STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
AND I DAY OF CONTROL OF THE PARTY OF THE PAR		A. BUILDING: _						
		MHL014-089	B. WING		R 01/05/2022			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
FOOTHILI	S REGIONAL TREATME	NT CENTER	RGANTON BOU NC 28645	LEVARD, SUITE 200				
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE			
V 000	INITIAL COMMENTS		V 000					
	on 1-5-22. Deficiencie This facility is license categories: 10A NCA Medical Detoxification Substance Abusers a Facility Based Crisis Disability Groups.	d for the following service C 27G .3100 Nonhospital n for Individuals who are and 10A NCAC 27G. 5000 Service for Individuals of All						
V 219	27G .3102 Nonhospit	al Med. Detox Staff	V 219					
	V 219 27G .3102 Nonhospital Med. Detox Staff 10A NCAC 27G .3102 STAFF (a) A minimum of one direct care staff member shall be on duty at all times for every nine or fewer clients. (b) The treatment of each client shall be under the supervision of a physician. (c) The services of a certified alcoholism counselor, a certified drug abuse counselor or a certified substance abuse counselor shall be available to each client. (d) Each facility shall have at least one staff member on duty at all times trained in the following areas: (1) substance abuse withdrawal symptoms, including delirium tremens; and (2) symptoms of secondary complications to substance abuse. (e) Each direct care staff member shall receive continuing education to include understanding of the nature of addiction, the withdrawal syndrome, group therapy, family therapy and other treatment methodologies.							

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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FOOTHILI	LS REGIONAL TREATME	NT CENTER			LEVARD, SUITE 200		
	T		LENOIR, N	C 28645			
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V 219	Continued From page	e 1		V 219			
	-Staff list was not sep but provided for the fa	ews and interviews, the yone direct care staffly at all times for every findings are: of staffing list revealed arrated by service cate accility as a whole. I with Staff #1 revealed Based Crisis (FBC) the same for detoxification.	f nine d: egory				
	Interview on 12-21-21 -Staff #1 worked with -Staff switched who y day to day.						
	Interview on 12-21-2 ² -At least 5 staff were -Only one or two of the		nifts.				
	Record review on 1-3 revealed: -Job title for Staff #1 v Treatment Specialist" "FBC/Detox"Job title for Registere was "Facility Nurse (F"FBC/Detox".	was "FBC and Detox in the Department of ed Nurse (RN) #1 and	#2				
	Interview on 12-21-2 ^o Professional (QP) rev -There was no differe detoxification or FBC	realed: ntiation between staff	for the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
FOOTHILI	LS REGIONAL TREATME	NT CENTER	ORGANTON BOUI R, NC 28645	LEVARD, SUITE 200			
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V 219			V 219				
V 270	ratios that ensure the served in the facility. (b) Staff with training provision of care to the present at all times with the facility shall hadditional staff on site supervision, treatment response to the need (d) The treatment of	2 STAFF maintain staff to client health and safety of clients and experience in the le needs of clients shall be hen clients are in the facility. have the capacity to bring to provide more intensive tt, or management in	V 270				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
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		MHL014-089	B. WING		01/05/2022				
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
FOOTHILI	S REGIONAL TREATME	ENT CENTER 2415 MOR		LEVARD, SUITE 200					
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V 270	(e) Each direct care access at all times to are qualified in the diswith whom the staff is (f) Each direct care and have basic know and psychotropic meeffects; mental retard developmental disabile behaviors; the nature and the withdrawal symethodologies for ad	24-hour per day basis. staff member shall have qualified professionals who sability area(s) of the clients working. staff member shall be trained dedge about mental illnesses dications and their side ation and other lities and accompanying of addiction and recovery yndrome; and treatment ults and children in crisis. shall be provided by a	V 270						
	facility failed to identification ratios that ensured in the facilients served in the facilients served in the facilients served in the facility was not seput provided for the facility was Facility Specialist. We were all trained to and facility based crisults. Interview on 12-21-24-Staff #1 worked with	ews and interviews, the fy staff to maintain staff to re the health and safety of acility. The findings are: of staffing list revealed: arated by service category acility as a whole. I with Staff #1 revealed: Based Crisis (FBC) the same for detoxification sis services. I with Client #1 revealed:							

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STATE FORM 6899 N5YX11 If continuation sheet 4 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		MHL014-089	B. WING		R 01/05/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
FOOTHILI	S REGIONAL TREATME	ONT CENTER 2415 MOR		LEVARD, SUITE 200		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE	
V 270	Continued From page	e 4	V 270			
	Interview on 12-21-21 with Client #2 revealed: -At least 5 staff were working during day shiftsOnly one or two of those were in the FBC role.					
	revealed: -Job title for Staff #1 v Treatment Specialist" "FBC/Detox"Job title for Registere	in the Department of ed Nurse (RN) #1 and #2 RN)" in the Department of				
	Professional (QP) revealed: -There was no differentiation between staff for the detoxification or FBC servicesSpecialists and Nurses were trained on both crisis and detoxification.					
	Mental Health Couns -All the staff were work provided by the facilit	rking for both services y. ailable to bring in if there is				
	Director of Operations -Staff were not separa -An RN was on shift a -The facility worked o -The first shift staffing on shift at all times, a LPN (Licensed Practi specialist during the o -The second shift staf RN and typically a se	ated by service category. at all times. n shifts per day. pattern consisted of an RN long with a secondary RN or cal Nurse), and an FBC				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (A. BUILDING:						
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NAME OF PI	MHL014-089 B. WING 01/05/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
FOOTHILL	FOOTHILLS REGIONAL TREATMENT CENTER 2415 MORGANTON BOULEVARD, SUITE 200 LENOIR, NC 28645								
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V 270	Continued From page	<u>.</u>	V 270						
	. 3	eeded, as were LPNs.							
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