STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-579	A. BUILDING: _____ B. WING _____	R-C 07/07/2022

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THE EMMANUEL HOME III	5212 SWEETBRIAR DRIVE RALEIGH, NC 27609

(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 A complaint and follow up survey was completed on 7/7/22. Complaint (Intake #00190070) was unsubstantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G 5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for six and currently has a census six clients. The survey sample consisted of audits of three current clients.	V 000	DHSR - Mental Health AUG 8 2022 Lic. & Cert. Section	
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 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.	V 112		

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview the facility failed to develop goals to address one of three audited client (#5's) behaviors. The findings are: Review on 6/30/22 of client #5's record revealed: -Admission: 6/29/18 -Diagnoses: Autism Spectrum Disorder, Mild Intellectual Developmental Disability, Major Depressive Disorder and Schizophrenia Psychotic Disorder. -Treatment Plan dated 6/4/22, no goals present to address client #5's verbal and physical aggression. Interview on 6/30/22 the Chief Operating Officer (COO) stated: -A few weeks ago client #5 and client #3 had been in a physical altercation in the facility. -Client #5 had a history of physically hitting at staff and other clients when he was having a behavior. -Client #5 also would call clients and staff "racist" names which would upset the clients. -Had spoken to client #5's mother about this, but it was an ongoing issue with him. -During the last altercation, client #5 had called client #3 the "N" word. -Client #3 then punched client #5 resulting in client #3 getting bit by client #5. -The police were called and both clients went to the hospital.	V 112	Page 2 V 112 David's PCP has been updated and signed by the guardian. The updated goals addressed his verbal disrespect towards house mates and physical aggression. -ED Emmanuel homes will review PCP's quarterly to update any goals to meet the members needs ED Emmanuel Homes scheduled training for staff to on 7/13/22 and 7/22/22 address how to deal with behaviors and also reviewed nnovation members behavior ns with staff.	

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V 112	Continued From page 2 -Staff knew to recognize when client #5 starts to have these behaviors and get him to his room to calm down. Interview on 6/30/22 staff #1 stated: -On 6/13/22 the clients were in line to receive their PM medications. -She noticed client #5 was acting "different" so she asked did he want a snack and he declined. -Client #5 then called client #3 the "N" word and client #3 punched client #5. -Client #3 would call staff and clients "racist" names when he got upset. -Tried to keep client #3 away from client #5 during the altercation as client #5 was not listening to her. -Contacted the police and the clients were taken to the hospital. -No one had told her any strategies to use when addressing client #5's outburst that leads to the name calling and hitting. Interview on 7/7/22 the Qualified Professional (QP) stated: -Had been aware of client #5's behaviors of verbal and physical aggression. -Client #5 would call other clients in the home the "N" word and it would escalate to physical altercations between them. -Client #5 had hit staff as well in the past, "mostly women." -Had spoken to client #5's mother about addressing these behaviors in his treatment plan. -"Feels like it should be added, my mistake." -Just completed his treatment plan for the year, but will look at adding new goals to address this. [This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.]	V 112		

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V 118	Continued From page 3	V 118		
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		

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V 118	Continued From page 4 This Rule is not met as evidenced by: Based on record review and interview the facility failed to administer medications as prescribed for 1 of 3 audited clients (#1). Additionally, the facility failed to assure the MAR was current for 2 of 3 audited clients (#1 & 3). The findings are: A. Review on 6/30/22 of client #1's record revealed: -Admitted: 4/10/20 -Diagnoses: Epilepsy, Type 2 Diabetes, Hypertension, Liver Neoplasm with Metastasis, Traumatic Brain Injury (TBI), History of (H/O) Prostate Cancer and Hyperlipidemia -Physician's order dated 5/6/22 revealed Finger Stick Blood Sugar Check before meals and at bedtime. -Physician's order dated 5/6/22 for Humalog sliding scale: 70 - 150 = 0 units 151-200 = 2 units 201-250 = take 4 units 251-300 = take 6 units 301-350 = take 8 units Greater than 350 take 10 units, "Do not give humalog at night, only with meals." Review on 6/30/22 of client #1's Blood Sugar Log from 5/23/22-6/30/22 revealed the following days where Blood Sugar (BS) was not checked per his physician order: -5/26/22- 11:30 AM-"out of the home" and 2 pm-7 pm- "out of the home" (2 BS checks completed) -5/31/22-11:30 AM-"out of the home" (3 BS checks completed) -6/3/22- 11:30 AM-"out of the home" (3 BS checks completed) -6/5/22-no bedtime check (3 BS checks completed) -6/7/22-11:30 AM "out of the home" and no	V 118		

