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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-393 NAME OF PROVIDER OR SUPPLIER STREET AD		B. WING		(X3) DATE SURVEY COMPLETED		
				04/01/2024		
N ENRICHMENT SER	RVICESTIC					
(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO	ION SHOULD BE COMPLET THE APPROPRIATE DATE		
INITIAL COMMEN	TS	V 000				
on April 1, 2024. Th unsubstantiated (In Deficiencies were c This facility is licens	ne complaint was take #NC 214192). bited. sed for the following service					
census of 2. The su	urvey sample consisted of					
27G .1705 Resider P	ntial Tx. Child/Adol - Req. for L	V 297				
LICENSED PROFE (a) Face to face cli provided in each fa week by a licensed this Rule, licensed individual who hold license issued by th a human service pr Carolina. For subs shall include a licer Specialist or a certi (b) The consultation	ESSIONALS inical consultation shall be cility at least four hours a professional. For purposes of professional means an s a license or provisional ne governing board regulating rofession in the State of North tance-related disorders this need Clinical Addiction fied Clinical Supervisor. on specified in Paragraph (a) of					
 (1) clinical su professional specifi Section; (2) individual services; or (3) involvement 	ipervision of the qualified ied in Rule .1702 of this , group or family therapy ent in child or adolescent					
	PROVIDER OR SUPPLIER N ENRICHMENT SEF SUMMARY STA (EACH DEFICIENC' REGULATORY OR L INITIAL COMMENT An annual and com on April 1, 2024. Th unsubstantiated (Im Deficiencies were of This facility is licens category: 10A NCA Treatment Staff Se Adolescents. The facility is licens census of 2. The su audits of 2 current 27G .1705 Resider P 10A NCAC 27G .17 LICENSED PROFE (a) Face to face cl provided in each fa week by a licensed this Rule, licensed individual who hold license issued by th a human service pr Carolina. For subs shall include a licer Specialist or a certif (b) The consultation this Rule shall include (1) clinical supprofessional specific Section; (2) individual services; or (3) involvements)	OF CORRECTION IDENTIFICATION NUMBER: MHL034-393 PROVIDER OR SUPPLIER STREET A NENRICHMENT SERVICES LLC 221 FOD WINSTO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS An annual and complaint survey was completed on April 1, 2024. The complaint was unsubstantiated (Intake #NC 214192). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. Adolescents. The facility is licensed for 3 and currently has a census of 2. The survey sample consisted of audits of 2 current clients and 1 former client. 27G .1705 Residential Tx. Child/Adol - Req. for L P 10A NCAC 27G .1705 REQUIREMENTS OF LICENSED PROFESSIONALS (a) Face to face clinical consultation shall be provided in each facility at least four hours a week by a licensed professional. For purposes of this Rule, licensed professional means an individual who holds a license or provisional license issued by the governing board regulating a human service profession in the State of North Carolina. For substance-related disorders this shall include a licensed Clinical Addiction Specialist or a certified Clinical Supervisor. (b) The consultation specified in Paragraph (a) of this Rule shall include: (1) clinical supervision of the qualified professional specified in Rule .1702 of this Section; (2) (2) individual, group or f	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: MHL034-393 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, S' NENRICHMENT SERVICES LLC 221 FOXCROFT DRIVE WINSTON SALEM, NC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG INITIAL COMMENTS V 000 An annual and complaint survey was completed on April 1, 2024. The complaint was unsubstantiated (Intake #NC 214192). V 000 Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. V 297 The facility is licensed for 3 and currently has a census of 2. The survey sample consisted of audits of 2 current clients and 1 former client. V 297 27G .1705 Residential Tx. Child/Adol - Req. for L P V 297 10A NCAC 27G .1705 REQUIREMENTS OF LICENSED PROFESSIONALS (a) Face to face clinical consultation shall be provided in each facility at least four hours a week by a licensed professional. 