		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		ML054-018	B. WING		05/0	2/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
NEW DE			ACKLEFOR			
NEW BE	GINNINGS KINSTON	KINSTON	NC 28504			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	ΓS	V 000			
	An annual survey w Deficiencies were c	vas completed on May 2, 2022. ited.				
	category: 10A NCA	sed for the following service C 27G .1400 Day Treatment olescents with Emotional or ances.				
		urrent census of 0. The sisted of audits of 3 former				
V 118	27G .0209 (C) Med	ication Requirements	V 118			
	only be administered order of a person and drugs.  (2) Medications shat clients only when and client's physician.  (3) Medications, included and individual statements of the privileged to prepare (4) A Medication Ad all drugs administer current. Medications recorded immediate MAR is to include the (A) client's name;	inistration: non-prescription drugs shall and to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be any licensed persons, or by a trained by a registered nurse, a legally qualified person and a and administer medications. Iministration Record (MAR) of a de to each client must be kept a sadministered shall be ally after administration. The				
	(C) instructions for (D) date and time the	and quantity of the drug; administering the drug; ne drug is administered; and of person administering the				

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		ML054-018	B. WING		05/0	2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NEW BE	GINNINGS KINSTON		IACKLEFOR , NC 28504	D ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU! CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 118	drug. (5) Client requests checks shall be recipile followed up by a with a physician.  This Rule is not me	for medication changes or corded and kept with the MAR appointment or consultation	V 118			
	failed to ensure 1 or client #2) had physical administered. The Review on 5/02/22 record revealed:  - 14 year old male.  - Admitted 2/03/22,  - Diagnoses included Dysregulation Disorder, mild.  - No signed and da propranolol ("for agontablets; give 2.5 tabincluding at noon.  - Medication Admin 2/04/22 - 4/13/22 in propranolol 50 mg weekday at 12:00 recorded.	of former client #2's (FC#2)  discharged 4/13/22. ed Disruptive Mood rder, Attention Deficit der, Conduct Disorder, ssive Disorder, and Cannabis  ted physician's order for gression") 20 milligram (mg) olets (50 mg) three times daily, istration Records dated icluded documentation was administered each moon.  5/02/22 the Qualified				

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STATE FORM BHSN11 If continuation sheet 2 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1 1			) DATE SURVEY COMPLETED	
7.110 1 27.11	or correction.	BENTH 16, WIGHT WOMBER.	A. BUILDING:				
		ML054-018	B. WING		05/0	2/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
NEW BE	GINNINGS KINSTON		ACKLEFOR , NC 28504	D ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 118	- There was not a cophysician's order in - The signed and datached to the med - FC#2 had medical discharged from the medication was retroriginal package She understood the copy of the signed a medications.	copy of the signed and dated FC#2's record. ated physician's order was	V 118				
	without advance no (g) Licenses for fac any clients during th not be renewed. (h) DHSR shall cor 24-hour facilities ar months, to occur no July 1, 2007. (i) Written requests a minimum of 30 da changes: (1) Construct renovation of an ex (2) Increase of program service typ (3) Change ir (4) Change ir (j) Written no to DHSR a minimum the following change	D PERIOD duct inspections of facilities rice. cilities that have not served ne previous 12 months shall induct inspections of all naverage of once every 12 collater than 15 months as of as shall be submitted to DHSR ays prior to any of the following tion of a new facility or any isting facility; or decrease in capacity by oe; in program service; or in location of facility. otification must be submitted in of 30 days prior to any of					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COMPLET	
		MI 054 040	B. WING		0=10	0/0000
		ML054-018	D. WING		05/0	2/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
NEW BE	GINNINGS KINSTON		ACKLEFOR , NC 28504	D ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
V 139	change in partnersh (2) Change ir (k) When a license discontinue a servic days in advance sh affected clients, and legally responsible of This notice shall ad clients in the facility (I) Licenses shall e DHSR for an additional expiration of a licent to DHSR the following (1) Annual Ferman (2) Description facility since the lass submitted; (3) Local currow (4) Annual satisfies the exception of a count of that does not handly inspection report is (5) The name owner, partners or significant and continued in the sexperior of a count of the country of the coun	nip; or name of facility. The plans to close a facility or one, written notice at least 30 all be provided to DHSR, to all did when applicable, to the persons of all affected clients. It did when applicable, to the persons of all affected clients. It did when applicable, to the persons of all affected clients. It did written services to the set of th	V 139			
	Licensee failed to p	et as evidenced by: view and interview, the rovide written notice to DHSR closing the facility. The				
	Service Regulation	of the Division of Health Mental Health Licensure and n "Client Census Form"				

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If continuation sheet 5 of 5

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AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		ML054-018	B. WING		05/0	2/2022
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00.0	
NEW BE	GINNINGS KINSTON		ACKLEFOR NC 28504	D ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 139	completed by the Q no current clients so During interview on Professional stated served at the facility suspended effective During interview on Director stated: - Services were terrelocation of the Da-The Licensee wou location separate at the Psychiatric Resulting interview on Psychiatric Resident Services stated accomplete of the Local Material Services at the facility planned to relocate	pualified Professional revealed erved at the facility.  5/02/22 the Qualified there were no clients being y. Services were temporarily e 4/13/22.  5/02/22 the Executive apporarily suspended pending by Treatment program. In the facility to a not distinct from the campus of idential Treatment Facility.  5/02/22 the Director of thial Treatment Facility cording to the Chief Executive enagement Entities (LME's) temporary suspension of ity. Because the Licensee the facility and resume and distinct think notifying DHSR	V 139			

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