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13362178842

From: Lisa Morrison

Division of Health Service Regulation

PRINTED: 07/16/2021 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING:		COMPLETED
					07/1 <b>4/</b> 2021
		MHL0411172	D. VVIIVG		
NAME OF O		CTDFFF AN	DOEGG AITV ATATE	7D CODE	<u> </u>
NAMEOFP	ROVIDER OR SUPPLIER		DRESS, CITY, STATE,		
SUCCESS	FUL VISIONS, LLC		ENSTONE PLACI	<u>.</u>	
			NT, NC 27265		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
V 000	INITIAL COMMENTS	3	V 000	c	
	An annual survey wa 2021. Deficiencies w	s completed on July 14, ere cited.			
		d for the following service 27G .1700 Residential are for Children and			
V 107	27G .0202 (A-E) Per	sonnel Requirements	V 107		
	which: (1) specifies the competency, work expualifications for the	have a written job rector and each staff position e minimum level of education, experience and other position;			
	the position;	e duties and responsibilities of the staff member and the	-		
	(b) All facilities shall each staff member of provides care or sent the facility:  (1) is at least 1  (2) is able to refollow directions;  (3) meets the recompetency, work equalifications for the (4) has no submeglect listed on the Personnel Registry.	nad, write, understand and minimum level of education, experience, skills and other			
	applicants for emplo conviction. The imp	yment disclose any criminal act of this information on a			
	alth Service Regulation DIRECTOR'S OR ROVIDER	/SUPPLIER REPRESENTATIVE'S SIGNATUR	<b>!E</b>	TITLE	(X6) DATE

Jisa Monism

Executive Director

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13362178842

From: Lisa Morrison

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		A. BUILDING;	COMPLETED			
		MHL0411172	B. WING	B. WING		
NAME OF B	ROVIDER OR SUPPLIER	QTDEET AS	DORESS, CITY, STATE,	ZIR CODE		
NAME OF F	KOVIDER OR SUFFLIER		EENSTONE PLACE			
SUCCESS	FUL VISIONS, LLC		ENSTONE PLACE INT, NC 27265			
(X4) ID	SHMMARVST	ATEMENT OF DEFICIENCIES	IN 1, NO 2/203	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 107	Continued From page	<b>1</b>	V 107			
	upon the offense in rewhich the applicant is (d) Staff of a facility of currently licensed, reaccordance with applications provided. (e) A file shall be matemployed indicating the shall be sha	or a service shall be gistered or certified in icable state laws for the intained for each individual he training, experience and or the position, including				
	facility failed to ensur and the Qualified Pro written and signed jol to meet the minimum findings are: Review on 7/13/21 of -A hire date of 7/6/21 -No written and signe -No documentation of	ews and interviews, the re 3 of 7 audited staff (#1, #2 ofessional #2 (QP #2)) had a re description and verification relevel of education. The restaff #1's record revealed: red job description f verified education  f staff #2's record revealed: red job description f staff #2's record revealed:				
	<u> </u>	f the Qualified Professional				
Division of He	alth Service Regulation					

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From: Lisa Morrison

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL0411172	B. WING		07/1	14/2021
SUCCESSFUL VISIONS, LLC 1906 GRE		DRESS, CITY, STA ENSTONE PLA NT, NC 27265	ACE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 107	the staffs' recordsThe Licensee was restaff met the minimum position  Interview on 7/14/21 - Was responsible for written and signed joil -Was responsible for	realed:  d job description  with QP #1 revealed: esponsible for maintaining esponsible for ensuring the in level of education for the  with the Licensee revealed: ensuring all staff had a	V 107	Trainings have been scheduled for staff for 8/11/2021, and the highest level of edubeen placed in all files along with signed judescriptions.	cation has	8/11/2021
∨108	(g) Employee trainin provided and, at a mi following: (1) general organiza (2) training on client delineated in 10A NC 10A NCAC 26B; (3) training to meet client as specified in plan; and (4) training in infecti bloodborne pathoger (h) Except as permitt5602(b) of this Subc	tion shall be documented. g programs shall be nimum, shall consist of the tional orientation; t rights and confidentiality as EAC 27C, 27D, 27E, 27F and the mh/dd/sa needs of the the treatment/habilitation ous diseases and ns. ed under 10a NCAC 27G hapter, at least one staff ilable in the facility at all s present. That staff	V 108			

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13362178842

From: Lisa Morrison

Division o	of Health Service Regu	lation			i Olin	APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	ONSTRUCTION	(X3) DATE 8 COMPL	
		MHL0411172	B. WING	071	14/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
I SUCCESSFUL VISIONS, LLC			EENSTONE PLACE DINT, NC 27265	<b>:</b>	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	iD PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 108	including seizure mato provide cardiopuli trained in the Heimlitechniques such as the American Heart Aequivalence for relie (i) The governing beimplement policies areporting, investigati	anagement, currently trained monary resuscitation and ch maneuver or other first aid those provided by Red Cross,	V 108			
	facility failed to ensuland the Qualified Printrained on client right Bourne Pathogens (MR/DD needs of the treatment/habilitation) Review on 7/13/21 (Annual of the clients)	riews and interviews, the are 3 of 7 audited staff (#1, #2 ofessional #2 (QP #2)) were at's, confidentiality, Blood (BBP) and training to meet the exclients as specified in the an plans. The findings are:  of staff #1's record revealed:  of training to meet the MR/DD  of staff #2's record revealed:  of staff #2's record revealed:  of training on client rights of training on				
	needs of the clients Review on 7/13/21 of	of the Qualified Professional				

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13362178842

From: Lisa Morrison

PRINTED: 07/16/2021

FORM APPROVED

SUCCESS	FUL VISIONS, LLC	1906 GREENSTONE PLACE				
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		HIGH POINT, NC 2726	5			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATION	111=117	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE		
V 108	Continued From page 4  #2 (QP #2)'s record revealed: -A hire date of 6/9/2021 -No documentation of training on client rights -No documentation of training on Confidentiality/HIPPA -No documentation of training to meet the MR needs of the clients  Interview on 7/13/21 with the Licensee revealershe was responsible for ensuring all staff had the required trainings.	ed:	Staff has reincorporated supervisions the last supervisions were completed on July 14th, 2021 and the next supervision will be held on August 11, 2021.	8/11/2021		
V110	27G .0204 Training/Supervision Paraprofessionals  10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements paraprofessionals. (b) Paraprofessionals shall be supervised by 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 rulemak then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills.	an				

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From: Lisa Morrison

PRINTED: 07/16/2021 FORM APPROVED

Division of	of Health Service Regu	lation			
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL0411172	B. WING		07/14/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE	
CHOOSES	EUL MOIONE LLO	1906 GF	REENSTONE PLACE	Ĕ	
SUCCESSFUL VISIONS, LLC HIGH F		HIGH PO	DINT, NC 27265		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	ON (X6) D BE COMPLETE RIATE DATE	
V 110	Continued From pag	e 5	V 110		
	develop and impleme	dy for each facility shall ent policies and procedures e individualized supervision n paraprofessional.			
	audited staff (the Lic demonstrate the kno required by the popu audited staff failed to supervision plans. Th	ews and interviews, 1 of 7 ensee (L)) failed to wledge, skills and abilities lation served and 4 of 7 have individualized ne findings are:			
	Review on 7/13/21 or -A hire date of 7/1/20 -No documentation of				
	Review on 7/13/21 o -A hire date of 7/6/21 -No documentation of				
	Review on 7/13/21 o -A hire date of 8/28/2 -No documentation of	-			
	Review on 7/13/21 o #2 (QP #2)'s record -A hire date of 6/9/21 -No documentation of				
	-The Licensee was re trainings and mainta	with staff #1 revealed: esponsible for all the staff ining the staff's records. vidualized supervision plan			

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From: Lisa Morrison

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Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ MHL0411172 07/14/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1906 GREENSTONE PLACE SUCCESSFUL VISIONS, LLC HIGH POINT, NC 27265 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X.5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 110 Continued From page 6 V 110 with an Associate Professional (AP) or a Qualified Professional (QP). Interviews on 7/12/21 with the AP revealed: -The Licensee was responsible for all the staff trainings and maintaining the staff's records. -Did not have an individualized supervision plan with a QP. Interviews on 7/13/21 and 7/14/21 with staff #2 revealed: -The Licensee was responsible for all the staff trainings and maintaining the staff's records. -Had not had any supervision yet. Interviews on 7/13/21 and 7/14/21 with the L revealed: -Had no explanation as to why all of the facility staff had not been trained in client right's. confidentiality, Blood Bourne Pathogens (BBP) and training to meet the MR/DD needs of the clients as specified in the treatment/habilitation plans. - Had no explanation as to why all of the facility staff did not have written and signed job descriptions and verification to meet the minimum level of education. -Was responsible for ensuring all staff had their required trainings, job descriptions and supervision plans -Was aware of client #4's sexualized behaviors -Was not sure why client #4's sexualized behaviors had not been addressed but it had been mentioned to an outside therapist -Had only conducted one fire drills in the last 12 months -Had conducted no disaster drills in the last 12 -"I know one fire drill has been done." - Had no explanation as to why the drills were not

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From: Lisa Morrison

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	COMPLETED		
		MHL0411172	B. WING		07/14/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE	
OHACEO	EIII MICIONIC III C	1906 GR	EENSTONE PLAC	E	
SUCCESS	FUL VISIONS, LLC	HIGH PC	DINT, NC 27265		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX YAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 110	conducted in the last		V 110		
	into containers that d information on them, thought it would be ea	id not have the required the Licensee stated "I asier for some staff. We are			
	-Was recently made a blanks on them	switch pharmacies" aware the clients' MARs had ting their medications. I am			
	supposed to check th this month (July 2021 documenting on the N	e MARs monthly, but not for			
	the last 12 months.	one level II incident report in			
	client." -When asked why QF	P #1 was not in the facility			
	present, the Licensee the Comprehensive C	e stated "he usually works on linical Assessments (CCA)			
		ans off site. He also has nave [QP #2] work in the ugh Friday"			
	Licensee stated she	he client/staff ratio, the was aware the client/staff of 2 staff for every 4 clients.			
	-"With COVID, it was had a lot of turn over	hard to keep staff. We have			
	trainings on preventa	the staff had not had tive and restrictive ensee stated, "I have			
	contacted the instruc trained within the nex	tor, so the staff will be tt two weeks."			
	and inside the facility	physical plant issues outside r, including the mouse traps s, the Licensee stated she			
	-"I was not aware the	e mice outside the facility. Fre were mouse droppings in This is an old house. I am			

From: Lisa Morrison

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FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_ MHL0411172 B. WING 07/14/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1906 GREENSTONE PLACE SUCCESSFUL VISIONS, LLC HIGH POINT, NC 27265 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 8/11/2021 We are reviewing the requirements of the V 110 V 110 Continued From page 8 paraprofessionals with staff and training them on any questions they have within the job requirements currently looking to move the facility to another and/or duties. location ..." -When asked about the portable space heaters, the Licensee stated "I was not aware space heaters were not allowed in the facility ..." V 112 27G .0205 (C-D) V 112 Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE **PLAN** (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement: (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both: (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.

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Division o	of Health Service Regul	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
	*	*****	B. WING			
		MHL0411172	D. \$\$110		07/1	4/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	FE, ZIP CODE		
		1906 GR	EENSTONE PLAC	CE		
SUCCESS	FUL VISIONS, LLC	HIGH PO	INT, NC 27265			
24.15	SI IMMADO ST	ATEMENT OF DEFICIENCIES	<del></del>	PROVIDER'S PLAN OF CORRECTIO	NI I	445)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
V 112	Continued From page	a 0	V 112			
V 116	Continued From page		V 112			
		•				ar.
1						
	This Rule is not met					
	Based on record review	ews and interviews, the				
	facility staff failed to d	levelop and implement				
	strategies in 1 of 4 cli	ent (#4)'s treatment plans to				
	address the needs of	the clients. The findings				
	are:					
	Review on 7/13/21 of	client #4's record revealed:				. 1
	-An admission date o	f 9/23/20				
		sitional Defiant Disorder,				
		eractivity Disorder, Disruptive				
	Mood Dysregulation	Disorder				
	-Age 15					
		ed 10/26/20 noting "was				
		for past 5 months due to				
Ì		mental aggression towards				
		f control behaviors. Mother				
		rights to [a local Department				
i	-	SS) in May 2019, had				
		ng at night, disruptive				
		g at group home, had been				
		srespectful to staff and was				
	manipulative."	- 4 5/40/04				
		ed 5/13/21 noting "client will				
•		rustration in a healthy way by	ļ			
	reducing incidents of					
	threatening. He will v	· · · · · · · · · · · · · · · · · · ·				
		e coping skills to manage his				
		from self, family school				
		team members. Client will				
		th no more than 2 verbal				
		n assigned tasks following				
	expectations/rules ar	· - ·				
		reports from self, family,		·		
		nd other team members.				
		rted by one staff to and from				
		eded. He will follow all				
	recommendations from	om his therapist and other				

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reported that there were several incidents of him having inappropriate sexual communications

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ MHL0411172 07/14/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1906 GREENSTONE PLACE SUCCESSFUL VISIONS, LLC HIGH POINT, NC 27265 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 112 Continued From page 11 V 112 towards others in the group home. They have responded in feeling uncomfortable and it has resulted in altercations in which staff had to intervene. Client has reported that he hears other masturbating in their rooms and beds shaking. He frequently makes comments ' that's why country people have been molested in reference to another client that is from the country and has a history of sexual abuse when younger. Client has also asked other peers to 'suck in d\*\*k', in front of staff. Staff is having to monitor and intervene in situations with him and others. The team is concerned regarding client's inability to control his urges/impulses in efforts to prevent from expressing inappropriate things and engaging in inappropriate touching others or invading others personal space. Team has discussed upcoming plans to have him participate in a possible forensic evaluation to assess these symptoms along with providing possible reconditions for treatment." -No documentation to address client #4's sexualized behaviors/comments/gestures Interview on 7/13/21 with the Licensee revealed: -Was aware of client #4's sexualized behaviors -Was not sure why client #4's sexualized behaviors/gestures/comments had not been addressed. -Would meet with both QP's to develop and implement strategies to address these behaviors in client #4's treatment plan. -Had met with the treatment team to discuss sexualized behaviors and comments from client #4 to his peers and to staff. -Stated client #4 refuses to participate in treatment. -Had brought these concerns to the attention of an outside therapist, recently -Felt client #4 needed a sex offender evaluation.

