STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
				A. BOILDING.			₹
		MHL0411	245	B. WING			23/2023
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SUCCES	SFUL VISIONS-ROLI	ING ROAD		LING ROAD NT, NC 2726			
(X4) ID PREFIX TAG		ATEMENT OF DEFIC Y MUST BE PRECEI SC IDENTIFYING IN	DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMEN	TS		V 000			
	An annual, compla completed on 8/23/ substantiated (intal Deficiencies were o	/23. The comp ke # NC002047	laint was				
	This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.						
	This facility is licensed for 4 and currently has a census of 3. This survey sample consisted of audits of 3 current clients and 1 former client.						
V 114	27G .0207 Emerge	ency Plans and	Supplies	V 114			
	14 27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use.						
	This Rule is not m Based on record re failed to ensure fire at least quarterly an	eview and interve and disaster d	riew, the facility rills were held				

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		MHL0411	245	B. WING		08/2	R 23/2023
	PROVIDER OR SUPPLIER SFUL VISIONS-ROLL	ING ROAD	3600 ROL	DRESS, CITY, S LING ROAD NT, NC 2720			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 114	the 1st quarter of 20 - No disaster dril shift during the 2nd Interview on 8/23/20 Professional and th - The facility had February 2023	of the facility's a revealed: held on 2nd sl (January - Mar held on 3rd sh (April - June) of the facility's a revealed: ls were held on 223 (January - ls were held on quarter of 202) with the Qual e Owner/Direct begun serving follows: 1st shift am) and 3rd sk he shifts ran from the fire and dered; however, sorms (using the fire drill) ector planned to	nift during the ch) iift during the disaster drill log 3rd shift during March) 2nd or 3rd 3 (April - June) ified for revealed: clients in it (8 am - 4 pm); hift (12 am - 8 bm 8 am - 8 pm isaster drills staff had failed d disaster drill o redo the	V 114			
V 118	27G .0209 (C) Med 10A NCAC 27G .02 REQUIREMENTS	09 MEDICATIO		V 118			
	(c) Medication adm (1) Prescription or r		n drugs shall				

AND DUAN OF CODDECTION TO DENTIFICATION NUMBER.		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		MHL0411245		B. WING			R 23/2023
	PROVIDER OR SUPPLIER	ING ROAD	600 ROL	DRESS, CITY, S LING ROAD NT, NC 2720			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	only be administered order of a person andrugs. (2) Medications shat clients only when and client's physician. (3) Medications, incomparts administered only bunlicensed persons pharmacist or other privileged to prepare (4) A Medication Administer current. Medication recorded immediate MAR is to include the (A) client's name; (B) name, strength, (C) instructions for (D) date and time the (E) name or initials drug. (5) Client requests checks shall be recorded.	ed to a client on the write outhorized by law to present all be self-administered outhorized in writing by the cluding injections, shall by licensed persons, or outrained by a registered of legally qualified person e and administer medical liministration Record (Mared to each client must of sadministered shall be only after administration.	be be larger and cations. AR) of be kept larger grand	V 118			
	failed to ensure the and instructions for	view and interview, the quantity of the medical administering the medi lient's MAR affecting 1	tions ications				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
7.1.12 . 27.11	0. 0020	.52.***		A. BUILDING:			
		MHL0411	245	B. WING			⋜ 2 <mark>3/2023</mark>
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SUCCES	SFUL VISIONS-ROLL	ING BOAD	3600 ROL	LING ROAD			
30000	OF VISIONS-NOLL	ING ROAD	HIGH POI	NT, NC 2720	65		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 3		V 118			
	Review on 8/16/23 - An admission d	of client #2's re late of 6/9/23 ost Traumatic s by History; Atte Jnspecified by evere without P	Stress Disorder ention Deficit History; Mood sychotic				
	Review on 8/16/23 of the June 2023 MAR for client #2 revealed: The following medications and the times when the medications were to be administered: Vitamin D3 50 mcg (8 am); Geodon 20 mg (8 am); Geodon 80 mg (5 pm); Cetirizine 10 mg (8 pm); Lamotrigine 200 mg; (8 pm); Trazodone 50 mg (8 pm); Fish Oil 3000 mg (8 pm) and Prazosin 1 mg (8 pm) No evidence of instructions of how to administer the medications listed on the MAR						
	Interview on 8/23/23 with the Qualified Professional and the Owner/Director revealed: - Acknowledgement client #2's June MAR did not have the instructions as to how the medications were to be administered; however, staff followed the instructions listed on the bubble pack" that contained the medications - Each individual "bubble pack" contained all the medications to be administered at a specific time, (i.e., individual "bubble packs" held the number of pills/capsules client #2 was to receive at 8 am; 5 pm and 8 pm) - Staff opened a specific "bubble pack" and administer all the medications held in that specific "bubble" to client #2 - The pharmacy sent over a July MAR with the medications and instructions listed when they began filling the client's prescriptions If staff had any questions regarding how to administer the clients' medications, they knew to						

