recorded immediately after administration. The MAR is to include the following:

(A) client's name;

Division of	of Health Service Regu	ılation				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPL ER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL049-157	B. WING		03/0	06/2023
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, STATE			
BLUE HO	DRIZONS	STATES	SVILLE, NC 2862	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFIC ENCIES CY MUST BE PRECEDED BY FULL LSC IDENT FYING INFORMATION)	ID PREFIX TAG	PROV DER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETE DATE
V 000	INITIAL COMMENT	-S	V 000			
	unsubstantiated (in Deficiencies were ci	3. The complaint was take #NC00195928). tted. ed for the following 0A NCAC 27G .1700				
V 118	has a census of 4.	ed for 4 and currently The survey sample of 3 current clients and 2	V 118			
	10A NCAC 27G .02 REQUIREMENTS (c) Medication admi (1) Prescription or n shall only be admin written order of a pe to prescribe drugs. (2) Medications sha by clients only whe by the client's phys (3) Medications, inc administered only b unlicensed persons nurse, pharmacist of person and privileg administer medication Administration Recc administered to eac	nistration: non-prescription drugs istered to a client on the erson authorized by law all be self-administered en authorized in writing ician. luding injections, shall be y licensed persons, or by trained by a registered or other legally qualified				

(B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE STATE FORM 6899 M9RL11 If continuation sheet 1 of 11

Division	of Health Service Regu	ılation				D: 03/07/2023 1 APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPL ER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMPLE	
	MHL049-157 B. WING		03/0	06/2023		
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, Z P CODE 130 SAINT JILL CIRCLE					
BEOL III	ONLONG	STATESV	ILLE, NC 2862	25		
(X4) ID SUMMARY STATEMENT OF DEFIC ENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENT FYING INFORMATION)		ID PREFIX TAG	PROV DER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETE DATE	

(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.			
This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure medications were administered by persons trained by a registered nurse, pharmacist, or other legally qualified person and privileged to prepare and administer medications for 2 of 3 audited staff (Associate Professional (AP) and Qualified Professional (QP)). The findings are:		Horizons Kids Human Resource Manager has/will implement a training calendar addressing the following rule Medication Administration to ensure all new employees received training prior to entering the facility for their first official date of employment. Horizons Kids Human Resource Manager has/will update their policy to address any training timelines to ensure that all required trainings has been completed by the new hire prior to entering the facility.	03/13/23- 05/13/23 Ongoing
Review on 3/3/23 of the AP's record revealed: - Hire date: 2/27/23 - A Medication Administration training certificate was not in her file.		Quality Assurance Manager(QP) will audit the Employee file before the official start date to ensure all required paperwork & training have been completed. This is an on-going process and be monitor weekly, monthly and quarterly depending on the employee need.	03/13/23- 05/13/23 Ongoing
revealed: - Hire date: 10/16/22 - A Medication Administration training certificate was not in her file. Interview on 3/6/23 with the AP revealed:		Quality Assurance Manager(QP) will submit notification to Human Resource Manager that the employee file is complete and ready to start in the facility.	03/13/23- 05/13/23 Ongoing
was scheduled for 3/8/23 Interview on 3/6/23 with the Executive Director revealed: - The QP reviewed the Medication Administration			
	(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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure medications were administered by persons trained by a registered nurse, pharmacist, or other legally qualified person and privileged to prepare and administer medications for 2 of 3 audited staff (Associate Professional (AP) and Qualified Professional (QP)). The findings are: Review on 3/3/23 of the AP's record revealed: - Hire date: 2/27/23 - A Medication Administration training certificate was not in her file. Review on 3/3/23 of the QP's record revealed: - Hire date: 10/16/22 - A Medication Administration training certificate was not in her file. Interview on 3/6/23 with the AP revealed: - Her Medication Administration training was scheduled for 3/8/23 Interview on 3/6/23 with the Executive Director revealed:	(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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure medications were administered by persons trained by a registered nurse, pharmacist, or other legally qualified person and privileged to prepare and administer medications for 2 of 3 audited staff (Associate Professional (AP) and Qualified Professional (QP)). The findings are: Review on 3/3/23 of the AP's record revealed: - Hire date: 2/27/23 - A Medication Administration training certificate was not in her file. Review on 3/3/23 of the QP's record revealed: - Hire date: 10/16/22 - A Medication Administration training certificate was not in her file. Interview on 3/6/23 with the AP revealed: - Her Medication Administration training was scheduled for 3/8/23 Interview on 3/6/23 with the Executive Director revealed:	(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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure medications were administered by persons trained by a registered nurse, pharmacist, or other legally qualified person and privileged to prepare and administer medications for 2 of 3 audited staff (Associate Professional (AP) and Qualified Professional (QP)). The findings are: Review on 3/3/23 of the AP's record revealed: - Hire date: 2/27/23 - A Medication Administration training certificate was not in her file. Review on 3/3/23 of the QP's record revealed: - Hire date: 10/16/22 - A Medication Administration training certificate was not in her file. Review on 3/6/23 with the AP revealed: - Her Medication Administration training was scheduled for 3/8/23 linterview on 3/6/23 with the Executive Director revealed:

