STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL091-095	A. BUILDING: _____ B. WING _____	R-C 03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEYOND CHALLENGES COMMUNITY SERVICI	406 DABNEY DRIVE HENDERSON, NC 27536

(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)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint and follow up survey was completed on 3/24/23. The complaint was substantiated Intake #NC00198948. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5400 Day Activity for Individuals of All Disability Groups. This facility has a current census of 18. The survey sample consisted of audits of 3 current clients.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112	RECEIVED MAY 2 6 2023 DHSR-MH Licensure Sect	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL091-095	A. BUILDING: _____ B. WING _____	R-C 03/24/2023

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BEYOND CHALLENGES COMMUNITY SERVICI	406 DABNEY DRIVE HENDERSON, NC 27536

(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)	(X5) COMPLETE DATE
V 112	Continued From page 1	V 112		

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to ensure goals and strategies were developed to meet the needs for 1 of 3 audited clients (#1). The findings are:

Review on 3/23/23 of client #1's record revealed:
- diagnosis of: Severe Intellectual Development Disability
- a treatment plan dated 7/12/22 - "learn not to take things that don't belong to her"
- no goals or strategies to address client #1 behaviors of fabrication

Review on 3/23/23 of an incident report for client #1 revealed:
- dated 2/15/23: "...upon entering into the building, [client #1] reported to staff that she was hit on the face by her teacher...she was sitting down eating and she was slapped by her worker..."

During interview on 3/23/23 staff #1 reported:
- worked with her at a previous day program
- can accidentally touch her and she will say "she hit me"
- verified the February 2023 incident
- client #1 will "exaggerated" stories

During interview on 3/23/23 the Day Program Qualified Professional (QP) reported:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL091-095	A. BUILDING: _____ B. WING _____	R-C 03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEYOND CHALLENGES COMMUNITY SERVICI	406 DABNEY DRIVE HENDERSON, NC 27536

(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)	(X5) COMPLETE DATE
V 112	Continued From page 2 - ensure treatment plans were written for the clients - verified the February 2023 incident - client #1 will fabricate or be dishonest about someone or something - should be in the treatment plan During interview on 3/23/23 the Director of Operations reported: - client #1 could be "dishonest; not vindictive" - worked with client #1 at a previous day program - she would say a client hit her but it would not be true - for example: would say very amateur like "she hit me" - had not witnessed that behavior at the current facility - being dishonest should be in the treatment plan During interview on 3/23/23 the Licensee reported: - after the February 2023 incident, residential staff informed him client #1 would fabricate stories - client #1's fabrication should be in the treatment plan	V 112		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section.	V 132		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL091-095	A. BUILDING: _____ B. WING _____	R-C 03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEYOND CHALLENGES COMMUNITY SERVICI	406 DABNEY DRIVE HENDERSON, NC 27536

(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)	(X5) COMPLETE DATE
V 132	Continued From page 3 (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by:	V 132		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL091-095	A. BUILDING: _____ B. WING _____	R-C 03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEYOND CHALLENGES COMMUNITY SERVICI	406 DABNEY DRIVE HENDERSON, NC 27536

(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)	(X5) COMPLETE DATE
V 132	Continued From page 4 Based on record review and interview the facility failed to notify Health Care Personnel Registry (HCPR) of all allegations of alleged abuse by 1 of 1 audited former staff (FS#3). The findings are: Review on 3/23/23 of client #1's record revealed: - diagnosis of: Severe Intellectual Development Disability Review on 3/23/23 of an incident report for client #1 revealed: - dated 2/15/23: "...upon entering into the building, [client #1] reported to staff that she was hit on the face by her teacher...she was sitting down eating and she was slapped by her worker..." - submitted in IRIS (Incident Response Improvement System) on 2/20/23 - MCO/LME - requested the following: 2/21/23 - "upload internal review report" 3/15/23 - "provider notified of updates still needed" 3/21/23 - "the supporting documentation also lists an allegation of physical abuse by a teacher, which is not mentioned in this report..." - no documentation of a swollen lip Review on 3/23/23 of a body check for client #1 revealed: - completed 2/15/23 - "lip was swollen in appearance, no bleeding or cut skin" - written by staff #1 During interview on 3/23/23 staff #1 reported: - verified the 2/15/23 incident - lip looked like a possible "scratch... can't tell if it was there previously" - somebody else looked and said it (client #1's lip) was possibly swollen	V 132		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL091-095	A. BUILDING: _____ B. WING _____	R-C 03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEYOND CHALLENGES COMMUNITY SERVICI	406 DABNEY DRIVE HENDERSON, NC 27536

