STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: mhl059-035			(X2) MULTIPLE C	· · ·	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		B. WING		05/15/2024		
AME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
ECOVER	Y VENTURES CORPOR	ATION	ISTOWN ROAD			
			RT, NC 28762			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	O THE APPROPRIATE DAT	
V 000	INITIAL COMMENTS		V 000			
	An annual and follow-up survey was completed on 5/5/24. Deficiencies were cited.					
	This facility is licensed for the following service category: 10A NCAC 27G.4300 Therapeutic Community.					
	-	d for 62 and has a current rvey sample consisted of ents.				
V 256	27G .4303 Therapeut	tic Community - Staff	V 256			
	present at all times w the premises, except been deemed capabl without supervision for qualified therapeutic (b) Staff-client ratios and a minimum of on community profession each 100 clients in a (c) Each direct care training in the followin employment: (1) the history, of the therapeutic con (2) manipulativ self-defeating behavior (3) behavior m (4) in programs to incarceration, train (A) personality criminogenic behavio (B) the crimina	e staff member shall be hen an adult or child is on when an adult client has e of remaining in the facility or a specified time by a community professional. in the facilities shall be 1:30 e qualified therapeutic nal shall be available for facility. staff member shall receive ng areas within 90 days of philosophy and operations nmunity; e, anti-social and ors; odification techniques; and s which serve as alternatives ing shall be received on: traits of offenders and r; and l justice system. staff member shall receive				

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		mhl059-035	5 V/W2		05/15/2024	
			TADDRESS, CITY, STATE, ZIP CODE			/15/2024
		904 DA	VISTOWN ROAD			
	Y VENTURES CORPOR	OLD FC	ORT, NC 28762			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ACTION SHOULD BE COMPL TO THE APPROPRIATE DAT	
V 256	Continued From pag	je 1	V 256			
	withdrawal syndrome complications to sub addiction, HIV/AIDS, diseases, and drug s (e) In a facility with o women, each direct receive training in: (1) developme behavior manageme (2) signs and s (3) signs and s (3) signs and s depression; (4) therapeutio (5) dynamics a adults diagnosed as (6) domestic v sexual assault; (7) pregnancy and	children and pregnant care staff member shall entally-appropriate child ent; symptoms of pre-term labor; symptoms of post-partum c parenting skills; and needs of children and				
	failed to ensure each received continuing understanding the na withdrawal syndrom complications to sub addiction, and drug s Director) of 3 staff at Review on 5/15/24 of employee file reveal -date of hire 3/2/10.	iew and interview the facility in direct care staff member education to include ature of addiction, the e, symptoms of secondary ostance abuse or drug screening affecting 1 (Facility udited. The findings are: of the Facility Director's ed:				

STATE FORM

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: mhl059-035		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED 05/15/2024	
		B. WING		05			
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
RECOVER	RY VENTURES CORPORA	ΔΤΙΟΝ	VISTOWN ROAD RT, NC 28762				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	FCORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET DATE	
V 256	Continued From page	2	V 256				
	-there was no documentation of more recent trainings of the continuing education requirements.						
	Interview on 5/14/24 with the Facility Director revealed: -he was unsure of what trainings he received within the past year or so. -his most recent trainings would be in his employee file.						
		ive Officer revealed: e continuing education e completed annually.					
	This deficiency consti and must be correcte	itutes a re-cited deficiency d within 30 days.					
V 736	27G .0303(c) Facility	and Grounds Maintenance	V 736				
		EMENTS					
		n and interview, the facility n a clean, attractive and					
	-Room #1 - client batl	rview on 5/14/24 at .m. with Staff #1 revealed: hroom had paint peeling e the shower/tub and a					

Division of Health Service Regulation STATE FORM

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
		mb1059, 025				
					0:	5/15/2024
ME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE /ISTOWN ROAD	, ZIP CODE		
ECOVER	RY VENTURES CORPOR	RATION	RT, NC 28762			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIEI	ACTION SHOULD BE COMPL TO THE APPROPRIATE DAT	
V 736	Continued From page 3		V 736			
	sprinkler bar along the Room #2 - client bar substance on the ce shower/tub area. -Room #3 - client bar substance on the ce shower/tub area. -Staff #1 felt the blace	throom had a black-like iling in the corners of the throom had a black-like iling in the corners of the ckened spots on the ceilings the would ensure this and				