PRINTED: 02/07/2025 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	ZIP CODE  EET  PROVIDER'S PLAN OF CORRECTION		
AND FLAN	OF CORRECTION	A. BUILDING:				
		MHL0601379	B. WING		01/1	6/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
HARMON	Y RECOVERY CENTER, I	LLC	TH TRYON ST	REET		
(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 SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	on 1/16/25. One com Two complaints were	w up survey was completed plaint was substantiated. unsubstantiated (Intake 224460, NC00224467).				
	This facility is licensed for the following service categories: 10A NCAC 27G .3300 Outpatient Detoxification for Substance Abuse, 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program (SAIOP), 10A NCAC 27G .4500 Substance Abuse Comprehensive Outpatient Treatment (SACOT), 10A NCAC 27G .1100 Partial Hospitalization for Individuals who are acutely Mentally III.					
	.4400 Substance Abu Program (SAIOP) has .4500 Substance Abu Outpatient Treatment current census of 15 a Hospitalization for Inc Mentally III has a curr survey sample consis SAIOP client, 1 current	Program (SACOT) has a and the .1100 Partial lividuals who are acutely ent census of 24. The sted of audits of 1 current on SACOT client and 1 alization for Individuals who				
V 108	27G .0202 (F-I) Perso	onnel Requirements	V 108			
	<ul><li>(g) Employee training provided and, at a min following:</li><li>(1) general organiza</li></ul>	tion shall be documented. g programs shall be nimum, shall consist of the				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL0601379	0601379 B. WING		01	C / <b>16/2025</b>
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	1 -	7.10.2020
HARMON	V DECOVEDY CENTED	11403 NO	RTH TRYON STR	EET		
HARMON	Y RECOVERY CENTER,	CHARLO	TTE, NC 28262			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 108	Continued From page	e 1	V 108			
	10A NCAC 26B; (3) training to meet to client as specified in the plan; and (4) training in infection bloodborne pathogen (h) Except as permitted. 5602(b) of this Subclamember shall be available times when a client is member shall be trainingluding seizure mare to provide cardiopulm trained in the Heimlic techniques such as the American Heart A equivalence for reliev (i) The governing book implement policies are reporting, investigating	s. ed under 10a NCAC 27G hapter, at least one staff ilable in the facility at all s present. That staff hed in basic first aid hagement, currently trained honary resuscitation and h maneuver or other first aid hose provided by Red Cross, ssociation or their ing airway obstruction.				
	facility failed to ensur Therapist was trained	ews and interviews, the e 2 of the 7 Primary				
	personnel record reversely - Date of hire 1/9/23;	the Primary Therapist #2's ealed: of CPR/First Aid training.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		, ,	(X3) DATE SURVEY COMPLETED	
		MHL0601379	B. WING	B. WING		C / <b>16/2025</b>
					1 01	110/2025
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT			
HARMON	Y RECOVERY CENTER,	l I C	ORTH TRYON STI TTE, NC 28262	KEEI		
()(1) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CO	PRECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 108	Continued From page	e 2	V 108			
	personnel record reve - Date of hire 8/27/24 - Completed America for CPS/First Aid on	; n Red Cross online course I0/4/24. vith the Primary Therapist #2				
	process of doing trainings, CPR certification that will be happening tomorrow."					