(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)	(X5) COMPLETE DATE
V 132	Continued From page 5 During interview on 3/23/23 the HCPR representative reported: - spoke with the Director of Operations (DOO) about the 2/15/23 incident - was informed client #1 was known to fabricate stories - DOO informed her there were no injuries to client #1 - the incident was screened out based on the DOO statement - she was not aware there was a possible injury During interview on 3/23/23 the Licensee reported: - a thorough investigation of the 2/15/23 incident was completed by his staff - all information was uploaded into IRIS (Incident Response Improvement System) During interview on 3/23/23 the Director of Operations reported: - she initially uploaded the 2/15/23 incident in IRIS on 2/20/23 - was not aware the body check needed to be uploaded with the incident report on 2/20/23 - did not witness client #1's lip being swollen on 2/15/23, therefore informed HCPR representative there were no injuries - uploaded client #1's body check into IRIS on 3/18/23 after additional information was requested by the Local Management Entity-Managed Care Organization	V 132		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL091-095	A. BUILDING: _____ B. WING _____	R-C 03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEYOND CHALLENGES COMMUNITY SERVICI	406 DABNEY DRIVE HENDERSON, NC 27536

(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)	(X5) COMPLETE DATE
V 367	Continued From page 6 CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL091-095	A. BUILDING: _____ B. WING _____	R-C 03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEYOND CHALLENGES COMMUNITY SERVICI	406 DABNEY DRIVE HENDERSON, NC 27536

(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)	(X5) COMPLETE DATE
V 367	Continued From page 7 (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL091-095	A. BUILDING: _____ B. WING _____	R-C 03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEYOND CHALLENGES COMMUNITY SERVICI	406 DABNEY DRIVE HENDERSON, NC 27536

(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)	(X5) COMPLETE DATE
V 367	Continued From page 8	V 367		

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to ensure a completed incident report was submitted to the Managed Care Organization/Local Managed Entity (MCO/LME) within 72 hours. The findings are:

Review on 3/23/23 of client #1's record revealed:
- diagnosis of: Severe Intellectual Development Disability

Review on 3/23/23 of an incident report for client #1 revealed:
- dated 2/15/23: "...upon entering into the building, [client #1] reported to staff that she was hit on the face by her teacher...she was sitting down eating and she was slapped by her worker..."
- submitted in IRIS (Incident Response Improvement System) on 2/20/23
- MCO/LME - requested the following:
  2/21/23 - "upload internal review report"
  3/15/23 - "provider notified of updates still needed"
  3/21/23 - "the supporting documentation also lists an allegation of physical abuse by a teacher, which is not mentioned in this report..."
- no documentation of a swollen lip

Review on 3/23/23 of a body check for client #1 revealed:
- completed 2/15/23
- "lip was swollen in appearance, no bleeding

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL091-095	A. BUILDING: _____ B. WING _____	R-C 03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEYOND CHALLENGES COMMUNITY SERVICI	406 DABNEY DRIVE HENDERSON, NC 27536

(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)	(X5) COMPLETE DATE
V 367	Continued From page 9 or cut skin" - written by staff #1 During interview on 3/23/23 staff #1 reported: - verified the 2/15/23 incident - lip looked like a possible "scratch... can't tell if it was there previously" - somebody else looked and said it (client #1's lip) was possibly swollen During interview on 3/23/23 the Licensee reported: - the incident reports were initially uploaded in IRIS - any additional information was uploaded at the MCO/LME request During interview on 3/23/23 the Director of Operations reported: - she initially uploaded the 2/15/23 incident in IRIS on 2/20/23 - was not aware the body check needed to be uploaded with the incident report on 2/20/23 - uploaded client #1's body check into IRIS on 3/18/23 after additional information was requested by the MCO/LME	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (CMS-2567)

Provider/Supplier/CLIA Identification Number:	Multiple Construction:	Date Survey Completed:
Beyond Challenges Comm. Servs MHL091-095 (X1)	A. Building: B. Wing: (X2)	03/24/2023 (X3)

Name of Facility Surveyed:	Facility Address (Street, City, State. Zip Code)
Beyond Challenges Community Services LLC MHL091-095	312 S. Chesnut St Henderson NC 27536

Name of Accrediting Organization Performing Survey (if applicable):
Division of Health Service Regulation