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From: Lisa Morrison

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

1906 GREENSTONE PLACE

SUCCESS	SUCCESSFUL VISIONS, LLC						
	HIGH PC	DINT, NC 27265					
(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) COMPLETE DATE			
V112	Continued From page 12  -Stated the Guardian Ad Litem (GAL) attorney did not want client #4 to participate in any therapy as it related to his sexualized behaviors/gestures/comments	V 112	We have collaborated to create new goals to target consumers specific needs and also created a safety plan to ensure other consumers in the group home are safe from sed consumer.				
V 114	27G .0207 Emergency Plans and Supplies  10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall beposted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use.	V 114					
	This Rule is not met as evidenced by: Based on record reviews and interviews, the facility staff failed to ensure fire and disaster drills were conducted once per shift per quarter. The findings are:  Review on 7/13/21 of the facility's fire and disaster drills from 7/2020 to 7/2021 revealed: -1/21/10 at 6:45pm on second shift with 2 clients present. "staff yelled fire and the clients went out the front door with staff at the end of the driveway/mailbox in a timely manner" -No other documentation was provided						

Division of Health Service Regulation

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From: Lisa Morrison

Division o	f Health Service Regu	ation			, , , , , , , , , , , , , , , , , , , ,
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL0411172	B. WING		07/14/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST.	ATE, ZIP CODE	
			EENSTONE PL		
SUCCESS HIGH P	SFUL VISIONS, LLC OINT, NC 27265				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
V 114	Continued From page	÷ 13	V 114		
	-Had been at the faci-Had not participated had not participated finterview on 7/12/21 had been at the faci-Had not participated had not	in any fire drills; in any disaster drills.  with client #2 revealed: lity for 5 months in any fire drills; in any disaster drills.  with client #3 revealed: lity for 6 months in any fire drills; in any disaster drills.  with client #4 revealed: lity for 10 months in any fire drills; in any disaster drills.  with client #4 revealed: lity for 10 months in any fire drills; in any disaster drills.  h staff #1 revealed: the facility ntil 4pm. drills, she stated "we have in I will have to discuss them left I think they are supposed ionths"  with the Associate realed: acility staff were conducting is, the AP stated "I have only			
	not conducted any d	with the Licensee revealed:		Staff has created and implemented a fire drill and disaster drill schedule once per sh quarter.	8/30/2021 ift per
Division of He	alth Service Regulation		· · · · · · · · · · · · · · · · · · ·		
STATE FORM			6899	RYF511	If continuation sheet 14 of 44

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From: Lisa Morrison

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Division o	f Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ITED
	•	MHL0411172	B. WING		07/14	4/2021
		OWNER T A		70.0005		
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,			
BUODEDO		1906 GR	EENSTONE PLACE			
5000E88	FUL VISIONS, LLC	HIGH PC	DINT, NC 27265			
(X4) ID		TATEMENT OF DEFICIENCIES	ID I	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG	<b>X</b> .	LY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	1	COMPLETE DATE
,,,,,		,		DEFICIENCY)		
1447	A . ( ) E		V447			
V 117	Continued From pag	e 14	V 117			
V 117	27G .0209 (B) Medic	ation Requirements	V 117			
	10A NCAC 27G .020	9 MEDICATION	-			
	REQUIREMENTS					
	(b) Medication pack					
		n drug containers not				
		macist shall retain the				
	visible;	with expiration dates clearly	-			
		dications, whether purchased				
		les, shall be dispensed in				
	-	kaging that will minimize the				
		estion by children. Such				
		plastic or glass bottles/vials				
	•	t caps, or in the case of				
		d drugs, a zip-lock plastic bag				
	may be adequate;	abal of each proportion				
		abel of each prescription t include the following:	,			
	(A) the client's name					
	(B) the prescriber's					
	(C) the current dispe					
	(D) clear directions	for self-administration;				
	(E) the name, stren	gth, quantity, and expiration				
	date of the prescribe					
	1 1 1	ess, and phone number of the				
		sing location (e.g., mh/dd/sa				
	center), and the nan practitioner.	re of the dispensing				
	ргасиновег.	·				
			A A A A A A A A A A A A A A A A A A A			
	This Rule is not met	<del>-</del>				'
		ons, record reviews and				
		y failed to ensure prescription				
	medications were di	spensed with the prescriber's				

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From: Lisa Morrison

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Division o	of Health Service Regu	lation			1 ORIVI	AFFROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SU	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
		MHL0411172	B. WING		07/1	4/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
10,4120,			REENSTONE PLACE			
SUCCESS	FUL VISIONS, LLC		DINT, NC 27265			
242.15	CHAMADVC	TATEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CORRECTIO	N	
(X4) ID PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	DATE
				DEI TOTE (NOT)		
V <b>1</b> 17	Continued From pag	e 15	V 117			
	name the current dis	spensing date, the name,				
		d expiration date of the				
		on, the name, address and				,
	· •	pharmacy and the name of				
		itioner for 4 of 4 clients (#1,				
	#2, #3 and #4). The f					
	,			-		
	Observations on 7/1:	2/21, from approximately				
	12:30pm to 2:10pm,	the medication revealed:				
		spensing personal pill				
	packets for 7 days					
		of the prescriber's name,				
	•	number of the pharmacy				
		of the current dispensing date of the name, strength,				
'		on date of the prescribed				
	medication	on date of the prescribed				
		of the name of the dispensing			-	·
	Practitioner	, 0			ĺ	
	Į	1 with clients #1, #2, #3 and				
	#4 revealed:					
		edications were administered				
		spensing personal pill				
	packets by facility sta	all.				
	Interview on 7/13/21	with the staff #1 revealed:				
	l .	lications out of the personal				
	pill packets for the cl					
		to do so from the Licensee.	F			
			THE TAXABLE PARTY.			
	1	with the staff #2 revealed:				
	1	lications out of the personal			1	
	pill packets for the cl					
	-one was instructed	to do so from the Licensee.				
	Interview on 7/13/21	with the Licensee revealed:				
	1	staff found it difficult to				
	-	s' medications from the				
	prescription bottles					
Division of He	alth Service Regulation					

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From: Lisa Morrison

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Division o	of Health Service Regu	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAIN	OF CORRECTION	IDENTIFICATION NOIMBER.	A. BUILDING		COMPL	EIEB
		MHL0411172	B. WING		07/1	4/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE	***************************************	377
DILAGEOG	eris santoso 110	1906 GRE	ENSTONE PL	ACE		
SUCCESS	FUL VISIONS, LLC	HIGH PO	NT, NC 27265	<b>.</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE IATE	(X5) COMPLETE DATE
V 117	medications in the inclients. I asked the standications that way -Was aware of the ne requirements/informatedications when the -Would ensure facility	e easier for staff to put the dividual packets for the aff to administer the " eeded ation to have on prescription	V117	Staff held a medication training for employ on July 14 <sup>th</sup> 2021, to address medication management requirements. Staff also implemented new policies about Medical FAdministration and the consequences if not properly followed.		7/14/2021
V 118	only be administered order of a person aut drugs.  (2) Medications shall clients only when aut client's physician.  (3) Medications, incluadministered only by unlicensed persons to pharmacist or other liprivileged to prepare  (4) A Medication Admall drugs administered current. Medications recorded immediately MAR is to include the (A) client's name;  (B) name, strength, at (C) instructions for according to the contractions of the contractions	istration: in-prescription drugs shall to a client on the written horized by law to prescribe  be self-administered by horized in writing by the uding injections, shall be licensed persons, or by rained by a registered nurse, egally qualified person and and administer medications. inistration Record (MAR) of d to each client must be kept administered shall be y after administration. The e following:	V118			

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From: Lisa Morrison

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION		SURVEY PLETED	
		MHL0411172	B. WING		07	//14/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		1111	
SUCCESS	SFUL VISIONS, LLC		EENSTONE PLAC	CE			
	0.000		NNT, NC 27265				
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCES		PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From pag	e 17	V 118				
	checks shall be reco	or medication changes or rded and kept with the MAR opointment or consultation		·			
	This Rule is not met						
	Based on record reviews and interviews, the facility staff failed to ensure medications were immediately recorded after administration for 4 of 4 current clients (#1, #2, #3 and #4). The findings are:						
	-An admission date of -Diagnoses of Diagn Disorder, Unspecifie Hyperactivity Disorder Trauma and Stresso Specified Schizophre-A physician's order, following medication dinner every night G	oses of Oppositional Defiant					
·	2021 revealed: -Blanks on the MAR on the following date 7/8 -Blanks on the MAR the following dates: 7/1, 7/2, 7/4, 7/5, 7/6	f client #1's MAR for July for Guanfacine 3mg tablets es: 7/1, 72, 7/4, 7/5, 7/6 and for Amantadine 100mg on i, 7/11 for Latuda 30mg on the					

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13362178842

From: Lisa Morrison

Division o	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION		SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
			-			
		MHL0411172	B. WING		07	/14/2021
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,			
SUCCESS	FUL VISIONS, LLC		EENSTONE PLACE	=		
		HIGH PC	DINT, NC 27265			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A		COMPLETE DATE
,,,,,,,		•		DEFICIENCY)		
V 118	Continued From pag	e 18	V 118			
					-	
	following dates:7/1, 7	7/4, 7/6, 7/8, 7/11				
	Boulous on 7/12/21 o	f client #2's record revealed:				
	-An admission date of					
		ecified Schizophrenia				
		Psychotic Disorder, Conduct				
		Onset Type, Disruptive Mood				
		ler (DMDD), Post-Traumatic				
	Stress Disorder (PTS					
	Obsessive-Compuls					
	Unspecified.					
	-Physician's order da	ted 2/10/21 for the following				
	medications: Trazod	- , ,				
	-	ated 2/12/21 for the following				
		D, 2,000 Units, 1poqd				
		ated 3/17/21 for the following				
		azole 5mg, 1poqhs, for				
	***	ine 100mg, ½ pobid for				
	DMDD.					
	   Review on 7/13/21 o	f client #2's MARs, from				
	7/1/21 to 7/12/21 rev		]			
		for Trazodone 150mg from				
	7/2 to 7/6, 7/8 and 7/					
	-Blanks on the MAR	for Aripiprazole 5mg from 7/2				
	to 7/6, 7/8 and 7/11					
		for Lamotrigine 100mg from				
	7/2 to 7/6, 7/8, 7/10	and 7/11				
	Davious of allows #01-	record revealed:				
1	Review of client #3's -An admission date of					
		uct Disorder Childhood-Onset				
	, -	od Dysregulation Disorder,				
	Schizoaffective Diso					
		m, ADHD, Combined Type.				
		s dated 6/22/21 for the		·	$\Sigma$	
	following medication	s: Guanfacine 2pmg,				
		mg, 1poq5pm, Jornay 40mg,				
	1poq5pm, Olanzapir	ne 30mg, 1poqd, and				
	Melatonin 3mg, 4pod	д5рт (12mg)				
	alth Service Regulation	<u> </u>				

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From: Lisa Morrison

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(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A, BUILDING: B. WING MHL0411172 07/14/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1906 GREENSTONE PLACE SUCCESSFUL VISIONS, LLC HIGH POINT, NC 27265 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) V 118 V 118 Continued From page 19 Review on 7/13/21 of client #3's MARs, from 5/1/21 to 7/12/21 revealed: -Blanks on the MARs for all medications on 5/1 to 5/3, 5/8 and 5/9 --Blanks on the MARs for all medications on 7/2 through 7/6 and on 7/8 and 7/11 Review of client #4's record revealed: -An admission date of 9/23/20 -Diagnoses of ODD, ADHD and DMDD -A physician's order dated 9/20/20 for the following medications: Clonidine 0.2mg, 1poghs Review on 7/13/21 of client #4's MARs, from 6/1/21 to 7/12/21 revealed: -Blanks on the MARs for Clonidine 0.2mg 6/19, 6/20 and 6/26 -Blanks on the MARs for Clonidine 0.2mg on 7/3 to 7/6, 7/8 and 7/11 Interviews on 7/12/21 with clients #1, #2, #3 and #4 revealed: -Their medications were administered to them by staff. Interviews on 7/14/21 with staff #2 revealed: -Medications are kept in a locked cabinet -You were not to touch the medications, but you can put in them in a cup -Qualified Professional #2 (QP #2) was notified when there were blanks on the MARs. -When asked if he had seen blanks on the MARs recently, staff #2 stated "yes, but I do not want to get anvone in trouble ..." Interview on 7/12/21 with the Associate Professional (AP) revealed: -Had noticed blanks on the client's MARs. -"There were no initials, so I am not sure whether

Division of Health Service Regulation

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From: Lisa Morrison

PRINTED: 07/16/2021

FORM APPROVED

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WNG MHL0411172 07/14/2021

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS. CITY, STATE, ZIP CODE

## 1906 GREENSTONE PLACE

SUCCESS	JCCESSFUL VISIONS, LLC  HIGH POINT, NC 27265						
(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) COMPLETE DATE			
V 118	Continued From page 20 or not medications were given." -She was sure the clients were getting their medications, "but I think I staff are just forgetting to document" -Seeing the individual pill packets was new to her"It is not the best form (to administer medications). It was an automatic red flag for me"	V 118	Staff held a medication training for employees on July 14 <sup>th</sup> , 2021, to address medication management requirements. Staff also implemented new policies about Medical Records Administration and the consequences if not properly followed.	7/14/2021			
77	Interview on 7/13/21 with Qualified Professional (QP #2) revealed: -"I am working on the MARs. I know you have seen them. I do not like the pharmacy (current). [The Licensee] was calling another pharmacy right now to get them switched (to a new pharmacy)"						
	Interviews on 7/13/21 and 7/14/21 with the Licensee revealed: -Was responsible for reviewing the MARs monthly to ensure there were no issues"It's our policy for me to review the MARs, but I have not reviewed them this month." -It was recently brought to her attention there were blanks on the MARsWould ensure facility staff was retrained on Medication Administration						
V 294	27G .1702 Residential Tx. Child/Adol -Req. for Q P  10A NCAC 27G .1702 REQUIREMENTS OF QUALIFIED PROFESSIONALS (a) Each facility shall utilize at least one direct care staff who meets the requirements of a qualified professional as set forth in 10 A NCAC 27G .0104(18). In addition, this qualified professional shall have two years of direct client care experience. (b) For each facility of five or less beds:	V 294					

Division of Health Service Regulation

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From: Lisa Morrison

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(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A. BUILDING; B. WING MHL0411172 07/14/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1906 GREENSTONE PLACE SUCCESSFUL VISIONS, LLC HIGH POINT, NC 27265 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 294 Continued From page 21 V 294 (1) the qualified professional specified in Paragraph (a) of this Rule shall perform clinical and administrative responsibilities a minimum of 10 hours each week; and (2)70% of the time shall occur when children or adolescents are awake and present in the facility. (c) For each facility of six or more beds: the qualified professional specified in (1) Paragraph (a) of this Rule shall perform clinical and administrative responsibilities a minimum of 32 hours each week; and (2) 70% of the time shall occur when children or adolescents are awake and present in the facility. (d) The governing body responsible for each facility shall develop and implement written policies that specify the clinical and administrative responsibilities of its qualified professional(s). At a minimum these policies shall include: supervision of its associate professional(s) as set forth in Rule .1703 of this Section: (2)oversight of emergencies: provision of direct psychoeducational (3)services to children or adolescents; (4) participation in treatment planning meetings: coordination of each child or (5)adolescent's treatment plan; and provision of basic case management functions. This Rule is not met as evidenced by:

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13362178842

From: Lisa Morrison

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING; \_\_\_ B. WING MHL0411172 07/14/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1906 GREENSTONE PLACE SUCCESSFUL VISIONS, LLC HIGH POINT, NC 27265 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY V 294 Continued From page 22 V 294 Based on record reviews and interviews, 1 of 2 Qualified Professionals (QP #1) failed to perform clinical and administrative responsibilities 70% of the time when children or adolescents were awake and present at the facility. The findings are: Review on 7/13/21 of the QP #1's record revealed: -A hire date of 8/28/20 -A job description of a QP Interviews on 7/12/21 with clients #1, #2, #3 and #4 revealed: -They did not know the QP #1's name when asked. -"Who is that? I haven't ever seen him here." Interview on 7/14/21 with QP #1 revealed: -Had previously been through the survey process. -"I know how the state comes in and tells you the things you need to do as well ..." -Stated he was rarely at the facility in person -"But I have been there for a couple of hours a week. I mainly do things over the phone. We have had a lot of turn over. I have not been at the facility since I recently got a new job. Now that [the Qualified Professional #2 (QP #2)] has been hired, she would be at the facility Monday through Friday." -When asked about documentation and meeting with the clients, he stated, "hmmm there have been notes but none recently. We share responsibility with [the other QP (#2)] ..." -Stated before QP #2 took the position, he would be at the facility a couple of hours per week. Interview on 7/13/21 with the Licensee revealed: -Was aware QP #1 was not coming to the facility when clients were present 70% of the time

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From: Lisa Morrison

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: A MING MHL0411172 07/14/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1906 GREENSTONE PLACE SUCCESSFUL VISIONS, LLC HIGH POINT, NC 27265 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ın (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX CROSS-REPERENCED TO THE APPROPRIATE DATE REGULATORY OR USC (DENTIFYING INFORMATION) TAG TAG DEFICIENCY) QP will be at the facility 32 hours while the 8/30/2021 V 294 V 294 Continued From page 23 children are awake. -"It was due to COVID. I have hired [QP #2] to be at the facility Monday through Friday." V 296 27G .1704 Residential Tx. Child/Adol - Min. V 296 Staffing 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: two direct care staff shall be present for one, two, three or four children or adolescents: three direct care staff shall be present for five, six, seven or eight children or adolescents: and four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff during child or adolescent sleep hours is as follows: two direct care staff shall be present (1)and one shall be awake for one through four children or adolescents; two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in

