Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL0601337	B. WING		l l	R <b>30/2024</b>	
NAME OF I	PROVIDER OR SUPPLIER	STDEET AF	NDDESS CITY S	STATE, ZIP CODE			
NAIVIL OI I	-NOVIDEN ON SUFFEIEN		TIONS FORD				
BONNIE'	S HOME FOR YOUTH		TTE, NC 282				
(X4) ID							
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE	
V 000	INITIAL COMMENTS		V 000				
	on April 30, 2024. A	w up survey was completed deficiency was cited.					
		sed for the following service C 27G .1700 Residential Staff or Adolescents.					
		ed for 3 and currently has a irvey sample consisted of clients.					
V 294	27G .1702 Residen P	tial Tx. Child/Adol -Req. for Q	V 294				
	care staff who meet qualified profession 27G .0104(18). In a professional shall h care experience. (b) For each facility (1) the qualifity Paragraph (a) of thi	ESSIONALS all utilize at least one direct ts the requirements of a al as set forth in 10A NCAC addition, this qualified ave two years of direct client of five or less beds: ed professional specified in s Rule shall perform clinical responsibilities a minimum of					
	<ul><li>(2) 70% of the children or adolescent the facility.</li><li>(c) For each facility.</li><li>(1) the qualifity.</li></ul>	e time shall occur when ents are awake and present in of six or more beds: ed professional specified in s Rule shall perform clinical					
	and administrative in 32 hours each week (2) 70% of the children or adolescenthe facility.	responsibilities a minimum of					

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

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		R	
		MHL0601337	B. WING			0/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	STATE, ZIP CODE		
BONNIE'S HOME FOR YOUTH 8616 NATIONS FORD ROAD CHARLOTTE, NC 28217						
(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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (COMMITTEE OF THE APPROPRIATE OF T		
V 294	policies that specify responsibilities of it a minimum these p (1) supervision professional(s) as a Section; (2) oversight (3) provision services to childrent (4) participation meetings; (5) coordination adolescent's treatment in the specific services to childrent (4) participation meetings; (5) coordination adolescent's treatment in the specific services to childrent (4) participation meetings; (5) coordination adolescent's treatment in the specific services to childrent (4) participation meetings; (5) coordination in the specific services to childrent (4) participation in the specific services (5) coordination in the specific services to childrent (4) participation in the specific services (5) coordination in the speci	o and implement written the clinical and administrative s qualified professional(s). At olicies shall include: on of its associate set forth in Rule .1703 of this of emergencies; of direct psychoeducational or adolescents; on in treatment planning	V 294			
	failed to utilize one requirements of a C The findings are:  Review on 4/8/24 or revealed: -Hire date 6/25/19Job description of 6/25/19: a graduate a baccalaureate deservice field and habaccalaureate accuexperience with the	and record review the facility staff person who meets the Qualified Professional (QP).  If QP's personnel record  a QP signed and dated of a college or university with gree in a not related human is four years of full-time post-imulated MH/DD/SAS oppulation served; time work experience in				

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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	
			A. BUILDING:		R	
		MHL0601337	B. WING		04/30/2024	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BONNIE	S HOME FOR YOUTH		IONS FORD			
0.00.15	CLIMMA DV CTA		TTE, NC 282		ONI	(X5)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
V 294	Continued From page 2		V 294			
V 294	Continued From page 2 Disability/Substance Abuse Services (MH/DD/SAS)Bachelor's Degree in history.  Interview on 4/12/24 with the QP revealed: -employed at the facility from 2008-2009Graduated college in 2018 with a Bachelor's Degree in historyOne year full- time pre- baccalaureate MH/DD/SAS experienceNo full- time post baccalaureate MH/DD/SAS experience prior to hireReceived training from the QP at a sister facility.  Interview on 4/16/24 with the Executive Director revealed: -Was not aware the QP needed four years of post- baccalaureate experience since the QP's degree was in non human service field"I thought her (QP) pre baccalaureate experience counted, she has helped me for years." -Would move the QP to another position and hire a full time QP.		V 294			

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