ID Prefix Tag (X4)	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency should be preceded by full regulatory or LSC identifying information)	ID Prefix Tag	PLAN OF CORRECTION (Each corrective action should be cross-referred to the appropriate deficiency)	Completion Date (X5)
V112	27G .0205 (C-D) Assessment/Treatment/Plan (c)The plan shall be developed based on the assessment, and in partnership with the clien or both, within 30 days of adminssion for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1)client outcomes that are anticipated to be achieved by provision of the service and a projected date of achievement: (2) strategies (3) staff responsible; (4) a schedule for review of the plan at least annually inconsultation with the client of legally responsible person or both; (5) basis for evaluation or assessment of autcome achievment; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could	V112	> Measures put in place to correct the deficient are of practice: Beyond Challenges will ensure any type of behavior that a member exhibit will be put in the behavior plan section to the ISP. >What measure will be put in place to prevent the problem for occurring again:effective communicaion between all staff will ensure that any type of behavior will be documented from the begining to the end. Qualified Professional will ensure through staff supervison and monthly monitoring that all or any updated behavior will be mention to ensure the safety of the members and others that may be in their space will be safe. > Each Qualified Professional will monitor the situation to ensure that it will not happen again. >Monitoring will take place monthly on a normal basis. However if anyone notice any unusal behavior it will be address immeiately.	4/4/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (CMS-2567)

Name of Facility Surveyed:	Date Survey Completed:
Beyond Challenges Community Services LLC MHL091-095	03/24/2024

ID Prefix Tag (X4)	SUMMARY STATEMENT OF DEFICIENCIES Each deficiency should be preceded by full regulatory or LSC identifying information	ID Prefix Tag	PLAN OF CORRECTION Each corrective action should be cross-referred to the appropriate deficiency	Completion Date (X5)
V112	Continued From page 1 not be obtained. -No Goals or strategies to address client behaviors of fabrication		A meetining will be scheduled and all parties will meet to discuss the current or any type of behavior regarging the member to ensure safety.	4/4/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (CMS-2567)
(continued)

- Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. *(See instructions.)*
- Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided.
- For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility.
- If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Laboratory Director's or Provider/Supplier Representative's Signature	Title	Date (X6)
Liz Dayse	CEO/Founder	05/24/2023

INSTRUCTIONS FOR COMPLETION OF THE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (CMS-2567)

I. PURPOSE

This document contains a listing of deficiencies cited by the surveying State Agency (SA), Accrediting Organization (AO) or Regional Office (RO) as requiring correction. The Summary Statement of Deficiencies is based on the surveyors' professional knowledge and interpretation of Medicare and/or Medicaid or Clinical Laboratory Improvement Amendments requirements.

II. FORM COMPLETION

Name and Address of Facility – Indicate the name and address of the facility identified on the official certification record. When surveying multiple sites under one identification number, identify the site where a deficiency exists in the text of the deficiency under the Summary Statement of Deficiencies column.

Prefix Identification Tag – Each cited deficiency and corrective action should be preceded by the prefix identification tag (as shown to the left of the regulation in the State Operations Manual or survey report form). For example, a deficiency in Patient Test Management (493.1107) would be preceded by the appropriate D-Tag in the 3000 series. A deficiency cited in the Life Safety Code provision 2-1 (construction) would be preceded by K8. Place this appropriate identification tag in the column labeled ID Prefix Tag.

III. **Summary Statement of Deficiencies** – Each cited deficiency should be followed by full identifying information, e.g., 493.1107(a). Each Life Safety Code deficiency should be followed by the referenced citation from the Life Safety Code and the provision number shown on the survey report form.

IV. **Plan of Correction** – In the column Plan of Correction, the statements should reflect the facility's plan for corrective action and the anticipated time of correction (an explicit date must be shown). If the action has been completed when the form is returned, the plan should indicate the date completed. The date indicated for completion of the corrective action must be appropriate to the level of the deficiency(ies).

V. **Waivers** – Waivers of other than Life Safety Code deficiencies in hospitals are by regulations specifically restricted to the RN waiver as provided in section 1861(e)(5) of the Social Security Act. The long-term care regulations provide for waiver of the regulations for nursing, patient room size and number of beds per room. The regulations provide for variance of the number of beds per room for intermediate care facilities for the mentally handicapped. Any other deficiency(ies) must be covered by an acceptable plan of correction. The waiver principle cannot be invoked in any other area than specified by regulation.

VI. **Waiver Asterisk(*)** – The footnote pertaining to the marking by asterisk of recommended waivers presumes an understanding that the use of waivers is specifically restricted to the regulatory items. In any event, when the asterisk is used after a deficiency statement, the CMS Regional Office should indicate in the right hand column opposite the deficiency whether or not the recommended waiver has been accepted.