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From: Lisa Morrison

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Division o	of Health Service Regul	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S COMPLI	
·····		MHL0411172	B. WING		07/1	4/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
OUCCECC	THE MOIONS IN C	1906 GRE	ENSTONE PLA	CE		
SUCCESS	FUL VISIONS, LLC	HIGH PO	NT, NC 27265			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 296	Continued From page	e 24	V 296			
V 296	the facility based on individual needs as splan.  (e) Each facility shall supervision of childre are away from the facility or adolescent's needs as specified in.  This Rule is not met Based on observation failed to ensure the typesent for one, two, adolescents. The find Observations on 7/12 9:50am to 10:14am, IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	the child or adolescent's pecified in the treatment  be responsible for ensuring on or adolescents when they cility in accordance with the individual strengths and the treatment plan.  as evidenced by: as and interviews, the facility we direct care staff were three or four children or dings are:  2/21, from approximately revealed: asional (AP) was alone at a this hift at 10:14am  on 7/12/21, at approximately ein the front yard of the one the office area is were in the back yard on ack yard, on her phone, and	V 296			
	, , , , , , , , , , , , , , , , , , , ,					

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2021-12-06 20:02:39 GMT

13362178842

From: Lisa Morrison

PRINTED: 07/16/2021 FORM APPROVED

Division o	f Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED.
_		MHL0411172	B. WING		07/1	14/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE. ZIP CODE		
	,		EENSTONE PLA	•		
SUCCESSFUL VISIONS, LLC HIGH F			DINT, NC 27265			
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN OF CORRECTION	N	(X5)
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V 296	Continued From pag	^ 2K	V 296			
V 250	Continued From pag	e 25	V 290			
·	0 744	AMA Farrer				
	Observations on 7/13 2:44pm, revealed:	3/21, from approximately				-
		ving room and hallway,				
	playing around with r		-			
	-All 3 of the staff pres	sent remained in the office.				
		#4 were in the hallway horse				
	playing	o office door talking with 2				
	-Client #1 stood at the office door, talking with 3 staff.					
		he facility and asked the				
	Licensee if he could					
		the front yard/driveway				
	<ul><li>-2 staff remained in t</li><li>-The Licensee was b</li></ul>	he office working on files				
		d unsupervised outside.				
	, ,		***************************************			
		ne surveyors observed all				
		in sight given the position of				
	where the 2 staff we	re sitting in the office.				
	Interview on 7/12/21	with client #1 revealed:				
	-Usually there were 2	2 staff at the facility on each				
	shift.					
		wakes up during the night night, there is usually only 1	<b>!</b>	t 		
		/21) there was only 1 staff on				
	third shift. It happens					
		with client #2 revealed:				
		only (staff) here (at the staff #7] or [staff #8]"				
		manners and an factoring and an				
	Interview on 7/12/21	with client #3 revealed:				
		client/staff ratios at the				
		ed "there is usually either 1 or				
	2 staff on the shifts. only one until [staff#	But this morning, there was				
	Only One until [stall #	ij gotilolo				

Interview on 7/12/21 with client #4 revealed:

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13362178842

From: Lisa Morrison

PRINTED: 07/16/2021

FORM APPROVED

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A. BUILDING: B. WING MHL0411172 07/14/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1906 GREENSTONE PLACE SUCCESSFUL VISIONS, LLC HIGH POINT, NC 27265 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRFFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Staff has completed hiring to reflect 2 staff on each 7/14/2021 V 296 Continued From page 26 V 296 -There were usually two staff working at the -Had gotten up one night "and there was only 1 staff here." Interview on 7/12/21 with staff #1 revealed: -Was on the schedule to work first shift, 8am to 4pm. on 7/12/21 -He son was having surgery on 7/12/21 Interview on 7/12/21 with the AP revealed: -She had only been working at the facility for 5 davs -Her shift was Monday through Friday from 8am to 4pm -Staff #1 was scheduled to work first shift on 7/12/21 -"She called to say her son was having surgery and [staff #2] was on his way ..." Interview on 7/14/21 with the Qualified Professional #1 -The client/staff ratio was 2 staff to every 1, 2, 3, 4 clients. -Was not sure why there was only 1 staff present when the surveyors arrived at the facility. Interview on 7/14/21 with the Licensee revealed: -Was aware the client/staff ratio was a minimum of 2 staff for every 4 clients. -She was not aware staff #1 would be out on 7/12/21 -With COVID it was hard to keep staff. -"We have had a lot of turn over." Staff will report each Level 1 incident in an incident 8/23/2021 log within the facility. Staff will complete each level V 367 27G .0604 Incident Reporting Requirements V 367 2 incident within IRIS, all incidents' reports whether 1 or 2 will be submitted quarterly (any time the police 10A NCAC 27G .0604 INCIDENT come out the incident report will be completed in REPORTING REQUIREMENTS FOR

Division of Health Service Regulation

iris).

PRINTED: 07/16/2021 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ MHL0411172 B. WING 07/14/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1906 GREENSTONE PLACE SUCCESSFUL VISIONS, LLC HIGH POINT, NC 27265 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE PROVIDER'S PLAN OF CORRECTION ID

Division of Health Service Regulation

TAG

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

PREFIX

TAG

RYF511

DATE

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

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13362178842

From: Lisa Morrison

V 367	Continued From page	27	V 367			
	level II incidents, except the provision of billab consumer is on the princidents and level II to whom the provider 90 days prior to the ir responsible for the caservices are provided becoming aware of the submitted on a for Secretary. The report in person, facsimile of means. The report in person, facsimile of means. The report information:  (1) reporting providentification information: (2) client identification information: (3) type of incidentification information: (4) description of the cause of the incident; (5) status of the cause of the incident; (6) other individent or responding. (b) Category A and B missing or incomplete shall submit an updat report recipients by the day whenever: (1) the provided erroneous, misleading (2) the provided required on the incided unavailable. (c) Category A and B upon request by the I obtained regarding the	providers shall report all ept deaths, that occur during le services or while the oviders premises or level III deaths involving the clients rendered any service within reident to the LME techment area where within 72 hours of e incident. The report shall improvided by the transport of electronic all include the following ovider contact and ion; ication information; ent; of incident; effort to determine the and luals or authorities notified providers shall explain any einformation. The provider ed report to all required the end of the next business thas reason to believe that in the report may be gor otherwise unreliable; or obtains information and form that was previously providers shall submit, LME, other information e incident, including:				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	(X3) DATE SURV COMPLETE	
	- W-44-W-44-W-44-W-44-W-44-W-44-W-44-W-	MHL0411172	B. WING		07/14/2	021
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA E <b>nstone pl</b> a	•		
SUCCESS	FUL VISIONS, LLC		T. NC 27265	NOE		
/VALUE	CI HAMADV OT	ATEMENT OF DEFICIENCIES	1	DBUNDEDIG DI ANI DE CODDECTION		(AE/
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IVISION OF HEA TATE FORM	Ith Service Regulation		6899	DVE511	If continuation si	neet 29 nf 44
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From: Lisa Morrison

V 367	Continued From page	28	V 367			
	information; (2) reports by o (3) the provider (d) Category A and B of all level III incident Mental Health, Develo Substance Abuse Ser becoming aware of the providers shall send a incidents involving a d Health Service Regula becoming aware of the client death within set or restraint, the provid immediately, as requi .0300 and 10A NCAC (e) Category A and B report quarterly to the catchment area where The report shall be su by the Secretary via e include summary info (1) medication (2) restrictive in the definition of a level II o (2) restrictive in the definition of a level (3) searches of (4) seizures of (4) seizures of (5) the total nur incidents that occurre (6) a statement been no reportable in incidents have occurr meet any of the criteri (a) and (d) of this Rule through (4) of this Par	a copy of all level III slient death to the Division of ation within 72 hours of the incident. In cases of the incident. In cases of the incident. In cases of the incident of the eigenstate of seclusion of the shall report the death of the incident of the eigenstate of the eigensta				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE S COMPLI	
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From: Lisa Morrison

V 367	Continued From page	29	V 367			
	facility failed to Level submitted to the Loca	as evidenced by:  ews and interviews, the  Il incident reports were  I Management Entity (LME)  quired. The findings are.				
		the Incident Response (IRIS) revealed no Level II months.	•		:	
	-The police came out -"They come out beca	with client #2 revealed; to the facility. ause of another client. He way and he threatened				
	year (2021)	e had come to the facility this evious client that was no				
	Interview on 7/14/21 with staff #2 revealed:  -He had called the police in the past.  -Had not completed any incident reports  -Had called the police to come and speak with the former client  Interview on 7/14/21 with Qualified Professional #1 revealed:  -When asked about incidents, she stated "I would assume the person here during the incident					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE S COMPL	
		MHL0411172	B. WING		07/1	14/2021
	ROVIDER OR SUPPLIER SFUL VISIONS, LLC	1906 GRE	DRESS, CITY, ST	ACE		
	#\.^^		INT, NC 27265			
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Division of Hea	alth Service Regulation		6999	RYF511	If continuat	ion sheet 31 of 44

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From: Lisa Morrison

V 367	-The only incident rep an incident that occur November 2020Was aware the police recently.  27E .0107 Client Right Int.  10A NCAC 27E .0107 ALTERNATIVES TO INTERVENTIONS (a) Facilities shall impractices that emphase to restrictive intervent (b) Prior to providing disabilities, staff inclue employees, students demonstrate compete completing training in other strategies for crubich the likelihood or injury to a person verification of the provider agencies based on state compete compliance and demogathered. (d) The training shall include measurable testing (we shall a surable testing	with the Licensee revealed: ort submitted into IRIS was red with a former client in exame to the facility  ts - Training on Alt to Rest.  TRAINING ON RESTRICTIVE  Delement policies and size the use of alternatives ions. services to people with ding service providers, or volunteers, shall ence by successfully communication skills and eating an environment in fimminent danger of abuse with disabilities or others or revented. Se shall establish training etencies, monitor for internal constrate they acted on data the competency-based, earning objectives, written and by observation of	V 367	Staff will report each Level 1 incident in an ir log within the facility. Staff will complete eac 2 incident within IRIS, all incidents' reports v 1 or 2 will be submitted quarterly (any time the come out the incident report will be complete iris).	th level whether he police	
	include measurable le measurable testing (v behavior) on those of methods to determine course.	earning objectives,	1 ' '	LE CONSTRUCTION ()	(3) DATE SURV COMPLETED	
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Division of Hea	l alth Service Regulation		6899	RYF511	If continuation sh	l neet 32 of 44

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13362178842

From: Lisa Morrison

Division o	of Health Service Regul	lation			TOTAL TROVES
V 536	Continued From page	e 31	V 536		
	by each service provident annually).  (f) Content of the traprovider wishes to enthe Division of MH/DI Paragraph (g) of this (g) Staff shall demonfollowing core areas:  (1) knowledge people being served;  (2) recognizing behavior;  (3) recognizing external stressors that disabilities;  (4) strategies for relationships with performation or an interest of the person decisions about their (7) skills in assescalating behavior;  (8) communication and de-escalating pot and (9) positive behaviors which are of the person decisions are person decisions and the person decisions are pers	der periodically (minimum ining that the service apploy must be approved by D/SAS pursuant to Rule.  Instrate competence in the and understanding of the and interpreting human at the effect of internal and at may affect people with or building positive sons with disabilities; a cultural, environmental and at that may affect people with the importance of and and in a that may affect people with the importance of and and in a that may affect people with a the importance of and and in a that may affect people with a the importance of and and in a that may affect people with a the importance of and and in a that may affect people with a the importance of and and in a that may affect people with a the importance of and and in a that may affect people with a the importance of and and in a that may affect people with a that may affect people	V 536		
	(A) who particip outcomes (pass/fail);	ution shall include:  Pated in the training and the  where they attended; and			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	' '	***************************************	COMPLETED
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NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE	
SUCCESS	FUL VISIONS, LLC		ENSTONE PL		
	01) 24 54 67	<del></del>	NT, NC 27265		
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From: Lisa Morrison

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<u>Division o</u>	f Health Service Regul	ation				
V 536	Continued From page	32	V 536			
	(C) instructor's	name.				
		of MH/DD/SAS may				
		ocumentation at any time.	1			
	(i) Instructor Qualifica					
	Requirements:					
	•	all demonstrate competence				
		esting in a training program				
		educing and eliminating the				
	need for restrictive int					
		all demonstrate competence				
-	. ,	grade on testing in an				
	instructor training pro					
	(3) The training					
		nclude measurable learning				
	•	le testing (written and by				
		or) on those objectives and				
		to determine passing or				
	failing the course.					
		t of the instructor training the	-			
}	service provider plans		1			
	• •	ion of MH/DD/SAS pursuant				
	to Subparagraph (i)(5					
		instructor training programs				
		not limited to presentation of:				
		ng the adult learner;				
	(B) methods for	r teaching content of the				
	course;					
	(C) methods for	r evaluating trainee				
	performance; and					
	(D) documentati	ion procedures.				
	(6) Trainers sha	all have coached experience				
	teaching a training pr	ogram aimed at preventing,				
	reducing and eliminat	ting the need for restrictive				
	interventions at least	one time, with positive	·			
	review by the coach.					
	(7) Trainers sha	all teach a training program				
	aimed at preventing, i	reducing and eliminating the				
	need for restrictive in	terventions at least once				
	annually.		·			
	•					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
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Division of Health Service Regulation

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From: Lisa Morrison

V 536	Continued From page	33	V 536							
	(8) Trainers shall instructor training at let (j) Service providers a documentation of initial training for at least thr (1) Docume (A) who participe outcomes (pass/fail); (B) when and w (C) instructor's (2) The Division request and review this (k) Qualifications of C (1) Coaches shall requirements as a train (2) Coaches shall competence by compitation-the-trainer instru (l) Documentation shall as for trainers.  This Rule is not met a Based on record reviet facility failed to ensure alternatives to restrict findings are:	all complete a refresher east every two years. shall maintain al and refresher instructor ee years. Intation shall include: ated in the training and the shere attended; and name. In of MH/DD/SAS may is documentation any time. It is documentation any time. It is all teach at least three times being coached. It is all demonstrate letion of coaching or coaching or coached. It is all be the same preparation all be the same preparation interviews, the estaff had initial training on ive interventions. The								
~~ · ~ · · · · · · · · · · · · · · · ·	alternatives to restrict		0(0) M B 700)		3(0) DATE OF THE STATE OF THE S					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1906 GREENSTONE PLACE  HIGH POINT, NC 27265										
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From: Lisa Morrison

V 536	Continued From page	34	V 536	Training on client de-escalation and NCI v	vill be held 8/1 1/2	021
	Review on 7/12/21 of the Qualified Professional #1 revealed: -No documentation of initial training on alternatives to restrictive interventions.  Interview on 7/12/21 with the AP revealed: -The facility had not provided training on alternatives to restrictive interventionsThe Licensee had scheduled the training 2 weeks from today's date.  Interview on 7/13/21 with the Licensee revealed: -The agency worked very hard in using verbal de-escalation with the clientsHad reached out to the instructor whom provided the trainingIn approximately two weeks, staff that are not training in alternatives to restrictive interventions, would be trained.  V537  27E .0108 Client Rights - Training in Sec Rest & ITO  10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or		V 536	Training on client de-escalation and NCI von 8/11/2021	vill be held 8/11/2	021
OT ATCHENT	•		0/0) 14 0 705	S A A MOTEUR (STICK)	0.00 m 6 mm 20 (m) 4m	
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From: Lisa Morrison

