STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILDING:		C	
MHL054-7		B. WING		09/01/2022	
PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
OD FACILITY		-	ORD ROAD		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
INITIAL COMMEN	TS	V 000			
1, 2022. Two comp (intake #'s NC0019 deficiency was cited This facility is licens category: 10A NCA Residential Treatma Adolescents. This facility is licens census of 9. The s	olaints were substantiated 2412 and NC00192413). A d. sed for the following service AC 27G .1900 Psychiatric ent for Children and sed for 12 and currently has a survey sample consisted of				
27G .1902 Psych. I	Res. Tx. Facility - Staff	V 315			
 (a) Each facility sh physician board-elig psychiatry or a gen experience in the tr adolescents with m (b) At all times, at l members shall be p or adolescents in e (c) If the PRTF is h specifically assigned responsibilities sep an acute medical u (d) A psychiatrist s consultation to revision or adolescent admities 	all be under the direction a gible or certified in child eral psychiatrist with reatment of children and ental illness. least two direct care staff present with every six children ach residential unit. nospital based, staff shall be ed to this facility, with arate from those performed or nit or other residential units. hall provide weekly ew medications with each child itted to the facility. Il provide 24 hour on-site				
	OF CORRECTION PROVIDER OR SUPPLIER DD FACILITY SUMMARY STA (EACH DEFICIENCY REGULATORY OR L INITIAL COMMENT A complaint survey 1, 2022. Two comp (intake #'s NC0019 deficiency was citer This facility is licens category: 10A NCA Residential Treatm Adolescents. This facility is licens category: 10A NCA Residential Treatm Adolescents. This facility is licens census of 9. The s audits of 1 current 27G .1902 Psych. I 10A NCAC 27G .19 (a) Each facility sh physician board-elip psychiatry or a gen experience in the tr adolescents with m (b) At all times, at members shall be p or adolescents in e (c) If the PRTF is h specifically assigner responsibilities sep an acute medical u (d) A psychiatrist s consultation to revi or adolescent admi (e) The PRTF sha	OF CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: MHL054-125 PROVIDER OR SUPPLIER STREET AI 2002 A & KINSTOP SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS A complaint survey was completed on September 1, 2022. Two complaints were substantiated (intake #'s NC00192412 and NC00192413). A deficiency was cited. ML000192413). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents. Adolescents. This facility is licensed for 12 and currently has a census of 9. The survey sample consisted of audits of 1 current client. 27G .1902 Psych. Res. Tx. Facility - Staff 10A NCAC 27G .1902 STAFF (a) Each facility shall be under the direction a physician board-eligible or certified in child psychiatry or a general psychiatrist with experience in the treatment of children and adolescents with mental illness. (b) At all times, at least two direct care staff members shall be present with every six children or adolescents in each residential unit. (c) If the PRTF is hospital based, staff shall be specifically assigned to this facility, with responsibilities separate from those performed or an acute medical unit or other residential units. (d) A psychiatrist shall provide weekly This facility shall provide weekly	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: MHL054-125 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST DD FACILITY 2002 A & B SHACKLEF KINSTON, NC 28502 SUMMARY STATEMENT OF DEFICIENCIES ID REQULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG INITIAL COMMENTS V 000 A complaint survey was completed on September 1, 2022. Two complaints were substantiated V 000 A complaint survey was completed on September 1, 2022. Two complaints were substantiated V 000 A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents. V 315 This facility is licensed for 12 and currently has a census of 9. The survey sample consisted of audits of 1 current client. V 315 27G .1902 Psych. Res. Tx. Facility - Staff V 315 10A NCAC 27G .1902 STAFF (a) Each facility shall be under the direction a physician board-eligible or certified in child psychiatry or a general psychiatrist with experience in the treatment of children and adolescents with mental illness. (b) At all times, at least two direct care staff members shall be present with every six children or adolescents in each residential unit. (c) If	OF CORRECTION IDENTIFICATION NUMBER: MHL054-125 A. BUILDING: B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECODED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D INITIAL COMMENTS ID A complaint survey was completed on September 1, 2022. Two complaints were substantiated (intake #'s NC00192412 and NC00192413). A deficiency was cited. V 000 This facility is licensed for the following service category: 10A NCAC 27G 1900 Psychiatric Residential Treatment for Children and Adolescents. V 315 27G .1902 Psych. Res. Tx. Facility - Staff V 315 10A NCAC 27G .1902 STAFF (a) Each facility shall be under the direction a physician board-eligible or certified in child psychiatry or a general psychiatrist with experience in the treatment of children and adolescents with mental illness. V 315 (b) At all times, at least two direct care staff members shall be present with every six children or adolescents and the viery six children or adolescents in each residential unit. V 315 (c) If the PRTF is hospital based, staff shall be specifically assigned to this facility, with responsibilities separate from those performed on an acute medical unit or other residential units. (d) A psychiatrist shall provide veekly consultation to review medications with each child or adolescent admitted to the facility.	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: COM MHL054-125 B. WING 09/ ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 09/ DD FACILITY 2002 A & B SHACKLEFORD ROAD KINSTON, NC 28502 09/ SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER SPLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) INITIAL COMMENTS V 000 V 000 A complaint survey was completed on September 1, 2022. Two complaints were substantiated (intake #s NC00192412 and NC00192413). A deficiency was cited. V 000 This facility is licensed for the following service category: 10A NCAC 27G. 1900 Psychiatric Residential Treatment for Children and Adolescents. V 315 This facility is licensed for 12 and currently has a census of 9. The survey sample consisted of audits of 1 current client. V 315 27G .1902 Psych. Res. Tx. 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AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			(X3) DATE SURVEY COMPLETED C 09/01/2022	
		MHL054-125					
			DDRESS, CITY, ST		03/	01/2022	
			B SHACKLEF				
PINEWOC	D FACILITY	KINSTO	N, NC 28502				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 315	Continued From pa	ige 1	V 315				
	Based on record re facility failed to ens were present with e at all times. The fin Review on 8/31/22 - 15 year old male. - Admission date of - Diagnoses of Inte Oppositional Defiar Deficient Hyperacti Borderline Functior Review on 8/31/22	of client #4's record revealed: f 8/19/20. rmittent Explosive Disorder, nt Disorder, Anxiety, Attention vity Disorder and Intellectual ning. of Former Staff (FS) #2's					
	personnel record re - Date of hire: 7/11/ - Job title: Paraprof	22.					
	Review on 8/31/22 revealed: - Date of hire: 6/6/2 - Job title: Paraprof						
	Taken:Residentia Director will determ	8/23/22 revealed "Actions I Supervisor/Residential ine & address matters related of the second staff assigned					
	since 2020. - He recalled an alle #2.	2 client #4 stated: old and had lived at the facility egation he made against FS aff, FS #2, during the incident					

