AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			- (X3) DATE SURVEY COMPLETED - R-C - 02/15/2024	
		MHL054-147				
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
IOSEPH	'S EMPOWERMENT (CENTER	QUEEN STREE [®] N, NC 28503	т		
(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 DEFICIENC	TION SHOULD BE COMPL THE APPROPRIATE DAT	
V 000	INITIAL COMMENTS		V 000			
	A complaint and follow up survey was completed on February 15, 2024. The complaint was unsubstantiated (Intake #NC00212589). A deficiency was cited.					
	categories: 10A NC Rehabilitation Facil Severe and Persist 27G .1400 Day Tre Adolescents with E Disturbances and 1	sed for the following service AC 27G .1200 Psychosocial ities for Individuals with ent Mental Illness, 10A NCAC atment for Children and motional or Behavioral 0A NCAC 27G .4500 Comprehensive Outpatient				
		urrent census of 35. The sisted of 2 former current				
V 185	27G .1402 Day Tx ·	- Staff	V 185			
	 who has a minimum child or adolescent educational prepara education, social warelated field. (b) A minimum of t present with clients occasions when on in which case only of to be present. (c) A minimum ratio eight clients shall be 	402 STAFF all have a program director n of two years experience in services and who has ation in administration, ork, nursing, psychology or a wo staff members shall be at all times except on ly one client is in the program one staff member is required o of one staff member to ever e maintained at all times. sultation shall be available for	y			

