

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mh1041-818</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>06/15/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SUCCESSFUL TRANSITIONS, LLC RESIDENTIAL CAF</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1458 LONDON DRIVE</b> <b>HIGH POINT, NC 27262</b>
--	--

(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	<p><b>INITIAL COMMENTS</b></p> <p>A complaint and follow up survey was completed on 6/15/23. One complaint was unsubstantiated (Intake #NC201953) and the other complaint was substantiated (Intake #NC202080) . Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.</p> <p>This facility is licensed for 4 and currently has a census of 4. The survey sample consisted of 1 former client.</p>	V 000		
V 111	<p><b>27G .0205 (A-B)</b> <b>Assessment/Treatment/Habilitation Plan</b></p> <p><b>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN</b></p> <p>(a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to:</p> <ol style="list-style-type: none"> <li>(1) the client's presenting problem;</li> <li>(2) the client's needs and strengths;</li> <li>(3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission;</li> <li>(4) a pertinent social, family, and medical history; and</li> <li>(5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs.</li> </ol> <p>(b) When services are provided prior to the</p>	V 111		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mh1041-818</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>06/15/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SUCCESSFUL TRANSITIONS, LLC RESIDENTIAL CAF</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1458 LONDON DRIVE</b> <b>HIGH POINT, NC 27262</b>
--	--

(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 111	<p>Continued From page 1</p> <p>establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.</p> <p>This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure an assessment was completed prior to the delivery of services affecting 1 of 1 former client (FC) #5. The findings are:</p> <p>Review on 6/13/23 of FC #5's record revealed:</p> <ul style="list-style-type: none"> <li>- Admission date: 4/19/23</li> <li>- Discharge date: 4/21/23</li> <li>- Age: 16</li> <li>- Diagnoses: Intellectual Disability, moderate; Unspecified Trauma- and Stressor-Related Disorder and Intermittent Explosive Disorder</li> <li>- No admission assessment</li> </ul> <p>Interview on 6/15/23 with the Qualified Professional revealed:</p> <ul style="list-style-type: none"> <li>- She had FC #5's admission assessment stored on her computer, and she would email it.</li> <li>- She did not provide a copy of FC #5's admission assessment.</li> </ul>	V 111		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mh1041-818</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>06/15/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SUCCESSFUL TRANSITIONS, LLC RESIDENTIAL CAF</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1458 LONDON DRIVE</b> <b>HIGH POINT, NC 27262</b>
--	--

(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 736 V 736	<p>Continued From page 2</p> <p>27G .0303(c) Facility and Grounds Maintenance</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility was not maintained in a safe, clean, attractive, and orderly manner. The findings are:</p> <p>Observations on 6/15/23 from 11:34 am - 11:36 am of the inside of the facility revealed:</p> <ul style="list-style-type: none"> <li>- The flooring around the front door was uneven.</li> <li>- The bedroom facing the street had a broken window.</li> <li>- There were 2 holes in the hallway walls.</li> <li>- The hardwood floor planks were separated in multiple areas.</li> <li>- The stairs going down to the rec room had peeling linoleum and the stairs were unsteady.</li> <li>- The back porch had a horizontal metal rod missing.</li> <li>- Flooring in the kitchen was missing.</li> </ul> <p>Interview on 6/15/23 with the Licensee revealed:</p> <ul style="list-style-type: none"> <li>- The home had "settled" over time which caused the flooring to be uneven and some of the wood planks to separate.</li> <li>- 30 days ago, a consumer had thrown a brick at the front window which caused it to break.</li> <li>- The holes in the hallway walls occurred about</li> </ul>	V 736 V 736		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mh1041-818</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>06/15/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SUCCESSFUL TRANSITIONS, LLC RESIDENTIAL CAF</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1458 LONDON DRIVE</b> <b>HIGH POINT, NC 27262</b>
--	--

(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 736	<p>Continued From page 3</p> <p>20 days ago.</p> <ul style="list-style-type: none"> <li>- He had previously bolted and nailed down the stairs to the rec room.</li> <li>- He did not know about the missing horizontal metal rod on the back porch.</li> <li>- He was working on replacing the rest of the kitchen floor and needed to purchase more flooring.</li> </ul> <p>This deficiency has been cited 4 times since the original cite on 12/9/21 and must be corrected within 30 days.</p>	V 736		