Division of Health Service Regulation

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V 118	Continued From page 5 bedtime check (2 BS checks completed) -6/8/22-no before dinner check (3 BS checks completed) -6/9/22-no before dinner and no bedtime check "client refused test" (2 BS checks completed) -6/11/22- no before bed check (3 BS checks completed) -6/13/22-no before dinner and no before bed (2 BS checks completed) -6/21/22-no before breakfast and no before lunch (2 BS checks completed) -6/28/22-no before breakfast and no before lunch- "out" (2 BS checks completed) -6/29/22-no before breakfast and no before lunch "out" (2 BS checks completed) Review on 6/30/22 of client #1's MAR from 5/23/22-6/30/22 revealed the following initials indicating BS had been checked for days that the Blood Sugar Log had listed "out of the home," or left blank on the Blood Sugar Log: -6/3/22, 6/7/22, 6/8/22, 6/9/22, 6/11/22 Review on 6/30/22 of client #1's Blood Sugar Log revealed Humalog was administered on 6/10/22 10 units of Humalog was given at 7:56 PM, but was not initialed on the MAR. B. Review on 6/30/22 of client #3's record revealed the following, -Admitted: 2/23/20 -Diagnoses- Schizoaffective Disorder, Post Traumatic Stress Disorder, Anxiety, Gastroesophageal reflux (GERD), Insomnia, Cocaine Use, TBI, Severe Polysubstance Use -Physician order dated 6/13/22-Gabapentin 300 miligram (mg) twice a day (anticonvulsant), Augmentin 875 mg every 12 hours for 10 days (antibiotic), Naproxen 500 mg 2 times a day for 7 days (for pain).	V 118	Page 5 V 118 Staff continues to receive weekly trainings. MARs are reviewed weekly to assure in compliance. COO will continue to training staff on taking blood sugar and the blood sugar scales monthly. COO will follow up with staff weekly to see if BS have been completed and if more training is needed to assure compliance. COO has trained staff on documentation for BS and medication to assure staff is documenting per policy. MARs will be reviewed weekly to assure compliance.	

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V 118	Continued From page 6 Review on 6/30/22 client #3's MAR revealed: -Gabapentin 300 mg not initialed for the AM doses on 6/17/22, 6/21/22, 6/23/22, 6/27/22, 6/28/22 and the PM dose on 6/28/22. -Augmentin not initialed for the AM doses on 6/17/22, 6/18/22, 6/21/22, 6/23/22. -Naproxen not initialed for the AM doses of 6/17/22 & 6/21/22 Interview on 6/30/22 staff #1 stated: -Had been working in the facility a few weeks. -Mostly worked first shift. -The House Manager (HM) and the Licensee/Registered Nurse (RN) had trained her on client #1's diabetic protocol. -Had tried to check his BS four times a day, but in the mornings, "its hard because it's a lot going on here and I forget." -Client #1 went out with his brother a few days a week and he wouldn't have his blood sugar checked during those times. -Did not check his BS when he returned to the facility. -Did give client #1 Humalog one night because his BS was high per the sliding scale. -Did not realize you couldn't give the Humalog at night without a meal, Had not been told that. -Mostly worked days and gave the insulin then with meals. -The morning staff was supposed to have checked the BS when she arrived. -Some days when she got there, noticed sometimes the BS had not been checked. Interview on 6/30/22 client #1 stated: -Staff did not always check his BS four times a day. -Would tell them to check the BS, but not sure why they did not do it.	V 118		

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V 118	Continued From page 7 -Staff would give him the insulin if it was too high. -In the past, had felt bad, and would tell them to check his BS. -Went out with his brother a few days a week. -Staff didn't check his BS when he returned from outings with his brother. Interview on 6/30/22 the HM stated: -Client #1's BS was to be checked four times a day. -He had a sliding scale for insulin if BS was over 150. -Had been out of work for the last two weeks due to being in the hospital, "I can't tell you what happened during that time." -Had trainings on all client #1's diabetes protocol by the Licensee/RN -Had helped train the new staff on BS checks and client #1's sliding scale insulin. -Had informed everyone of the sliding scale insulin and not to give it at night without meals. -Reviewed the blood sugar logs and the MARs when he was working in the home to ensure they were marked and initialed. -Had "gotten on" some staff about not checking client #1's BS or writing it down. -Client #3's medication had been administered, not sure why it was not initialed. -Two of client #3's medications were for 7-10 days and they were not present in the facility. -Will continue to check the blood sugar log and the MARs for accuracy. Interview on 7/7/22 the Qualified Professional (QP) stated: -She only wrote the client treatment plans, staff supervision and helped with incident reports. -"I don't do the medication part with the clients." -Mostly the HM and the Licensee/RN checked client #1's BS logs and MARs.	V 118		

