STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

(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	INITIAL COMMENTS An annual, complaint and follow up survey was completed on March 29, 2022. Six complaints were unsubstantiated (intakes #NC00187356, #NC00187357, #NC00187323, #NC00187015, #NC00186904, #NC00184938) and two complaints were substantiated (intakes #NC00187041, #NC00186339). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents. This facility is licensed for 12 and currently has a census of 11. The survey sample consisted of audits of 5 current clients and 1 former client.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and	V 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	03/29/2022

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V 105	Continued From page 1 (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105		

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	MHL054-126	A. BUILDING: _____ B. WING _____	03/29/2022

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V 105	Continued From page 2	V 105		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to: (1) implement the facility admission policy when a client was admitted from a sister facility, and (2) implement written standards that assured operational and programmatic performance meeting applicable standards of practice to report serious occurrences to the State designated Protection and Advocacy system, Disability Rights North Carolina (DRNC), before the end of the next business day following a serious occurrence. The findings are:

Finding #1:
Review on 3/29/22 of client #12's record revealed:
-17 year old male admitted 2/20/22 from a sister facility.
-Diagnoses included conduct disorder, unspecified onset; attention deficit hyperactive disorder (ADHD), unspecified, phonological disorder, and expressive language disorder.
-No documentation of an admission pre-screening or admission assessment for the facility 2/20/22 admission.
-4/13/2020, the admission date to the sister facility, was documented as the admission date on client #12's Monthly Treatment Team Review summaries dated 2/21/22 and 3/15/2022.

Interview on 3/23/22 client #12 stated he had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

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V 105	Continued From page 3 been at the facility for more than a year. Interview on 3/28/22 the Assistant Clinical Director stated: -The procedure for admitting clients included getting authorization, conducting an assessment, and developing goals based on client needs. -The admission policy and procedure was not implemented when a client was moved from one sister facility on the campus to another. -Client #12 did not have an admission assessment or goals reviewed/updated to meet his needs when he was admitted to the facility on 2/20/22. -Client #12's guardian/parent had been notified of client #12's move but it had not been documented. Interview on 3/28/22 the Program Director stated the facility had never implemented the admission policy and procedure when clients were moved from one sister facility to another. Finding #2: Review of client #10's record on 3/2/22 revealed: -16 year old male admitted 4/2/21. -Diagnoses included unspecified metal disorder (non-psychotic), mood disorder not otherwise specified, reactive attachment disorder of infancy or early childhood, and ADHD. Review on 3/2/22 of client #10's North Carolina Incident Response Improvement System (IRIS) report, incident date of 1/18/22 revealed: -1/18/22 client #10 was playing basketball, "...dropped down hard on both feet after rebounding the ball. Pain causes consumer to immediately sit down on the ground." Physician was informed and gave an order to have client #10 see an Orthopedic provider.	V 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

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V 105	Continued From page 4 -1/25/22 client #10 was seen by the Orthopedic provider and received orders for Meloxicam, a prescription medication for discomfort, a knee brace, and a MRI (magnetic resonance imaging). -MRI was done on 2/2/22 with an Orthopedic follow up visit on 2/4/22. -On 2/11/22 client #10 had a surgical procedure, ACL (anterior cruciate ligament) repair of his left knee. Review on 3/3/22 of client #10's "Serious Occurrence/Sentinel Event Report" for incident on 1/18/22 revealed the incident had been reported to DRNC on 3/2/22 at 8:40 pm. Interview on 3/2/22 the Program Director stated: -Client #10's left knee injury on 1/18/22 was not identified initially as a serious occurrence, and had not been reported to DRNC as a serious occurrence. -Following Client #10's knee injury he continued to complain of discomfort and his treatment progressed up to the point of surgery. -As his symptoms and treatment increased this should have been submitted to DRNC as a serious occurrence, but had been overlooked. -Now that this had been identified (during the survey) it was sent to DRNC. This deficiency was cited 5 times on 8/14/20, 10/23/20, 1/8/21, 2/19/21, 4/19/21.	V 105		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

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V 112	Continued From page 5 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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure goals/strategies were developed to meet client needs affecting 1 of 1 former clients (FC) audited (FC#13). The findings are: Reviews on 2/22/22 and 3/2/22 of FC#13's record revealed: -17 year old female admitted to the facility on 6/15/21. -Diagnoses included post traumatic stress disorder (PTSD) and oppositional defiant disorder	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	03/29/2022

