57 year old female - Admission date of					

Division of Health Service Re STATE FORM

N9XU11

If continuation sheet 6 of 9

	of Health Service Re	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(Y3) DAT	E SURVEY
	I OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED	
		MHL078-212	B. WING		R <b>09/29/202</b> 2	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
NU-IMA	GE		N STREET RINGS, NC 28	377		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLET DATE
V 282	Continued From pa	ige 6	V 282			
	Use Disorder, Post and Major Depress - Discharge date: 0					
	Summary revealed: - Admitted 11/09/20 - Discharged 08/30, - Reason for dischar Outpatient Therapy intensive outpatient - Referred to: "Disc stepped down to ou - "Narrative Dischar charged from SACC - No documentation SAIOP program for Finding #2: Review on 09/29/27 - 55 year old male. - Admission date of - Diagnoses of Majo	<ul> <li>).</li> <li>/21.</li> <li>arge: "Stepped down to //SAIOP (substance abuse t program)."</li> <li>harged from SACOT and utpatient therapy/SAIOP."</li> <li>rge Summary: [FC #14] was OT to a lower level of care."</li> <li>n FC #14 was referred to a treatment.</li> <li>1 of FC #15's record revealed:</li> <li>f 09/12/19.</li> <li>for Depressive the construction of the construction</li></ul>				
	Summary revealed: - Admitted 09/12/19 - Discharged 03/09, - Last date of conta - Discharged due to - No documentation	1 of FC #15's Discharge : ). /21. ict was 03/08/21.				
	- SAIOP was not cu	21 the Licensee stated: irrently offered at the program to have at least three clients				

Division of Health Service Regulation STATE FORM

6899

	of Health Service Re NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		MHL078-212	B. WING			R <b>29/2021</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
NU-IMAC	GE	127 MAIN	-	977		
(X4) ID	SUMMARY STA		INGS, NC 28	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLET DATE
V 282	Continued From pa	ge 7	V 282			
	appropriate level of summary. - FC #15 was disch	lients should be referred to the care noted on the discharge arged due to noncompliance. discharge plan should be				
V 752	27G .0304(b)(4) Ho	t Water Temperatures	V 752			
	EQUIPMENT (b) Safety: Each fa constructed and eq ensures the physica visitors. (4) In areas of exposed to hot wate	604 FACILITY DESIGN AND cility shall be designed, uipped in a manner that al safety of clients, staff and of the facility where clients are er, the temperature of the tained between 100-116 t.				
	failed to maintain th	et as evidenced by: on and interviews, the facility he water temperature between ahrenheit. The findings are:				
	Observation on 09/ 10:58am revealed: - The client bathroc temperature of 80 c					
		21 the Qualified Professional the hot water working at the				
		21 the Licensee stated she n the building owner to emperature.				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	or connection	IDENTIFICATION NOMBER.	A. BUILDING:				
		MHL078-212	B. WING			R <b>29/2021</b>	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
NU-IMAG	iΕ		N STREET RINGS, NC 283	377			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
V 752	Continued From pa	age 8	V 752				
		nstitutes a re-cited deficiency cted within 30 days.]					