Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL063-052	A. BUILDING: _____ B. WING _____	R 02/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAN CIRCLE	1222 PEE DEE ROAD ABERDEEN, NC 28315

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V 000	INITIAL COMMENTS An annual and follow up survey was completed on 2/24/22. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. The survey sample consisted of audits of 3 current clients.	V 000	DHSR - Mental Health MAR 14 2022 Lic. & Cert. Section	
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and	V 108		

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V 108	Continued From page 1 implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure four of four audited staff (#1, #2, #3 and the Director) had current training in Cardiopulmonary Resuscitation (CPR) and First Aid (FA). The findings are: a. Review on 2/23/22 of the facility's personnel files revealed: - Staff #1 date of hire was 2/4/03. - Staff #1 was hired as a Habilitation Technician. - Staff #1's CPR training was completed online on 8/24/20. -There was no documentation of CPR completed by an instructor for staff #1. b. Review on 2/23/22 of the facility's personnel files revealed: - Staff #2 date of hire was 12/1/98. - Staff #2 was hired as a Habilitation Technician. - Staff #2's FA and CPR training was completed online and expired on 4/1/21. -There was no documentation of current CPR and FA training for staff #2. c. Review on 2/23/22 of the facility's personnel files revealed: - Staff #3 date of hire was 6/25/13. - Staff #3 was hired as a Habilitation Technician. - Staff #3's CPR training was completed online on	V 108		

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V 108	Continued From page 2 6/22/21. -There was no documentation of CPR completed by an instructor for staff #3. d. Review on 2/23/22 of the facility's personnel files revealed: -The Director date of hire was 12/21/97. -The Director's CPR training was completed online on 1/26/22. -There was no documentation of CPR completed by an instructor for the Director. Interview on 2/24/22 with staff #1 revealed: -They did CPR training on the computer. -She did not think they did training in person because of Covid. -They did not do any chest compressions during the CPR training online. Interview on 2/24/22 with staff #3 revealed: -They did their CPR training online. -She did not think they did CPR training with a trainer since Covid started about 2 years ago. Interview on 2/24/22 with the Director revealed: -They used to do the CPR and FA training with an instructor in person. -They had been doing CPR and FA online due to Covid. -He didn't realize they could not do the CPR training online. -He confirmed staff #1, staff #3 and himself completed their CPR training online. -He confirmed staff #2 had no current training in FA and CPR.	V 108	SSeP, Inc., will ensure that all Alan Circle will receive in person CPR training following COVID-19 protocol.	4-25-22
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS	V 114		

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V 114	Continued From page 3 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 be posted 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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to conduct fire and disaster drills under conditions that simulate emergencies. The findings are: Review on 2/24/22 of the facility's fire drill log revealed: -1/5/22-1st shift -12/6/21-1st shift -11/8/21-2nd shift -10/5/21-1st shift -9/6/21-1st shift -8/3/21-1st shift -7/5/21-1st shift -6/7/21-1st shift -5/5/21-1st shift -4/7/21-1st shift -3/9/21-1st shift -2/5/21-1st shift -There was no documentation of a 3rd shift fire drill for the 4th quarter of 2021.	V 114		

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V 114	Continued From page 4 -There was no documentation of 2nd and 3rd shift fire drills for the 3rd quarter of 2021. -There was no documentation of 2nd and 3rd shift fire drills for the 2nd quarter of 2021. Review on 2/24/22 of the facility's disaster drill log revealed: -1/18/22-2nd shift -12/28/21-1st shift -12/13/21-1st shift -12/22/21-2nd shift -11/16/21-1st shift -11/26/21-1st shift -10/13/21-2nd shift -10/29/21-1st shift -9/20/21-1st shift -9/29/21-1st shift -8/13/21-1st shift -8/26/21-2nd shift -7/19/21-2nd shift -7/27/21-1st shift -6/16/21-1st shift -6/14/21-2nd shift -5/18/21-2nd shift -5/27/21-1st shift -4/13/21-3rd shift -4/23/21-1st shift -3/18/21-1st shift -3/30/21-2nd shift -2/10/21-2nd shift -2/23/21-1st shift -There was no documentation of a 3rd shift disaster drill for the 4th quarter of 2021. -There was no documentation of a 3rd shift disaster drill for the 3rd quarter of 2021. Interview on 2/24/22 with client #1 revealed: -Staff did fire and disaster drills with them. -He did not know how often the drills were completed.	V 114		

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V 114	Continued From page 5 Interview on 2/24/22 with client #3 revealed: -He was not sure if staff did fire or disaster drills with them. Interview on 2/24/22 with the Director revealed: -The group home had three separate shifts. -He didn't realize staff were completing the fire and disaster drill inconsistently during 2nd and 3rd shift. -He confirmed staff failed to conduct fire and disaster drills under conditions that simulate emergencies.	V 114	The Director of Residential Services has provided all Alan Circle-PDR staff with a monthly Fire, Hurricane, and Tornado Drill schedule to ensure that these drills are all done each month by alternating shifts. (See attachment #1)	4-25-22
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of	V 536		