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V 118	Continued From page 8 Interview on 6/30/22 the Licensee/RN stated: -After the last survey, she took client #1 to a nutritionist/dietitian to help with his diet. -The doctor was going to reduce the number of times his BS was checked daily. -Had at least three trainings with new and old staff since last survey on client #1's diabetes protocol. -If client #1 was out of the facility, when he returned staff should check his BS. -"There is nothing in stone that says when 'off sight' they have to check his blood sugar." -When client #1 refused to have his BS checked, he would become combative and he will hit at staff. -Had spoken with his neurologist and primary care physician about this. -Had been "spot checking" the blood sugar log and MAR since the last survey (5/2/22). -Had found some errors and written staff up or moved them to a home where there was not a diabetic client. -Usually at the home every day or so and looked at the blood sugar logs and MARs. -These last two weeks she had not been checking the blood sugar logs or MARs like she should. -Had been so busy running clients to their appointments, she missed some of the errors. -The QP is supposed to look over it and check the blood sugar logs and MARs when she went to the home. Review on 6/30/22 of Plan of Protection completed by the Licensee/RN dated 6/30/22 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? -Mandatory weekly trainings and updates on	V 118		

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V 118	Continued From page 9 medication requirements to correct errors and to come into compliance. -Employees making frequent med. (medication) errors will only be able to administer meds. under supervision of an experienced employee or supervision. -All insulin related issues re (regarding) :documentation, use of glucometer, sliding scale protocol, checking MARs, MD (Medical Doctor) orders, R/X's (prescriptions) will be reviewed every two days by RN or designee. A sign in sheet will be provided. Correction date to begin trainings will begin on 7/1/22. -Describe your plans to make sure the above happens. -Daily monitoring will be will be done by RN & QP. All staff who do not show improvement in administration and documentation with in 2 weeks will be suspended or terminated." Clients whose diagnoses included Traumatic Brain Injury, Diabetes, H/O Prostate Cancer, Liver Neoplasm with Metastasis, Epilepsy, Schizoaffective Disorder and Severe Polysubstance Use Disorder resided at the facility. The staff were inconsistently documenting on 2 different forms related to client #1's BS results and what insulin was administered. Between 5/23/22-6/30/22 client #1's blood sugar was not checked six times due to being "out of the home." One occasion during the time period reviewed, insulin was given in the evening hours without food. From 5/23/22 - 6/30/22, there were 19 opportunities to have client #1's BS checked. On 6/13/22 client #3 was prescribed three medications and staff did not initial the MAR six days during the review period. This deficiency constitutes a Failure to Correct the Type A1 rule violation originally cited for serious neglect. An administrative penalty of $500.00 per day is	V 118		

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V 118	Continued From page 10 imposed for failure to correct within 23 days.	V 118		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or	V 367		

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V 367	Continued From page 11 (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have	V 367		

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V 367	Continued From page 12 been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on on record review and interview the facility failed to ensure a level II incident report was completed regarding a physical altercation of two clients. The findings are: Review on 6/30/22 of the Incident Reporting Improvement System (IRIS) regarding an incident with client #3 and #5 on 6/13/22 revealed no level II incident report. Interview on 6/30/22 the Chief Operating Officer (COO) stated: -A few weeks ago client #5 and client #3 had been in a physical altercation in the facility. -Client #5 had a history of physically hitting at staff and other clients when he was having a behavior. -Client #5 also would call clients and staff "racist" names which would upset the clients. -Had spoken to client #5's mother about this, but it was an ongoing issue with him. -During the last altercation, client #5 had called client #3 the "N" word. -Client #3 then punched client #5 resulting in client #3 getting bit by client #5. -The police were called and both clients went to	V 367		

TEMENT OF DEFICIENCIES) PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-579	A. BUILDING: _____ B. WING _____	R-C 07/07/2022