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OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

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V 112	Continued From page 6 (ODD). -PRTF (Psychiatric Residential Treatment Facility) Comprehensive Clinical Assessment dated 6/15/21 documented FC#13 attempted to kill herself by jumping in front of a car outside of a hospital; FC#13 reported she had thoughts of suicide at least twice a week "at the present time" and had these thoughts since age 12. -Comprehensive Clinical Assessment Addendum dated 5/20/21 documented an incident prior to admission when FC#13 broke a mirror, cut her hand, hit her head on the mirror, had been taken to an Emergency Department where she attempted to run away and ran out into moving traffic. Due to safety concerns a higher level of care, PRTF, was recommended by the Licensed Clinical Mental Health Counselor. -Tool for Assessment of Suicide Risk: Adolescent Version (TASR-A) dated 6/15/21 documented FC#13 was a "moderate" level of immediate suicide risk. Suicidal ideation, suicidal intent, and past suicidal behavior were all noted, "Yes." -TASR-A dated 8/20/21 documented suicidal ideation as "Yes" and that FC#13 was at "low risk" for suicide. -There were no goals or strategies in FC#13's treatment plan to address suicidal behaviors or ideation. Review on 2/22/22 and 3/2/22 of FC#13's North Carolina Incident Response Improvement System (IRIS) report for the incident dated 12/6/21 revealed: -"Consumer was found sitting on the floor of the bathroom with shoestrings tied around her neck and to the crossbar of the stall doors." Review on 3/2/22 of FC #13's discharge summary dated 12/15/21 revealed: -Reason for admission included self harming	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	03/29/2022

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V 112	Continued From page 7	V 112		

behaviors, suicidal ideations, physically and verbally aggressive.
-FC#13 was making progress towards her treatment goals, but then started to experience command auditory hallucinations and depression telling her to kill herself. As a result of those behaviors and attempted suicide FC#13 was involuntarily committed.

Unable to interview FC#13 on 3/2/22 due to her discharge from the hospital and to another PRTF outside of the local area.

Interview on 3/7/22 FC#13's Guardian stated:
-FC#13 had a long history of self harming behaviors and suicide attempts.
-He was called by facility staff on 12/5/21 and informed FC#13 had been outside playing, went to the bathroom without permission, and when the staff went to check on her she had a shoe string tied around her neck.
-He was called at 7pm on 12/6/21 and told they were sending FC#13 to the hospital.
-When he admitted FC#13 to the facility it was his understanding the facility was capable of caring for FC#13 with her history of these behaviors.

Interview on 3/2/22 the Consumer Affairs Coordinator (CAC) #1 stated:
-She was the social worker and functioned as the case manager for client #13.
-As the CAC she was responsible to write the client's goals, facilitate monthly Child/Family Treatment Team (CFT) meetings, and keep the guardians and the care coordinators informed of client issues.
-She had been aware that FC#13 had tried to commit suicide a couple of times before she came to the facility.
-FC#13 was depressed and there was a lot of "up

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	MHL054-126	A. BUILDING: _____ B. WING _____	03/29/2022

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V 112	Continued From page 8 and down" with FC#13 and "you did not know what to expect." -During interview CAC #1 reviewed FC#13's treatment plan and could not identify any goals or strategies to address FC#13's suicidal thoughts or behaviors. -Even though self injurious behaviors (SIB) were not written in a goal, she considered SIB to be violent/aggressive behaviors that was listed in her goals.	V 112		
V 314	27G .1901 Psych Res. Tx. Facility - Scope 10A NCAC 27G .1901 SCOPE (a) The rules in this Section apply to psychiatric residential treatment facilities (PRTF)s. (b) A PRTF is one that provides care for children or adolescents who have mental illness or substance abuse/dependency in a non-acute inpatient setting. (c) The PRTF shall provide a structured living environment for children or adolescents who do not meet criteria for acute inpatient care, but do require supervision and specialized interventions on a 24-hour basis. (d) Therapeutic interventions shall address functional deficits associated with the child or adolescent's diagnosis and include psychiatric treatment and specialized substance abuse and mental health therapeutic care. These therapeutic interventions and services shall be designed to address the treatment needs necessary to facilitate a move to a less intensive community setting. (e) The PRTF shall serve children or adolescents for whom removal from home or a community-based residential setting is essential to facilitate treatment. (f) The PRTF shall coordinate with other	V 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