Division of Health Service Regulation

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AND DIAN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		MHL0411	1245	B. WING			R 23/2023
NAME OF	PROVIDER OR SUPPLIER	2511		DRESS, CITY, S	STATE, ZIP CODE	1 00/2	20/2020
SUCCES	SFUL VISIONS-ROLL	ING ROAD		LING ROAD			
	Г			NT, NC 2720		DECTION .	
(X4) ID PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 118	Continued From page 4			V 118			
	call either the QP of concerns	r the Owner/Di	rector with their				
V 131	G.S. 131E-256 (D2 Verification) HCPR - Prior	Employment	V 131			
	G.S. §131E-256 HE REGISTRY (d2) Before hiring h health care facility of health care facility of Personnel Registry of access in the app	ealth care person service, even shall access the and shall note	sonnel into a ry employer at a e Health Care each incident				
	This Rule is not me Based on record re failed to ensure a cl Personnel Registry to the date of hire for The findings are: Review on 8/16/23 - The date of hire - The HCPR was	view and intervineck of the He (HCPR) was a or 1 of 5 audite of staff #1's receives 6/15/23	view, the facility alth Care accessed prior d staff (#1).				
	Interview on with the She was the on behalf of new emploration Acknowledgem completed after statinstance	e who accesso byees ent the HCPR	ed the HCPR on check was				

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BONP11 If continuation sheet 5 of 22