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Division of Health Service Regulation						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL ER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED			
	MHL049-157	B. WING	03/06/2023			

130 SAINT JILL CIRCLE

BLUE HORIZONS

STATESVILLE, NC 28625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FYING INFORMATION)	ID PREFIX TAG	PROV DER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 2	V 118		
	Review sheets each month. - The QP did not administer medications to the clients; therefore, he thought she did not need the Medication Administration training. - The AP's Medication Administration training was supposed to be completed this past weekend (3/4/23-3/5/23). "I don't know if it (Medication Administration training) was done."			
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int.	V 536		
	10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (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			

DIVISION	of theathr octated regu	ilation	_			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPL ER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPLET	
		MHL049-157	B. WING		03/0	6/2023
NAME OF	PROVIDER OR SUPPLIER					
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BI HE H	ORIZONS	130 SAII	NT JILL CIRCLE			
DLOL III	SKIZONO	STATES	VILLE, NC 2862	25		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFIC ENCIES BY MUST BE PRECEDED BY FULL LSC IDENT FYING INFORMATION)	ID PREFIX TAG	PROV DER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETE DATE
V 536	Continued From pagannually). (f) Content of the traprovider wishes to elevate by the Division of Maragraph (g) of this (g) Staff shall demote the following core at (1) knowledge and upeople being served (2) recognizing and behavior; (3) recognizing the external stressors the with disabilities; (4) strategies for burelationships with pagainizational factor with disabilities; (6) recognizing curorganizational factor with disabilities; (6) recognizing the external stressors the with disabilities; (6) recognizing curorganizational factor with disabilities; (6) recognizing the external stressors at (7) skills in assessing escalating behavior; (8) communication at de-escalating potentiand (9) positive behavior means for people was activities which direct behaviors which are (h) Service provider documentation of in for at least three yet (1) Documentation at (A) who participated	ge 3 aining that the service employ must be approved IH/DD/SAS pursuant to sexule. Instrate competence in areas: Inderstanding of the di; Interpreting human effect of internal and hat may affect people ilding positive ersons with disabilities; Iltural, environmental and on's that may affect people importance of and on's involvement in bout their life; Ing individual risk for attrategies for defusing and tially dangerous behavior; ral supports (providing ith disabilities to choose city oppose or replace e unsafe). Is shall maintain itial and refresher training ars. Is in the training and the	V 536			
	outcomes (pass/fail) (B) when and where (C) instructor's nam	e they attended; and				

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DEFICIENCY)

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL ER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING _ MHL049-157 03/06/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, Z P CODE **130 SAINT JILL CIRCLE BLUE HORIZONS** STATESVILLE, NC 28625 (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFIC ENCIES PROV DER'S PLAN OF CORRECTION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENT FYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE

V 536	Continued From page 4	V 536	
	(2) The Division of MH/DD/SAS may		
	review/request this documentation at any		
	time. (i) Instructor Qualifications and		
	Training		
	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 a passing grade on testing in an		
	instructor training program.		
	(3) 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.		
	(4) 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 (i)(5) of this Rule.		
	(5) Acceptable instructor training programs		
	shall include but are not limited to presentation		
	of: (A) understanding the adult learner;		
	(B) methods for teaching content of the		
	course;		
	(C) methods for evaluating trainee		
	performance; and		
	(D) documentation procedures.		
	(6) Trainers shall have coached experience		
	teaching a training program aimed at		
	preventing, reducing and eliminating the need		
	for restrictive interventions at least one time,		
	with positive review by the coach.		
	(7) Trainers shall teach a training program		
	aimed at preventing, reducing and eliminating		
	the need for restrictive interventions at least		
	once annually.		
	(8) Trainers shall complete a refresher		

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPL ER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED	
	MHL049-157	B. WING	03/06/2023	

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, Z P CODE

130 SAINT JILL CIRCLE

BLUE HORIZONS

STATESVILLE, NC 28625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FYING INFORMATION)	ID PREFIX TAG	PROV DER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	instructor training at least every two years. (j) 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 outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) 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. (l) Documentation shall be the same preparation as for trainers.	V 536		
	This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure staff completed training on alternatives to restrictive interventions at least annually affecting 1 of 3 audited staff (Associate Professional (AP)). The findings are: Review on 3/3/23 of the AP's record revealed: - Hire date: 2/27/23 - An alternatives to restrictive interventions training certificate was not in her file.		Horizons Kids Human Resource Manager has/will implement a training calendar addressing the following rule TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS to ensure all new employees received training prior to entering the facility for their first official date of employment. Horizons Kids Human Resource Manager has/will update their policy to address any training timelines to ensure that all required training has been completed by the new hire prior to entering the facility. Quality Assurance Manager(QP) will audit the Employee file before the official start date to ensure all required paperwork & training have been completed. This is an on-going process and is monitored weekly, monthly and quarterly depending on the employee's needs. Quality Assurance Manager(QP) will submit notification to Human Resource Manager that the employee file is complete and ready to start in the facility.	03/13/23 05/13/23 On-going 03/13/23 05/13/23 On-going 03/13/23 On-going

Division of Health Service Regulation STATE FORM 6899 M9RL11 If continuation sheet 6 of 11 PRINTED: 03/07/2023 FORM APPROVED						
Division of	of Health Service Regu	ılation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL ER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL049-157		B. WING		03/06/2023		
NAME OF	PROVIDER OR SUPPLIER	STREET ADDR	ESS, CITY, STATE	F Z P CODE		
			T JILL CIRCLE			
BLUE HORIZONS STATESVILLE, NC 28625						
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFIC ENCIES CY MUST BE PRECEDED BY FULL LSC IDENT FYING INFORMATION)	ID PREFIX TAG	PROV DER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETE DATE

V 536	Continued From page 6	V 536	
	Interview on 3/6/23 with the AP revealed: - She had received training in alternatives to restrictive interventions from her prior place of employmentShe had requested her alternatives to restrictive interventions certificate from her prior place of employment, but she had not received her certificate.		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO	V 537	
	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,		

STATE FORM ⁶⁸⁹⁹ M9RL11 ^{If continuation sheet 7} of 11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPL ER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	MHL049-157	B. WING	03/06/2023

STREET ADDRESS, CITY, STATE, Z P CODE

130 SAINT JILL CIRCLE

BLUE HORIZONS

STATESVILLE, NC 28625

W 537 Continued From page 7 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 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; (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 maintain	(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FYING INFORMATION)	ID PREFIX TAG	PROV DER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the	V 537	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 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:	V 537	DEFICIENCY)	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPL ER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		COMPLETED
	MHL049-157	B. WING	03/06/2023