Division o	f Health Service Regula	ation				
V 537	Continued From page	35	V 537			
V 537	volunteers shall comp seclusion, physical rea and shall not use these training is completed a demonstrated.  (c) A pre-requisite for demonstrating competrating in preventing, the need for restrictive (d) The training shall include measurable testing (whose between the demonstration on those observation of the training shall include measurable testing (whose between the demonstration of the training shall include measurable testing (whose to determine course.  (e) Formal refresher the demonstration of the training provider plans to empthe Division of MH/DE Paragraph (g) of this (g) Acceptable training that are not limited to, (1) refresher information of the use of restrictive in (2) guidelines of (understanding imminothers);  (3) emphasis of rights and dignity of a concepts of least restrictive interventions which in assessment and more	elete training in the use of straint and isolation time-out the interventions until the and competence is a taking this training is tence by completion of reducing and eliminating is interventions. The competency-based, parning objectives, written and by observation of objectives and measurable is passing or failing the training must be completed der periodically (minimum ming that the service loy must be approved by D/SAS pursuant to Rule.  The programs shall include, presentation of: formation on alternatives to interventions; on when to intervene tent danger to self and in safety and respect for the all persons involved (using rictive interventions and an intervention); or the safe implementation cions; imergency safety	V 537			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE S	IIRVEY
	OF DEFICIENCIES DE CORRECTION	IDENTIFICATION NUMBER:	į.	E CONSTRUCTION	COMPL	
		MHL0411172	B. WING		07/1	4/2021
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA			
SUCCESSFUL VISIONS, LLC		ENSTONE PLA	ACE			
			NT, NC 27265			
(X4) ID PREFIX TAG	(EACH DEFICIENC) REGULATORY OR L	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
ivision of Hea TATE FORM	alth Service Regulation		6899	RYF511	If continuat	on sheet 37 of 44

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13362178842

From: Lisa Morrison

Division o	f Health Service Regul	ation	-		
V 537	Continued From page	36	V 537		
	use of restraint through restrictive intervention (6) prohibited p (7) debriefing simportance and purpor (8) documentation of initiat least three years.  (1) Documentation of initiat least three years.  (1) Documentation of initiat least three years.  (1) Documentation of initiat least three years.  (2) The Division review/request this documentation of initiation in the content of the content	ghout the duration of the n; rocedures; trategies, including their ose; and ion methods/procedures. shall maintain al and refresher training for tion shall include: ated in the training and the where they attended; and name. In of MH/DD/SAS may ocumentation at any time. Action and Training all demonstrate competence esting in a training program reducing and eliminating the terventions. In all demonstrate competence esting in a training program reducing and eliminating the terventions. In all demonstrate competence esting in a training program reducing and eliminating the terventions. In shall be include measurable learning lie testing (written and by or) on those objectives and to determine passing or the first of the instructor training the is to employ shall be sign of MH/DD/SAS pursuant			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL0411172	B. WING		07/14/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
SUCCESS	FUL VISIONS, LLC		ENSTONE PLA	ACE	
			NT, NC 27265		
(X4) ID PREFIX TAG	(EACH DEFICIENC) REGULATORY OR L	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETE
ivision of Hea TATE FOR <mark>M</mark>	alth Service Regulation		6899	RYF511	If continuation sheet 38 of 44

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From: Lisa Morrison PRINTED: 07/16/2021 FORM APPROVED

		~-	11.50-			
V 537	Continued From page	37	V 537			
	(6) Acceptable	instructor training programs				
		be limited to, presentation				
	of:	·				
	(A) understandi	ng the adult learner;				
		r teaching content of the				
	course;					
	(C) evaluation	of trainee performance; and				
		ion procedures.				
	, <del>,</del>	all be retrained at least				
		trate competence in the use				
	of seclusion, physical	restraint and isolation			•	
		in Paragraph (a) of this				
	Rule.					
	(8) Trainers sh	all be currently trained in				
	CPR.					
	(9) Trainers sh	all have coached experience				
		f restrictive interventions at				
		a positive review by the				
	coach.					
	(10) Trainers sh	all teach a program on the				
	use of restrictive inte	rventions at least once				
	annually.					
	(11) Trainers sha	all complete a refresher				
	instructor training at I	east every two years.				
	(k) Service providers shall maintain documentation of initial and refresher instructor					
	training for at least th	ree years.				
	(1) Documenta	tion shall include:				
	(A) who particip	ated in the training and the				
	outcome (pass/fail);					
	(B) when and v	vhere they attended; and				
	(C) instructor's	name.				
		n of MH/DD/SAS may				
		ocumentation at any time.				
	(I) Qualifications of C					
	(1) Coaches sh	nall meet all preparation				
	requirements as a tra	iner.				
	` '	nall teach at least three				
	times, the course whi	ch is being coached.				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	LE CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	:	COMPL	ETED
		MHL0411172	B. WING		07/°	14/2021
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, S			
SUCCESS	FUL VISIONS, LLC		REENSTONE PI			
	·	HIGH P	OINT, NC 2726	5		
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IAG		man makes in coose or Crawiti Delay	IMG	DEFICIENCY)	10/31 <b>C</b>	
ivision of Hea	alth Service Regulation					<u></u>
TATE FORM	•		6699	RYF511	If continuat	ion sheet 39 of 44

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13362178842

Staff has scheduled the training on clients' rights on 8/11/2021

From: Lisa Morrison

V 537	Continued From page	38	V 537	Staff has scheduled the training on clients' 8/11/2021, training will be	rights on	8/11/2021
	(3) Coaches sh competence by comp train-the-trainer instru (m) Documentation s preparation as for train	ction. hall be the same		completed by Licensed Professional.		
	facility failed to ensure seclusion, physical retime-out. The findings Review on 7/13/21 of (AP)'s record revealed. No documentation of physical restraint and Review on 7/13/21 of #1's record revealed: No documentation of physical restraint and Interview on 7/12/21 v-She had not had train restraint and isolation. "[The Licensee] told can provide the training Interview on 7/13/21 v-Had reached out to the training.	ews and interviews, the estaff were trained in straint and isolation are:  the Associate Professional disolation time-out the Qualified Professional training in seclusion, isolation time-out with the AP revealed: ning in seclusion, physical time-out me she has someone that				
	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE S COMPL	
		MHL0411172	B, WING		07/1	4/2021
	ROVIDER OR SUPPLIER SFUL VISIONS, LLC	1906 GRE	DRESS, CITY, STA Enstone Pla NT, NC 27265	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC) REGULATORY OR L	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
ivision of Hea TATE FORM	alth Service Regulation		6899	RYF511	If continuat	ion sheet 40 of 44

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13362178842

From: Lisa Morrison

Division o	f Health Service Regul	ation	· · · · · · · · · · · · · · · · · · ·		
V 736	Continued From page	39	V 736		
V 736	27G .0303(c) Facility	and Grounds Maintenance	V 736		
		EMENTS			
	staff failed to ensure	ns and interviews, the facility the facility and its grounds safe, clean, orderly and			
		de of the facility revealed: e facility's outside walls was			
The state of the s	-There were 3 rodent -There was a hole, ap 12 inches, in the midd	traps around the home.  proximately 18 ½ inches by  lle of the deck.  ainst the facility in both the			
	the home	entified tanks on the side of ere down in and around the tside of the facility's			
111/27	Observations on 7/12 11:05am, of the inside -Mouse dropping were kitchen drawer near the	e of the facility revealed: e located inside the right			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL0411172	B. WING		07/14/2021
	ROVIDER OR SUPPLIER	1906 GRE	DRESS, CITY, STA ENSTONE PLA NT, NC 27265		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR' DEFICIENCY)	BE COMPLETE
Division of Hea	lth Service Regulation		6899	RYF511	If continuation sheet 41 of 44

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From: Lisa Morrison

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V 736	Continued From page	40	V 736			
	and a pot had been pl	aced under it to catch the		O A A A A A A A A A A A A A A A A A A A		
]	water.		- Landanian	and the state of t		}
		closet had no lock on it.				1
		ing over the mirror in the				
	clients' bathroom.	anar in the clients!				
	-There was no toilet p bathroom.	aper in the clients		·		
		nder the sink in the clients'				
	bathroom.	idor aro onitrir aro anonto	***************************************			
		en in client #3 and #4's				
	bedroom					
	-Blinds were also brol	ken in the kitchen.			***************************************	
	Interview on 7/12/21	with staff #1 revealed:				
	-Was not aware of mo	ouse droppings in the				
	kitchen drawer					
		ce or bugs in the facility.				
		pest control comes out			4	
	every 2 or 3 weeks to the facility."	spray inside and outside				
		vare of the hole in the deck.				
	1	ne two tanks, staff#1 stated				
	"I don't know what the	e tanks are"				
		with staff #2 revealed:				
		th mice about 4 months ago.				
	When the weather sta					
	see them personally	e mice outside, "but I didn't			Ì	
	-Pest control had been out to the facility and put 3 boxes outside of the facility and one in the					
	kitchen.		Į.		Ť	
	-" I haven't seen noth	ing inside of the home. I				
	l	rawers in the kitchen. I use				
	the one by the stove					
	1	s "suitable" for a group				
	home			Į.	***************************************	
	Interview on 7/12/21	with the Associate				
	Professional (AP) rev					
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	,	COMPLE	IED
		MHL0411172	B. WING		07/14	1/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	FATE, ZIP CODE		
SUCCESS	SFUL VISIONS, LLC	1906 GF	REENSTONE PL	ACE		
		HIGH PO	OINT, NC 2726	5		
(X4) ID		ATEMENT OF DEFICIENCIES	۵I	PROVIDER'S PLAN OF CORREC		(X5)
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	alth Service Regulation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
TATE FORM	1		6899	RYF511	If continuation	n sheet 42 of 44

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From: Lisa Morrison

	<u> </u>			T T		
V 736	Continued From page	41	V 736			
***************************************	-During the walk throu	igh of the facility with the				
	<u> </u>	nt dropping? No, No ma'am.				
	1	es? I didn't know about that.				
	My goodness."					
		odent traps outside of the				
	home.	·				
	-Had noticed the hole	in the deck				:
	-When asked about th	ne tanks located in the back				
	yard, the AP stated "I	don't know about these				
	tanks"					
	Interview on 7/12/21 v			1	1	
	Professional #1 (QP#	· ·				
		e, "but [the Licensee] talked ) about it. [The Licensee]	i i			
		professions to come and				
	address that.	professions to come and				
	\$	ing done, nearby, and felt				
	1	nice have been coming to				
	the home.	· ·				
		e Licensee, he was aware				
	that mice droppings h	ad been seen in the home.				
	Interview on 7/12/21	with the QP #2 revealed:				
	-"I really don't know a	bout the mouse droppings.				
	The home is pretty of	d, and the owner needs to				
		home. We are actually	ar e- va comme			
	looking for a new place	ce."				
	Interview on 7/12/21 v	with the Licensed				·
	Professional (LP) rev					
		ad seen any mice in the				
	facility, the LP stated	"Oh no. I do to into the				
		ow they are keeping their				
		ut the house. I go to the				
	1	ey are doing their chores. I				
	go outside. I have no	t noticed the mouse traps				
OTATEMEN)		(V4) SDAV(SER/ELISDI ITTO/CLIA	/V//\ k# # Time	E COMOTOMOTION	(VALDATE C	LIDS (TV)
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
			A. BOILDING,			
		MHL0411172	B. WING	AAA	07/4	4/2021
					1 0///	77.444.
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, ST. REENSTONE PL			
SUCCESS	SFUL VISIONS, LLC		DINT, NC 27265			
OVA: Im	TO VOLAMMIS	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	NI	(X5)
(X4) ID PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
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ivision of He	alth Service Regulation			DEI 10(ENO.17		
TATE FORM			6899	RYF511	If continuati	on sheet 43 of 44

13362178842

From: Lisa Morrison

Division o	f Health Service Regul	ation				
V 736	-Was aware there we -"The exterminator plantside to trap the mid- control." -Was not aware one of had mouse droppings -Would be talking to the making the needed re outside of the facility"This is an old house	with the Licensee revealed: re mice outside the facility. aced the black boxes be and keeping them under of the drawers in the kitchen in it. he landlord to see about apairs both inside and a. I am currently looking to bother location. A house that	V 736	Staff has contacted the owner of the home an him to fix everything that was insufficient su (mice droppings, dripping water from sink, w deck, residue from window).	ch as	30/2021
V 744	EQUIPMENT (b) Safety: Each facili constructed and equi	FACILITY DESIGN AND  ty shall be designed,  pped in a manner that  safety of clients, staff and	V 744			
	failed to ensure the faconstructed and equi- ensured the physical visitors. The findings Observation on 7/12/ 10:35am, of the inside	is and interviews, the staff icility was designed, oped in a manner that safety of clients, staff and are:				
	his bed and a table.  OF DEFICIENCIES	e heater located in between  (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION (	X3) DATE SUF	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:			COMPLET	
NAME OF PE	ROVIDER OR SUPPLIER		ADDRESS, CITY, STA		07/14/	2021
SUCCESS	FUL VISIONS, LLC		REENSTONE PLA DINT, NC 27265	40E		
(X4) ID PREFIX TAG	(EACH DEFICIENC REGULATORY OR I	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETE DATE
Division of Hea STATE FORM	Ith Service Regulation		8699	RYF511	If continuation	sheet 44 of 4

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From: Lisa Morrison

PRINTED: 07/16/2021 FORM APPROVED

Division of Health Service Regulation Staff has removed space heaters from the facility. 7/14/2021 V 744 V 744 Continued From page 43 Interview on 7/14/21 with the Department of Health and Human Service's Engineer Plan Reviewer revealed: -Since the facility was considered a residential care facility with more than 3 people, "the facility had to follow the building code sections which prevented portable space heaters." -"If the staff are using portable space heaters in the facility, they are not following the building codes." Interviews on 7/12/21 with client #2 revealed: -When asked about space heaters in the facility. client #2 stated "the space heaters have been here since I have been here." Interview on 7/14/21 with the Licensee revealed: -Was not aware space heaters were not allowed in the facility -Would immediately ensure all the space heaters were removed from the facility.

RYF511

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C  A. BUILDING:	(X3) DATE SURVEY COMPLETED	
	MHL0411172	B. WING		07/14/2021
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE	
SUCCESSFUL VISIONS, LLC	1906 GR	REENSTONE PLACE	≣	
	HIGH PO	DINT, NC 27265		
PREFIX (EACH DEFICIENCE	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETE
V 000 INITIAL COMMENTS	3	V 000		
2021. Deficiencies w	d for the following service 27G .1700 Residential			
V 107 27G .0202 (A-E) Pers	sonnel Requirements	V 107		
which:  (1) specifies the competency, work exqualifications for the p  (2) specifies the the position;  (3) is signed by supervisor; and  (4) is retained ir  (b) All facilities shall each staff member or provides care or servithe facility:  (1) is at least 18  (2) is able to reafollow directions;  (3) meets the micompetency, work exqualifications for the p  (4) has no substangled in the Nersonnel Registry.  (c) All facilities or senapplicants for employr	have a written job ector and each staff position eminimum level of education, perience and other position; duties and responsibilities of the staff member and the the staff member's file. ensure that the director, any other person who ces to clients on behalf of years of age; d, write, understand and nimum level of education, perience, skills and other		DHSR - Mental DEC 1 0 202 Lic. & Cert. Sec	1

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Executive Director 8/5/20

STATE FORM

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0411172 07/14/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1906 GREENSTONE PLACE SUCCESSFUL VISIONS, LLC HIGH POINT, NC 27265 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) V 107 | Continued From page 1 V 107 decision regarding employment shall be based upon the offense in relationship to the job for which the applicant is applying. (d) Staff of a facility or a service shall be currently licensed, registered or certified in accordance with applicable state laws for the services provided. (e) A file shall be maintained for each individual employed indicating the training, experience and other qualifications for the position, including verification of licensure, registration or certification. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 3 of 7 audited staff (#1, #2 and the Qualified Professional #2 (QP #2)) had a written and signed job description and verification to meet the minimum level of education. The findings are: Review on 7/13/21 of staff #1's record revealed:

Division of Health Service Regulation

-A hire date of 7/6/21

-A hire date of 8/28/20

-No written and signed job description -No documentation of verified education

-No written and signed job description -No documentation of verified education

Review on 7/13/21 of staff #2's record revealed:

Review on 7/13/21 of the Qualified Professional

(X3) DATE SURVEY

Division of Health Service Regulation

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION IDE		IDENTIFICATION NUMBER:	A. BUILDING	t	COMPI	LETED
		MHL0411172	B. WING		07/	14/2021
	ROVIDER OR SUPPLIER	1906 GF	DDRESS, CITY, ST	ACE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 107	#2 (QP #2) record rev -A hire date of 6/9/21 -No written and signed Interview on 7/13/21 w -The Licensee was re the staffs' recordsThe Licensee was re staff met the minimum position Interview on 7/14/21 w -Was responsible for e written and signed job -Was responsible for e minimum level of educe	ealed: d job description with QP #1 revealed: sponsible for maintaining sponsible for ensuring the level of education for the with the Licensee revealed: ensuring all staff had a description. ensuring the staff met the cation for the position	V 107	Trainings have been scheduled for staff for 8/11/2021, and the highest level of educe been placed in all files along with signed jo descriptions.		8/11/2021
V 106	(g) Employee training provided and, at a min following: (1) general organizati (2) training on client of delineated in 10A NCA 10A NCAC 26B; (3) training to meet the client as specified in the plan; and (4) training in infection bloodborne pathogens (h) Except as permitted.	personnel on shall be documented. programs shall be imum, shall consist of the onal orientation; rights and confidentiality as AC 27C, 27D, 27E, 27F and the mh/dd/sa needs of the ne treatment/habilitation the diseases and did under 10a NCAC 27G tapter, at least one staff table in the facility at all present. That staff	V 108			

(X2) MULTIPLE CONSTRUCTION

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) P

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL0411172	B. WING		07/14/2021
	PROVIDER OR SUPPLIER	1906 GR	DDRESS, CITY, STATE, EENSTONE PLACE DINT, NC 27265		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	D BE COMPLETE
V 108	including seizure mar to provide cardiopulm trained in the Heimlici techniques such as th the American Heart As equivalence for reliev (i) The governing bod implement policies an reporting, investigatin	nagement, currently trained onary resuscitation and naneuver or other first aid ose provided by Red Cross, sociation or their ng airway obstruction.	V 108		
	facility failed to ensure and the Qualified Prof trained on client right's Bourne Pathogens (B MR/DD needs of the otreatment/habilitation)  Review on 7/13/21 of s-A hire date of 8/27/20 -No documentation of needs of the clients  Review on 7/13/21 of s-A hire date of 8/28/20 -No documentation of confidentiality/HIPPA -No documentation of confidentiality/HIPPA -No documentation of needs of the clients	ews and interviews, the a 3 of 7 audited staff (#1, #2 essional #2 (QP #2)) were so, confidentiality, Blood BP) and training to meet the elients as specified in the plans. The findings are:  Staff #1's record revealed:  Staff #2's record revealed:  Staff #2's record revealed:			

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE (	PLE CONSTRUCTION (X3) [		SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		:	60 00	PLETED
			711 501251110			
		MHL0411172	B. WING		07/	/14/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE. ZIP CODE		
CHOOLOG	SELII MISIONO LLO		EENSTONE PL			
SUCCESS	SFUL VISIONS, LLC	HIGH PO	INT, NC 2726	i		
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	1	
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI	ATE	DATE
				DEFICIENCY)		
V 108	Continued From page	2 4	V 108	Staff has reincorporated supervisions the	4th 2021	8/11/2021
	#2 (QP #2)'s record re	evealed:		last supervisions were completed on July 14 and the next supervision will be held on Au		
	-A hire date of 6/9/2021			2021.	gust 11,	
	-No documentation of	training on client rights				
	-No documentation of					
	Confidentiality/HIPPA					
		training to meet the MR/DD				
	needs of the clients					
	interview on 7/13/21 with the Licensee revealed:					
<ul> <li>She was responsible for entire the required trainings.</li> </ul>						
	tiro roquirou trainingo.		-			
V 110	27G .0204 Training/Su	inenvision	V 110			
	Paraprofessionals	aper vision	V 110			
		COMPETENCIES AND				
		ARAPROFESSIONALS				
		privileging requirements for				
	paraprofessionals.	1.111				
	associate professional	shall be supervised by an				
		ied in Rule .0104 of this				
	Subchapter.	Truic :0104 of this				
	(c) Paraprofessionals	shall demonstrate				
	knowledge, skills and a	abilities required by the				
	population served.					
	(d) At such time as a					
		established by rulemaking,				
	then qualified professionals shall dor					
	(e) Competence shall	nonstrate competence.				
	exhibiting core skills in					
	(1) technical knowled					- 1
	(2) cultural awareness					1
1	(3) analytical skills;					
4 1	(4) decision-making;					
	(5) interpersonal skills					ĺ
	(6) communication sk	ills; and				
	(7) clinical skills.					
					1	

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		MHL0411172	B. WING	B. WING		
	ROVIDER OR SUPPLIER	1906 GF	ADDRESS, CITY, STATE, REENSTONE PLACE OINT, NC 27265			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 110	develop and implemen	y for each facility shall nt policies and procedures individualized supervision paraprofessional.	V 110			
	Based on record revie audited staff (the Lice demonstrate the know required by the popula audited staff failed to be supervision plans. The	ws and interviews, 1 of 7 nsee (L)) failed to rledge, skills and abilities ation served and 4 of 7 nave individualized findings are:  the L's record revealed:				
	-A hire date of 7/6/21 -No documentation of a Review on 7/13/21 of s -A hire date of 8/28/20 -No documentation of a	staff #2's record revealed: a supervision plan he Qualified Professional vealed: a supervision plan				
	trainings and maintaini	ponsible for all the staff ng the staff's records. dualized supervision plan				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	(X3) DATE SURVEY COMPLETED				
	MHL0411172		B. WING		07/14/	2021	
	STREET ADDRESS, CITY, STATE, ZIP CODE  SUCCESSFUL VISIONS, LLC  HIGH POINT, NC 27265						
PRI	FIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
	Interviews on 7/1 -The Licensee was trainings and male and point of have an with a QP.  Interviews on 7/1 revealed: -The Licensee was trainings and male and trainings and trainings and trainings and trainings and training to male and training to male and training to male and training to male and trainings are specified plans Had no explanate staff did not have descriptions and the level of education and th	e Professional (AP) or a Qualified e).  2/21 with the AP revealed: as responsible for all the staff intaining the staff's records. individualized supervision plan  3/21 and 7/14/21 with staff #2 as responsible for all the staff intaining the staff's records.  supervision yet.  3/21 and 7/14/21 with the L  ion as to why all of the facility in trained in client right's, bod Bourne Pathogens (BBP) eet the MR/DD needs of the ed in the treatment/habilitation  tion as to why all of the facility written and signed job verification to meet the minimum in for ensuring all staff had their in job descriptions and	V 110				

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATI	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			COMPLETED	
		MHL0411172	B. WING	B. WING		07/14/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE			
CHOOLO	SELII VIISIONIS LLO	1906 GR	EENSTONE PLA	ACE			
SUCCES	SFUL VISIONS, LLC	HIGH PO	INT, NC 27265				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	F CORRECTION	(V5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 110	Continued From page	7	V 110				
	conducted in the last						
		e-dispensing medications					
		id not have the required					
	information on them,						
		asier for some staff. We are					
		switch pharmacies"					
		aware the clients' MARs had					
	blanks on them						
-"I know they are getting their medical							
	supposed to check the MARs monthly, but not for						
	this month (July 2021	, 0					
		IARs after giving the clients					
	their medications."						
		one level II incident report in					
	the last 12 months.						
	-"I am aware the polic client."	e came out for a discharged					
		#1 was not in the facility					
		clients were awake and					
		stated "he usually works on					
		nical Assessments (CCA)					
		ns off site. He also has					
		ave [QP #2] work in the					
	facility, Monday through						
	-When asked about th	ne client/staff ratio, the					
	Licensee stated she w	vas aware the client/staff					
	ratio was a minimum o	of 2 staff for every 4 clients.					
		nard to keep staff. We have					
	had a lot of turn over."						
	-Was aware some of t	he staff had not had				1	
	trainings on preventat	ive and restrictive					
	interventions, the Lice	nsee stated, "I have					
	contacted the instructo	or, so the staff will be					
	trained within the next	two weeks."					
	-When asked about ph	nysical plant issues outside					
		including the mouse traps					
		, the Licensee stated she					
	was aware there were mice outside the facility.						
		e were mouse droppings in					
		his is an old house. I am					

AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	S:	COMPLETED	
		MHL0411172	B. WING		07/	14/2021
	ROVIDER OR SUPPLIER	1906 GF	ADDRESS, CITY, S' REENSTONE PL OINT, NC 2726	ACE		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 110	currently looking to m location" -When asked about th	ove the facility to another ne portable space heaters, was not aware space	V 110	We are reviewing the requirements of the paraprofessionals with staff and training the questions they have within the job requiremand/or duties.	em on any	8/11/2021
V 112	PLAN  (c) The plan shall be assessment, and in palegally responsible per of admission for client receive services beyon (d) The plan shall incl (1) client outcome(s) achieved by provision projected date of achie (2) strategies;  (3) staff responsible;  (4) a schedule for revannually in consultation responsible person or (5) basis for evaluation outcome achievement (6) written consent or responsible party, or a	developed based on the artnership with the client or rson or both, within 30 days s who are expected to nd 30 days. ude: that are anticipated to be of the service and a evement; view of the plan at least n with the client or legally both; on or assessment of	V 112			

Division of Health Service Regulation

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AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  MHL0411172  B. WING  07/14/2021  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  SUCCESSFUL VISIONS, LLC  1906 GREENSTONE PLACE HIGH POINT, NC 27265   (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V112  Continued From page 9  V112  This Rule is not met as evidenced by: Based on record reviews and interviews, the facility staff failed to develop and implement strategies in 1 of 4 client (#44)'s treatment plans to		T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	(X3) DATE	(X3) DATE SURVEY	
MHL0411172  B. WING  O7/14/2021  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  SUCCESSFUL VISIONS, LLC  1906 GREENSTONE PLACE HIGH POINT, NC 27265   (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 112  Continued From page 9  V 112  This Rule is not met as evidenced by: Based on record reviews and interviews, the facility staff failed to develop and implement	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1906 GREENSTONE PLACE HIGH POINT, NC 27265  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  V112 Continued From page 9  V112  This Rule is not met as evidenced by: Based on record reviews and interviews, the facility staff failed to develop and implement							
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1906 GREENSTONE PLACE HIGH POINT, NC 27265  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  V112 Continued From page 9  V112  This Rule is not met as evidenced by: Based on record reviews and interviews, the facility staff failed to develop and implement			MHI 0411172	B. WING		0.7	14.4/0004
SUCCESSFUL VISIONS, LLC  1906 GREENSTONE PLACE HIGH POINT, NC 27265  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 112  Continued From page 9  V 112  This Rule is not met as evidenced by: Based on record reviews and interviews, the facility staff failed to develop and implement			IIII COTTITZ			077	14/2021
SUCCESSFUL VISIONS, LLC  HIGH POINT, NC 27265  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY)  V 112 Continued From page 9  V 112  This Rule is not met as evidenced by: Based on record reviews and interviews, the facility staff failed to develop and implement	NAME OF P	ROVIDER OR SUPPLIER					
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 112  Continued From page 9  V 112  This Rule is not met as evidenced by: Based on record reviews and interviews, the facility staff failed to develop and implement	SUCCESS	SFUL VISIONS, LLC	1906 GF	REENSTONE PLAC	Ē		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 112  Continued From page 9  V 112  This Rule is not met as evidenced by: Based on record reviews and interviews, the facility staff failed to develop and implement  (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE  COMPLETE TAG  (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE  COMPLETE TAG  (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE  COMPLETE TAG  (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE  COMPLETE DATE		T	HIGH PO	OINT, NC 27265			
This Rule is not met as evidenced by: Based on record reviews and interviews, the facility staff failed to develop and implement	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACCROSS-REFERENCED TO	CTION SHOULD BE O THE APPROPRIATE	COMPLETE
This Rule is not met as evidenced by: Based on record reviews and interviews, the facility staff failed to develop and implement	V 112	Continued From page	9	V 112			
Based on record reviews and interviews, the facility staff failed to develop and implement		Continued From page		V 112			
Based on record reviews and interviews, the facility staff failed to develop and implement							
Based on record reviews and interviews, the facility staff failed to develop and implement							
Based on record reviews and interviews, the facility staff failed to develop and implement		This Rule is not met	as evidenced by:				
facility staff failed to develop and implement							
address the needs of the clients. The findings							
are:		100000000000000000000000000000000000000	the election the infamige				
Review on 7/13/21 of client #4's record revealed:		Review on 7/13/21 of	client #4's record revealed:				
-An admission date of 9/23/20							
		-Diagnoses of Oppositional Defiant Disorder,					
		Attention Deficit Hyperactivity Disorder, Disruptive					
Mood Dysregulation Disorder							
-Age 15			olooi dei				
-An assessment dated 10/26/20 noting "was		1000	d 10/26/20 noting "was				
previously at a PRTF for past 5 months due to			9				
severe physical and mental aggression towards							
his mother and out of control behaviors. Mother							
signed over parental rights to [a local Department							
of Social Services (DSS) in May 2019, had							
problems with sleeping at night, disruptive							
behaviors since being at group home, had been							
bulling peers, was disrespectful to staff and was							
manipulative."			respective to other and was				
-A treatment plan dated 5/13/21 noting "client will			ed 5/13/21 noting "client will				
learn to express his frustration in a healthy way by							
reducing incidents of cursing, yelling and							
threatening. He will verbalize his feelings	# # # # #						
		appropriately and use coping skills to manage his					
emotions per reports from self, family school							
staff, DSS and other team members. Client will							
follow instructions with no more than 2 verbal							1
prompts by staying on assigned tasks following							
expectations/rules and completing daily			0				- 1
chores/regimen per reports from self, family,							l
school, staff, DSS and other team members.							
Client will be transported by one staff to and from		■ Comment of Commen					
appointments as needed. He will follow all							I
recommendations from his therapist and other							

	Bryteloff of Theater Convice Regulation					
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	1	COMP	PLETED
			D 14/110			
	MHL0411172		B. WING		07/	/14/2021
NAMEOED	ROVIDER OR SUPPLIER	STREET AS	DDEEC CITY OF	ATE ZID CODE		
TO WILL OF T	NOVIDEN ON OUT FIELD		DRESS, CITY, ST			
SUCCESS	FUL VISIONS, LLC	1906 GRE	ENSTONE PL	ACE		
		HIGH PO	NT, NC 27265	5		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	NATE	DATE
				DEFICIENCY)		
V 112	Continued From page	10	V 112			
			V 112			
		services. Client will engage				
	in appropriate bounda					
	responsibility for his a	ctions by refraining from				
	exhibiting manipulativ	e behaviors and				
	embellishing accounts	s as measured by				
	observations and doc	umentation per reports;				
	Client will develop hea	althy social skills by				
		eelings through positive				
		using direct eye contact,				
		proved social interactions				
		ults, family members) and				
		rts per reports, client will				
		ify triggers to his anger and				
		hat produce unwanted				
		couraged to keep a journal				
		and triggers, Will develop				
	an awareness of his p					
	response to triggers o					
	recognize and verbaliz	4.00 M × 1.00 M × 1.				
		connected to disruptive,				
	antagonistic, or negati					
		rticipate in individual and				
	group therapy session					
	-A Child and Family Te	eam (CFT) meeting was				
	held on 1/4/21 noting,					
		on the butt, often wants				
		staff. Staff has had to put				
	limitations in place to p					
	happening. There was	an incident in where a				1
		ntentional grabbed their				l
	private parts when the					
		accident. The team plans				
		erns and possible need for				
		luding possible forensic				
		nere may be some things				
		him when he was younger				
	that he has not fully ex					
		d on 3/11/21 where it was				
						1
	reported that there wer	e several incidents of him				

Division of Health Service Regulation

having inappropriate sexual communications

	of rieditif Service Regu					
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	£	COMPLETED	
		MHL0411172	B. WING			
WITEOTITE		WITE U411172			07/14/202	1
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
SUCCESS	SELII VISIONS LLO	1906 GR	EENSTONE PL	ACE		
SUCCESS	SFUL VISIONS, LLC	HIGH PO	INT, NC 27265	i		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES				
PREFIX		MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		K5) PLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		ATE
				DEFICIENCY)		
V 112	Continued From page	11	V 112			
	- The state of the		V 112			
		group home. They have				
		uncomfortable and it has				
	resulted in altercation	s in which staff had to				
		eported that he hears other				
		ooms and beds shaking.				
	He frequently makes	comments ' that's why			10.0	
	country people have b	een molested' in reference				
	to another client that i	s from the country and has				
		use when younger. Client				
		peers to 'suck in d**k', in				
	front of staff. Staff is h	aving to monitor and				
	intervene in situations	with him and others. The				
	team is concerned reg	garding client's inability to				
	control his urges/impu	llses in efforts to prevent				
	from expressing inapp					
		iate touching others or				
	invading others person					
	discussed upcoming p					
		le forensic evaluation to				
		ns along with providing				
	possible reconditions t					
	-No documentation to					
1	sexualized behaviors/o					
		3				
	Interview on 7/13/21 w	ith the Licensee revealed:				
		4's sexualized behaviors				- 1
	-Was not sure why clie					- 1
	behaviors/gestures/cor					
	addressed.					
	-Would meet with both QP's to develop and implement strategies to address these behaviors					
	in client #4's treatment					
1	-Had met with the treat					
10		and comments from client				
	#4 to his peers and to					
	-Stated client #4 refuse					
	treatment.	participate III				
		ncerns to the attention of				
	an outside therapist, re					

Division of Health Service Regulation

-Felt client #4 needed a sex offender evaluation.