DIVISION	of Health Service Re	egulation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					F	?
		MHL0411245	B. WING			3/2023
		•			, 00/2	<u></u>
NAME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, S			
SUCCES	SFUL VISIONS-ROLL	ING ROAD	OLLING ROAD			
		HIGH F	OINT, NC 272	65		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
IAG	REGOE WORLD	iso ibertii tiito iiti ortiik triori,	IAG	DEFICIENCY)		
1/000			1,,000			
V 366	Continued From pa	age 5	V 366			
V 366	27G .0603 Incident	Response Requirments	V 366			
	10A NCAC 27G .06					
	RESPONSE REQU					
	CATEGORY A AND					
		d B providers shall develop ar	nd			
		policies governing their				
	•	II or III incidents. The policie	es			
		ovider to respond by:				
		to the health and safety need	ds			
	of individuals involv					
		ng the cause of the incident;				
		ng and implementing corrective	/e			
		ng to provider specified				
	timeframes not to e					
		ng and implementing measurencidents according to provide				
		es not to exceed 45 days;	I			
		person(s) to be responsible				
		of the corrections and				
	preventive measure					
		to confidentiality requirement				
		, Article 2A, 10A NCAC 26B,	.5			
		d 3 and 45 CFR Parts 160 ar	nd			
	164; and					
		ng documentation regarding				
		(1) through (a)(6) of this Rule	·.			
		ne requirements set forth in				
		is Rule, ICF/MR providers				
		ents as required by the federa	al			
	regulations in 42 CI	FR Part 483 Subpart I.				
		ne requirements set forth in				
		is Rule, Category A and B				
		g ICF/MR providers, shall				
		ment written policies governir	ıg 📗			
	•	level III incident that occurs				
		s delivering a billable service				
		s on the provider's premises.				
	The policies shall re	equire the provider to respon	d			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				R	2
	MHL0411245	B. WING		08/2	3/2023
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SUCCESSFUL VISIONS-ROLL	ING ROAD	LING ROAD NT, NC 2720			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
by: (A) obtaining to (B) making a (C) certifying (D) transferring review team; (2) convening review team within a internal review team within a internal review team who were not involved were not responsible with direct professions services at the time review team shall confollows: (A) review the determine the facts and make recommon occurrence of future (B) gather off (C) issue writt within five working of preliminary findings LME in whose catch located and to the Lift different; and (D) issue a find owner within three refinal report shall be catchment area the LME where the clief final written report standingled by the interior include all public do incident, and shall reminimizing the occurrence occurrence of future (B) gather off (C) issue writt within five working of preliminary findings (D) issue a find owner within three refinal report shall be catchment area the LME where the clief final written report standingly the interior of the control	ely securing the client record the client record; photocopy; the copy's completeness; and g the copy to an internal g a meeting of an internal 24 hours of the incident. The n shall consist of individuals yed in the incident and who le for the client's direct care or onal oversight of the client's of the incident. The internal complete all of the activities as a copy of the client record to and causes of the incident endations for minimizing the	V 366			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL0411245	B. WING		 	⋜ 23/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
SUCCES	SFUL VISIONS-ROLL	ING ROAD	LING ROAD INT, NC 2720			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
V 366	available within thre LME may give the p three months to sul (3) immediat (A) the LME r area where the ser Rule .0604; (B) the LME r different; (C) the provice for maintaining and treatment plan, if di provider; (D) the Depar (E) the client applicable; and	ee months of the incident, the provider an extension of up to bmit the final report; and ely notifying the following: esponsible for the catchment vices are provided pursuant to where the client resides, if der agency with responsibility updating the client's fferent from the reporting	V 366			
	facility failed to imp governing their rest affecting 1 of 3 curn Former Clients (FC) Review on 8/16/23 - An admission of (D/O) and Mood De Review on 8/16/23 - An admission of	eviews and interviews, the lement written policies ponses to level II incidents rent clients (#1) and 1 of 1 at #4). The findings are: of client #1's record revealed: date of 2/14/23 Post-Traumatic Stress Disorder repressive D/O, Severe of FC #4's record revealed: date of 4/28/23 Oppositional Defiant D/O and				

Division of Health Service Regulation

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PRINTED: 08/24/2023 FORM APPROVED

Division of Health Service Regulation

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER	/SUPPLIER/CLIA TION NUMBER:	, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
				A. BUILDING:			D	
		MHL041	1245	B. WING			R 08/23/2023	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
SUCCES	SFUL VISIONS-ROLL	ING ROAD		LING ROAD NT, NC 2720				
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
V 366	Continued From pa	ge 8		V 366				
	- A discharge da	te of 7/26/23						
	client #1 and FC #4 permission and cou - On 7/19/23, the FC #4 failed to retu school day ended - On 7/26/23, the FC #4 left the facilit	e QP called the state of the called the state of the facility without staff	e police to report lity without staff ted by staff e police to report ty after the e police to report					
	could not be located by staff Review on 8/15/23 and 8/16/23 of the Incident Response Improvement System (IRIS) revealed: No evidence of any incident reports regarding the phone calls made by the QP to the police on 6/14/23; 7/19/23 and 7/26/23 No documentation of facility having provided a response to the Local Management Entity/Managed Care Organization (LME/MCO) via IRIS of how the facility had determined the cause of the elopements by client #1 and FC #4; what corrective measures the provider would develop and implement regarding these incidents; what measures the facility would develop and implement to prevent similar incidents and the assigned person(s)responsible for the implementation of the corrections and preventative actions Interview on 8/17/23 with the QP revealed: She had submitted an incident report about FC#4's elopement from the facility on 7/19/23 to							
	for the report - Believed that sincident number the							