NAME OF PROVIDER OR SUPPLIER

BLUE HORIZONS

STREET ADDRESS, CITY, STATE, Z P CODE

130 SAINT JILL CIRCLE

STATESVILLE, NC 28625

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH C	DER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE
- Communication Page 1	
(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 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPL ER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		MHL049-157	B. WING	B. WING		
	PROVIDER OR SUPPLIER ORIZONS	130 SA	DRESS, CITY, STATE, INT JILL CIRCLE SVILLE, NC 28625			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFIC ENCIES CY MUST BE PRECEDED BY FULL LSC IDENT FYING INFORMATION)	ID PREFIX TAG	PROV DER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
V 537	this Rule. (8) Trainers shall be CPR. (9) Trainers shall hat teaching the use of least two times with coach. (10) Trainers shall to use of restrictive into annually. (11) Trainers shall constructor training anyears. (k) Service provider documentation of in instructor training for (1) Documentation: (A) who participated outcome (pass/fail); (B) when and where (C) instructor's name (2) The Division of Preview/request this time. (I) Qualification (1) Coaches shall material requirements as a to (2) Coaches shall to times, the course with coached. (3) Coaches shall documents of the course with coached.	ed in Paragraph (a) of e currently trained in ave coached experience in restrictive interventions at a positive review by the each a program on the erventions at least once complete a refresher t least every two es shall maintain itial and refresher or at least three years. shall include: d in the training and the e they attended; and le. MH/DD/SAS may documentation at any ns of Coaches: neet all preparation rainer. each at least three hich is being emonstrate highetion of coaching or ruction. shall be the same	V 537			

This Rule is not met as evidenced by: Based on record reviews and interviews, the								
Division of Health Service Regulation STATE FORM 6899 M9RL11 If continuation sheet 10 of 11 PRINTED: 03/07/2023 FORM APPROVED								
Division of	of Health Service Regu	ılation			1 Ordivi	ALLINOVED		
STATEMENT OF DEFICIENCIES (X1) PROV		(X1) PROVIDER/SUPPL ER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMPLET			
		MHL049-157	B. WING		03/0	6/2023		
NAME OF PROVIDER OR SUPPLIER								
STREET ADDRESS, CITY, STATE, Z P CODE								
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CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

Horizons Kids LLC April 2023

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1 CPR/FIRST AID 9AM-2PM
2	3	4 ORIENTATION 9am-5pm	5 Blood Borne Med Admin/Seizure Manage 2PM-6PM	6 NCI Training 2pm-6pm	7	8
9	10	11	12	13	14	15
16	17	ORIENTATION 9am-5pm	Blood Borne Med Admin/Seizure Manage 2PM-6PM	20 NCI Training 2pm-6pm	21	22 CPR/FIRST AID 9AM-1PM
23	24	25	26	27	28	29
30						

ALL TRAININGD PROVIDED AT 1410 BOSTON RD NEWTON NC CONFERNCE ROOM

Horizons Kids LLC June 2023

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				NCI Training 2pm-6pm	2	3 CPR/ FIRST AID 9am-1pm
4	5	6	7	8	9	10
11	12	ORIENTATION 9am-5pm	14 Blood Borne Med Admin/Seizure Manage 2PM-6PM	NCI Training 2pm-6pm	16	17 CPR/ FIRST AID 9am-1pm
18	19	20	21	22	23	24
25	26	27 ORIENTATION 9am-5pm	28 Blood Borne Med Admin/Seizure Manage 2PM-6PM	29 NCI Training 2pm-6pm	30	

ALL TRIAININGS PROVIDED AT 1410 BOSTON RD. NEWTON NC CONFERNCE ROOM

Horizons Kids LLC March 2023

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			1	2	3	4
5	6	7 ORIENTATION 9am-5pm	8 Blood Borne Med Admin/Seizure Manage 2PM-6PM	9 NCI TRAINING 2pm-6pm	10	11
12	13	14	15	16	17	18
19	20	ORIENTATION 9am-5pm	22 Blood Borne Med Admin/Seizure Manage 2PM-6PM	23 NCI TRAINING 2pm-6pm	24	25
26	27	28	29	30	31	