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMP	LETED
		MHL0411172	B. WING		07/	14/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
SIICCESS	FUL VISIONS, LLC	1906 GRE	ENSTONE PL	ACE		
3000233	SPOL VISIONS, ELC	HIGH POI	NT, NC 27265			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 112	-Stated the Guardian	Ad Litem (GAL) attorney did participate in any therapy as lized	V 112	We have collaborated to create new goals to target consumers specific need created a safety plan to ensure other consungroup home are safe from sed consumer.		
V 114	AND SUPPLIES  (a) A written fire plan is area-wide disaster plan shall be approved by authority.  (b) The plan shall be staff and evacuation shall beposted in the staff and disaster of shall be held at least of repeated for each shift under conditions that it	EMERGENCY PLANS  for each facility and en shall be developed and the appropriate local  e made available to all procedures and routes facility.  drills in a 24-hour facility	V 114			
	facility staff failed to en were conducted once findings are: Review on 7/13/21 of disaster drills from 7/2 -1/21/10 at 6:45pm on	the facility's fire and 020 to 7/2021 revealed: second shift with 2 clients fire and the clients went out ff at the end of the timely manner"				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL0411172	B. WING	B. WING		/14/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	FATE, ZIP CODE		
SUCCES: HIGH F	SFUL VISIONS, LLC POINT, NC 27265	1906 GR	EENSTONE PL	ACE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 114	Continued From page	13	V 114			
	Interview on 7/12/21 v -Had been at the facil -Had not participated -Had not participated -Had not participated i	with client #1 revealed: ity for 2 weeks in any fire drills; in any disaster drills.  with client #2 revealed: ity for 5 months in any fire drills; in any disaster drills.  with client #3 revealed: ity for 6 months in any fire drills; in any disaster drills.  with client #4 revealed: ity for 10 months in any fire drills; in any disaster drills.  with client #4 revealed: ity for 10 months in any fire drills; in any disaster drills.  staff #1 revealed: ine facility iil 4pm. iills, she stated "we have I will have to discuss them I think they are supposed onths"  with the Associate ite saled: ithink they are conducting ith the Associate ithink they staff were conducting ith and any fire drills.  with the Associate ithink they are supposed onths"		Staff has created and implemented a fire drill and disaster drill schedule once per shift quarter.		8/30/2021

MML0411172    NAME OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY STATE ZIP CODE   1906 GREENSTONE PLACE   1906 GREENSTONE PLA		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  SITREET ADDRESS. CITY. STATE. 2IP CODE  1906 GREENSTONE PLACE  HIGH POINT, NC. 27265  WHICH POINT, NC. 27265  ID PROVIDER'S PLAN OF CORRECTION HOULD BE CARD DEFICIENCIES.  IEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V117  Continued From page 14  V117  IOA NCAC 27G .0209 (B) Medication Requirements  IOA NCAC 27G .0209 MEDICATION  RECUIREMENTS  (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing			MHI 0411172	B. WING			27/4 4/2024
INCLUDENCE SUCCESSFUL VISIONS, LLC  WIGH POINT, NC. 27265    (X4)   D.   PROVIDER'S PLAN OF CORRECTION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)    V117	NAME OF D	DOVIDED OD SLIDDLIED					07/14/2021
SUCCESSFUL VISIONS, LLC   HIGH POINT, NC. 27365	NAME OF P	ROVIDER OR SUPPLIER					
SUMMARY STATEMENT OF DEFICIENCIES   PREFIX   PROVIDER'S PLAN OF CORRECTION   PREFIX   TAG	SUCCESS	FUL VISIONS, LLC					
V117  27G .0209 (B) Medication Requirements  10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible: (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing	PREFIX	SUMMARY STATEMENT OF DEFICIENCIES  EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETE
10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing	V 117	Continued From page	: 14	V 117			
REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing	V 117	27G .0209 (B) Medica	ation Requirements	V 117			
This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure prescription		REQUIREMENTS (b) Medication packa (1) Non-prescription dispensed by a pharm manufacturer's label v visible; (2) Prescription medior obtained as sample tamper-resistant pack risk of accidental inge packaging includes pl with tamper-resistant unit-of-use packaged may be adequate; (3) The packaging lal drug dispensed must i (A) the client's name; (B) the prescriber's na (C) the current disper (D) clear directions fo (E) the name, strengt date of the prescribed (F) the name, addres pharmacy or dispensir center), and the name practitioner.	ging and labeling: drug containers not nacist shall retain the with expiration dates clearly ications, whether purchased es, shall be dispensed in aging that will minimize the stion by children. Such astic or glass bottles/vials caps, or in the case of drugs, a zip-lock plastic bag bel of each prescription include the following:  ame; nsing date; or self-administration; h, quantity, and expiration drug; and s, and phone number of the ng location (e.g., mh/dd/sa of the dispensing  s evidenced by: s, record reviews and				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
	MHL0411172	B. WING	B. WING		
NAME OF PROVIDER OR SUPPLIER SUCCESSFUL VISIONS, LLC	1906 GF	ADDRESS, CITY, STATE, REENSTONE PLACE DINT, NC 27265			
PREFIX (EACH DEFICIENCE	FATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
strength, quantity and prescribed medication phone number of the the dispensing Practiful, #3, #3 and #4). The form of the dispension of the the the dispension of the the the the dispension of the	spensing date, the name, d expiration date of the n, the name, address and pharmacy and the name of tioner for 4 of 4 clients (#1, indings are:  2/21, from approximately the medication revealed: spensing personal pill  If the prescriber's name, umber of the pharmacy of the current dispensing date of the name, strength, and date of the prescribed  If the name of the dispensing with clients #1, #2, #3 and dications were administered pensing personal pill  If the staff #1 revealed: cations out of the personal ents.  If the do so from the Licensee.  In the staff #2 revealed: cations out of the personal ents.  If the do so from the Licensee.  If the staff found it difficult to	V 117			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	ELE CONSTRUCTION  G:	(X3) DATE SURVEY COMPLETED	
		MHL0411172	B. WING		07/14/2021
	PROVIDER OR SUPPLIER	1906 GR	DDRESS, CITY, STEENSTONE PLOINT, NC 2726	ACE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETE
V117	-"I thought it would be medications in the inciclients. I asked the stamedications that wayWas aware of the ne requirements/informat medications when the -Would ensure facility medication administra Nurse.	easier for staff to put the lividual packets for the aff to administer the " eded cion to have on prescription y are administered staff had re-certified tion with a Registered	V 117	Staff held a medication training for employ on July 14 <sup>, th</sup> 2021, to address medication management requirements. Staff also implemented new policies about Medical R Administration and the consequences if not properly followed.	
	only be administered to order of a person authorugs.  (2) Medications shall be clients only when authorus client's physician.  (3) Medications, include administered only by light unlicensed persons transpharmacist or other legarity leged to prepare at (4) A Medication Adminiall drugs administered current. Medications a recorded immediately MAR is to include the form (A) client's name;  (B) name, strength, and (C) instructions for administered and time the design of the control of t	MEDICATION  tration: -prescription drugs shall of a client on the written prized by law to prescribe the self-administered by porized in writing by the self-administered by prized in writing by the self-administered persons, or by ined by a registered nurse, gally qualified person and administer medications is istration Record (MAR) of to each client must be kept definistered shall be after administration. The ollowing:	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

MHL0411172

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

1906 GREENSTONE PLACE
HIGH POINT, NC 27265

	WITEOTITIZ			07/14/2021
IAME OF P	ROVIDER OR SUPPLIER STREE	T ADDRESS, CITY, STATE,	ZIP CODE	
LICCESS	SFUL VISIONS, LLC	GREENSTONE PLACE	Ē	
UUUESS	HIGH	POINT, NC 27265		
(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
V 118	Continued From page 17	V 118		
	(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.			
	This Rule is not met as evidenced by: Based on record reviews and interviews, the facility staff failed to ensure medications were immediately recorded after administration for 4 of 4 current clients (#1, #2, #3 and #4). The findings are:			
	Review on 7/13/21 of client #1's record revealed: -An admission date of 7/1/21 -Diagnoses of Diagnoses of Oppositional Defiant Disorder, Unspecified, Attention Deficit Hyperactivity Disorder (ADHD), Other Specified Trauma and Stressor Related Disorder, Other Specified Schizophrenia Spectrum DisorderA physician's order, dated 6/22/21, for the following medications: Latuda 20mg, 1poqhs dinner every night Guanfacine ER, 3mg, 1po q5pm and Amantadine 100mg 2 poqam and 1poqhs 1:00pm.			
	Review on 7/13/21 of client #1's MAR for July 2021 revealed: -Blanks on the MAR for Guanfacine 3mg tablets on the following dates: 7/1, 72, 7/4, 7/5, 7/6 and 7/8 -Blanks on the MAR for Amantadine 100mg on the following dates: 7/1, 7/2, 7/4, 7/5, 7/6, 7/11 -Blanks on the MAR for Latuda 30mg on the			

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING		COMPLETED		
		MHL0411172	B. WING		07/	14/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, ST	ATE, ZIP CODE		
SUCCESS	SFUL VISIONS, LLC	1906 GREI	ENSTONE PL	ACE		
		HIGH POI	NT, NC 27265	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	Continued From page	: 18	V 118			
	following dates:7/1, 7/	4, 7/6, 7/8, 7/11				
	-An admission date of -Diagnoses of Unspectory Spectrum and other F Disorder; Childhood-C Dysregulation Disorder Stress Disorder (PTS) Obsessive-Compulsiv UnspecifiedPhysician's order date medications: Trazodo -Physician's order date medications: Vitamin -Physician's order date medications: Aripiprazi	cified Schizophrenia Psychotic Disorder, Conduct Onset Type, Disruptive Mood er (DMDD), Post-Traumatic D) and re Disorder (OCD), ed 2/10/21 for the following ne 150mg, 1poqhs ed 2/12/21 for the following D, 2,000 Units, 1poqd ed 3/17/21 for the following				
	7/1/21 to 7/12/21 reve -Blanks on the MAR fo 7/2 to 7/6, 7/8 and 7/1 -Blanks on the MAR fo to 7/6, 7/8 and 7/11	or Trazodone 150mg from 1 or Aripiprazole 5mg from 7/2 or Lamotrigine 100mg from				
	Type, Disruptive Mood Schizoaffective Disord Transvestic Fetishism, -A physician's orders of following medications:	4/26/21 t Disorder Childhood-Onset d Dysregulation Disorder, ler, Bipolar Type, , ADHD, Combined Type. dated 6/22/21 for the Guanfacine 2pmg, g, 1poq5pm, Jornay 40mg, 30mg, 1poqd, and		ş		

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) P

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL0411172			A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		B. WING		07/14/2021				
	PROVIDER OR SUPPLIER	1906 GR	DDRESS, CITY, STATE, EEENSTONE PLACE DINT, NC 27265					
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	D BE COMPLETE
V 118	Review on 7/13/21 of 5/1/21 to 7/12/21 rev -Blanks on the MARs 5/3, 5/8 and 5/9Blanks on the MARs through 7/6 and on 7/ Review of client #4's r -An admission date of -Diagnoses of ODD, A -A physician's order of following medications:  Review on 7/13/21 of 6/1/21 to 7/12/21 reve -Blanks on the MARs 6/20 and 6/26 -Blanks on the MARs to 7/6, 7/8 and 7/11  Interviews on 7/12/21 #4 revealed: -Their medications we staff.	client #3's MARs, from ealed: for all medications on 5/1 to for all medications on 7/2 8 and 7/11  ecord revealed: 9/23/20 DHD and DMDD ated 9/20/20 for the Clonidine 0.2mg, 1poqhs client #4's MARs, from aled: for Clonidine 0.2mg 6/19, for Clonidine 0.2mg on 7/3  with clients #1, #2, #3 and re administered to them by	V 118					
	can put in them in a cu-Qualified Professiona when there were blank-When asked if he had recently, staff #2 state get anyone in trouble.  Interview on 7/12/21 w Professional (AP) reversional (AP) reversional had noticed blanks or	in a locked cabinet I the medications, but you I the medications, but you I #2 (QP #2) was notified Is on the MARS. Is seen blanks on the MARS I wes, but I do not want to I with the Associate I aled:						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL0411172	B. WING		07/	14/2021
	ROVIDER OR SUPPLIER	1906 GREE	RESS, CITY, ST.			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL	IT, NC 27265  ID  PREFIX  TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE
V118	REGULATORY OR LSC IDENTIFYING INFORMATION)		V118	Staff held a medication training for employ July 14th, 2021, to address medication mana requirements. Staff also implemented new policies about Medical Records Admi and the consequences if not properly follow	gement nistration	7/14/2021
V 294	27G .1702 Residentia	Tx. Child/Adol -Req. for Q	V 294			
	care staff who meets to qualified professional a 27G .0104(18). In add	SIONALS utilize at least one direct the requirements of a s set forth in 10A NCAC ition, this qualified the two years of direct client				