AND DUAN OF CODDECTION . IDENTIFICATION NUMBER		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED			
				A. BUILDING.			R	
		MHL041	1245	B. WING			23/2023	
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
SUCCES	SFUL VISIONS-ROLL	ING ROAD		LING ROAD				
(X4) ID	SUMMARY STA	TEMENT OF DEFI		ID ID	PROVIDER'S PLAN OF COR	RECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR LS	MUST BE PRECE	EDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETE DATE	
V 366	Continued From pa	ge 9		V 366				
	successfully to the	system						
	 Had completed 	only internal i						
	regarding the incide	ent on 6/14/23	and on 7/26/23					
	Review on 8/17/23	of a copy of th	ne incident report					
	the QP submitted to		ng FC #4 and					
	the events of 7/19/2 - A page of the in		which reflected					
	an incident number	; however, the	date listed on					
the report was 1/1/0001 which was an indication the report was not accepted by IRIS								
	the report was not a	accepted by in	NIO					
V 367	27G .0604 Incident	Reporting Re	quirements	V 367				
	10A NCAC 27G .06	04 INCIDI	ENT					
	REPORTING REQU							
	(a) Category A and							
	level II incidents, ex	cept deaths, t	that occur during					
	the provision of billa consumer is on the							
	incidents and level							
	to whom the provide	er rendered ai	ny service within					
	90 days prior to the responsible for the							
	services are provide							
	becoming aware of							
	be submitted on a for Secretary. The rep							
	in person, facsimile	or encrypted	electronic					
	means. The report	shall include	the following					
	information: (1) reporting	provider conta	act and					
	identification inform	ation;						
	. ,	itification infor	mation;					
		n of incident;						
	(5) status of t	he effort to de	etermine the					
	cause of the incider	nt; and						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.	·	.	
		MHL0411245	B. WING			२ 23/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
SIICCES	SFUL VISIONS-ROLL	ING POAD 3600 RO	LLING ROAD	1		
5000	331 OL VISIONS-ROLL	HIGH PO	INT, NC 272	65		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 367	Continued From pa	ige 10	V 367			
V 36/	(6) other indior responding. (b) Category A and missing or incomplishall submit an upor report recipients by day whenever: (1) the provide erroneous, mislead (2) the provide required on the inciunavailable. (c) Category A and upon request by the obtained regarding (1) hospital minformation; (2) reports by (3) the provide (3) the provide Mental Health, Dev Substance Abuse Subcoming aware of providers shall senincidents involving Health Service Regueroning aware of client death within sor restraint, the provident death within sor restraint, the provide (e) Category A and report quarterly to the catchment area who the report shall be by the Secretary via	viduals or authorities notified I B providers shall explain any ete information. The provider lated report to all required the end of the next business der has reason to believe that din the report may be ling or otherwise unreliable; or der obtains information dent form that was previously I B providers shall submit, et LME, other information the incident, including: ecords including confidential other authorities; and der's response to the incident. I B providers shall send a copy not reports to the Division of elopmental Disabilities and Services within 72 hours of the incident. Category A do a copy of all level III a client death to the Division of elopmental Disabilities and services within 72 hours of the incident. In cases of seven days of use of seclusion vider shall report the death quired by 10A NCAC 26C AC 27E .0104(e)(18). I B providers shall send a he LME responsible for the ere services are provided, submitted on a form provided a electronic means and shall aformation as follows:				