STATE FORM

MQGR11

If continuation sheet 2 of 4

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	R: A. BUILDING:		(X3) DATE SURVEY COMPLETED C		
	MHL054-125		B. WING		09/	09/01/2022	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
PINEWO	OD FACILITY		B SHACKLEF N, NC 28502	ORD ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
V 315	Continued From pa	age 2	V 315				
	- Two staff always v	worked in the facility.					
	from another facility - She had not called before she left FS # - When she returned in behaviors. - She was away from minutes. - There were usual during shifts at the Interview on 9/1/22 - Staff #1 left the fa - She was gone at	acility to walk a female client y. d for a replacement staff #2 in the facility with 5 clients. ed to the facility, client #4 was on the facility for about 10 ly at least 2 staff working facility. FS #2 stated: cility to go another facility. least 15 minutes.					
	and ended shortly to Interview on 8/31/2 - She was not able went. - Staff #1 left the fa	2 the Therapist stated: to determine where staff #1 cility approximately 8:15pm					
	Supervisor (RSS) s - Staff #1 was work #2. - Staff #1 was not t did not get permiss	2 the Residential Services stated: ing 8/23/22 the facility with FS here during the incident and ion to leave the facility.					
	client. - He had not knowr she returned to the he got there. - Staff #1 should ha	nother unit, walking another in how long she was gone, but facility about 5 minutes after ave called him so he could facility or sent another staff to 2.					

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING: B. WING		C 09/01/2022	
	MHL054-125					
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
INEWO	OD FACILITY		B SHACKLEF N, NC 28502	FORD ROAD		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF		
TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	DATE
V 315	- There are normally always 2 staff working. Interview on 06/22/21 the Director of PRTF		V 315			
during the incide - She did not kno away from the fa - The Residentia		vn the whereabouts of staff #1				
	during the incident	with client #4 and FS #2.				
		how long staff #1 she was lity.				
	- The Residential E	Director was supposed to				
		S to determine where staff was	;			
	during the moldent					

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