of Health Service Re			CONSTRUCTION			
OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NUMBER: A. BUILDING:			(X3) DATE SURVEY COMPLETED R-C	
	MHL054-147			02/15/2024		
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
'S EMPOWERMENT (SENTER		т			
	KINSTO	N, NC 28503				
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
Continued From pa	ge 1	V 185				
Based on record re facility failed to ensi- members were pre- except on occasion program. The findir Review on 02/14/24 record revealed: -8 year old male. -Admission date of -Discharge date of -Diagnoses of Atter Disorder, Combined	views and interviews the ure a minimum of two staff sent with clients at all times s when only one client is in the ogs are: 4 of Former Client (FC) #7's 06/01/23. 12/08/23. htion Deficit Hyperactivity d Type, Autism Spectrum					
Report dated 12/08 "-On 12/8/23 during jumped across the #7] on his head. Pa redirected her to sta pulling over to the s stopped hitting her van and began ass any injuries. PP no Professional (QP) a Program Director. contact with PP to a Director talked with and instructed staff injuries. Program D he stated that he w informed PP that st	/23 revealed: (transport home, [FC #8] van seat and began hitting [FC araprofessional (PP) op hitting her peer as staff was shoulder of the road. [FC #7] peer and PP had her exit the essing the peer [FC #7] for tified the Qualified and the QP notified the The Program Director made assess the incident. Program PP and talked with [FC #7] to reassess [FC #7] for Director taked with [FC #7] and as okay. Program Director ne would make the calls to					
	PROVIDER OR SUPPLIER 'S EMPOWERMENT O SUMMARY STA (EACH DEFICIENCY REGULATORY OR LA Continued From pa This Rule is not me Based on record re facility failed to ensume members were pres- except on occasion program. The findir Review on 02/14/24 record revealed: -8 year old male. -Admission date of -Discharge date of -Discharge date of -Disorder, Combined Disorder and Psych Factors. Review on 02/14/24 Report dated 12/08 "-On 12/8/23 during jumped across the #7] on his head. Par redirected her to stap pulling over to the stap stopped hitting her van and began assimation Professional (QP) a Program Director. Contact with PP to a Director talked with and instructed staff injuries. Program Director. Contact with PP to a Director talked with and instructed staff injuries. Program Director.	OF CORRECTION IDENTIFICATION NUMBER: MHL054-147 MHL054-147 PROVIDER OR SUPPLIER STREET AI 'S EMPOWERMENT CENTER 2005 N C SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure a minimum of two staff members were present with clients at all times except on occasions when only one client is in the program. The findings are: Review on 02/14/24 of Former Client (FC) #7's record revealed: -8 year old male. -Admission date of 06/01/23. -Discharge date of 12/08/23. -Diagnoses of Attention Deficit Hyperactivity Disorder, Combined Type, Autism Spectrum Disorder and Psychosocial and Contextual Factors. Review on 02/14/24 of the Accident/Incident Report dated 12/08/23 revealed: "-On 12/8/23 during transport home, [FC #8] jumped across the van seat and began hitting [FO #7] on his head. Paraprofessional (PP) redirected her to stop hitting her peer as staff was pulling over to the shoulder of the road. [FC #7] stopped hitting her peer and PP had her exit the van and began assessing the peer [FC #7] for any injuries. PP notified the Qualified Professional (QP) and the QP notified the Program Director. The Program Director made contact with PP to assess the incident. Program Director talked with PP and talked with [FC #7] and instructed staff to reassess [FC #7] for	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	OF CORRECTION IDENTIFICATION NUMBER: A.BUILDING: MHL054-147 B. WING *ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE *S EMPOWERMENT CENTER 2005 N QUEEN STREET KINSTON, NC 28503 SUMMARY STATEMENT OF DEFICIENCIES D *GEALTORY OR LSC IDENTIFYING INFORMATION) D PROVIDER'S PLAN OF (EACH CORRECTIVE ACK CORSECTIVE ACK CORSECTION ACK CORSECTIVE ACK CORSECTION ACK CORSECTI	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: COM MHL054-147 B. WING COM PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SEMPOWERMENT CENTER 2005 N QUEEN STREET KINSTON, NC 28503 PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSCIDENTIFYING INFORMATION) ID PREFIX Continued From page 1 V 185 This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure a minimum of two staff members were present with clients at all times except on occasions when only one client is in the program. The findings are: Review on 02/14/24 of Former Client (FC) #7's record revealed: -3 year old male. -Admission date of 08/01/123. -Diagnoses of Attention Deficit Hyperactivity Disorder, Combined Type, Autism Spectrum Disorder and Psychosocial and Contextual Factors. Review on 02/14/24 of the Accident/Incident Report dated 12/08/23 revealed: "-On 12/8/23 during transport home, [FC #8] jumped across the van seat and began hitting [FC #7] on his head. Paraprofessional (PP) redirected her to stop hitting her peer as staff was pulling over to the shoulder of the Qualified Professional (QP) and the QD notified the Professional (QP) and the QD notified the Profes	

4AMZ11

BIHEIEII	of Health Service Re	egulation	-				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL054-147		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		B. WING			R-C 02/15/2024		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
JOSEPH	'S EMPOWERMENT O	SENTER	UEEN STREE	т			
			I, NC 28503				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TO THE APPROPRIATE DAT		
V 185	Continued From page 2		V 185				
	Person Contacted: Name [Mother/Guardian] ([Quality Management] 3 way call with [School Social Worker]) Date: 12/8/23 Time: 2:42pm."						
	During interview on 2/14/24 staff #2 revealed: -He had worked for the agency for 6 years. -He worked at various programs within the agency.						
	-He provided transportation for the adolescent day program. -He recalled the incident on 12/8/24 between FC						
	FC #7 and FC #8.	van with 4 children including / 2 staff on the van but that					
	day a staff did not come in. -The entire incident was approximately 2 minutes -He did not see any injuries and he contacted his supervisors.						
	-We now ensure 2 transportation at all	staff on the van during times. viously physically harmed					
	other clients during	transport.					
	Director revealed:	02/14/24 the Program					
	an adjacent county.	y staff #2 of an altercation					
	-There was 1 parap -There are now 2 st transportation.	professional staff to 4 clients. taff on the vans during					
	-FC #7 and FC #8 a	are no longer at the facility.					
		4 the Quality Management facility had addressed the					