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AND DIAN OF CORRECTION TO TRENTIFICATION NUMBERS		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		MHL041124	.5	B. WING			R 08/23/2023	
NAME OF	PROVIDER OR SUPPLIER				TATE, ZIP CODE	·		
SUCCES	SSFUL VISIONS-ROLL	ING ROAD		LING ROAD NT, NC 2726	65			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN MUST BE PRECEDED CONTROL METERS METERS	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 367	definition of a level (2) restrictive the definition of a le (3) searches (4) seizures of the possession of a (5) the total re incidents that occur	n errors that do n II or level III incid- interventions that evel II or level III in of a client or his I of client property of client; number of level II red; and ent indicating that incidents whenever urred during the q eria as set forth in cule and Subparae	ent; t do not meet noident; iving area; or property in and level III there have ver no uarter that n Paragraphs	V 367				
	(D/O) and Mood De Review on 8/16/23 - An admission of	view and interview evel II incidents to (LME) responsible reservices were ecoming aware controlled the findings are of client #1's recolled of 2/14/23 eost-Traumatic Strepressive D/O, Second FC #4's record	w, the facility the Local ble for the provided of the incident d 1 of 1 : ord revealed: ress Disorder evere					

STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					R	
		MHL0411245	B. WING		1	3/2023
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SUCCES	SFUL VISIONS-ROLL	ING ROAD	LING ROAD NT, NC 2720			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG			COMPLETE DATE
V 367	Continued From pa	ge 12	V 367			
	Disruptive Mood Dy - A discharge da					
	completed by the Corevealed: - On 6/14/23, cliefacility without staff pm - Staff called the clients (#1 and FC and again when the between 3:30 and 4 "assist for (the clients).	of in-house incident reports qualified Professional (QP) ent #1 and FC #4 left the permission some time after 9 police after learning the #4) were not in their bedrooms by returned to the facility the 4 am the morning of 6/15/23 to ints') safety and wellbeing."				
	#4 failed to return to ended - On 7/26/23, the	e QP called the police after FC of the facility after school e QP called the police after (no time provided) without				
	Interview on 8/17/23 with the QP revealed: - She had submitted an incident report about FC#4's elopement from the facility on 7/19/23 to the Incident Response Improvement System (IRIS) as required and had been given an incident number - She had completed only internal incident reports regarding the incident on 6/14/23 and on 7/26/23					
	Review on 8/17/23 of IRIS revealed: - No evidence of any incident report concerning the telephone call to the police on 7/19/23 to report FC #4's failure to return to the facility after school					
		of a copy of the incident report als regarding FC #4 and the evealed:				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED		
MHL0411245		B. WING			R 23/2023		
	PROVIDER OR SUPPLIER	ING ROAD	3600 ROL	DRESS, CITY, S LING ROAD NT, NC 272			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 367	an incident number the report was 1/1/0	ge 13 ncident report which ; however, the date l 0001 which was an in accepted by the syst	listed on ndication	V 367			
V 536	practices that emph to restrictive interverse. (b) Prior to providing disabilities, staff incompletes, student demonstrate competed completing training other strategies for which the likelihood or injury to a persor property damage is (c) Provider agency based on state compound compliance and degathered. (d) The training shall include measurable testing behavior) on those methods to determine course. (e) Formal refreshed by each service programually). (f) Content of the training shall include the service programually).	O7 TRAINING OD RESTRICTIVE Implement policies a passize the use of alternations. In grand services to people luding service provious or volunteers, shapetence by successfulin communication signification of imminent danger with disabilities or on the communication of imminent danger or with disabilities or on the communication of imminent danger or with disabilities or on the communication of imminent danger or with disabilities or on the communication of imminent danger or on the communication of imminent danger or other controls.	ond ernatives e with ders, II IIy kills and ment in of abuse others or aining for internal d on data ased, ervation of surable the completed inimum ce roved by	V 536			