Division of Health Service Regulation

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	T (V2) MUII TIDI	LE CONSTRUCTION		(VO) DATE	OLIDI EL
	OF CORRECTION	IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
			A. BUILDING	A. BUILDING:		COMP	LETED
		MHL0411172	B. WING			07	/14/2021
						071	114/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
SUCCESS	SELII VISIONE LLO	1906 GR	EENSTONE PL	ACE			
SUCCESS	SFUL VISIONS, LLC	HIGH PO	DINT, NC 27265				
(VA) ID	CLIMMADV CT	ATEMENT OF DEFICIENCIES		<del></del>			
(X4) ID PREFIX		/ MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		_	(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO			DATE
			30000000	DEFICIENC	CY)		
V 294	Cantinuad Frances	04	1,004				+
V 294	Continued From page	21	V 294				
	(1) the qualified	professional specified in					
		Rule shall perform clinical					
		sponsibilities a minimum of					
	10 hours each week;						
		time shall occur when					
	1.0	ts are awake and present in					
	the facility.	process.					
	(c) For each facility of	f six or more beds:					
		professional specified in					
		Rule shall perform clinical					
		ponsibilities a minimum of					
	32 hours each week;						
		ime shall occur when					
		s are awake and present in					
	the facility.	are arrane and process in					
		ly responsible for each					
	facility shall develop a						
1		e clinical and administrative					
		ualified professional(s). At					
	a minimum these police						
		of its associate					
		forth in Rule .1703 of this					
	Section;	iorum naie . 1703 orums					
-	W	emergencies;					
	323 37 S	direct psychoeducational					
	services to children or						
		in treatment planning					
	meetings;	in treatment planning					
	-	of each child or					
	adolescent's treatmen						
	functions.	pasic case management					
	TUTICUOTIS.						
							1
	TI . B .						
This Rule is not met as evidenced by:						1	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL0411172	B. WING		07/14/2021
	PROVIDER OR SUPPLIER	1906 GR	DDRESS, CITY, STATE, EENSTONE PLACE DINT, NC 27265		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED CORRECTION OF THE	) BE COMPLETE
V 294	Based on record revie Qualified Professional clinical and administrative time when childre awake and present at are:  Review on 7/13/21 of revealed: -A hire date of 8/28/20-A job description of a linterviews on 7/12/21 #4 revealed: -They did not know the asked"Who is that? I haven." Interview on 7/14/21 v.—Had previously been.—"I know how the state things you need to do.—Stated he was rarely.—"But I have been ther week. I mainly do thing have had a lot of turn facility since I recently [the Qualified Profession hired, she would be at Friday." -When asked about do with the clients, he state been notes but none responsibility with [the -Stated before QP #2 to be at the facility a couplinterview on 7/13/21 w.	ews and interviews, 1 of 2 Is (QP #1) failed to perform ative responsibilities 70% of n or adolescents were the facility. The findings  the QP #1's record  QP  with clients #1, #2, #3 and e QP #1's name when 't ever seen him here."  with QP #1 revealed: through the survey process. comes in and tells you the as well" at the facility in person e for a couple of hours a gs over the phone. We over. I have not been at the got a new job. Now that onal #2 (QP #2)] has been the facility Monday through  cumentation and meeting ted, "hmmm there have ecently. We share other QP (#2)]" ook the position, he would ole of hours per week.  with the Licensee revealed: s not coming to the facility	V 294		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL0411172	B. WING			07/14/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
SUCCESS	SFUL VISIONS, LLC	1906 GR	EENSTONE PL	ACE		
3000230	SPOL VISIONS, LLC	HIGH PO	INT, NC 2726	5		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 294	-"It was due to COVID at the facility Monday	. I have hired [QP #2] to be through Friday."	V 294	QP will be at the facility 32 hours children are awake.	while the	8/30/2021
V 296	telephone or page. A able to reach the facilitimes.  (b) The minimum num required when children present and awake is  (1) two direct ca one, two, three or four  (2) three direct of for five, six, seven or eadolescents; and  (3) four direct cannine, ten, eleven or two adolescents.  (c) The minimum num during child or adolescents.  (c) The minimum num during child or adolescents.  (1) two direct canning child or adolescents.  (2) two direct canning children or adolescents.  (3) three direct conditions and both shall be awake children or adolescents.  (3) three direct confidence of which two shall be a asleep for nine, ten, elevatolescents.  (d) In addition to the minimum num during children or adolescents.	MINIMUM STAFFING sional shall be available by direct care staff shall be ty within 30 minutes at all aber of direct care staff n or adolescents are as follows: re staff shall be present for children or adolescents; care staff shall be present eight children or are staff shall be present for elve children or ber of direct care staff cent sleep hours is as re staff shall be present te for one through four s; re staff shall be present te for five through eight s; and care staff shall be present wake and the third may be even or twelve children or	V 296			
	(d) In addition to the m	ninimum number of direct aragraphs (a)-(c) of this staff shall be required in				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
		MHL0411172	B. WING		07/14/2021
	ROVIDER OR SUPPLIER	1906 GRE	DRESS, CITY, STA ENSTONE PLA NT, NC 27265		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
V 296	the facility based on to individual needs as spelan.  (e) Each facility shall supervision of children are away from the facility or adolescent's inneeds as specified in a	the child or adolescent's pecified in the treatment be responsible for ensuring in or adolescents when they illity in accordance with the individual strengths and the treatment plan.  It is evidenced by: It is and interviews, the facility is and interviews, the facility is of direct care staff were increased in the interviews alone at its iff at 10:14am  In 7/12/21, at approximately in the front yard of the increase in the back yard on its increase in the back yard on in the phone, and	V 296		

AND PLAN OF CORRECTION (XT) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING:	COMPLETED	
		MHL0411172	L0411172 B. WING		07/14/2021
	ROVIDER OR SUPPLIER	1906 GR	DDRESS, CITY, STATE, EENSTONE PLACE		
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETE
V 296	Continued From page	25	V 296		
	2:44pm, revealed: -Clients were in the liv playing around with not all and around with not all around a staffClient #2 and client # playing -Client #1 stood at the staffClient #3 arrived at the Licensee if he could got all 4 clients went in the around around a staff remained in the around a staff remained in the around around a staff remained in the around a staff were around a staff were around a staff were around a staff. Last night (7/11/2 third shift. It happens a linterview on 7/12/21 wo around a staff. Last night, there was of accility). It is usually [still linterview on 7/12/21 wo a sked about client around a staff. Last night, there was of accility, client #3 stated around a staff.	ent remained in the office.  4 were in the hallway horse  2 office door, talking with 3  2 de facility and asked the 2 outside. 2 de front yard/driveway 2 de office working on files 3 ing interviewed 2 unsupervised outside. 3 surveyors observed all 4 sight given the position of 5 sitting in the office. 4 vakes up during the night 5 ight, there is usually only 1 6 21) there was only 1 staff on 6 a lot"  2 ith client #2 revealed: 3 nly (staff) here (at the 6 aff #7] or [staff #8]"  3 ith client #3 revealed: 4 ent/staff ratios at the 6 "there is usually either 1 or 6 ut this morning, there was 6 got here"			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			3:	COMPLETED		
		MHL0411172	B. WING		07/14/2	2021
	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
SUCCES	SFUL VISIONS, LLC	HIGH PC	DINT, NC 2726	5		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE (	(X5) COMPLETE DATE
V 296	-There were usually to facility -Had gotten up one ni staff here."  Interview on 7/12/21 v -Was on the schedule 4pm, on 7/12/21 -He son was having so Interview on 7/12/21 v -She had only been word days -Her shift was Monday to 4pm -Staff #1 was schedule 7/12/21 -"She called to say her and [staff #2] was on her and [staff #2] was on her clientsWas not sure why the when the surveyors ar Interview on 7/14/21 w	wo staff working at the ght "and there was only 1  with staff #1 revealed: to work first shift, 8am to  urgery on 7/12/21  with the AP revealed: orking at the facility for 5  through Friday from 8am ed to work first shift on  r son was having surgery nis way"  with the Qualified  was 2 staff to every 1, 2, 3, are was only 1 staff present rived at the facility.  with the Licensee revealed: staff ratio was a minimum tients. aff #1 would be out on  rd to keep staff.	V 296	Staff will report each Level 1 incident in an i		4/2021
V 367	27G .0604 Incident Re 10A NCAC 27G .0604 REPORTING REQUIR	INCIDENT	V 367	log within the facility. Staff will complete ea 2 incident within IRIS, all incidents' reports 1 or 2 will be submitted quarterly (any time t come out the incident report will be complete iris).	ch level 8/23/ whether he police	2021

PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	OULD BE COMPLETE
NAME OF PROVIDER OR SUPPLIER SUCCESSFUL VISIONS, LLC	1906 GR	DDRESS, CITY, STATE, EENSTONE PLACE DINT, NC 27265		
	MHL0411172			07/14/2021
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		W 00 00		

Division o	of Health Service Regi	ulation			101	WIATTOOLD
V 367	Continued From pag	• 0000000000000000000000000000000000000	V 367			
		B providers shall report all				
		cept deaths, that occur during				
		ble services or while the				
		providers premises or level III				
		I deaths involving the clients rendered any service within				
	90 days prior to the i					
		atchment area where				
	services are provide	d within 72 hours of				
		he incident. The report shall				
	be submitted on a fo					
		ort may be submitted via mail,				
		or encrypted electronic hall include the following				
	information:	riali include the following				
		rovider contact and				
	identification informa					
		ification information;				
	(3) type of incid					
	(4) description					
	(5) status of th cause of the incident	e effort to determine the				
		duals or authorities notified				
	or responding.					
		providers shall explain any				
		e information. The provider				
		ted report to all required				
		he end of the next business				
	day whenever: (1) the provide	r has reason to believe that				
	information provided					
		g or otherwise unreliable; or				
		r obtains information				
		ent form that was previously				
	unavailable.					
		providers shall submit, LME, other information				
	obtained regarding th					
	and the second s	as morastic, morasting.				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		MHL0411172	B. WING		07/1	4/2021
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SUCCESSF	UL VISIONS, LLC	1906 GREE	NSTONE PLA	ACE		
			T, NC 27265			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		

Division o	of Health Service Regu	ulation			1 Ortivi	MITHOVEL
V 367	Continued From page (1) hospital recinformation; (2) reports by (3) the provide (d) Category A and B of all level III inciden Mental Health, Deve Substance Abuse Sebecoming aware of the providers shall send incidents involving a Health Service Regulated becoming aware of the client death within seor restraint, the provident death within seor restraint death wi	cords including confidential other authorities; and or's response to the incident. By providers shall send a copy of reports to the Division of lopmental Disabilities and ervices within 72 hours of the incident. Category A a copy of all level III client death to the Division of lation within 72 hours of the incident. In cases of even days of use of seclusion der shall report the death irred by 10A NCAC 26C C27E .0104(e)(18). It providers shall send a set LME responsible for the reservices are provided. Submitted on a form provided delectronic means and shall formation as follows:  The errors that do not meet the or level III incident; and the client or his living area; client property or property in client; mber of level II and level III and level III and the cidents whenever no red during the quarter that it is as set forth in Paragraphs and Subparagraphs (1)	V 367			
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SUR COMPLETE	ED
		MHL0411172			07/14/	2021
NAME OF PRO	OVIDER OR SUPPLIER		DRESS, CITY, STATE,			
SUCCESSF	UL VISIONS, LLC		ENSTONE PLACE	Ē		
			NT, NC 27265			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE
IVISION OF Healt	ii service regulation					

Division o	f Health Service Regi	ulation			TOTAL	IVII I NOVEL
V 367	This Rule is not me Based on record rev facility failed to Leve submitted to the Loc within 72 hours as recorded as a record review on 7/12/21 of Improvement System incidents in the last 60 incide	t as evidenced by: iews and interviews, the I II incident reports were al Management Entity (LME) equired. The findings are. of the Incident Response in (IRIS) revealed no Level II months.  with client #2 revealed: t to the facility. ause of another client. He away and he threatened  with staff #1 revealed: te had come to the facility this revious client that was no any incident reports  with staff #2 revealed: blice in the past.	V 367			
;	#1 revealed: -When asked about ir	with Qualified Professional ncidents, she stated "I would ere during the incident				
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MULTIPLE	CONSTRUCTION	LOVON DATE OU	DUEV
	CORRECTION	IDENTIFICATION NUMBER:			(X3) DATE SU COMPLE	
		MHL0411172	B. WING		07/14	/2021
NAME OF PRO	VIDER OR SUPPLIER		PRESS, CITY, STATE			
SUCCESSF	UL VISIONS, LLC		ENSTONE PLAC NT, NC 27265	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IN CROSS-REFERENCED TO THE APPROPRING DEFICIENCY)	BE	(X5) COMPLETE DATE
or ricalti	. Sor Floo Megalation					

Division o	of Health Service Regu	ulation			1 0111	MAIFROVED
V 367	-The only incident re an incident that occu November 2020.	rtI don't have any	V 367	Staff will report each Level 1 incident in a log within the facility. Staff will complete 2 incident within IRIS, all incidents' report or 2 will be submitted quarterly (any tin come out the incident report will be compiris).	e each level rts whether ne the police	
V 536	27E .0107 Client Rigi Int.	hts - Training on Alt to Rest.	V 536			
	practices that empha to restrictive interven (b) Prior to providing disabilities, staff incluemployees, students demonstrate compet completing training ir other strategies for convict the likelihood or injury to a person property damage is person prope	plement policies and size the use of alternatives tions. It services to people with uding service providers, or volunteers, shall ence by successfully nommunication skills and reating an environment in of imminent danger of abuse with disabilities or others or prevented. It is shall establish training etencies, monitor for internal constrate they acted on data the competency-based, earning objectives, written and by observation of objectives and measurable as passing or failing the				
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
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		MHL0411172	B. WING		07/14	1/2021
NAME OF PR	OVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	FE, ZIP CODE		
SUCCESSE	FUL VISIONS, LLC	1906 GREE	ENSTONE PLA IT, NC 27265			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE
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Division of Health Service Regulation V 536 Continued From page 31 V 536 by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1)knowledge and understanding of the people being served; recognizing and interpreting human (2)behavior: (3)recognizing the effect of internal and external stressors that may affect people with disabilities: strategies for building positive relationships with persons with disabilities; recognizing cultural, environmental and organizational factors that may affect people with disabilities: (6)recognizing the importance of and assisting in the person's involvement in making decisions about their life; skills in assessing individual risk for (7)escalating behavior; communication strategies for defusing and de-escalating potentially dangerous behavior; and positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. Documentation shall include: (1)(A) who participated in the training and the outcomes (pass/fail); when and where they attended; and STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A. BUILDING: \_ B. WING MHL0411172 07/14/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1906 GREENSTONE PLACE SUCCESSFUL VISIONS, LLC HIGH POINT, NC 27265 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY)

Division of Health Service Regulation V 536 Continued From page 32 V 536 (C) instructor's name: (2)The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3)The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5)Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner: (B) methods for teaching content of the course: methods for evaluating trainee (C) performance; and (D) documentation procedures. (6)Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0411172 07/14/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1906 GREENSTONE PLACE SUCCESSFUL VISIONS, LLC HIGH POINT, NC 27265 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)**PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY)

Division of Health Service Regulation

Division of	of Health Service Regu	ulation			1 01(10)	MINOVED
V 536	Continued From pag  (8) Trainers shinstructor training at  (j) Service providers documentation of init training for at least th  (1) Docum  (A) who particip outcomes (pass/fail).  (B) when and outcomes (pass/fail).  (C) instructor's  (2) The Division request and review th  (k) Qualifications of (1) Coaches sh requirements as a training trainin	nall complete a refresher least every two years. shall maintain tial and refresher instructor nree years. entation shall include: bated in the training and the shall mane. on of MH/DD/SAS may his documentation any time. Coaches: hall meet all preparation ainer. hall teach at least three times being coached. hall demonstrate bletion of coaching or	V 536			ATT NOVED
	facility failed to ensural alternatives to restrict findings are: Review on 7/12/21 of (AP)'s record reveale -No documentation of alternatives to restrict	ews and interviews, the e staff had initial training on tive interventions. The  the Associate Professional d: finitial training on ive interventions.				
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SUI	
			A. BUILDING:		COMPLET	EU
		MHL0411172	B. WING		07/14	/2021
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STATE	, ZIP CODE	***************************************	
SUCCESSE	UL VISIONS, LLC	1906 GREI	ENSTONE PLAC	E		
			NT, NC 27265			
(X4) ID PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE
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Division of Health Service Regulation

V 536 Continued From page 34

Review on 7/12/21 of the Qualified Professional #1 revealed:

weeks from today's date.

de-escalation with the clients.

the training.

ITO

would be trained.

10A NCAC 27E .0108

ISOLATION TIME-OUT

-No documentation of initial training on alternatives to restrictive interventions.

Interview on 7/12/21 with the AP revealed:
-The facility had not provided training on alternatives to restrictive interventions.
-The Licensee had scheduled the training 2

Interview on 7/13/21 with the Licensee revealed:
-The agency worked very hard in using verbal

-Had reached out to the instructor whom provided

-In approximately two weeks, staff that are not training in alternatives to restrictive interventions.

V 537 27E .0108 Client Rights - Training in Sec Rest &

SECLUSION, PHYSICAL RESTRAINT AND

been trained and have demonstrated

competence at least annually.

