Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
		A. DOILDING.				
		MHH0976	B. WING		03/2	2/2024
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CAROLIN	NA DUNES BEHAVIO	RAI HEAITH	CANTILE DI NC 28451	RIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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)	LD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMEN	ΓS	V 000			
V 315	on March 22, 2024 substantiated (intak NC00214948) and unsubstantiated (in deficiency was cited This facility is licens category: 10A NCA Residential Treatme Adolescents. This facility is licens census of 41. The audits of 10 current	take #NC00214518) . A d. sed for the following service AC 27G .1900 Psychiatric ent for Children and sed for 54 and currently has a survey sample consisted of	V 315			
	10A NCAC 27G .1902 STAFF (a) Each facility shall be under the direction a physician board-eligible or certified in child psychiatry or a general psychiatrist with experience in the treatment of children and adolescents with mental illness. (b) At all times, at least two direct care staff members shall be present with every six children or adolescents in each residential unit. (c) If the PRTF is hospital based, staff shall be specifically assigned to this facility, with responsibilities separate from those performed on an acute medical unit or other residential units. (d) A psychiatrist shall provide weekly consultation to review medications with each child or adolescent admitted to the facility. (e) The PRTF shall provide 24 hour on-site coverage by a registered nurse.					

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
				A. BOILDING.			
		МНН0976		B. WING		03/2	22/2024
NAME OF	PROVIDER OR SUPPLIER	ST	REET ADD	RESS, CITY, S	STATE, ZIP CODE		
CAROLI	NA DUNES BEHAVIO	RAI HFAITH		CANTILE DI NC 28451	RIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIOI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 315	5 Continued From page 1			V 315			
	Based on record refacility failed to enswere present with at all times. The fin Review on 3/22/24 Staffing Sheets" for revealed: -200 Hall census ra-2 MHTs (Mental H 3/8/24, and 3/15/24-3 MHTs working on 3/6/24, 3/9/24-3/1 the 1st shift4 MHTs working on 3/1/24-3/3/24, 3/5 3/14/23 for the 1st -2 MHTs working on for the 2nd shift3 MHTs working on 3/6/24-3/10/24, 3/3/20/24 for the 2nd shift3 MHTs working on 2nd shift3 MHTs working on 2nd shift3 MHTs working on 3/5/24-3/6/24, 3/13/17/24 for the 3rd -4 MHTs working on 3/4/24, 3/7/24-3/13/18/24, and 3/19/24-300 Hall census ra-2 MHTs working on 15 MHTs wor	of a sample of "Facility r 2/24/24 through 3/20/24 anged from 15 - 16 client ealth Technician) workin 4 - 3/16/24 for the 1st shin 2/25/24 - 2/27/24, 3/4/21/24, 3/17/24, and 3/20/24, 3/7/24, and 3/13/24 shift. n 3/4/24, and 3/17/24 - 3/13/24 - 3/16/24, and 3/12/24 ishift. n 3/11/24 and 3/12/24 for 2/24/24, 3/1/24, and 3/12/24 for 2/24/24, 3/1/24, 3/2/24 2/24 - 3/13/24, 3/15/24, 3/2/24, 3/15/24, 3/13/24, 3/15/24,	Daily 4 ts. 19 on ift. 24, 124 for 19/24 - 19/				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		MHH0976		B. WING		03/2	2/2024	
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
				CANTILE DI				
CAROLI	NA DUNES BEHAVIOR		LELAND,	NC 28451				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEI MUST BE PRECEDEI CONTROL TEMENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
V 315	Continued From pa	ge 2		V 315				
	3/1/24 - 3/4/24, 3/6/ and 3/20/24 for the -4 MHTs working or 3/5/24, and 3/11/24 -5 MHTs working or -2 MHTs working or 2nd shift3 MHTs working or 3/7/24 - 3/12/24, 3/for the 2nd shift4 MHTs working or 3/13/24 - 3/14/24, a-3 MHTs working or 3/7/24, 3/10/24 - 3/for the 3rd shift4 MHTs working or 3/6/24, 3/8/24 - 3/9/3/20/24 for the 3rd shift4 MHTs working or 3/6/24, 3/8/24 - 3/9/3/20/24 for the 3rd shift3 MHTs working or 3/8/24 - 3/10/24, 3/15 shift2 MHTs working or 3/6/24, 3/9/24 - 3/10 the 2nd shift3 MHTs working or 3/6/24, 3/9/24 - 3/10 the 2nd shift3 MHTs working or 3/12/24 - 3/8/24 3/11 3/19/24 - 3/20/24 for 2 MHTs working or 3/12/243/14/24, 3/1 shift3 MHTs working or 3/12/243/14/24, 3/1	24, 3/8/24, 3/10/3 1st shift. 1 2/24/24, 2/27/24 - 3/13/24 for the 1st 3/4/24 and 3/16 1 2/24/24 - 2/27/3 15/24, and 3/17/2 15/24, and 3/17/2 15/24, and 3/17/2 15/24, and 3/15/24 13/24, and 3/15/24 13/24, and 3/15/24 13/24, and 3/15/24 13/3/24 for the 3/13/24 15/24 - 3/17/24, and shift. 