DIVISION	of Health Service Re	egulation					
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUME	EK:	A. BUILDING:		COMPLETED	
						F	,
		MHL0411245		B. WING		08/23/2023	
						1 00/2	0/2020
NAME OF F	PROVIDER OR SUPPLIER	S	TREET ADD	RESS, CITY, S	STATE, ZIP CODE		
SUCCES	SFUL VISIONS-ROLL	ING ROAD	600 ROLI	LING ROAD			
OOOOLO	OI OE VIOIOINO-NOEE	in to ROAD	IIGH POIN	NT, NC 2726	65		
(X4) ID		TEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTI		(X5)
PREFIX		/ MUST BE PRECEDED BY FL SC IDENTIFYING INFORMATION		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
TAG	REGOETHORT OR E	OO IDENTII TIINO IIN ONWAN	311)	TAG	DEFICIENCY)	1 1 (I) (I) L	
V 536	Continued From pa	ge 14		V 536			
	Paragraph (g) of thi	is Rule.					
		onstrate competence ir	n the				
	following core areas						
		e and understanding o	f the				
	people being serve						
	(2) recognizir	ng and interpreting hum	nan				
	behavior;						
		ng the effect of internal					
	external stressors t	hat may affect people v	with				
	disabilities;						
		for building positive					
		ersons with disabilities					
		ng cultural, environmen					
	_	ors that may affect peop	ole with				
	disabilities;	(1					
		ng the importance of ar					
	decisions about the	son's involvement in m	aking				
		ม แe, ssessing individual risk	for				
	escalating behavior		101				
	ū	, cation strategies for de	fusina				
		otentially dangerous b					
	and		,				
		ehavioral supports (pro	viding				
	means for people w	ith disabilities to choos	se				
	activities which dire	ctly oppose or replace					
	behaviors which are						
	(h) Service provide						
		nitial and refresher trair	ing for				
	at least three years						
	\ /	tation shall include:					
	• •	cipated in the training a	nd the				
	outcomes (pass/fail						
		where they attended;	and				
	(C) instructor						
		ion of MH/DD/SAS may					
		documentation at any injections and Training	uille.				
	Requirements:	icadons and Halling					

DIVISION	of Health Service Re	eguiation		_			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICA	TION NUMBER:	A. BUILDING:		COMPLETED	
				D WING		F	
		MHL041	1245	B. WING		08/2	3/2023
NAME OF E	PROVIDER OR SUPPLIER		STDEET AD	DDESS CITY S	STATE, ZIP CODE		
NAME OF I	NOVIDEN ON OUT LIEN						
SUCCES	SFUL VISIONS-ROLL	ING ROAD		LING ROAD			
00000			HIGH POI	NT, NC 2720	65		
(X4) ID	SUMMARY STA	TEMENT OF DEFI	CIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX	(EACH DEFICIENCY			PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING I	NFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
					DEFICIENCY)		
V 536	Continued From pa	ae 15		V 536			
V 000	Continued i Tom pa	90 10					
	(1) Trainers s	shall demonstr	ate competence				
	by scoring 100% or	n testing in a tr	aining program				
	aimed at preventing	a, reducing an	d eliminating the				
	need for restrictive		J				
			ate competence				
	by scoring a passin						
	instructor training p		sung in an				
		ng shall be					
	competency-based		surable learning				
	objectives, measura						
	observation of beha						
	measurable method	as to determin	e passing or				
	failing the course.	4 - £ 41 3 4	4 4 ! 4				
			uctor training the				
	service provider pla						
	approved by the Div						
	to Subparagraph (i)						
			aining programs				
	shall include but are						
	` ,	ding the adult					
	(B) methods	for teaching c	ontent of the				
	course;						
		for evaluating	trainee				
	performance; and						
	` '	ation procedu	res.				
		shall have coa	ched experience				
	teaching a training						
	reducing and elimin						
	interventions at leas						
	review by the coach						
			aining program				
	aimed at preventing						
	need for restrictive						
	annually.		at loadt office				
	,	shall complete	a refrecher				
	instructor training a						
	(j) Service provider						
	documentation of in		sner instructor				
	training for at least	three years.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED		
				A. BUILDING:			_
		MHL04	11245	B. WING			⋜ 2 <mark>3/2023</mark>
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SUCCES	SFUL VISIONS-ROLL	ING ROAD		LING ROAD NT, NC 2720			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC' REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 536	(1) Documents (1) Documents (2) The Divisor request and review (2) Qualifications of (1) Coaches requirements as a second (2) Coaches the course which is	mentation shabipated in the l); d where attended in the l); d where attended in the line in of MH/DD in this document of Coaches: shall meet all trainer. shall teach at its being coaches shall demons inpletion of contruction.	training and the ded; and //SAS may ntation any time. preparation least three times ed. trate aching or	V 536			
	This Rule is not managed on record refailed to ensure 2 or received initial train restrictive intervent to people with disal	eview and inte of 5 audited stand on alternations prior to p	rview, the facility aff (#1 and #2) atives to providing services				
	Review on 8/16/23 - The date of hire - Staff #1 comple alternatives to restr	e was 6/6/23 eted initial trai rictive interver	ning on ntions on 8/11/23				
	Review on 8/16/23 - The date of hire						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE: COMPI			SURVEY PLETED		
	MHL0411245		B. WING			R 23/2023	
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SUCCES	SFUL VISIONS-ROLL	ING ROAD		LING ROAD NT, NC 2720			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 536	- Staff #1 complete alternatives to restrict Interview on 8/23/23 revealed: - It was more expand #2) to a class in interventions with o attendance - She waited untite August 2023 in which be the only participal would be less experience.	eted initial trair ictive intervent 3 with the Owr pensive to sen alternatives to alternatives	ner/Director d just staff (#1 to restrictive them in ffered a class in d #2 would not the training	V 536			
V 537	27E .0108 Client Ri ITO 10A NCAC 27E .01 SECLUSION, PHYSISOLATION TIME-0 (a) Seclusion, physitime-out may be embeen trained and hacompetence in the to these procedures staff authorized to exprocedures are retricompetence at least (b) Prior to providing disabilities whose traincludes restrictive service providers, explusion, physical and shall not use the training is completed demonstrated. (c) A pre-requisited demonstrating completed and staff completed demonstrating completed dem	08 TRAIN SICAL RESTROUT sical restraint a proper use of s. Facilities shemploy and terained and have tannually. It annually. It annually interventions, employees, stumplete training restraint and increse intervention and competed for taking this	IING IN RAINT AND and isolation y staff who have ated and alternatives hall ensure that rminate these re demonstrated to people with itation plan staff including idents or j in the use of solation time-out ons until the ence is	V 537			

