STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED		
		MUI 054 426	B. WING		05/16/2024	
		MHL054-126	B: 111110		05/1	6/2024
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
OAKWO	OD FACILITY		E SHACKLE , NC 28504	FORD ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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)	D BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	rs	V 000			
	on May 16, 2024. T	take #NC00216708).				
		sed for the following service C 27G .1900 Psychiatric ent for Children and				
		sed for 12 and has a current survey sample consisted of clients.				
V 315	27G .1902 Psych. F	Res. Tx. Facility - Staff	V 315			
	physician board-elig psychiatry or a gene experience in the tra adolescents with many of the portion of the properties of the portion of the properties of the propertie	all be under the direction a gible or certified in child eral psychiatrist with eatment of children and ental illness. east two direct care staff present with every six children ach residential unit. Hospital based, staff shall be d to this facility, with arate from those performed on hit or other residential units. Hoall provide weekly ew medications with each child tted to the facility. I provide 24 hour on-site				

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL054-126	B. WING		05/16/2024	
NAME OF I	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	, , ,	
TW WILL OF T	THOUBER OR GOLF EIER			FORD ROAD		
OAKWO	OD FACILITY		NC 28504	TOND NOAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 315	Continued From pa	ge 1	V 315			
V 315	This Rule is not me Based on record re facility failed to main Rule 10A NCAC 27 compliance with proby a registered nurs. Review on 05/16/24 Regulation (DHSR) revealed: - No current approved 27G.1902 (e). - The last approved 27G.1902 (e) was vereigned with the previous facil dated 03/25/22 revereigned at the previous facil dated 03/25/22 revereigned for NOVA, Inc., [Solve of Facility, MHL-054-126, [Sister of Local] CountyPur contained in your lewhich was received review by our staff, request for waiver to 2022. This is based given to me by [Direst of the previous plants of the previous plants of the previous plants of the previous facility, MHL-054-126, [Sister of Local] CountyPur contained in your lewhich was received review by our staff, request for waiver to 2022. This is based given to me by [Direst of the previous plants of t	et as evidenced by: views and interviews, the intain an approved waiver of G .1902 (e) to ensure oviding 24-hr onsite coverage se (RN). If of Division of Health Service records for the facility ral waiver of Rule 10A NCAC waiver for Rule 10A NCAC valid until December 31, 2022 If of an approval of waiver sent lity program Director and lealed Request for Renewal of	V 315			
	Rule 10A NCAC 27 PRTF shall provide registered nurse." F allow the facility to o position per shift to on-site coverage fo	G.1902(e) provides, "[t]he 24 hour on-site coverage by a Renewal of the waiver will continue to utilize one RN provide twenty-four hour r the three PRTF facilities that				

Division of Health Service Regulation

PRINTED: 05/22/2024 FORM APPROVED

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Division of Health Service Regulation						
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
MHL054-126			B. WING		05/16/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
				FORD ROAD		
OAKWO	OD FACILITY		NC 28504	. ORD ROAD		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)N	(X5)
PREFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				DEI ICIENCI)		
V 315	Continued From pa	ge 2	V 315			
	approve your reque	est for renewal of waiver of				
		G.1902 (e) based on the				
		ations: The provider states, "				
		can effectively serve the				
		ney are on the same site and				
		oximity to each other. From				
		office, located in Building C; it				
		s) and 50 seconds to the				
		40 feet (80 yards) and 41				
		twood Facility, and it is 240				
		41 seconds to the [Sister]				
		der also states that the RN is clinical staff both during the				
		ing first shiftother clinical				
		Director who is an RN, the				
		vo Licensed Therapists and at				
		Professionals. Additionally,				
	NOVA utilizes two L	PNs (Licensed Practical				
	Nurse) per day shi	ft to assist the RNs with				
		ight there are two Residential				
	•	rs, the Director of PRTF				
		on call 24/7 to the facility. The				
		is always on call as well as a				
		nal. NOVA has a Psychiatrist				
		4/7 also." During 2021 there I follow-up surveys at the				
		Oakwood facilities. The				
		elated to client self governance				
		aintenance. None of the				
		elated to RN staffing. Despite				
		facilities Division staff notes 1				
		onitor 42 beds, which seems				
		norizing letter from the Board				
		es that the health, safety and				
		mers will not be threatened."				
		al Management Entity -				
		anization (LME/MCO) of the				
		pports approval of this waiver				
		orted that there are no current				
	sancions against tr	nese facilities. In accordance				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING.			
MHL054-126		B. WING		05/16/2024		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
OAKWO	OD FACILITY		E SHACKLE , NC 28504	FORD ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 315	with 10A NCAC 27G. 19 expiration date of the December 31, 2022 subject to renewal of the licensee." - Signed by the pre- Licensure & Certificon Review on 05/16/24 Carolina Division of Services/DHSR data facility President/CI - "To Whom It may Board of NOVA, Incomposition per shift for facilities (Oakwork Facility) regarding supports the requestafety, and welfare threatened." - "Request for Waits sister facilities "3. Rule Number as Sought 10A NCAC shall provide 24-ho Registered Nurse 4 a/b. (Reason for of request): NOVA, from Rule 10A NCAC facility], Oakwood as (located on one site Nurse per shift t protein the language of the of RNs 'onsite' verside the language of the of RNs 'onsite' verside the language of clients welfare of clients we	G .0813, the waiver of Rule 02 (e) cannot exceed the ne 2022 license which is 2; and, therefore shall be consideration upon the request vious Chief, Mental Health cation Section 4 of a letter sent to North Health and Human ted 11/03/23 and signed by the nief Executive officer revealed: Concern: The Governing c. authorizes the request for CAC 27G .1902 (e) to use one ft to provide onsite coverage cod, [Sister facility] and [Sister RN staffing. The board st and assures that the health, of the Consumers will not be over for Oakwood Facility and 2 and Title for Which Waiver is 27G .1902 staff (e) The PRTF are on-site coverage by a request & nature and extent Inc is requesting a waiver AC 27G .1902(e) for [Sister and [Sister facility] facilities are to share one registered ovide 24-hour onsite coverage. appears to be consistent with a rule in terms of the provision	V 315			

