	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		MHL067-203	B. WING			R 01/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE	·	
	SIS CENTER		MORIAL DRIN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMENT	ſS	V 000			
	completed on Febru	p, and complaint survey was uary 1, 2024. The complaint d (NC00211961). Deficiencies				
	categories: 10 NCA Medical Detoxificati Substance Abusers	eed for the following service AC 27G .3100 Non-hospital on-Individuals who are and 10 NCAC 27G 5000 s Service for Individuals of all				
	census of 12. The	ed for 16 and currently has a survey sample consisted of clients and 1 former client.				
V 220	10A NCAC 27G .31 (a) Monitoring Client written policy that re (1) procedure general condition at the first 72 hours of and (2) procedure recording each client and temperature at first 24 hours and a thereafter. (b) Discharge Plan Treatment/Rehabilit discharging the client discharge plan for e client who has com	nts. Each facility shall have a	V 220			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
	MHL067-203	B. WING			R 01/2024
NAME OF PROVIDER OR SUPPL	ER STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
DIX CRISIS CENTER		EMORIAL DRI			
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
V 220 Continued From	page 1	V 220			
Based on record facility failed to d policy that ensuin for medical deto recorded at leas hours and at leas affecting 1 of 2 d of 1 former clien are: Finding #1: Review on 1/31/ record revealed - 26 year old fen - Admission data - Diagnosis of un - Vital Signs wer	nale.				
	8pm (refused). 9pm.				
- She was admit - Staff checked	/24 client #2 stated: ted to the facility on 1/26/24. her vital signs once during the and "a few times a day" over the				
Finding #2: Review on 1/31/ revealed: rision of Health Service Regulat	24 and 2/1/24 of FC #3's record				

STATE FORM

STATEMEN	of Health Service Re TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL067-203		CONSTRUCTION	СОМ	E SURVEY PLETED R 01/2024
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		02/	01/2024
		215-B M	EMORIAL DRIN	/E		
(X4) ID	4) ID SUMMARY STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
V 220	Continued From pa	ge 2	V 220			
	 1/5/24. Diagnosis of unsp related disorder. Vital Signs were n for the first 24 hours Review on 1/31/24 documented vital si revealed: 1/3/24 at 1:15pm. 1/3/24 at 8:00pm. 1/4/24 at 8:21am. 1/4/24 at 8:21am. 1/4/24 at 4:41pm of Review on 2/1/24 o 6/2022, "Physical H operating procedure -"Once a participan taken every 12 hou ordered by a BHMF 	and 2/1/24 of FC #3's gns from 1/3/24 - 1/4/24				
	Practical Nurse (LP - She had worked w 2023. - Staff documented during the first 24 h - When a client refu documentation of th Interview on 1/31/24 stated the facility wo	4 and 2/1/24 the Licensed PN) stated: with the facility since June of vital signs every four hours ours following admission. used to have their vitals taken, he refusal was recorded. 4 and 2/1/24 the Director ould follow up to ensure the npleted and documented as				
		stitutes a recited deficiency ted within 30 days.				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED R. B. WING R. DUILDING:		of Health Service Re		1			
MHL067-203 B. WING 02/01/202 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE 215-89 MEMORIAL DRIVE 215-89 MEMORIAL DRIVE 216-89 MEMORIAL DRIVE 206 206 207 200 <th></th> <th></th> <th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th> <th></th> <th></th> <th></th> <th></th>			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
215-B MEMORIAL DRVE JACKSONVILLE, NC 28546 CMUE SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST DE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION BHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) CO V 366 27G .0603 Incident Response Requirements V 366 V 366 IOA NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(6) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 2B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, IC/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 433 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, IC/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 433 Subpart I. (c) In addition to the requirements set forth in			MHL067-203	B. WING			
DAX CRSIS CENTER JACKSONVILLE, NC 28546 (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 DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) (COM DEFICIENCY) V 366 27G .0603 Incident Response Requirements V 366 V 366 DEFICIENCY) V 366 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level 1, If or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraph (a) (11) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule. (c)/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 433 Subpart 1. (c) In addition to the requirements set forth in <td>NAME OF</td> <td>PROVIDER OR SUPPLIER</td> <td>STREET AD</td> <td>DRESS, CITY, ST</td> <td>TATE, ZIP CODE</td> <td></td> <td></td>	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
UNDERFORMANCE Description Providers PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PRETX TAG PROVIDERS PLAN OF CORRECTION SHOULD BC (EACH ODRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) V 366 27G. 0.603 Incident Response Requirements V 366 10A NCAC 27G. 0.603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY AAND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, CFMR providers shall address incidents as required by the federal regulations in 42 CFR Part 433 Subpart 1. (c) In addition to the requirements set forth in			215-B ME		VE		
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) construction con		SIS CENTER	JACKSO	NVILLE, NC 2	8546		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE D. V 366 27G .0603 Incident Response Requirements V 366 V 366 IOA NCAC 27G .0603 INCIDENT V 366 RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: V 366 (1) attending to the health and safety needs of individuals involved in the incident; V 366 V 366 (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.5 7.5. Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule. (CF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.	(X4) ID			ID			(X5)
 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in 					CROSS-REFERENCED TO TH	IE APPROPRIATE	COMPLET DATE
RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in	V 366	27G .0603 Incident	Response Requirements	V 366			
providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service		RESPONSE REQU CATEGORY A AND (a) Category A and implement written p response to level I, shall require the pro (1) attending of individuals involv (2) determini (3) developin measures accordin timeframes not to e (4) developin to prevent similar in specified timeframe (5) assigning for implementation preventive measure (6) adhering set forth in G.S. 75, 42 CFR Parts 2 and 164; and (7) maintainin Subparagraphs (a) (b) In addition to th Paragraph (a) of th shall address incide regulations in 42 CI (c) In addition to th Paragraph (a) of th providers, excluding develop and impler their response to a	JIREMENTS FOR D B PROVIDERS B providers shall develop and policies governing their II or III incidents. The policies povider to respond by: to the health and safety needs red in the incident; ng the cause of the incident; g and implementing corrective g to provider specified exceed 45 days; g and implementing measures notidents according to provider es not to exceed 45 days; person(s) to be responsible of the corrections and es; to confidentiality requirements , Article 2A, 10A NCAC 26B, d 3 and 45 CFR Parts 160 and ng documentation regarding (1) through (a)(6) of this Rule. the requirements set forth in is Rule, ICF/MR providers ents as required by the federal FR Part 483 Subpart I. the requirements set forth in is Rule, Category A and B g ICF/MR providers, shall ment written policies governing level III incident that occurs				

