STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		DENTIFICATION NOWDER.	A. BUILDING:			
		MHL046-042	B. WING		C 09/28/2023	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
PRING	LIFE BEHAVIORAL C	ARFIIC	TH ACADEMY E, NC 27910	STREET		
(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 ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMENT	ГS	V 000			
	A complaint survey was completed on September 28, 2023. The complaint was unsubstantiated (Intake #NC00206074). Deficiencies were cited.		r			
	categories: 10A NC Rehabilitation Facil Severe and Persist 27G .4400 Substan Program, & 10A NC	sed for the following service AC 27G .1200 Psychosocial ities for Individuals with ent Mental Illness, 10A NCAC ace Abuse Intensive Outpatien CAC 27G .4500 Substance sive Outpatient Treatment				
		urrent census of 48. The sisted of audits of 1 former				
V 110	27G .0204 Training Paraprofessionals	/Supervision	V 110			
	SUPERVISION OF (a) There shall be paraprofessionals. (b) Paraprofession associate profession professional as spe Subchapter. (c) Paraprofession knowledge, skills at population served. (d) At such time as employment system then qualified profe professionals shall					
	(1) technical knowl(2) cultural awaren					

R34G11

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL046-042	B. WING			C 9/28/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
PRING	LIFE BEHAVIORAL C	ARFIIC	TH ACADEMY	STREET		
		AHOSKI	E, NC 27910			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
V 110	Continued From pa	ige 1	V 110			
	develop and implem for the initiation of t	g; kills;				
	failed to ensure 1 o demonstrated the k	et as evidenced by: view and interview, the facility f 3 paraprofessional staff (#1) nowledge, skills and abilities pulation served. The findings				
	Review on 9/27/23 - Hired 2/20/23	of staff #1's record revealed:				
	record revealed: - Admitted 3/24/2 - Diagnoses of S (cocaine) moderate Major Depressive D Generalized Anxiety Hypertension, Hype Relationship Chang	y Disorder, Insomnia Disorder,				
		v with FC #1 on 9/27/23 was o the FC #1's phone number service.				

R34G11

	of Health Service Re				I	
STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
		MHL046-042				C 28/2023
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
		505 NOR				
SPRING	LIFE BEHAVIORAL C		E, NC 27910	••••==•		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF ((X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
V 110	Continued From pa	ge 2	V 110			
	 He started worl He was a count Comprehensive Out and Substance Abu Program (SAIOP) FC #1 was ass The SACOT pr person and virtually (Coronavirus) pand Clients came to "check in" and fill of Clients signed at for their group sess Clients that attes sign their paperwor office to "check in" FC #1 chose to phone during the C He signed FC # because "a lot of tir come into the office "She (FC #1) a of the signature" "It (signing the # between me (staff # Signing FC #1's problem" until she " (SACOT) anymore' He signed for F than 30 times for af The SACOT Que not know he was si #1 The facility con other Thursday" on Urine samples homes during the C 	a "signature sheet" to sign in sions ended sessions virtually had to k when they came into the attend sessions virtually or by OVID-19 pandemic #1's sign-in sheet for her mes she (FC #1) couldn't e" to check in sked me (staff #1) to take care sign-in sheet) was something #1) and her (FC #1)" s sign-in sheet was "not a 'wasn't in the program				

Division of Health Service Regulation STATE FORM

If continuation sheet 3 of 5

STATEMENT OF DEFICIENCIES (X1) PROVI					
	FICATION NUMBER:			(X3) DATE COMPI	SURVEY LETED
MHL	.046-042	B. WING		C 09/2	; 8/2023
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SPRING LIFE BEHAVIORAL CARE LLC	AHOSKIE	, NC 27910			
(X4) ID SUMMARY STATEMENT OF I PREFIX (EACH DEFICIENCY MUST BE PF TAG REGULATORY OR LSC IDENTIFYI	RECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 110 Continued From page 3		V 110			
 her urine samples "Either myself (staff #1) of that's no longer in the program collect the urine" "The person (mentor) was bono (without charge)it was person was training for future (Spring Life Behavioral Care, The "mentor" was "workin me out with my job" FC #1 was "good friends" He only used the "mentor half" "I didn't think I was doing During interview on 9/27/23 the reported: He was staff #1's direct states and the sign-in sheet for the conselors were sign the sign-in sheet for the conselors were sign the sign-in sheet for the conselors are not supp anything, even if the counselor permission" from the client He was unaware that staff sign-in sheet for FC #1 The facility conducted a unaware they (clients) or a counselor will go to the conselor will go to	n (SACOT) went to s doing it for pro mentoringthe employment here LLC)" of for mehelping with the "mentor" " for "a month and a anything wrong" he SACOT QP upervisor come to the office not supposed to clients a counselor was lients osed to sign r was given f #1 was signing the rinalysis every eir programs come to the office, client's house then ne sample) the next ient or FC to collect home				

Division of Health Service Regulation STATE FORM

R34G11

If continuation sheet 4 of 5

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
MHL046-042		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		B. WING			C 09/28/2023	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
	LIFE BEHAVIORAL O	SARELLO 505 NOR	TH ACADEMY	STREET		
PRING		ARE LLC AHOSKI	E, NC 27910			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 110	Continued From pa	age 4	V 110			
	 would tell the cours He would be considered by the constraint of t	oncerned if a counselor sent a samples because of a 9/27/23 the Chief Financial upposed to sign a sign-in shee lors) can do almost anything ing the paperwork (sign-in a time a counselor should sign t, for any reason" were collected from clients the (client's) home" ding counselors, can collect the (clients) home" ding counselors, can collect the clients oncerned if a urine sample was staff posed to "observe to make ple is securecleanrecord the urineand make sure the	5			

R34G11