

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-837	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/07/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BISBEE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 4821 BISBEE DRIVE GREENSBORO, NC 27407
---	--

(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 000	<p>INITIAL COMMENTS</p> <p>An annual survey was attempted on January 7, 2022.</p> <p>According to the Licensee there are no current clients receiving services at the facility. The last time clients resided at the facility was in March 2021.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children and Adolescents.</p> <p>The survey sample consisted of audits of 0 current clients, 1 former clients, 0 deceased clients.</p> <p>Observations on 1/7/22, at approximately 9:45am, of the inside of the facility revealed: -The thermostat was set at 60 degrees -No clients were present -Bedrooms were empty</p> <p>Interview on 1/7/22 with the Executive Director revealed: -There were no current clients at the facility -The last time the facility served clients was in March 2021 -The discharged client stepped down to a lower level of care -Had renewed his license for 2022 -Hoped to have clients by the end of January 2022 -Would contact DHHS once clients were admitted to the facility</p> <p>Review on 1/7/22 of Former Client #1 (FC #1)'s record revealed: -An admission date of 11/16/20</p>	V 000		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-837	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/07/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BISBEE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 4821 BISBEE DRIVE GREENSBORO, NC 27407
---	--

(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 000	<p>Continued From page 1</p> <p>-A discharged date of 3/21/21</p> <p>-Diagnoses of Intermittent Explosive Disorder, Disruptive Mood Dysregulation Disorder, and Attention Deficit Hyperactivity Disorder, Unspecified</p> <p>-An assessment dated 11/16/20 noted "functions well with peers in a group home environment, was previously in a foster home, was very disrespectful, pushed a tv off its stand, has abandonment issues, low self-esteem, verbally assaultive and oppositional. Needs to work on anger and defiant behaviors, needs crisis intervention, and is physically aggressive towards others."</p> <p>-A treatment plan dated 11/6/20 noted "will learn to track and recognize crying patterns and to regulate her emotions, will comply with medication requirements as well as nightly/sleep requirements set by authority figures that are responsible for health and safety, and will engage in age appropriate behaviors in school and the community,"</p>	V 000		