Division	of Health Service Re	aulation			FORM	APPROVED
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MHL067-203	B. WING		R 02/01/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	SIS CENTER	215-B ME	MORIAL DR	IVE		
		JACKSON	VILLE, NC	28546		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / 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)	D BE	(X5) COMPLETE DATE
V 366	Continued From pa	ge 4	V 366			
	 (1) immediate by: (A) obtaining a (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 responsible with direct profession services at the time review team shall c follows: (A) review the determine the facts and make recommend occurrence of future (B) gather otti (C) issue writh within five working of preliminary findings LME in whose catch located and to the L if different; and (D) issue a find owner within three a final report shall be catchment area the LME where the clies final written report set identified by the intering the occur all documents need. 	ely securing the client record the client record; photocopy; the copy's completeness; and og the copy to an internal 24 hours of the incident. The n shall consist of individuals ved in the incident and who le for the client's direct care or onal oversight of the client's of the incident. The internal omplete all of the activities as e copy of the client record to and causes of the incident endations for minimizing the				

AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _			
		MHL067-203	B. WING			R 01/2024
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	SIS CENTER		EMORIAL DRIN			
			,	PROVIDER'S PLAN OF	CORRECTION	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
V 366	Continued From pa	ge 5	V 366			
	three months to suit (3) immediate (A) the LME marea where the serve Rule .0604; (B) the LME marea different; (C) the provide for maintaining and treatment plan, if di provider; (D) the Depart (E) the client applicable; and	provider an extension of up to pomit the final report; and aly 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 tment; s legal guardian, as authorities required by law.				
		view and interview, the facility their response to level II				
	See Tag V367 for s	pecific details.				
	stated: - No level II inciden for FC #3's attempt - Moving forward, le	4 and 2/1/24 the Director t report had been completed ed suicide. evel II incident reports would entified in level II reporting				