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	` ′		COMPLETED	
			, a Boile Birto.		_	_
	MHL0411245		B. WING		08/2	3/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		3600 ROL	LING ROAD			
SUCCES	SSFUL VISIONS-ROLL	ING ROAD	NT, NC 2720			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 537	Continued From pa	ge 18	V 537			
	training in preventing the need for restrict (d) The training shall include measurable measurable measurable testing behavior) on those methods to determine course. (e) Formal refreshed by each service programmally). (f) Content of the training provider plans to enthe Division of MH/IP Paragraph (g) of this (g) Acceptable training but are not limited to (1) refresher the use of restrictive (2) guidelines (2) guidelines (3) emphasis rights and dignity of concepts of least resincemental steps in (4) strategies of restrictive interversions which assessment and mapsychological well-buse of restraint thrown restrictive intervential (6) prohibited (7) debriefing importance and pur	ing, reducing and eliminating cive interventions. Ill be competency-based, elearning objectives, (written and by observation of objectives and measurable one passing or failing the certraining must be completed ovider periodically (minimum raining that the service of mploy must be approved by DD/SAS pursuant to see Rule. Ining programs shall include, o, presentation of: information on alternatives to be interventions; on when to intervene of interventions and on safety and respect for the fall persons involved (using destrictive interventions and on an intervention); of the safe implementation entions; of emergency safety include continuous conitoring of the physical and design of the client and the safe oughout the duration of the on; of procedures; attategies, including their opose; and tation methods/procedures.				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			I COMP	SURVEY LETED
		A. BUILDING:			
MHL0411245		B. WING		08/2	3/2023
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SUCCESSFUL VISIONS-ROLLING ROAD		LING ROAD NT, NC 272			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE		1	PROVIDER'S PLAN OF CORRECT	ON	(VE)
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY TAG REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 537 Continued From page 19		V 537			
documentation of initial and refresher tr at least three years. (1) Documentation shall include: (A) who participated in the training outcomes (pass/fail); (B) when and where they attende (C) instructor's name. (2) The Division of MH/DD/SAS in review/request this documentation at ar (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate co by scoring 100% on testing in a training aimed at preventing, reducing and elimineed for restrictive interventions. (2) Trainers shall demonstrate co by scoring 100% on testing in a training teaching the use of seclusion, physical and isolation time-out. (3) Trainers shall demonstrate co by scoring a passing grade on testing in instructor training program. (4) The training shall be competency-based, include measurable objectives, measurable testing (written sobservation of behavior) on those object measurable methods to determine pass failing the course. (5) The content of the instructor to service provider plans to employ shall be approved by the Division of MH/DD/SAS to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training shall include, but not be limited to, prese of: (A) understanding the adult learned (B) methods for teaching content course; (C) evaluation of trainee performations.	g and the ed; and may ny time. Impetence program inating the meterical may restraint meterical may restraint meterical may restraint meterical man elearning and by citives and sing or raining the pe S pursuant programs entation er; of the	V 537			