(a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have

competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated

(b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or

V 536 Training on client de-escalation and NCI will be held 8/11/2021

V 537

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

TRAINING IN

(X2) MULTIPLE CONSTRUCTION
A. BUILDING:

(X3) DATE SURVEY COMPLETED

MHL0411172

SUMMARY STATEMENT OF DEFICIENCIES

B. WING \_\_\_\_\_\_ 07/14/2021

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SUCCESSFUL VISIONS, LLC

1906 GREENSTONE PLACE HIGH POINT, NC 27265

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG 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) COMPLETE DATE

Division of Health Service Regulation

(X4) ID

STATE FORM

Continued From page 35 V 537 volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: refresher information on alternatives to (1) the use of restrictive interventions; (2)guidelines on when to intervene (understanding imminent danger to self and others): (3)emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention): strategies for the safe implementation of restrictive interventions; the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A. BUILDING: B. WING MHL0411172 07/14/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1906 GREENSTONE PLACE SUCCESSFUL VISIONS, LLC HIGH POINT, NC 27265 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY)

Division of Health Service Regulation

Division of Health Service Regulation V 537 Continued From page 36 V 537 use of restraint throughout the duration of the restrictive intervention; (6)prohibited procedures; (7)debriefing strategies, including their importance and purpose; and documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2)The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0411172 07/14/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1906 GREENSTONE PLACE SUCCESSFUL VISIONS, LLC HIGH POINT, NC 27265 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY)

Continued From page 37 V 537 Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner: (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7)Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8)Trainers shall be currently trained in CPR. (9)Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10)Trainers shall teach a program on the use of restrictive interventions at least once annually. (11)Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1)Documentation shall include: (A) who participated in the training and the outcome (pass/fail): (B) when and where they attended; and (C) instructor's name. The Division of MH/DD/SAS may review/request this documentation at any time. (I) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. Coaches shall teach at least three (2)times, the course which is being coached. STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING MHL0411172 07/14/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1906 GREENSTONE PLACE SUCCESSFUL VISIONS, LLC HIGH POINT, NC 27265 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY)

Division of Health Service Regulation

V 537	Continued From pag	je 38	V 537	Staff has scheduled the training on clien 8/11/2021, training will be	ts' rights on	8/11/2021
	A 2000 CONTRACTOR OF THE PROPERTY OF THE PROPE	shall be the same		completed by Licensed Professional.		
	facility failed to ensu	iews and interviews, the re staff were trained in estraint and isolation				
	(AP)'s record revealed	of training in seclusion,				
	#1's record revealed	f training in seclusion,				
	-She had not had trainestraint and isolation	me she has someone that				
	-Had reached out to the trainingIn approximately two	with the Licensee revealed: he instructor whom provided b weeks, staff that are not s to restrictive interventions,				
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SI COMPLE	
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	OVIDER OR SUPPLIER	1906 GR	DDRESS, CITY, STA EENSTONE PLA BINT, NC 27265			
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Division of Healt	th Service Regulation		6899	RYE511	If continuation	on sheet 40 of 44

Division o	f Health Service Regu	ılation				
V 736	Continued From pag	e 39	V 736			
V 736	27G .0303(c) Facility	and Grounds Maintenance	V 736			
		REMENTS				
	staff failed to ensure were maintained in a attractive manner. The Observations on 7/12 10:50am, of the outsi-The grass against the approximately 18 inclarates were 3 rodent-There was a hole, ap 12 inches, in the midden of the facility and the home	ns and interviews, the facility the facility and its grounds safe, clean, orderly and he findings are:  2/21, at approximately de of the facility revealed: e facility's outside walls was hes tall.  It raps around the home. approximately 18 ½ inches by dle of the deck. A fainst the facility in both the don the and deck entified tanks on the side of the down in and around the				
	11:05am, of the inside -Mouse dropping werk kitchen drawer near tl	2/21, at approximately e of the facility revealed: e located inside the right he sink. al was leaking under the sink				
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SU	RVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLET	TED
		MHL0411172	B. WING		07/14	1/2021
NAME OF PRO	OVIDER OR SUPPLIER	TO MILES CANDING TO SERVICE TO SE	DRESS CITY STATE	ZID CODE	1 0//14	# ZUZ I
			DRESS, CITY, STATE ENSTONE PLACE			
SUCCESSF	UL VISIONS, LLC		NT, NC 27265			
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ivision of Health	Service Regulation					

Division o	of Health Service Regi	ulation			FORIV	APPROVEL
V 736	Continued From pag	ge 40	V 736			
	and a pot had been water.  -The cleaning supply -A light bulb was mis clients' bathroomThere was no toilet bathroomThere was cleaner to bathroomThe blinds were brobedroom -Blinds were also brown bedroom -The blinds were also brown bedroom -Blinds were also brown bedroom -The blinds were also brown bedroom -The blinds were brown bedroom -Blinds were also brown bedroom -The blinds were brown bedroom -There was no toilet bedroom -There was cleaner to bedroom -The blinds were brown -The blinds	placed under it to catch the  y closet had no lock on it. sing over the mirror in the  paper in the clients'  under the sink in the clients'  ken in client #3 and #4's  oken in the kitchen.  with staff #1 revealed: ouse droppings in the  lice or bugs in the facility. e pest control comes out o spray inside and outside  ware of the hole in the deck. he two tanks, staff #1 stated e tanks are"  with staff #2 revealed: th mice about 4 months ago. arted breaking re mice outside, "but I didn't" en out to the facility and put 3 facility and one in the  ling inside of the home. I rawers in the kitchen. I use	V 736			
	Interview on 7/12/21 v	with the Associate				
	Professional (AP) rev					
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUILDING:		COMPLE	IED
		MHL0411172	B. WING		07/14	/2021
NAME OF PRO	VIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STATE	E, ZIP CODE	<del></del>	****
SUCCESSF	UL VISIONS, LLC	1906 GREE	ENSTONE PLAC	CE		
	0.000		NT, NC 27265			
(X4) ID PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE
ivision of Health	Service Regulation					

V 736	Continued From pag	e 41	V 736			
	AP, she stated "rode Do you mean like fee My goodness." -Had not noticed the homeHad noticed the hole -When asked about t	ough of the facility with the ent dropping? No, No ma'am. ces? I didn't know about that.  rodent traps outside of the e in the deck the tanks located in the back I'l don't know about these				
	with him (pest contro was coordinating with address that. -Construction was be that was why some in the home. -After talking with the					
	-"I really don't know a The home is pretty of	with the QP #2 revealed: about the mouse droppings. Id, and the owner needs to home. We are actually ce."				
	facility, the LP stated clients' room to see h space. I go throughou bathrooms to see if th go outside. I have not outside."	realed: and seen any mice in the "Oh no. I do to into the now they are keeping their at the house. I go to the ney are doing their chores. I t noticed the mouse traps				
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPL	
		MHL0411172	B. WING		07/1	4/2021
NAME OF PR	OVIDER OR SUPPLIER	STREET ADDR	RESS, CITY, STAT	TE, ZIP CODE		
SUCCESSF	FUL VISIONS, LLC		NSTONE PLACE T, NC 27265	CE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
Division of Healt	th Service Regulation					

Division	of Health Service Reg	ulation				
V 736	-Was aware there w -"The exterminator p outside to trap the m control." -Was not aware one had mouse dropping -Would be talking to making the needed outside of the facility -"This is an old hous	with the Licensee revealed: ere mice outside the facility. blaced the black boxes lice and keeping them under of the drawers in the kitchen gs in it. the landlord to see about repairs both inside and f. e. I am currently looking to mother location. A house that	V 736	Staff has contacted the owner of the home him to fix everything that was insufficien (mice droppings, dripping water from sindeck, residue from window).	t such as	8/30/2021
V 744	27G .0304(b) Safety		V 744			
	10A NCAC 27G .030 EQUIPMENT (b) Safety: Each faci constructed and equ	4 FACILITY DESIGN AND lity shall be designed, ipped in a manner that safety of clients, staff and				
	failed to ensure the factoristructed and equi	ns and interviews, the staff acility was designed, pped in a manner that safety of clients, staff and				
	Observation on 7/12/					
		e of the facility revealed: 2's bed, there was a space				
	heater -Client #4 had a spachis bed and a table.	e heater located in between				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SL	JRVEY
AND PLAN OF	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
		MHL0411172	B. WING		07/14	4/2021
NAME OF PR	OVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
SUCCESSE	FUL VISIONS, LLC		ENSTONE PLA NT, NC 27265	CE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE
vision of nealt	in dervice Regulation					

V 744	Continued From page 43	V 744	Staff has removed space heaters from the facility.	7/14/2021
	Interview on 7/14/21 with the Department of Health and Human Service's Engineer Plan Reviewer revealed: -Since the facility was considered a residential care facility with more than 3 people, "the facility had to follow the building code sections which prevented portable space heaters." -"If the staff are using portable space heaters in the facility, they are not following the building codes."  Interviews on 7/12/21 with client #2 revealed:			
	-When asked about space heaters in the facility, client #2 stated "the space heaters have been here since I have been here."  Interview on 7/14/21 with the Licensee revealed: -Was not aware space heaters were not allowed in the facility -Would immediately ensure all the space heaters were removed from the facility.			

Consumer	81-	See man
I onsumer	MA	LIFT

Service Record #

Date the Child and Family Team met to develop this discharge/transition plan: 11/12/12/

## <u>Division of MH/DD/SAS</u> Division of Medical Assistance

## Child/Adolescent Discharge/Transition Plan

This document must be submitted with the completed ITR, the required PCP (i.e. introductory, complete or update) and any other supporting documentation justifying the request for authorization and reauthorization of Residential Levels III and IV. In addition, for reauthorization of Residential Level III and IV, a new comprehensive clinical assessment by a psychiatrist (independent of the residential provider and its provider organization) that includes clinical justification for continued stay at that level of care is required to be submitted. This document is also required for an initial care review for a PRTF only. An incomplete ITR, PCP or tack of Discharge/Transition Plan and a new comprehensive clinical assessment (when applicable) will result in a request being "unable to process".

<ol> <li>The recipient's expected discharge da</li> </ol>			
x Residential Level III	Expected Discharge Date: 2 /25/22		
Residential Level IV	Expected Discharge Date: / /		
o PRTF	Date of Initial Care Review Only://		
II. At time of discharge the recipient will to indicate both the planned date of admondate of admondate and Community Supports Outpatient Individual Therapy Outpatient Family Therapy Outpatient Group Therapy Medication Management Respite Intensive In-Home Multisystemic Therapy Substance Abuse Intensive Outpatient Day Treatment Level II Program Type Therapeutic Foster Care PRTF	transition and/or continue with the following services. Please ission to each applicable service and the anticipated provider.  (Provide details in Section III.)  // Provider: Successful VisionS  // Provider: Successful VisionS  // Provider: Neuropsychiatric (are Center  // Provider: // Provider: // Provider:		
Other transminal dving	Provider: IBD		
Other	/ / Provider:		
the strengths of the recipient and his/he Name/Agency Name/Agency	ed the following natural and community supports to both build on a family and meet the identified needs.  Role: Matter Date: Organia Role: Date: / / Date: / / / Date: / / / / / / / / / / / / / / / / / / /		
Name/Agency	Role: Date: //		
V. Input into the Person-Centered Plan de following (Check all that apply):  XReciplent  Family/Caregivers  Natural Supports  Community Supports (e.g. civic & faith togranizations)  Local Management Entity  Residential Provider	eveloped by the Child and Family Team was received from the  MH/SA TCM Provider Court Counselor School (all those involved) Social Services Medical provider Other		
Division of Mental Health, Developmental Division of Medical Assistance REVISED February 18, 2015	Disabilities, and Substance Abuse Services 1		

Consumer Name	Service Record #
V. Please explain your plan for transition to new se community supports, identification of new provide meetings with new providers, etc.) Who will do Activity Responsible Party Responsible Party Continue Medication Management. Continue Individual Therapy - Success Referral to Transitional Care - S	ders, visits home or to new residence, transition what by when?  ImplementationDate  Neuropsychiatric. Care. Center  ucess ful VisionS  skul VisionS
VI. The Child and Family Team updated the Crisis is safety at home, at school and in the community.  2 Yes No Please explain:	Plan as part of the PCP Revision to include issues of
/HI. The Child and Family Team has identified and ad the discharge/transition plan.	ults and peers. Client spirals He very manipulative and  Idressed the following potential barriers to success of itated we thinks about stepping the stated on many occasions
IX. The Child and Family Team will meet again on discharge/transition plan and address potential ba	/ / in order to follow-up on the arriers.
X Required Signatures	
Recipient	Date / /
Legally Responsible Person	
Qualified Professiona (Person responsible for the PCP)	Le HSUCCS4 Date//124124
I agree with the Child and Family Team recommed to not agree with the Child and Family Team re (*Please note signature below is required by SOC reg Signature does not indicate agreement or disagreement preview of discharge plan.)	commendation. gardless of agreement with recommendation.

Name:	DOB:	Medicaid ID:	Record #:
		PLAN SIGNATURES	
I. PERSON	RECEIVING SERVICES:	To the transfer of the transfe	
provide	ed.	the development of this PCP. My signature mea	
for this	PCP.	e providers and may change service providers at	
with m		d understand that I have the choice of seeking ca ng in the Community Alternatives Program for inc	
Legally Respon	sible Person: Self: Yes 🗌 No		
Person Receivi	ng Services: (Required when pe	erson is his/her own legally responsible pers	son)
Signature:			Date: / /
l agally Respon	eible Person (Required if other	(Print Nam than person receiving Services)	e;
	sible reison (required if other	1070	Date / /
		(Print Nam	
Relationship to the	ne Individual.		
		CP: The following signature confirms the re ates agreement with the services/supports to	
mid-ultravier service p., all the control of	7 7 7		The same of the sa
Signature/	VI HILLINS	Name of Case Managem	Visions Date: 11
	- (Person responsible for the PCP)	(Name of Case Managem	ent Agency)
Child Mental H	lealth Services Only:		
		of age (less than 18 for State funded se	
		ctively involved with the Department of J em, the person responsible for the PCP	
	the following requirements as s		must attest that he of she has
•	the Child and Family Team -		Date: / /
OR Chil	d and Family Team meeting schedule	d for -	Date:
	gned a TASC Care Manager -		Date/_/
		plicable LME to conduct care coordination. It the box below and then sign as the Person Res	manaphia for the DCD
☐ This-chil	d is not actively involved with the Den	artment of Juvenile Justice and Prevention or the	e adult criminal court system
Signature:	The lest	artment of Juvenile Justice and Preventing or the 1824 (St. ) Tensent of Juvenile Justice and Preventing or the 1824 (Print Name)	Date 11
	Person responsible for the PCP)	(Print Name)	
		Medicaid funded services; RECOMMEND ne Medicaid approved licensed signatorio	
	ow confirms the following: (Che		
		sent, and constitutes the Service Order(s).	
		e order has had direct contact with the individual.	
	ed professional who signs this service	e order has reviewed the individual's assessmen	tered beard
ignature:	AND THE RESIDENCE OF THE PROPERTY OF THE PROPE	Lice	ense # Date: _ / _ /
remarks a remark to the first the first of t		(Print Name) / Licensed Professionals (LP) ordering:	
	CAP-MR/DD or Modicaid Targeted Case Management	t (TCM) continue (if not audound in Continue A)	
	OR recommended for any state-funder	t (TCM) services (if not ordered in Section A)	
y signature belo		ck all appropriate boxes.) Signatory in this sect	ion must be a Qualified or Licensed
ofessional.			
		requested is present, and constitutes the Service	
		e requested is present, and constitutes the Service	
☐ Medical n	ecessity for the State-funded service(	s) requested is present, and constitutes the Serv	ice Order
gnature:		Li	cense #: Date:/_/
	(Name/Title Required)	(Print Name)	(If Applicable)
v. SIGNATUR	RES OF OTHER TEAM MEMI	BERS PARTICIPATING IN DEVELOPI	MENT OF THE DI AN.
T. DIGITATOR	CO O CHILL I LANG MENTE	LIGHT ANTIGIFATING IN DEVELOPI	MENT OF THE PLANT
her Team Memb	er (Name/Relationship):		Date:/_/
her Team Memb	er (Name/Relationship):		Date: / /

## **FAX COVER SHEET**

TO	NCDHHS
COMPANY	
FAXNUMBER	19197158078
FROM	LisaMorrison
DATE	2021-12-06 20:01:55 GMT
RE	SuccessfulVisionsLLC

## **COVER MESSAGE**

This my be why my License is being held up. I was in Cancun when I faxed it and I'm not sure if it came through. Please let me knoe if this is the issue