Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED	
		71. BOILBING.			
		MHL059-086	B. WING		R-C 03/14/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE	
TVAIVIL OF T	NOVIDER OR GOLT EIER		LINVILLE ROAD		
OLD LINV	ILLE GROUP HOME		NC 28752	•	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PRÉFIX TAG	`	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	
V 000	INITIAL COMMENTS		V 000		
	on March 14, 2023. Tsubstantiated (intake 00198944). A deficie	#NC 00198919 and #NC ncy was cited. d for the following service 27G. 1300 Residential			
		d for 4 and currently has a vey sample consisted of ents.			
V 109	27G .0203 Privileging	/Training Professionals	V 109		
	QUALIFIED PROFES ASSOCIATE PROFES (a) There shall be no qualified professionals (b) Qualified professi professionals shall de and abilities required (c) At such time as a employment system is then qualified profess professionals shall de (d) Competence shall exhibiting core skills ii (1) technical knowled (2) cultural awarenes (3) analytical skills; (4) decision-making; (5) interpersonal skil (6) communication s (7) clinical skills. (e) Qualified professi	privileging requirements for sor associate professionals. onals and associate monstrate knowledge, skills by the population served. competency-based sestablished by rulemaking, ionals and associate monstrate competence. I be demonstrated by including: dge; ss;			

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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:		R-C	
MHL059-086		MHL059-086	B. WING		03/14/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
OLD LINV	ILLE GROUP HOME	145 OLD LI MARION, N	INVILLE ROAD IC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
V 109	develop and impleme for the initiation of an plan upon hiring each (g) The associate pro	n the State Plan for dy for each facility shall ent policies and procedures individualized supervision associate professional. ofessional shall be fied professional with the the period of time as	V 109			
	facility failed to ensure Qualified Professiona demonstrated the kno	ews and interviews, the				
	-Date of Admission: 1 -Diagnoses: Post Tra Attention Deficit Hype	umatic Stress Disorder;				
	revealed: -Date of Hire: 8-1-22Job Title: Clinician.	f the Clinician's Professional				
	- "professional serv	vices to include but not				

Division of Health Service Regulation

STATE FORM 9899 YROM11 If continuation sheet 2 of 4

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL059-086	B. WING		R-C 03/14/2023	
NAME OF PROVIDER OR SUPPLIER OLD LINVILLE GROUP HOME STREET ADD 145 OLD LI			RESS, CITY, STA NVILLE ROAD IC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 109	service definition of C Level III services" The Clinician failed to by the following: -She provided nicotin allowed him to smoke Review on 3-13-23 of (CSB)/Licensee's For Clinician revealed: -The Clinician allowed presenceThis action took place with the client "This intervention was program nor was it could be compared to the country of t	ties in compliance with put Patient Therapy Plus and demonstrate competency et to a minor (Client #2) and et during a clinical session. If the Clear Sky Behavioral mal Counseling of the da client to smoke in her et during a clinical session as not part of the CSB ensistent with CSB policy" with the Clinician revealed: ga bad day at adult high sted and frustrated" er that "his Nana told him his et need to smoke" In the console of her car, and down. with the Behavioral Health is of the Clinician's decision moke a cigarette. unseled and written up as a rected to take an appropriate supervising clinician's a timeline was given.	V 109	DELIGIENCI)		
	recommendation and	a timeline was given. ected to not make any of				

Division of Health Service Regulation

STATE FORM 9899 YROM11 If continuation sheet 3 of 4

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Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 145 OLD LINVILLE GROUP HOME 145 OLD LINVILLE ROAD MARION, No. 28752 MARION, No. 28752 PREFIX TAG V 109 Continued From page 3 This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	CONSTRUCTION	(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 145 OLD LINVILLE ROAD MARION, NC 28752 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 109 Continued From page 3 This deficiency constitutes a re-cited deficiency This deficiency constitutes a re-cited deficiency STREET ADDRESS, CITY, STATE, ZIP CODE 145 OLD LINVILLE ROAD MARION, NC 28752 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE) COMPLETE DATE							₹-C	
OLD LINVILLE GROUP HOME 145 OLD LINVILLE ROAD MARION, NC 28752 (X4) ID PREFIX TAG V 109 Continued From page 3 This deficiency constitutes a re-cited deficiency 145 OLD LINVILLE ROAD MARION, NC 28752 ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE CROSS-REFERENCED TO THE APPROPRIATE DATE V 109 Continued From page 3 This deficiency constitutes a re-cited deficiency			MHL059-086	B. WING		03	/14/2023	
OLD LINVILLE GROUP HOME MARION, NC 28752 (X4) ID PREFIX TAG V 109 Continued From page 3 This deficiency constitutes a re-cited deficiency MARION, NC 28752 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE) COMPLETE DATE V 109 V 109	NAME OF P	ROVIDER OR SUPPLIER			E, ZIP CODE			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 109 Continued From page 3 This deficiency constitutes a re-cited deficiency V 109 (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTE DATE) V 109 (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTE DATE) V 109 (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTE DATE) TAG (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTE DATE) TAG (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTE DATE)	OLD LINV	ILLE GROUP HOME						
This deficiency constitutes a re-cited deficiency	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE		
	V 109	This deficiency const	itutes a re-cited deficiency	V 109	DEFICIENC	Υ)		

Division of Health Service Regulation

STATE FORM 9899 YROM11 If continuation sheet 4 of 4