STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-159	A. BUILDING: ______ B. WING ______	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD FACILITY	**2002-G SHACKLEFORD ROAD KINSTON, NC 28502**

(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. Seven complaints were substantiated (intake #NC00184217, #NC00184223, #NC00185470, #NC00185853, #NC00185847, #NC00187037, and #NC00187712) and one complaint was unsubstantiated (intake #NC00183943). 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 18 and currently has a census of 13. The survey sample consisted of audits of 3 current clients.	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
	MHL054-159	A. BUILDING: ______ B. WING ______	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD FACILITY	**2002-G SHACKLEFORD ROAD KINSTON, NC 28502**

(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 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-159	A. BUILDING: ______ B. WING ______	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD FACILITY	**2002-G SHACKLEFORD ROAD KINSTON, NC 28502**

(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 105	Continued From page 2	V 105		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to implement written standards that assured operational and programmatic performance meeting applicable standards of practice to report serious occurrences by the close of business on the next business day after a serious occurrence to the State designated Protection and Advocacy system (Disability Rights North Carolina (DRNC)) and failed to implement written policies for adoption of standards that assure operational and programmatic performance meeting applicable standards of practice for 1.) the training in non-physical interventions and the use of physical restraints semi-annually as required by CFR §483.376(f) for 1 of 3 audited staff (Residential Services Supervisor #3). The findings are:

Finding #1:
Review of client #4's record from 2/17/22 - 2/22/22 revealed:
-12 year old male admitted on 11/19/21.
-Diagnoses included disruptive mood dysregulation disorder (DMDD) and attention deficit hyperactive disorder (ADHD).
-Between 12/3/21 and 1/21/22 there were 9 restrictive interventions (RI) that were reported greater than by the close of business on the next business day following the restrictive intervention to DRNC as follows:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-159	A. BUILDING: ______ B. WING ______	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD FACILITY	**2002-G SHACKLEFORD ROAD KINSTON, NC 28502**

(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 105	Continued From page 3 -RI: 12/3/21 (Friday); reported 12/8/21 -RI: 12/4/12 (Saturday); reported 12/8/21 -RI: 12/4/21 (Saturday); reported 12/8/21 -RI: 12/5/21 (Sunday); reported 12/8/21 -RI: 12/6/21 (Monday);reported 12/8/21 -RI: 12/6/21 (Monday);reported 12/8/21 -RI: 12/7/21 (Tuesday);reported 12/9/21 -RI: 12/17/21 (Friday);reported 12/21/21 -RI: 1/21/22 (Friday); reported 1/26/22 Finding #2: Review on 03/15/17 of CFR §483.376 (f) revealed: "Staff must demonstrate their competencies as specified in paragraph (a) of this section on a semiannual basis...(a) the facility must require staff to have ongoing education, training and a demonstrated knowledge of: 1)Techniques to identify staff and resident behaviors, events and environmental factors that may trigger emergency safety situation; 2) The use of nonphysical intervention skills, such as de-escalation, mediation, conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations and (3) the safe use of restraint and the safe use of seclusion, including the ability to respond to signs of physical distress in residents who are restrained or in seclusion." Review on 3/3/22 of Residential Services Supervisor #3 (RSS #3) personnel record revealed: - Hire date of 11/16/20. - Previous two trainings for "Nonviolent Crisis Intervention" (non-physical interventions and the use of physical restraints) were completed on 11/16/21 and 11/17/20.	V 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-159	A. BUILDING: ______ B. WING ______	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD FACILITY	2002-G SHACKLEFORD ROAD KINSTON, NC 28502

(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 105	Continued From page 4 During interview on 3/4/22 the Personnel Manager stated if there was no documentation of current training in the records, the training probably had not been completed at the 6 month mark. Interview on 2/21/22 the Admissions Assistant stated: -It was her job to send the serious occurrence reports to DRNC. -She reported serious occurrences to DRNC by faxing a copy of the IRIS (Incident Response Improvement System) report for that incident. -She did not send the IRIS report to DRNC until it was finalized. -She had 72 hours to submit IRIS reports, but they were typically completed the day following an incident. -She could not print an IRIS report for 24 hours after she submitted; therefore, she printed copy before she would submit. That was the reason the date "1/1/001" was printed on the IRIS reports sent to DRNC. -She started her job in September 2021 and around October or November 2021 she had to submit all RI to DRNC starting with 1/1/2021. Interview on 2/21/22 the Program Director stated: -Initially when they were reporting past RI to DRNC (back to 1/1/2021) they were sending the name of client, a brief description of the event and the RI done. -DRNC requested more detailed reporting, so they began sending the IRIS reports. -Sending IRIS reports had resulted in some late reporting, so the Admissions Assistant had provided additional training of the Qualified Professionals/Consumer Affairs Coordinators on 2/9/22 and 2/17/22.	V 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-159	A. BUILDING: ______ B. WING ______	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD FACILITY	2002-G SHACKLEFORD ROAD KINSTON, NC 28502