VII. **Signature** – This form should be signed and dated by the provider or supplier representative or the laboratory director. The original, with the facility's proposed corrective action, must be returned to the appropriate surveying agency (SA, AO or RO) within 10 days of receipt. Please maintain a copy for your records.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (CMS-2567)

Provider/Supplier/CLIA Identification Number:	Multiple Construction:	Date Survey Completed:
Beyond Challenges CCC MHL091095 (X1)	A. Building: B. Wing: (X2)	03/24/2023 (X3)

Name of Facility Surveyed:	Facility Address (Street, City, State. Zip Code)
Beyond Challenges Community Services LLC MHL091-095	312 S. Chesnut St Henderson NC 27536

Name of Accrediting Organization Performing Survey (if applicable):
Division of Health Service Regulation

ID Prefix Tag (X4)	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency should be preceded by full regulatory or LSC identifying information)	ID Prefix Tag	PLAN OF CORRECTION (Each corrective action should be cross-referred to the appropriate deficiency)	Completion Date (X5)
V132	G.S. 131 E256 (G) HCPR- Notification, Allegations, & Protection. Facilities must have evidence that all alleged acts are investigated and must make eery effort to protect residents form harm while the investigation is inh progress. The results of all investigations must be reported to the Department with fi e working days of the initial notification ot the Departmen	V132	>Beyond Challenges will changes its procedures in documenting on the Health Care Registry. We have always only completed what was given on the reporting screen. Our Agency had a meeting with the responsible person from the HCPR and she assisted our agency in the proper and expected information that would deem a futher investigation. Beyond Challenges changed it process to meet the current situation to ensure all facets of information concering incidents will be included in the initial application process. We acknowledge this as a formal training and will exercise the updated information to ensure quality of care. 2. If the alleged act is a form of abuse, a body check will be completed. However a witness will be brought in for support. 3. Preventing from any information being lift out the inform staff will report all matter to the supervior on the same day.	3/24/2023

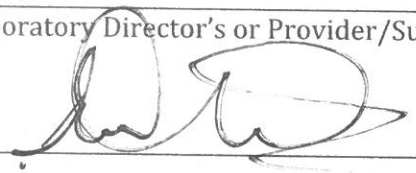
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (CMS-2567)

Name of Facility Surveyed:	Date Survey Completed:
Beyond Challenges Community Services LLC MHL091-095	03/24/2024

ID Prefix Tag (X4)	SUMMARY STATEMENT OF DEFICIENCIES Each deficiency should be preceded by full regulatory or LSC identifying information	ID Prefix Tag	PLAN OF CORRECTION Each corrective action should be cross-referred to the appropriate deficiency	Completion Date (X5)
V132	G.S. 131 E256 (G) HCPR- Notification, Allegations, & Protection. Facilities must have evidence that all alleged acts are investigated and must make eery effort to protect residents form harm while the investigation is inh progress. The results of all investigations must be reported to the Department with fi e working days of the initial notification ot the Department.	V132	>Beyond Challenges will put the following measuring in place to prevent this problem form occuring again. 1. Once a alleged act is reported that staff will completed a full stated regarding what member or staff stated to them. 2. If the alleged act is a form of abuse, a body check will be completed. . However a witness will be brought in for support. 3. Preventing from any information being lift out the inform staff will report all matter to the supervior on the same day. 4. When completing the report all uploaded unformation ie: bodycheck forms will be uploaded to the HCPR. Point of contact will be made to ensure the receipt of the report and to make sure all area are covered and or additional information is needed. > The Quality Manager [redacted] and the QA/QI team will moniitor situation to ensure it will not occur again. > Monthly monitoring will take place to review and evaluate all HCPR reports for assurance.	3/24/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (CMS-2567)
(continued)

- Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. *(See instructions.)*
- Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided.
- For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility.
- If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Laboratory Director's or Provider/Supplier Representative's Signature	Title	Date (X6)
	CEO/Founder	05/24/2023

INSTRUCTIONS FOR COMPLETION OF THE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (CMS-2567)

I. PURPOSE

This document contains a listing of deficiencies cited by the surveying State Agency (SA), Accrediting Organization (AO) or Regional Office (RO) as requiring correction. The Summary Statement of Deficiencies is based on the surveyors' professional knowledge and interpretation of Medicare and/or Medicaid or Clinical Laboratory Improvement Amendments requirements.

II. FORM COMPLETION

Name and Address of Facility – Indicate the name and address of the facility identified on the official certification record. When surveying multiple sites under one identification number, identify the site where a deficiency exists in the text of the deficiency under the Summary Statement of Deficiencies column.