DIVISION	of Health Service Re	egulation				
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		MHL0411245	B. WING		R 08/23/2023	
NAME OF	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, S	STATE. ZIP CODE		
		3600	ROLLING ROAD	,		
SUCCES	SSFUL VISIONS-ROLL	ING ROAD HIGH	POINT, NC 272	65		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETI	ΓE
V 537	Continued From pa	ge 20	V 537			
	(7) Trainers sannually and demo of seclusion, physic time-out, as specific Rule. (8) Trainers scenarios (9) Trainers so in teaching the use least two times with coach. (10) Trainers so use of restrictive information annually. (11) Trainers so instructor training an (k) Service provided documentation of intraining for at least (1) Document (A) who particulation of the course (pass/fail) (B) when and (C) instructor (2) The Divisic review/request this (I) Qualifications of (1) Coaches requirements as a scenario (2) Coaches times, the course work (3) Coaches competence by contrain-the-trainer instructor instructor (2) Coaches times, the course work (3) Coaches competence by contrain-the-trainer instructor instructor (2) Coaches times, the course work (3) Coaches competence by contrain-the-trainer instructor (2) Coaches competence by contrain-the-trainer instructor (3) Coaches competence (4) Coaches competence (5) Coaches (6) Coaches (7) Coaches	nitial and refresher instructo three years. Itation shall include: sipated in the training and the sipated in the training and the signature of where they attended; and signature of shall meet all preparation trainer. It shall teach at least three which is being coached. It shall demonstrate of truction. In shall be the same	nce at e			

6899

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	MUI 0444245		B. WING		R 08/23/2023	
		MHL0411245			00/2	3/2023
NAME OF I	PROVIDER OR SUPPLIER		LING ROAD	STATE, ZIP CODE		
SUCCES	SFUL VISIONS-ROLL	ING ROAD	NT, NC 2720			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 537	Continued From pa	ge 21	V 537			
	failed to ensure 2 or received initial train restraint and isolation	et as evidenced by: view and interview, the facility f 5 audited staff (#1 and #2) ing in seclusion, physical on time-out prior to providing with disabilities. The findings				
	The date of hireStaff #1 complete	of staff #1's record revealed: e was 6/6/23 eted initial training in seclusion, and isolation time-out on				
	- The date of hire - Staff #1 comple	of staff #2's record revealed: e was 5/31/23 eted initial training in seclusion, nd isolation time-out on				
	revealed: - It was more expland #2) to a class in and isolation time-cattendance - She waited until August 2023 in whice	3 with the Owner/Director Densive to send just staff (#1 In seclusion, physical restraint But with only the two of them in If the trainer offered a class in Inch staff #1 and #2 would not It and and thus the training Insive				