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V 314	Continued From page 9 individuals and agencies within the child or adolescent's catchment area. (g) The PRTF shall be accredited through one of the following; Joint Commission on Accreditation of Healthcare Organizations; the Commission on Accreditation of Rehabilitation Facilities; the Council on. Accreditation or other national accrediting bodies as set forth in the Division of Medical Assistance Clinical Policy Number 8D-1, Psychiatric Residential Treatment Facility, including subsequent amendments and editions. A copy of Clinical Policy Number 8D-1 is available at no cost from the Division of Medical Assistance website at http://www.dhhs.state.nc.us/dma/. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to coordinate with other individuals and agencies within the child or adolescent's catchment area to meet client needs affecting 1 of 1 former clients (FC) audited (FC#13). The findings are: Reviews between 2/22/22 and 3/2/22 of FC#13's record revealed: -17 year old female admitted to the facility on 6/15/21 and discharged on 12/15/21. -Diagnoses included post traumatic stress disorder (PTSD) and oppositional defiant disorder (ODD). -PRTF (Psychiatric Residential Treatment Facility) Comprehensive Clinical Assessment dated 6/15/21 documented FC#13 attempted to kill herself by jumping in front of a car outside of a	V 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	03/29/2022

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OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

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V 314	Continued From page 10	V 314		

hospital; FC#13 reported she had thoughts of suicide at least twice a week "at the present time" and had these thoughts since age 12.

Review on 2/22/22 and 3/2/22 of FC#13's Progress Notes dated 12/6/21 revealed:
-8:10 am: FC#13 had been placed on "1:1" supervision for "attempts to cause herself harm by tying a shoe string around her neck while going to the bathroom. Staff checked on her p (after) 3 minutes in the BR (bathroom) & found her sitting on the BR floor. Consumer has no difficulties breathing. Does not want to answer any questions nurse has. Returned to class."
-8:30 am: "Consumer sitting in class smiling. Staff at her side. AOC (administrator on call), Program Director, RSS (residential services supervisor), Drs (doctors) notified."
-8:50 am: "Called & spoke c (with) consumers guardian in ref (reference) to 1:1 & reasons she was on 1:1. He stated "Thank You.""
-8:16 pm: "Consumer assessed for 1:1 at 1950 (7:50 pm) - asleep in bed with staff outside door. [County Sheriff's Deputy] arrived at 2016 (8:16 pm) to transport consumer to [hospital] ED (emergency department) for IVC (involuntarily commitment) evaluation. Consumer sleepy but cooperative. Consumer did not have to be placed in handcuffs."
-9:05 pm: Call was made and message left for hospital ED nurse. FC#13's face sheet, medication list, and IVC forms were given to the deputy to give to the ED nurse.
-9:29 pm: Guardian was called and a message was left.

Review on 2/22/22 and 3/2/22 of FC#13's North Carolina Incident Response Improvement System (IRIS) report for the incident dated 12/6/21 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

(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 314	Continued From page 11 -"Consumer was found sitting on the floor of the bathroom with shoestrings tied around her neck and to the crossbar of the stall doors." Review on 3/9/22 of an e-mail dated 12/9/21 from FC#13's MCO (managed care organization) Care Coordinator to the Consumer Affairs Coordinator (CAC) #2 revealed: -E-mail message was sent on 12/9/21 at 4:25 pm to CAC#2. -Message read, "Good afternoon I need weekly treatment update on...." followed by 3 client names, one being FC#13. Review on 3/2/22 of FC #13's discharge summary dated 12/15/21 revealed: -Reason for admission included self harming behaviors, suicidal ideations, physically and verbally aggressive. -FC#13 was making progress towards her treatment goals, but then started to experience command auditory hallucinations and depression telling her to kill herself. As a result of those behaviors and attempted suicide attempt (SA), FC#13 was IVC'd. Interview on 3/7/22 FC#13's MCO Care Coordinator stated: -She received a call on either 12/14/21 or 12/15/21 regarding a treatment team meeting for FC#13. -In the 12/15/21 treatment team meeting she found out for the first time that FC#13 had been IVC'd on 12/6/21. -She had sent an email to CAC#2 on 12/9/21 asking for updates on her clients but received no response. -She was informed during the treatment team meeting that FC#13 was to be discharged from the facility because she had been in the hospital	V 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