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WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 221 FOXCROFT DRIVE WINSTON SALEM, NC 27103 PROVIDER'S PLAN OF (EACH DEFICIENCY WINSTON SALEM, NC 27103 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST DE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF (EACH CORRECTIVE AC (EACH CORRECTIVE AC (ID AN CAC 27G .1705 REQUIREMENTS OF LICENSED PROFESSIONALS (a) Face to face clinical Consultation shall be provided in each facility at least four hours a week by a licensed professional He State of North Carolina. For substance-related disorders this shall include a licensed corresion in the State of North Carolina. For substance-related disorders this shall include: (1) clinical supervision of the qualified professional specified in Rule .1702 of this Speciality or a certified Clinical Addiction Speciality or a certified Clinic	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMP MHL034-393 B. WING 04/0 PROVIDER OR SUPPLER STREET ADDRESS. CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES 221 FOXCROFT DRIVE WINSTON SALEM, NC 27103 SUMMARY STATEMENT OF DEFICIENCIES ID (HEQUATORY ON LSC DENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH DEPICENCY MUST BE PRECIDED BY FULL MEDUATORY ON LSC DENTIFYING INFORMATION) PRETX PROVIDER'S PLAN OF CORRECTION (EACH DEPICENCY MUST BE PRECIDED BY FULL MEDUATORY ON LSC DENTIFYING INFORMATION) INITIAL COMMENTS V 000 V 000 An annual and complaint survey was completed on April 1, 2024. The complaint was unsubstantiated (Intake #NC 214192). V 000 V 000 This facility is licensed for the following service category: 10A NCAC 27G. 1700 Residential Treatment Staff Secure for Children or Addlescents. V 297 The facility is licensed for 3 and currently has a census of 2. The survey sample consisted of audits of 2 current clients and 1 former client. V 297 10A NCAC 27G. 1705 REQUIREMENTS OF LICENSED PROFESSIONALS V 297 10A NCAC 27G. 1705 REQUIREMENTS OF LICENSED PROFESSIONALS V 297 (a) Face to face clinical consultation shall be provided in leach facility at least four hours a week by a licensed professional mans an individual who holds a license or provisional license issued by the governing boadr regulating a human service professional man	

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AND PLAN OF CORRECTION IDE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			(X3) DATE SURVEY COMPLETED 04/01/2024	
		MHL034-393			04/		
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
JOHNSC	ON ENRICHMENT SEF	RVICESTIC	CROFT DRIVE				
(X4) ID	_	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(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 297	Continued From pa	age 1	V 297				
	Based on record re facility failed to ens consultation was pu four hours a week l (LP). The findings a Review on 3/27/24 -Date of Admission -Diagnoses: Oppos Unspecified Traum Disorder;	of client #1's record revealed:					
	-"No one has come yet;	4 with client #1 revealed: e into the facility to do therapy ne therapist (LP) once. He days ago."					
	-Date of Admission -Diagnoses: Other Stressors Related I Hyperactivity Disord	of client #2's record revealed: : 1/4/24; Specified Trauma and other Disorder; Attention Deficit der, combined type; Conduct becified age of onset;					
	-"I saw a therapist	4 with client #2 revealed: (LP) once sometime in March al details were provided.					
	-He was not sure if	4 with staff #2 revealed: the clients were receiving not really answer the question.					

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Division of Health Service Regulation								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		MHL034-393	B. WING		04/0	1/2024		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
JOHNSC	ON ENRICHMENT SEP	RVICES I I C	ROFT DRIV					
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE		
V 297	revealed: -She was recently a therapy for the facil session with the cli -"I will be face to fa -She provided thera 9/22/22 until March	with the Licensed therapist asked to return to providing lity (unsure of when). Her first ents was on 3/25/24 via zoom; ice weekly in the group home;" apy to an individual client from o or April of 2023; I client left the program there	V 297					
Division of L	a altha Camaian Damidati							
Division of H	ealth Service Regulation							