Division of Health S	Service Re	aulation				APPROVED
STATEMENT OF DEFICIE AND PLAN OF CORRECT	NCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY PLETED
		MHL067-203	B. WING			२)1/2024
NAME OF PROVIDER OF	SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		215-B ME		VE		
DIX CRISIS CENTER	¢ (JACKSON	IVILLE, NC	28546		
()())		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)		COMPLETE DATE
V 367 Continued	l From pa	ge 6	V 367			
V 367 27G .0604	4 Incident	Reporting Requirements	V 367			
REPORT CATEGO (a) Catego level II inc the provisi consumer incidents to whom t 90 days p responsib services a becoming be submit Secretary in person, means. T informatic (1) identificat (2) (3) (4) (5) cause of t (6) or respon (b) Catego missing o shall subr report rec day when (1) informatic erroneous (2)	RY A AND lory A and idents, ex- ion of billa is on the and level I he provide rior to the le for the of avare of ted on a fo . The repor- facsimile the report of facsimile the report of a reporting p ion informa- client iden type of inco description status of the he incider other individes not an upda- ipients by ever: the provideos, misleadi the provideos	JIREMENTS FOR B PROVIDERS B providers shall report all cept deaths, that occur during ible services or while the providers premises or level III I deaths involving the clients er rendered any service within incident to the LME catchment area where ed within 72 hours of the incident. The report shall orm provided by the ort may be submitted via mail, or encrypted electronic shall include the following provider contact and ation; tification information; cident; n of incident; he effort to determine the				

SINTENDEAL OF CONFRECTION (X) INPUENT OF CONFRECTION (X) INPUENT OF CONFRECTION (X) INPUENT	Division	of Health Service Re	aulation			FORM	APPROVED
MME 0F PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZP CODE 21012024 VAME 0F PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZP CODE 21000000000000000000000000000000000000	STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				
215-E MEMORIAL DRIVE JACKSONVILLE, NC 28545 PROVIDER'S PLAN OF CORRECTION (EACH DEPRICENCY MUST BE PROCEEDED BY PULL PREFIX DPACENT (EACH DEPRICENCY DAMAGED AT THE PROCEEDED BY PULL PREFIX DPACENT (EACH DEPRICENCY DAMAGED AT THE PROCEEDED BY PULL UNAVAILABLE. DPACENT (EACH DEPRICENCY DAMAGED AT THE PROCEEDED BY DEPRICENCY UNAVAILABLE. DPACENT (EACH DEPRICENCY DAMAGED AT THE PROCEEDED AT THE PROCEED AT THE PROCEEDED AT THE PROCEEDED AT THE PROCEEDED AT THE PROCEED AT THE PROCEEDED AT THE PROCEEDED AT THE PROCEED AT THE PROCED AT THE PRO			MHL067-203	B. WING			
DX DORNS CENTE JACKSONVILLE, NC 28546 (XI) D REPUMENT STATEMENT OF DEPENDENCES TAG D REVENDENCES REPUMENT STATEMENT OF DEPENDENCES REPUMENT REPUMENT STATEMENT OF DEPENDENCES REPUMENT REPUM	NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
(X4) ID PREFIX ISUMARY STATEMENT OF DEFICIENCIES (EACH DEPICENCY MUST BE PRECEDED BY FULL RAG IPACY (EACH CORRECTIVA ACTION BROUND BE CRUSS REFERENCED TO THE APPROPRIATE DEFICIENCY) (COMPLETE (EACH CORRECTIVATION IS COMPLETE DEFICIENCY) V 367 Continued From page 7 V 367 V 367 Continued From page 7 V 367 (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including; (1) neoptial records including confidential information; V 367 (2) reports by other authorities; and (3) the provider's response to the incident. (4) Category A and B providers shall submit 72 hours of becoming aware of the incident. CategoryA providers shall see Services within 72 hours of becoming aware of the incident. In cases of dilent Health. Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. In cases of dilent death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E. 0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level II incident; (3) secures of dient property or property in the possession of a client; (5) me total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents wherever no incidents have occurred during the quarter that			215-B ME	MORIAL DR	IVE		
Přičný TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG Přičný TAG (EACH CORRECTIVA ATIDA SHOULD BE CROSS-REFERENCE OT OTHER APPROPRIATE CONSTRUE ATIDA SHOULD BE DEFICIENCY V 367 Continued From page 7 unavailable. (C) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including; (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (3) the provider's shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers involving a clent death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall send a report quarterly to the LME responsible for the catchemat area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) (1) medication errors that do not meet the definition of a level II or level II incident; (3) searches of a client, (4) searches of a client, (5) the total II molecul II incident; (6) a statemet indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that			JACKSON	NVILLE, NC	28546		
 unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Stubstance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 22C 0.3000 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level III and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that 	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
been no reportable incidents whenever no incidents have occurred during the quarter that		unavailable. (c) Category A and upon request by the obtained regarding (1) hospital re- information; (2) reports by (3) the provid (d) Category A and of all level III incident Mental Health, Deve Substance Abuse S becoming aware of providers shall send incidents involving a Health Service Reg becoming aware of client death within so or restraint, the prov- immediately, as req .0300 and 10A NCA (e) Category A and report quarterly to the catchment area who The report shall be by the Secretary via include summary in (1) medication definition of a level (2) restrictive the definition of a level (3) searchess (4) seizures of the total m incidents that occur	B providers shall submit, e LME, other information the incident, including: ecords including confidential of other authorities; and er's response to the incident. B providers shall send a copy in reports to the Division of elopmental Disabilities and cervices within 72 hours of the incident. Category A d a copy of all level III a client death to the Division of ulation within 72 hours of the incident. In cases of seven days of use of seclusion vider shall report the death uired by 10A NCAC 26C AC 27E .0104(e)(18). B providers shall send a he LME responsible for the ere services are provided. submitted on a form provided a electronic means and shall formation as follows: n errors that do not meet the II or level III incident; interventions that do not meet vel II or level III incident; of a client or his living area; of client property or property in client; umber of level II and level III red; and	V 367	DEFICIENCY)		
		incidents have occu					

STATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		E SURVEY PLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			PLETED
		MHL067-203	B. WING			R 01/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
סוא כסומ	SIS CENTER	215-B ME		/E		
		JACKSON	VILLE, NC 2	8546		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 367	Continued From pa	ge 8	V 367			
		eria as set forth in Paragraphs ule and Subparagraphs (1) Paragraph.				
	facility failed to ensu- were submitted to the Entity/Managed Car as required. The fir Review on 1/29/24 Response Improver	views and interviews the ure critical incident reports he Local Management re Organization (LME/MCO)				
	II reports submitted Review on 1/31/24 (FC) #3's record rev - 33 year old male. - Admission date of 1/5/24.	by the facility. and 2/1/24 of former client				
	Practical Nurse (LP - FC #3 was transpo- services (EMS) to a following an attemp - FC #3 had been s another facility prior	4 and 2/1/24 the Licensed N) stated: orted by emergency medical a local community hospital t to take his own life. cheduled to transition to to the attempt and the local transitioned him to the other				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
						R
		MHL067-203	B. WING		02/	01/2024
IAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
	SIS CENTER		MORIAL DRIN			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY;	E APPROPRIATE	COMPLET DATE
V 367	Continued From pa	ge 9	V 367			
	stated: - FC #3 was found it take his own life. - FC #3 had been u checks prior to the in-between checks. - Life saving measu FC# 3 was transpon services (EMS) to a - FC #3 had been s another facility prior	4 and 2/1/24 the Director in his room after an attempt to inder 15 minute observation incident and made the attempt ares were implemented and rted by emergency medical a local community hospital. cheduled to transition to r to the attempt and the local transitioned him to the other				
V 536	27E .0107 Client Ri Int.	ghts - Training on Alt to Rest.	V 536			
	practices that emph to restrictive interver (b) Prior to providir disabilities, staff inc employees, student demonstrate compe completing training other strategies for which the likelihood or injury to a persor property damage is (c) Provider agenci based on state com compliance and der gathered.	D RESTRICTIVE mplement policies and nasize the use of alternatives entions. Ing services to people with eluding service providers, ts or volunteers, shall etence by successfully in communication skills and creating an environment in I of imminent danger of abuse in with disabilities or others or				