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V 314	Continued From page 12	V 314		

for 7 days, and when she was discharged from the hospital the facility would "take her back."
-FC#13 was ready to be discharged from the hospital on 12/18/21 but the facility would not "take her back."
-If she would have been informed of FC#13's IVC before the day of her discharge (12/15/21) she would have "advocated" for FC#13 to return to the facility or tried to find her a psychiatric bed. "The goal is to get the clients out of the ED and back into treatment."
-FC#13 was finally placed in another PRTF on 3/3/22.
-FC#13 had only 1 behavioral episode during her hospital stay between 12/6/21 and 3/3/22; that behavior occurred after someone from the PRTF told her there was no bed available for her to return to the facility.

Interview on 3/9/22 CAC #2 stated:
-She had no role in the care and/or planning/care coordination for FC#13.
-She did not contact the care coordinator for FC#13 and did not receive any communication from the care coordinator.

Interview on 3/7/22 FC#13's Guardian stated:
-On 12/6/21 he received a call at 7 pm from a facility and told FC#13 was being sent to the hospital. Earlier he had been informed FC#13 had been found in the bathroom with a shoe string tied around her neck.
-He heard nothing more from the facility so he made a call on 12/14/21 trying to find out what was "going on."
-He received a voice mail message from a female on 12/14/21 that informed him FC#13 was going to be discharged because she had been in the hospital for 7 days.
-He had been told previously that the facility was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

(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 314	Continued From page 13	V 314		

equipped to deal with suicidal issues. He had understood the facility was "staffed" to handle these behaviors. FC#13 had a history of these behaviors.
-He participated in the treatment team meeting on 12/15/21 by telephone.

Interview on 3/2/22 the CAC #1 stated:
-She was the social worker and functioned as the case manager for client #13.
-As the CAC she was responsible to write the client's goals, facilitate monthly Child/Family Treatment Team (CFT) meetings, and keep the guardians and the care coordinators informed of client issues.
-She had not made calls to follow up on FC#13 after she had been sent to the hospital on 12/6/21.

Interview on 3/3/22 FC#13's Therapist stated:
-FC#13 was added to his case load after her first therapist left around October or early November 2021.
-Prior to 12/6/21 FC#13 had not made any comments about wanting to hurt herself.
-He recalled being informed during morning rounds that FC#13 attempted to hang herself with some shoe laces tied to a door.
-He did not see the FC#13 between the time of her SA on 12/6/21 (8:10 am) and when she left to go to the hospital to be IVC'd (8:16 pm).
-He was asked by the surveyor if it was routine for the therapist to see a client that had a SA before they left the facility to be IVC'd and he responded that he could not answer that because he had not had that situation before.
-He held a discharge planning meeting on 12/15/21.

Interview on 3/2/22 the Program Director stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

(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 314	Continued From page 14 FC#13 was IVC'd on 12/6/21 and once they were told the hospital was placing her in a hospital there was no need to follow up.	V 314		
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 course. (e) Formal refresher training must be completed by each service provider periodically (minimum	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

(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 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. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

(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 16 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 CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

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V 537	Continued From page 17 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 review and interview, 1 of 1 former staff (FS) audited (FS#5) failed to demonstrate competence in the use of physical restraints. The findings are: Review on 3/23/22 of FS#5's personnel record revealed:	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

(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 18	V 537		

-Hired 11/15/21 by the Licensee.
-Terminated after an allegation by client #4 on 3/18/22.
-Position, Paraprofessional.
-Completed NCI (North Carolina Interventions) Plus on 11/16/21.

Review on 3/28/22 of the internal investigation of client #4's allegation dated 3/18/22 revealed:
-On 3/18/22, at 5:35 pm, client #4 was placed in a physical restraint by Staff #1 and FS #5.
-Client #4 reported:
-FS#5 pulled her client #4's head down by her braids and her head went into a pillow because the client #4 had poured milk on FS#.
-FS#5 took client #4's food and gave it to her peers.
-FS#5 called the supervisor on duty (SOD) and told the SOD they needed to "wrap" client #4 because she was aggressive.
-Staff #1 initiated the wrap; FS#5 "had her feet."
-Staff (did not list which staff) called for additional staff because client #4 was "loose," meaning her hands and feet were unrestrained and she was kicking, swinging her arms. "... it took some time for other staff to finally come."
-Staff #1 "yelled" for one of her peers to bring her a spit guard; the peer placed it on client #4's head for the staff.
-Client #4 denied telling RSS#2 that FS#5 was hurting her knee by digging her nails into her.
-Client #4 was upset because FS#5 had tried to give her food away.
-Client #4 later ate some of her food.
Staff #1 reported:
-Client #4 was upset because FS#5 removed her food from her bedroom.
-She told FS#5 to "leave the situation alone" that she (Staff #1) would handle it. FS#5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