Attachment #1

Alan Circle-PDR Monthly Fire, Hurricane, and Tornado Drill Schedule

March - 2nd Shift Staff

April – 3rd Shift Staff

May – 1st Shift Staff

June – 2nd Shift Weekend Staff

July – 3rd Shift Weekend Staff

August – 1st Shift Weekend Staff

September – 2nd Shift Staff

October – 3rd Shift Staff

November – 1st Shift Staff

December – 2nd Shift Weekend Staff

January – 3rd Shift Weekend Staff

- **Monthly Designated Staff shall complete a Fire, hurricane, and Tornado drill every monthh.**

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V 536	Continued From page 6 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 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; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) 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; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) 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.	V 536		

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V 536	Continued From page 7 (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 Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) 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. (4) 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; (C) methods for evaluating trainee 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.	V 536		

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V 536	Continued From page 8 (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) 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 outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure three of four audited staff (#1, #2 and #3) had current training on the use of alternatives to restrictive interventions. The findings are:	V 536		

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V 536	Continued From page 9 a. Review on 2/23/22 of the facility's personnel files revealed: -Staff #1 date of hire was 2/4/03. -Staff #1 was hired as a Habilitation Technician. -Staff #1's National Crisis Intervention Plus (NCI+) Prevention training was completed on 6/8/20. -There was no documentation of a current training on the use of alternatives to restrictive interventions for staff #1. b. Review on 2/23/22 of the facility's personnel files revealed: -Staff #2 date of hire was 12/1/98. -Staff #2 was hired as a Habilitation Technician. -Staff #2's NCI+ Prevention training was completed on 8/23/20. -There was no documentation of a current training on the use of alternatives to restrictive interventions for staff #2. c. Review on 2/23/22 of the facility's personnel files revealed: -Staff #3 date of hire was 6/25/13. -Staff #3 was hired as a Habilitation Technician. -Staff #3's NCI+ Prevention training was completed on 6/28/20. -There was no documentation of a current training on the use of alternatives to restrictive interventions for staff #3. Interview on 2/24/22 with the Director revealed: -The agency did NCI + for training on the use of alternatives to restrictive interventions. -He didn't realize the NCI + training had expired for staff. -There was a Human Resources (HR) staff, however he had not seen her in a while. -He was not sure how often the HR staff came to	V 536		

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V 536	Continued From page 10 the office. -The HR staff was responsible for ensuring staff trainings and records were up to date. -He confirmed staff #1, staff #2 and staff #3 had no documentation of current training on the use of alternatives to restrictive intervention.	V 536		
V 537	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 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	V 537		

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V 537	Continued From page 11 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: (1) refresher information on alternatives to 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); (4) strategies for the safe implementation of restrictive interventions; (5) 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 use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) 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.	V 537		

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V 537	Continued From page 12 (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) 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. (5) 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. (6) 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	V 537		

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V 537	Continued From page 13 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. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure three of four audited staff (#1, #2 and #3) had training in the use of seclusion, physical restraints and isolation	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL063-052	A. BUILDING: _____ B. WING _____	R 02/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAN CIRCLE	1222 PEE DEE ROAD ABERDEEN, NC 28315

(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 537	Continued From page 14 time-out training on the use of alternatives to restrictive interventions. The findings are: a. Review on 2/23/22 of the facility's personnel files revealed: -Staff #1 date of hire was 2/4/03. -Staff #1 was hired as a Habilitation Technician. -Staff #1's National Crisis Intervention Plus (NCI+) Prevention training was completed on 6/8/20. -There was no documentation of current training in the use of seclusion, physical restraints and isolation time-out for staff #1. b. Review on 2/23/22 of the facility's personnel files revealed: -Staff #2 date of hire was 12/1/98. -Staff #2 was hired as a Habilitation Technician. -Staff #2's NCI+ Prevention training was completed on 8/23/20. -There was no documentation of a current training in the use of seclusion, physical restraints and isolation time-out for staff #2. c. Review on 2/23/22 of the facility's personnel files revealed: -Staff #3 date of hire was 6/25/13. -Staff #3 was hired as a Habilitation Technician. -Staff #3's NCI+ Prevention training was completed on 6/28/20. -There was no documentation of a current training in the use of seclusion, physical restraints and isolation time-out for staff #3. Interview on 2/24/22 with the Director revealed: -The agency did NCI + for training in the use of seclusion, physical restraints and isolation time-out. -He didn't realize the NCI + training had expired for staff.	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL063-052	A. BUILDING: _____ B. WING _____	R 02/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAN CIRCLE	1222 PEE DEE ROAD ABERDEEN, NC 28315

(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 537	Continued From page 15 -There was a Human Resources (HR) staff, however he had not seen her in a while. -He was not sure how often the HR staff came to the office. -The HR staff was responsible for ensuring staff trainings and records were up to date. -He confirmed staff #1, staff #2 and staff #3 had no documentation of current training in the use of seclusion, physical restraints and isolation time-out.	V 537	All Alan Circle-PDR have recieved training in National Crisis Intervention Plus, and are current. (See attachment # 2)	4-25-22

Attachment #2

NCI+
National Crisis Intervention Plus

certifies that the participant

SANDRA VAMPER

has fulfilled all requirements for competency.
Annual recertification is required.