Prefix Identification Tag – Each cited deficiency and corrective action should be preceded by the prefix identification tag (as shown to the left of the regulation in the State Operations Manual or survey report form). For example, a deficiency in Patient Test Management (493.1107) would be preceded by the appropriate D-Tag in the 3000 series. A deficiency cited in the Life Safety Code provision 2-1 (construction) would be preceded by K8. Place this appropriate identification tag in the column labeled ID Prefix Tag.

III. **Summary Statement of Deficiencies** – Each cited deficiency should be followed by full identifying information, e.g., 493.1107(a). Each Life Safety Code deficiency should be followed by the referenced citation from the Life Safety Code and the provision number shown on the survey report form.

IV. **Plan of Correction** – In the column Plan of Correction, the statements should reflect the facility's plan for corrective action and the anticipated time of correction (an explicit date must be shown). If the action has been completed when the form is returned, the plan should indicate the date completed. The date indicated for completion of the corrective action must be appropriate to the level of the deficiency(ies).

V. **Waivers** – Waivers of other than Life Safety Code deficiencies in hospitals are by regulations specifically restricted to the RN waiver as provided in section 1861(e)(5) of the Social Security Act. The long-term care regulations provide for waiver of the regulations for nursing, patient room size and number of beds per room. The regulations provide for variance of the number of beds per room for intermediate care facilities for the mentally handicapped. Any other deficiency(ies) must be covered by an acceptable plan of correction. The waiver principle cannot be invoked in any other area than specified by regulation.

VI. **Waiver Asterisk(*)** – The footnote pertaining to the marking by asterisk of recommended waivers presumes an understanding that the use of waivers is specifically restricted to the regulatory items. In any event, when the asterisk is used after a deficiency statement, the CMS Regional Office should indicate in the right hand column opposite the deficiency whether or not the recommended waiver has been accepted.

VII. **Signature** – This form should be signed and dated by the provider or supplier representative or the laboratory director. The original, with the facility's proposed corrective action, must be returned to the appropriate surveying agency (SA, AO or RO) within 10 days of receipt. Please maintain a copy for your records.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (CMS-2567)

Provider/Supplier/CLIA Identification Number:	Multiple Construction:	Date Survey Completed:
Beyond Challenges LLC MHL091095 (X1)	A. Building: B. Wing: (X2)	03/24/2023 (X3)

Name of Facility Surveyed:	Facility Address (Street, City, State. Zip Code)
Beyond Challenges Community Services LLC MHL091-095	312 S. Chesnut St Henderson NC 27536

Name of Accrediting Organization Performing Survey (if applicable):
Division of Health Service Regulation

ID Prefix Tag (X4)	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency should be preceded by full regulatory or LSC identifying information)	ID Prefix Tag	PLAN OF CORRECTION (Each corrective action should be cross-referred to the appropriate deficiency)	Completion Date (X5)
V367	27G. 0604 Incident Reporting Requirments 10A NCAC 27G..0604 Catgegory A and B Providers A. Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while th consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the proder rendered any services within 90 days proio to the incideent tgo the LME responsible to the catchment area where3 services are provided with 72 hours of becoming aware of the incident. The report hsall be submitted on the form provided by the Secretary. The report may be submitted bia mail, in person. facsimile or encryptged electronic means.	V367	>Beyond Challenges in discussion with the Incident Reporting System gave provided guidance to upload all reported information on the the report. The updated procedure will be to add all statements and bodychecks to the IRIS to ensure all information will be assess for the healh and safety of the clients. This was marked and a training for the staff that upload reports to the system > Measures put in place to prevent the problem occurring again will include but not limited to: 1. Gathering all reported information with the team. 2. Discuss each statement to ensure nothing will be lift off from the upload of the report to IRIS. 3. After completing report and upload of information. Contact reporting agency to ensure if information was recieved. And to make sure if they need anything else to make their decision.	3/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (CMS-2567)

Name of Facility Surveyed:	Date Survey Completed:
Beyond Challenges Community Services LLC MHL091-095	03/24/2024

ID Prefix Tag (X4)	SUMMARY STATEMENT OF DEFICIENCIES Each deficiency should be preceded by full regulatory or LSC identifying information	ID Prefix Tag	PLAN OF CORRECTION Each corrective action should be cross-referred to the appropriate deficiency	Completion Date (X5)
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (CMS-2567)
(continued)

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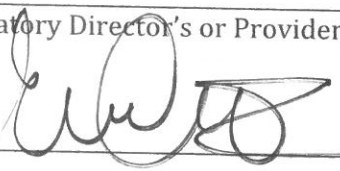	CEO/Founder	05/24/2023

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