(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 19	V 537		

continued to engage with client #4 and client #4 poured milk on FS#5.
-Client #4 was upset because she thought FS#5 had given client #4's food to the peers.
-Staff #1 did not see FS#5 give client #4's food to her peers, but she did see a peer with client #4's cake.
-Client #4 spit in FS#5's face and FS#5 pushed the top of client #4's head downward to prevent her from further spitting on FS#5.
-Staff #1 was not sure where client #4's head "ended up" but she knew client #4's head had been pushed "downwards."
-She asked FS#5 to "tap out" but she did not comply. Client #4 became combative, kicking FS#5 and swinging her arms.
-Staff #1 grabbed client #4's hands and proceeded to place her in a sitting restraint.
-Client #4 spit in FS#5's face and FS#5, again, pushed client #4's head downward to prevent client #4 from further spitting on FS#5.
-Client #4 and Staff #1 slid to the floor and FS#5 was able to get control of client #4's feet/legs.
-Staff #1 clarified that she did not "mean" to previously report that FS#5 pulled client #4 by her hair.
RSS#2 reported:
-When she arrived on the scene Staff #1, client #4, and FS#5 were on the floor.
-Client #4 stated FS#5 was hurting her knee and had taken her food.
-She asked FS#5 to remove her hand from client #4's knee and to make sure her fingernails were not pinching client #4's skin.
-Staff #6 and Staff#7 relieved Staff#1 from the physical restraint. No one was identified to have relieved FS#5.
-Staff #1 reported to RSS#2 that FS#5 had pushed client #4's head into the bed by her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

(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 20	V 537		

braids.
RN#1 reported:
-Staff #1 reported during the debrief that Staff #1 saw FS#5 push client #4's face into her mattress.
-Staff #1 expressed concern that client #4 might have injuries to her ankles due to FS#5's fingernails.
-RN#1 assessed client #4 and found no injuries.
FS#5 reported:
-Client #4 was upset because she was not allowed to eat in her room.
-She advised client #4 to return to the dining area.
-Client #4 became aggressive, throwing her milk on FS#5, kicking, and hitting FS#5.
-FS#5 had to "block" client #4 from hitting her.
-Staff #1 intervened and put client #4 in a wrap. FS#5 assisted by grabbing client #4's feet and legs to prevent kicking.
-Client #4 tried to "head butt" and spit on FS#5.
-Staff #6 and #7 relieved Staff #1; no one relieved FS#5 and and she continued to hold client #4's feet/legs for the remainder of the wrap.

Interview on 3/25/22 client #4 stated:
-There was one staff that tried to give away her lunch on a school day.
-Client #4 had been "acting up" because she did not want to go back to school.
-This staff said she was going to give client #4's food away.
-Client #4 threw her milk on the staff after she refused to let client #4 eat in her room.
-The staff threw the milk back on client #4 and walked away with her food.
-The staff gave her food back to her and told her to sit at the table.
-Client #4 was in her room on her bed and the staff picked her up and took her to the hallway.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