(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 105	Continued From page 5 This deficiency has been cited 8 times since the original cite on August 14, 2018 and must be corrected within 30 days.	V 105		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-159	A. BUILDING: ______ B. WING ______	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD FACILITY	**2002-G SHACKLEFORD ROAD KINSTON, NC 28502**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 6 This Rule is not met as evidenced by: Based on record review, observation, and interview, the facility failed to ensure medications were given as ordered and MARs kept current/accurate for 1 of 3 clients audited (#4). The findings are: Review of client #4's record 2/17/22 - 2/22/22 revealed: -12 year old male admitted 11/19/21. -Diagnoses included disruptive mood Dysregulation disorder and attention deficit hyperactive disorder. -Order dated 1/21/22 to discontinue Vyvanse due to increase in aggression and to start Strattera 25 mg (milligrams) every morning (both medications ordered for ADHD). -Guardian consent for Strattera dated 1/22/22. -No order for Risperidone 3 mg daily for 7 days, then discontinue. (mental/mood disorders) Review on 2/21/22 of client #4's MARs for 12/1/21 - 2/21/22 (8 am) revealed: -Strattera 25 mg was not printed on client #4's MAR for February 2022. -No documentation client #4 had received Strattera 25 mg from 2/1/22 - 2/21/22. -December MAR order entry for Risperidone 3 mg QD (daily) for 7 days at 8 am, then discontinue. Risperidone 3 mg documented as given on 12/8/21. Observation of client #4's medications on 2/21/22 between 2:30 pm and 2:50 pm revealed there was no Strattera on hand.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-159	A. BUILDING: ______ B. WING ______	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD FACILITY	2002-G SHACKLEFORD ROAD KINSTON, NC 28502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 7	V 118		

Interview on 3/3/22 client #4 stated:
-He had been at the facility since October of 2021.
-He took his medications as prescribed and had encountered no problems with his medications.
-Sometimes he did not always feel like taking his medications, but the registered nurse (RN) responsible for medication administration would always return to ensure he got his medications when he calmed down.

Interview on 2/21/22 RN #2 stated:
-The order for Strattera had not printed to client #4's February MAR.
-The facility had transitioned recently to the electronic MAR; she could not recall the exact date but remembered it to be on a Tuesday. (2/1/22 was a Tuesday.)
-She could not find an order for client #4 to receive Risperidone.
-The Pharmacy entered orders for the MARs and the night nurses were responsible to check for accuracy.

Interview on 2/22/20 the Psychiatrist stated:
-She was the psychiatrist for all clients in the facility.
-She did not believe the omission of client #4's Strattera from 2/1/22 - 2/21/22 would have increased his aggressive behaviors.
-She was not concerned about this omission because it would take several weeks to get the medication in his system.
-Vyvanse had been discontinued to decrease client #4's agitation. Missing doses of Strattera after the Vyvanse had been discontinued did not cause her any concern.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-159	A. BUILDING: ______ B. WING ______	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD FACILITY	**2002-G SHACKLEFORD ROAD KINSTON, NC 28502**

(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 8	V 736		
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. 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: Observation of the facility on 3/3/22 at approximately 2:15pm revealed: -The seclusion room (#1) had the door window removed. -The seclusion room (#2) had the door window removed and door jamb broken loose. -The seclusion room (#3) entry door frame was separated from the wall, -Unit 2: Bedroom A2 had a door frame with various holes drilled in the top of the frame. Holes extended approximately 6 inches across the top of the frame. There were large screws protruding through the the back of the bedroom door by about 1/4 inch. -Unit 2: Bedroom A3 had a bedroom door frame bent at the bottom of the door. The bedroom door was detached at the bottom hinge. Interview on 3/3/22 the Maintenance Supervisor stated: -Clients had kicked the seclusion room doors resulting in the damage presented.	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-159	A. BUILDING: ______ B. WING ______	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD FACILITY	2002-G SHACKLEFORD ROAD KINSTON, NC 28502

(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 9 -The facility had been working with a local contractor to repair and replace seclusion room doors. -He would complete repairs needed to bedrooms. Interview on 3/3/22 the Program Director stated: -The facility was awaiting new doors to replace the seclusion room doors. -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 5/18/21.	V 736		