Division	of Health Service Re	aulation			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		MHL067-203	B. WING		F 02/0	२ 1/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	TATE, ZIP CODE		
		215-B ME	MORIAL DRI	VE		
	SIS CENTER	JACKSON	IVILLE, NC	28546		
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
V 536	Continued From pa	ge 10	V 536			
	measurable testing behavior) on those methods to determin course. (e) Formal refreshe by each service pro- annually). (f) Content of the tr provider wishes to be the Division of MH/I Paragraph (g) of this (g) Staff shall demo- following core areas (1) knowledge people being servee (2) recognizin behavior; (3) recognizin external stressors the disabilities; (4) strategiess relationships with per (5) recognizin organizational factor disabilities; (6) recognizin assisting in the persidecisions about the (7) skills in as escalating behavior (8) communic and de-escalating per and (9) positive be means for people we	onstrate competence in the s: e and understanding of the d; ng and interpreting human ng the effect of internal and hat may affect people with for building positive ersons with disabilities; ng cultural, environmental and rs that may affect people with ng the importance of and son's involvement in making ir life; seessing individual risk for ; cation strategies for defusing potentially dangerous behavior; ehavioral supports (providing vith disabilities to choose ctly oppose or replace e unsafe).				
Division of H	ealth Service Regulation					

Division	of Health Service Re	equilation			FORM	APPROVED
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MHL067-203	B. WING		F 02/0	२ 1/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	SIS CENTER					
			NVILLE, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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)	D BE	(X5) COMPLETE DATE
V 536	Continued From pa	ge 11	V 536			
	documentation of in at least three years. (1) Documen (A) who partic outcomes (pass/fail (B) when and (C) instructor (2) The Divisi review/request this (i) Instructor Qualifi Requirements: (1) Trainers s by scoring 100% on aimed at preventing need for restrictive (2) Trainers s by scoring a passing instructor training p (3) The trainin competency-based, objectives, measura observation of beha measurable method failing the course. (4) The conte service provider pla approved by the Div to Subparagraph (i) (5) Acceptabl shall include but are (A) understan (B) methods course; (C) methods performance; and (D) document (6) Trainers s	itial and refresher training for tation shall include: ipated in the training and the); where they attended; and 's name; on of MH/DD/SAS may documentation at any time. ications and Training shall demonstrate competence testing in a training program g, reducing and eliminating the interventions. shall demonstrate competence g grade on testing in an rogram. ng shall be include measurable learning able testing (written and by avior) on those objectives and ds to determine passing or ent of the instructor training the ins to employ shall be <i>v</i> ision of MH/DD/SAS pursuant				

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: MHL067-203		IDENTIFICATION NUMBER:	A. BUILDING:			
		B. WING			R 02/01/2024	
NAME OF F	ROVIDER OR SUPPLIER	TATE, ZIP CODE				
	IS CENTER					
			NVILLE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 536	Continued From page 12		V 536			
	review by the coach (7) Trainers a aimed at preventing need for restrictive annually. (8) Trainers a instructor training a (j) Service provided documentation of ir training for at least (1) Docum (A) who partice outcomes (pass/fai (B) when and (C) instructor (2) The Divis request and review (k) Qualifications of (1) Coaches requirements as a f (2) Coaches the course which is (3) Coaches competence by cor train-the-trainer ins (I) Documentation as for trainers.	shall teach a training program g, reducing and eliminating the interventions at least once shall complete a refresher it least every two years. rs shall maintain nitial and refresher instructor three years. mentation shall include: cipated in the training and the l); d where attended; and 's name. ion of MH/DD/SAS may this documentation any time. of Coaches: shall meet all preparation trainer. shall teach at least three times being coached. shall demonstrate npletion of coaching or truction. shall be the same preparation	5			
	Based on record re	et as evidenced by: views and interviews the ure 2 of 3 audited staff (Shift				

Division of Health Service Re STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
		MHL067-203				R 02/01/2024
NAME OF PF	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
	S CENTER		MORIAL DRIV			
(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLET DATE
V 536	Continued From pa	ge 13	V 536			
	(PSP) #3) received	and Peer Support Specialist training in alternatives to ons. The findings are:				
	Review on 1/31/24 of SS #1's personnel record revealed: - Date of hire: 9/7/23. - No documentation of training in alternatives to					
	restrictive interventi					
1	Review on 1/31/24 revealed: - Date of hire: 7/4/2	of PSP #3's personnel record				
		of training in alternatives to				
	- She had worked w approximately 5 mc - She was schedule					
	7 months.	th the facility for approximately I to complete a training in				
		4 and 2/1/24 the Director				
i	in alternatives to res - Alternative to restr	I staff needed current training strictive interventions. ictive intervention training had uled in February for those that				