Division of Health Service Regulation

	(X3) DATE SURVEY COMPLETED	
MHL054-126 B. WING 05/16/2	/2024	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
OAKWOOD FACILITY 2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
And welfare of all consumers will not be threatened should this request be granted. NOVA has a waiver in effect for many years, since 2010 without compromise of the provided nursing services as evidence by multiple surveys that have not resulted in sanctions regarding the use of one RN. We further believe that one RN per shift can effectively serve the facilities because they are on the same site and are in very close proximity to each other. From the central nursing office, located in Building C; it is 270 feet (90 yards) and 50 seconds to the [Sister] Facility; is 240 feet (80 yards) and 41 seconds to the Oakwood Facility, and it is 240 feet (80 yards) and 41 seconds to the Oakwood Facility, and it is 240 feet (80 yards) and 41 seconds to the Presence of several clinical staff to include a Nursing Director and Program Director who are both RNs, three Licensed Therapits and at least five Qualified Professionals. Additionally, NOVA utilizes two LPNs per day per shift to assist the RNs with related duties. Although we have a reduced number of clinical staff after 7 p.m we have supports in place to assist the RN on duty. Aside from the presence of two Residential Services Supervisors, the Director of PRTF Services is an experienced mental health RN and is on call 24/7 to the facility. A second RN is on call at all times, as well as a Qualified Professional. NOVA has a Psychiatrist and MD (Medical Doctor) on call 24/7 also. Most of our consumers retire for bed by 9 p.m. and many of them choose to retire earlier. Our campus is generally calm and quiet throughout the second shift with little to be done by an RN. - 5. NOVA, Inc. requests that this waiver be granted for the 2024 calendar year." Interview on 05/16/24 the Licensed Practical		

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Nurse stated:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL054-126	B. WING			6/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
OAKWO	OD FACILITY		E SHACKLE , NC 28504	FORD ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	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	- She had worked a 2021 She usually worke - She will occasiona which covers both (facility on the same Interview on the Ch - The facility had crud DHSR and the LME - They had not had submission.	at the facility since February and at a sister facility. Ally work in the central building Dakwood Facility and a sister campus. ief Operating Officer stated: eated and sent in waivers to	V 315			
V 736			V 736			

Division of Health Service Regulation

STATE FORM 5899 JLKZ11 If continuation sheet 6 of 8

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
MHL054-126			B. WING		05/	16/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
OAKWO	OD FACILITY		E SHACKLE , NC 28504	FORD ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 736	MHL054-126 E OF PROVIDER OR SUPPLIER STREET AD 2002 D & KINSTON OID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)					

Division of Health Service Regulation STATE FORM

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	
		MHL054-126	B. WING		05/1	16/2024
	PROVIDER OR SUPPLIER	2002 D &		STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 736	repairing items in th	ne facility. stitutes a re-cited deficiency	V 736			

Division of Health Service Regulation STATE FORM