(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 21 -One staff had her legs and was digging her nails into her arms when they picked her up. Interview on 3/25/22 Staff #1 stated: -Client #4 had been having behaviors earlier the day of the allegation (3/18/22). -Client #4 did not want to eat dinner at the table. She was redirected and told she could not eat in her room. -Client #4 took her food to her room and FS#5 followed and told her she could not eat in her room. -Staff #1 could hear the confrontation between FS#5 and client #4 as she (Staff #1) was completing a write up of an earlier incident. -She told FS#5 to leave client #4 alone and not get in a power struggle, but she did not think FS#5 heard her. -Staff #1 went back to client #4's room and saw the client holding her milk in her hand; FS#5 was standing in the doorway. -FS#5 took client #4's food back to the dining room area as Staff #1 tried to counsel client #4. -Client #4 saw another peer with her cake and client #4 tossed a chair. -FS#5 tried to counsel client #4 but she became physical, kicking and hitting. -Staff #1 took client #1's hands as Staff #1 stood behind client #4. -FS#5 pushed client #4's head down to avoid having the client spit on FS#5. -Staff #1 told FS#5 to "tap out." Staff #1 took client #4's hands again and put her in a sitting restraint. -Client #4 "scooted" onto the floor and FS#5 took her by her feet. Client #4 spit in FS#5's face, and FS#5 grabbed her head again and pushed it forward. -Staff #1 yelled for the supervisor and for another consumer to bring her a spit guard. Client #6 put	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

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V 537	Continued From page 22 the spit guard on client #4. -Staff came out of the office and 2 of the staff "took over" for Staff #1, but they did not let FS#5 "tap out." -Client #4 said FS#5 was hurting her knees and complained FS#5's nails were hurting her. FS#5 had her hands on client #4's knees. -The staff are taught not to place their hands on the knees,\but to hold a client by the ankles. -Client #4 complained that FS#5 had pulled her hair. -Staff #1 was not sure if FS#5 pulled the client's hair. Unable to interview FS#5 as she did not answer phone calls on 3/25/22 or return a call by the end of the survey.	V 537		
V 539	27F .0102 Client Rights - Living Environment 10A NCAC 27F .0102 LIVING ENVIRONMENT (a) Each client shall be provided: (1) an atmosphere conducive to uninterrupted sleep during scheduled sleeping hours, consistent with the types of services being provided and the type of clients being served; and (2) accessible areas for personal privacy, for at least limited periods of time, unless determined inappropriate by the treatment or habilitation team. (b) Each client shall be free to suitably decorate his room, or his portion of a multi-resident room, with respect to choice, normalization principles, and with respect for the physical structure. Any restrictions on this freedom shall be carried out in accordance with governing body policy.	V 539		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

(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 539	Continued From page 23 This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to provide accessible areas for personal privacy, affecting 4 of 12 client rooms (D2, D4, E1, E4). The findings are: Observations on 3/3/22 between 2:15 pm and 3 pm during facility tour revealed: -There were 2 buildings labeled building "D" and "E" with 6 client rooms in each. -Each client room had a window to the outside that was covered with an opaque film on the exterior side of the window for privacy. -Large portions of the film were torn away in the following rooms making it possible to see into the rooms from the outside: D2, D4, E1, E4. -There were no other window coverings to provide for client privacy. Interview on 3/3/22 the Maintenance Manager stated: -The window film was used to provide privacy. -He would follow up for repairs or to look for more sustainable options.	V 539		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

(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 736	Continued From page 24 This Rule is not met as evidenced by: Based on observation and interviews, the facility was not maintained in a safe, clean attractive and orderly manner. The findings are: Observations of the facility on 3/3/22 between approximately 2:20 pm and 2:45 pm revealed: -The front door was difficult to close and did not secure tightly to the frame. -Entrance door, building D, inside paint surface worn and stained. -Finish was worn to bare wood on picnic table in client dining areas in buildings D and E. -Building D back door, inside, area above handle and over to the right missing sections on paint. -Orange/brown discoloration on side of refrigerator. -Broken and missing sections of floor tiles in kitchen areas where appliances had been removed in buildings D and E. -Sections of countertop laminate missing along cabinet edges in building E. -The bedroom door was missing portions of wood fragments located near the door handle. -Bedroom E5 had a split in the wood extending down the spine of the bedroom door. There was visible damage around the door handle. Interview on 3/3/22 Facility Support Coordinator stated: -The cabinets would be removed soon as part of a renovation plan. -The refrigerators had been removed leaving the areas of missing tile exposed. Interview on 3/3/22 the Maintenance Supervisor stated: -The clients had been rough on the doors throughout the facility, but he would complete	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

(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 736	Continued From page 25 repairs needed to bedrooms. Interview on 3/3/22 the Program Director stated: -The previous maintenance concerns from the bedrooms from the survey completed in October of 2021 had been completed, but the clients had created new damage to the rooms since then. This deficiency has been cited 3 times since the original cite on 4/19/21 and must be corrected within 30 days.	V 736		