© *NCI+ - PREVENTION* *(Level:)*

DHSR - Mental Health
MAR 14 2022
Lic. & Cert. Section

Everett Mitchell	*06/27/2021*
NAME OF THE INSTRUCTOR	*DATE*
SIGNATURE	*06/26/2022*
	EXPIRATION DATE:

A curriculum of NCI+; www.nciplus.com

Attachment #2

NCI+

National Crisis Intervention Plus

certifies that the participant

VANESSA HOWARD

has fulfilled all requirements for competency.
Annual recertification is required.

© *NCI+ - PREVENTION* *(Level:)*

Everett Mitchell	*06/07/2021*
NAME OF THE INSTRUCTOR	*DATE*
SIGNATURE	*06/06/2022*
	EXPIRATION DATE:

A curriculum of NCI+; www.nciplus.com

Attachment #2

NCI+

National Crisis Intervention Plus

certifies that the participant

HENRY ISSAC

has fulfilled all requirements for competency.
Annual recertification is required.

© NCI+ - PREVENTION

(Level:)

Everett Mitchell

SIGNATURE

06/07/2021

DATE

06/06/2022

EXPIRATION DATE:

A curriculum of NCI+; www.nciplus.com

Attachment #2

NCI+
National Crisis Intervention Plus

certifies that the participant

MICHAEL QUICK

has fulfilled all requirements for competency.
Annual recertification is required.

© NCI+ - PREVENTION

(Level:)

Everett Mitchell	*09/20/2020*
SIGNATURE	*DATE*
	09/19/2021
	EXPIRATION DATE:

A curriculum of NCI+; www.nciplus.com

Attachment # 2

NCI+

National Crisis Intervention Plus

certifies that the participant

SANDRA PATE

has fulfilled all requirements for competency.
Annual recertification is required.

© NCI+ - PREVENTION

(Level:)

Everett Mitchell	09/20/2020
SIGNATURE	DATE
	09/19/2021
	EXPIRATION DATE:

A curriculum of NCI+; www.nciplus.com

Attachment #2

NCI+

National Crisis Intervention Plus

certifies that the participant

EARLENE MCCRIMMON

has fulfilled all requirements for competency.
Annual recertification is required.

© *NCI+ - PREVENTION*

(Level:)

Everett Mitchell

SIGNATURE

08/09/2021

DATE

08/08/2022

EXPIRATION DATE:

A curriculum of NCI+; www.nciplus.com

Attachment #2

NCI+

National Crisis Intervention Plus

certifies that the participant

BARRY MCCRIMMON

has fulfilled all requirements for competency.
Annual recertification is required.

© NCI+ - PREVENTION (Level:)

Everett Mitchell	03/06/2021
NAME OF THE INSTRUCTOR	DATE
SIGNATURE	03/05/2022
	EXPIRATION DATE:

A curriculum of NCI+; www.nciplus.com

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

March 1, 2022

Robert Evans, Director
Specialized Services & Personnel, Inc.
P.O. Box 1356
Aberdeen, NC 28315

Re: Annual and Follow up Survey completed February 24, 2022
Alan Circle, 1222 Pee Dee Road, Aberdeen, NC 28315
MHL # 063-052
E-mail Address: uncp1914@yahoo.com, kstockwellssp@gmail.com

Dear Mr. Evans:

Thank you for the cooperation and courtesy extended during the Annual and Follow up survey completed February 24, 2022.

As a result of the follow up survey, it was determined that all of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- All tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is 4/25/22.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Bryson Brown at 919-855-3822.

Sincerely,

Kimberly R Sauls
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc:

_DHSR_Letters@sandhillscenter.org
Pam Pridgen, Administrative Assistant

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL063-052 Y1	A. Building B. Wing DHSR - Mental Health Y2	2/24/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAN CIRCLE	1222 PEE DEE ROAD ABERDEEN, NC 28315

MAR 14 2022

Lic. & Cert. Section

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0736 Reg. # 27G .0303(c) LSC	Correction Completed 02/24/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR Kimberly R Sauls	DATE 3/1/22
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE Facility Compliance Consultant I	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
6/6/2019	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

March 1, 2022

Robert Evans, Director
Specialized Services & Personnel, Inc.
P.O. Box 1356
Aberdeen, NC 28315

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NC Division of Health Service Regulation
2718 Mail Service Center
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Sincerely,

Kimberly R Sauls
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc:

_DHSR_Letters@sandhillscenter.org
Pam Pridgen, Administrative Assistant

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL063-052 Y1	A. Building B. Wing Y2	2/24/2022 Y3

DHSR - Mental Health

MAR 14 2022

Lic. & Cert. Section

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAN CIRCLE	1222 PEE DEE ROAD ABERDEEN, NC 28315

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0736 Reg. # 27G .0303(c) LSC	Correction Completed 02/24/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR** Kimberly R Sauls	**DATE** 3/1/22
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE** Facility Compliance Consultant I	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 6/6/2019	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

 EVENT ID: SHZU12