ALL TRAININGS PROVIDED AT 1410 BOSTON RD NEWTON NC CONFERNCE ROOM

Horizons Kids LLC May 2023

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1	2 ORIENTATION 9am-5pm	3 Blood Borne Med Admin/Seizure Manage 2PM-6PM	4 NCI Training 2pm-6pm	5	6 CPR/ FIRST AID 9AM-2PM
7	8	9	10	11	12	13
14	15	ORIENTATION 9am-5pm	17 Blood Borne Med Admin/Seizure Manage 2PM-6PM	NCI Training 2pm-6pm	19	20 CPR/ FIRST AID 9AM-2PM
21	22	23	24	25	26	27
28	29	30 ORIENTATION 9am-5pm	31 Blood Borne Med Admin/Seizure Manage 2PM-6PM	NCI Training 2pm-6pm		

ALL TRAININGS PROVIDED AT 1410 BOSTON RD. NEWTON NC CONFERNCE ROOM From:

Sent: Thursday, March 9, 2023 7:59 AM

To:

RE: Lentz Wastewater Subject:

Caution! This message was sent from outside your organization.

Allow sender Block sender

I spoke to the guys this morning and confirmed that the tank was replaced, and they filled the dirt back in and recovered the tank.

Please let me know if you have any questions or concerns.















From:

Sent: Wednesday, March 8, 2023 7:31 PM

To:

Subject: RE: Lentz Wastewater

Let me know once the dirt is filled back int.

Thanks,

LB&J Certified Public Accountants 5936 Monroe Road Charlotte, NC 28212 www.LBJcpa.com

Offic Direc Fax (



Subject: Lentz Wastewater

Good Afternoon,

I just wanted to let you know that we did complete the tank replacement at Horizon kids this morning. I did email you a copy of the paid invoice for your records. In addition, I also wanted to let you know that the inspector was on site and everything is completed.

Thank,



Lentz Wastewater Management, Inc

463 Lentz Road Statesvi e, NC 28625 office@ entzwastewater.com | www.entzwastewater.com



RECIPIENT:

Horizon Kids, LLC.

130 Saint Ji Circ e Statesvi e, North Caro ina 28625

Invoice #65846	
Issued	03/08/2023
Due	03/08/2023
Paid	03/08/2023
Total	\$4,800.00
Accoun Balance	\$0 00

Septic Tank Replacement

PRODUCT / SERVICE	DESCRIPTION	TOTAL
03/08/2023		
Septic Tank Rep acement	 Pump, crus and fi exis ing septic tank Insta 1000 g on septic tank with fi ter and risers Insta new 4"S h 40 PVC 2-way c ean out and new 4" Sch 40 PVC supp y ine from house to tank Insta new distribution box (Set with speed eve s to feed grave bed first before overf owing to conventiona ines) Insta new distribution box to feed grave bed Make a necessary connections to existing drain fie d Environmenta Hea th Department on site for approva, prior to covering 	\$4,800.00 *

* Non-taxab e

Cert. Insta er(Grade Leve IV) #3360 Inspector #3360I SS Operator #999423

Lentz Wastewater Management, Inc 20-1899031

Subtota	\$4,800.00
Irede County (6.75%)	\$0.00
Total	\$4,800.00
Paid	- \$4,800.00
Invoice balance	\$0.00
Account ba ance	\$0.00

Horizons Kids LLC

5936 Monroe Road Charlotte, NC 28212 (980) 434-5328 www.HorizonsK.com

March 14, 2023

Private & Confidential

Mental Health Licensure and Certification Section NC Division of Health Service Regulation 2718 Mail Service Center Raleigh, NC 27699-2718

Subject: Plan of Correction

Facility: 130 St. Jill Circle, Statesville, NC 28625

ID: MHL # 049-157

Dear

Please find enclosed the Plan of Correction for Horizons Kids LLC as it relates to our facility located at 130 St. Jill Circle, Statesville, NC 28625.

As you will see in the Plan of Correction, in order to address any future incidents with staff not receiving the proper training, we have pre-scheduled training with our vendors for the next 90-days in case we onboard any new employees or have a need. If this process is effective we will continue to do so. In addition, we will make sure that our Quality Assurance person validates that the employee has received the necessary certifications and training before entering a facility.

On a separate note, please note that the septic system in the back yard has been repaired and the ground covered back up. I have enclosed the invoice and e-mail from the vendor for your records.

If you have any questions, please do not hesitate to contact me at (704) 458-7189.

Very truly yours,

Horizons Kids LLC