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMMANUEL HOME III	5212 SWEETBRIAR DRIVE RALEIGH, NC 27609

(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 367	Continued From page 13 the hospital. -She and the Qualified Professional (QP) usually complete the IRIS reports. -Had not completed one regarding the fight between client #5 and #3. -Was not sure if an incident report needed to be done. -Will do one immediately in IRIS. Interview on 6/30/22 client #3 stated: -Client #5 called him a "racist" name a few weeks ago in the facility. -He punched client #5 in the face and they began to fight. -He had client #5 in a "headlock" and client #3 bit his arm and stomach. -Staff #1 broke the fight up and called the police. -Police came out and he was taken to the Emergency Room due to his bights. -The bight on his arm was deep and bleeding. -Was prescribed medication at the hospital for the bight and received a shot. Interview on 6/30/22 staff #1 stated: -On 6/13/22 the clients were in line to receive their PM medications. -She noticed client #5 was acting "different" so she asked did he want a snack and he declined. -Client #5 then called client #3 the "N" word and client #3 punched client #5. -Client #3 will call staff and clients "racist" names when he got upset. -Tried to keep client #3 away from client #5 during the altercation as client #5 was not listening to her. -Contacted the police and the clients were taken to the hospital. Interview on 7/7/22 the QP stated: -She and the COO do the IRIS reports for all	V 367	Page 14 V 367 QP will meet with staff daily to assure all incident reports has been completed and will be in IRIS within 72 hours. QP has reviewed all incident reports and assured that are all in IRIS. QP also has monthly supervisions to assure staff knows how to complete incident reports per policy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-579	A. BUILDING: _____ B. WING _____	R-C 07/07/2022

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THE EMMANUEL HOME III	5212 SWEETBRIAR DRIVE RALEIGH, NC 27609

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V 367	Continued From page 14 incidents. -Did not recall completing the IRIS report for client #3 and #5. -"Must have missed that one."	V 367		
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 interview the facility failed to ensure the home was maintained in a safe and attractive manner. The findings are: Observation on 6/30/22 at 2:00 PM of the home revealed: -A large 4 x 4 inch hole was in the wall located in the living area. Interview on 6/30/22 client #3 stated: -He and client #5 got into a physical altercation a few weeks ago. -They were in the living area waiting to receive their medications. -Client #5 called him a racial name and he punched him. -They were pushing and hitting each other and one of them hit the wall. -No one has fixed the hole so far.	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-579	A. BUILDING: _____ B. WING _____	R-C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMMANUEL HOME III	5212 SWEETBRIAR DRIVE RALEIGH, NC 27609

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V 736	Continued From page 15 Interview on 7/7/22 the Qualified Professional (QP) stated: -Had noticed the hole in the wall last week when she visited the home. -It was from the altercation between client #5 and #3 a few weeks ago. -Told the Licensee/Registered Nurse (RN) to have someone out to patch it.	V 736	Page 16 V736 The whole has been fixed in the living area. QP will assure home is clean during home visits and assure there are no damages.	

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

VIA Certified Mail

June 15, 2022

Ms. Eloise M. Dowtin, Licensee/Director
P.O. Box 26153
Raleigh, NC 27611

Re: Complaint and Follow Up Survey completed 7/7/22
The Emmanuel Home III, 5212 Sweetbriar Drive, Raleigh, NC 27609
MHL # 092-579
E-mail Address: eloisedowtin@gmail.com
Intake #: 00190070

Dear Ms. Dowtin:

Thank you for the cooperation and courtesy extended during the complaint and follow up survey completed 7/7/22.

As a result of the follow up survey, it was determined that none of the deficiencies are in compliance. 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

- Type A1 rule violation is ***continued*** for 10A NCA 27G .0209 Medication Requirements (V118).
- Re-cited standard level deficiency.
- All other tags are standard level deficiencies.

Time Frames for Compliance

- Re-cited standard level deficiency must be ***corrected*** within 30 days from the exit of the survey, which is 8/6/22.
- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is 9/5/22.

Time Frame for Compliance – Continued Type A1

- *You must submit in writing, via mail, the date by which the deficiency will be corrected. The second follow up visit will be scheduled after your submitted date of compliance is received by our office.* When the second follow-up visit is completed and the facility is determined to be in compliance with the previously cited deficiency, you will be notified by mail of the total penalty amount owed. However, if it is determined the facility is still out of compliance, administrative penalties will continue to accrue until such time the deficient practice is corrected.

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 Renee Kowalski at 919-552-6847.

Sincerely,

Kimberly Thigpen

Kimberly Thigpen
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: DHSRreports@dhhs.nc.gov, DMH/DD/SAS
DHSR@Alliancebhc.org
Pam Pridgen, Administrative Supervisor