1 3/3/24 for the 3/15/24 - 3/17/24, and 3/15/24 15/24 - 3/17/24, and 3/16/24 15/24, 3/11/24 - 3/17/24, and 3/16/24 15/24, 3/13/24 - 3/17/24, and 3/16/24 15/24, 3/13/24 - 3/17/24, and 3/16/24 15/24, 3/13/24 - 3/16/24 15/24, 3/13/24 - 3/16/24 15/24, 3/13/24 - 3/16/24 15/24, 3/13/24 - 3/16/24 15/24, 3/13/24 - 3/16/24 15/24, 3/13/24 - 3/16/24 15/24, 3/13/24 - 3/16/24 15/24, 3/13/24 - 3/16/24 15/24, 3/13/24 - 3/16/24 15/24, 3/13/24 - 3/16/24 15/24/24 - 2/25/2 15/24/24 - 2/25/2 15/24/24 - 2/25/2 15/24/24 - 2/25/2 15/24/24 - 2/25/2	4, 2/29/24, 1st shift. st shift. st shift. st shift. st shift. st shift. st shift. 24, 3/3/24, e 2nd shift. - 3/2/24, e4 - 3/16/24 e4, 3/4/24 - 3/17/24 - end shift. clients. - 3/3/24, and 3/20/24 e24, 2/27/29 - 14/24 for the - 3/4/24, e - 3/18/24 for e4, 2/27/24, 5/24 , and e4, 2/28/24,					
	3/12/243/14/24, 3/1 shift.	8/24, and 3/20/24 n 2/24/24 - 2/26/2 /24 - 3/11/24, 3/1	24, 2/28/24, 3/24, 3/15/24					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		MHH0976		B. WING		03/:	22/2024
CAROLINA DUNES BEHAVIORAL HEALTH				DRESS, CITY, S RCANTILE DI NC 28451	STATE, ZIP CODE RIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC MUST BE PRECEDED E SC IDENTIFYING INFORI	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 315	Continued From parallel Interview on 3/22/24-He had been at the He resided on the There were 2 - 4 staff were consisted checks on every shaff were solden on the There were 8 clien on the There were 3 - 4 staff were consisted checks on every shaff were "a lot"	4 client #1 stated: 4 client #1 stated: 5 facility for 5 month 400 hall. 5 taff on each shift. 6 the facility for 5 month 6 facility for 5 week 6 facility for 5 week 6 400 hall. 6 taff working each sent in making 15 mile 6 facility for 5 - 6 mile 7 client #3 stated: 7 and facility for 5 - 6 mile 8 and hall. 8 client #3 stated: 8 taff working each sent in making 15 mile 8 taff working each sent in making 15 mile 8 client #5 stated: 8 client #5 stated: 8 client #6 stated: 8 clients on the hall 8 client #6 stated: 9 and facility for 4 month 8 and facility for 4 month 8 client #6 stated: 9 and facility for 4 month 9 and facility for 5 miles 9 and facility	nute s. hift. nonths. hift. nute th. hift. nute ths. each shift. nute	V 315			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHH0976	B. WING		03/2	2/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CAROLII	NA DUNES BEHAVIOR	RAI HEAITH	RCANTILE DI	RIVE		
(VA) ID	CHMMADV CTA	TEMENT OF DEFICIENCIES	NC 28451	PROVIDER'S PLAN OF CORRECT	FION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 315	Continued From pa	ge 4	V 315			
	-She resided on the -Staff were consiste checks on every sh -There were 2 - 4 s Interview on 3/22/2-He had been at the -He resided on the -There were 2 - 3 s	to the facility last year. 200 hall. ent in making 15 minute ift. taff working each shift. 4 client #10 stated: e facility for 2 months. 400 hall. taff working each shift. ent in making 15 minute ift.				
	Compliance and Ri -The facility had clo the 400 hall to 8 clie staffing ratiosHe and the Chief E met with administra Health Service Reg with meeting staffin working with their c new measures to a -The facility continu ratios and explore a meet staffing requir turnover presented Interview on 3/22/2 -The facility had clo the 400 hall to 8 clie staffing ratiosHe and the Directo Risk Management I staff from the Divisi	A Director of Quality sk Management stated: used the 100 hall and reduced ents to assist with meeting executive Officer (CEO) had ative staff from the Division of culation to review concerns grequirements. They were corporate office to implement ddress the staffing concerns. Led to work to improve staffing additional options in order to rements, as call-outs and staff congoing challenges. A the CEO stated: Used the 100 hall and reduced ents to assist with meeting or of Quality Compliance and that met with administrative on of Health Service wongoing staffing issues at				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
		MHH0976	B. WING		03/2	22/2024
	PROVIDER OR SUPPLIER NA DUNES BEHAVIOR	RAL HEALTH 2050 MER	DRESS, CITY, S RCANTILE D NC 28451	STATE, ZIP CODE RIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 315	-He was working wi explore additional of staffing requirement -The facility continuture shortages with ongoing open positions. -Call-outs and staffichallenges with ma	ith his corporate office to options in order to meet	V 315			

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