	#4 revealed: - Completed on traini - Aware CPR training person. Interview on 1/14/25 President of Clinical Crevealed:	with the Senior Vice Operations and Compliance rces Director was revamping pleted for staff; some of the same				
V 267	10A NCAC 27G .4402 (a) Each SAIOP shat Licensed Clinical Add Certified Clinical Supminimum of 50% of the operation. (b) When a SAIOP separation is shall be at least one of the requirements of a	se Intensive Outpt- Staff  2 STAFF  Il be under the direction of a lictions Specialist or a ervisor who is on site a ne hours the program is in erves adult clients there direct care staff who meets Qualified Professional as C 27G .0104 (18) for every	V 267			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		С	
		MHL0601379	B. WING		1	<i>6</i> /2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
HARMON	Y RECOVERY CENTER,	LLC	TH TRYON ST	REET		
	0.11.11.15.4.07		TE, NC 28262	DD0 #D5D10 D1 AN 05 00DD5 0710		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 267	there shall be at least meets the requirement Professional as set for (18) for every 6 or few (d) Each SAIOP shat care staff present in the following areas:  (1) alcohol and symptoms; and  (2) symptoms; and  (2) symptoms of due to alcoholism and (e) Each direct care education that included (1) understand addiction;  (2) the withdraw (3) group thera (4) family thera (5) relapse prefers (6) other treatm (f) When a SAIOP see each direct care staff includes the following (1) adolescent	erves adolescent clients t one direct care staff who ents of a Qualified orth in 10A NCAC 27G .0104 ever adolescent clients. Il have at least one direct the program who is trained in other drug withdrawal of secondary complications d drug addiction. staff shall receive continuing es the following: ing of the nature of eval syndrome; py; evention; and ent methodologies. erves adolescent clients shall receive training that	V 267			
	failed to ensure the P	as evidenced by: ew and interview, the facility rimary Therapist received of 7 audited staff (Priamry				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
						С
		MHL0601379	B. WING		01	/16/2025
	ROVIDER OR SUPPLIER	11403 N	NDDRESS, CITY, STATE			
HARMON	Y RECOVERY CENTER, I	CHARLO	OTTE, NC 28262			
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 267	Continued From page	2 4	V 267			
	Therapist #5). The fin	dings are:				
	revealed: - Date of Hire 5/15/23 - No documentation of alcohol and other dru and symptoms of sect alcoholism and drug at - No documentation of education.  Interview on 1/15/25 of #5 revealed: - Hired as a group fact - Became a therapist	of the required trainings g withdrawals symptoms ondary complications due to addiction; of required continuing  with the Primary Therapist cilitator in October 2024; o provide substance abuse  ints being treated for				
	Director revealed: - Started new positior - Realized there were are not qualified to pr - Stopped several sta therapist services to contact the staff of the staf	staff providing services they ovide;  ff from providing primary clients;  ff that will start in the new s to meet the requirements				
V 281	10A NCAC 27G .4502 (a) The SACOT shall Licensed Clinical Add	be under the direction of a	V 281			

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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 SOLESING.			
		MHL0601379	B. WING		01	C / <b>16/2025</b>	
			DRESS, CITY, STATE				
		CHARLO	TTE, NC 28262				
(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 ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 281	operation. (b) For each SACOT direct care staff who represent the following areas: (1) alcohol and symptoms; and (2) symptoms of due to alcoholism and (d) Each direct care education that include	there shall be at least one meets the requirements of a all as set forth in 10 A NCAC very 10 or fewer clients. All have at least one direct the program who is trained in other drug withdrawal of secondary complications at drug addiction.	V 281				
	(2) the withdraw (3) group thera (4) family thera (5) relapse pre (6) other treatm  This Rule is not met Based on record revie failed to ensure the P required training for 1 Therapist #5). The fin  Review on 1/15/25 of revealed: - Date of Hire 5/15/23 - No documentation of	py; vention; and nent methodologies.  as evidenced by: ew and interview, the facility rimary Therapist received of 7 audited staff (Priamry idings are:					

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OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
	MHL0601379	B. WING		C <b>01/16/2025</b>	
OVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DECOVEDY CENTED	11403 NOR	TH TRYON ST	REET		
HARMONY RECOVERY CENTER, LLC CHARLOTTE, NC 28262					
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
Continued From page	÷ 6	V 281			
alcoholism and drug a	addiction;				
Interview on 1/15/25 with the Primary Therapist #5 revealed: - Hired as a group facilitator - Became a therapist in October 2024; - Had no credentials to provide substance abuse					
counseling; - Caseload had 8 clients being treated for substance abuse;					
Interview on 1/6/25 ar Director revealed: - Started new position - Realized there were are not qualified to pro- - Stopped several star therapist services to co- - Have hired new staffew days to few week	nd 1/15/25 with the Clinical n on 1/6/25; staff providing services they ovide; ff from providing primary clients; f that will start in the new s to meet the requirements				
	OVIDER OR SUPPLIER  RECOVERY CENTER, I  SUMMARY ST.  (EACH DEFICIENC' REGULATORY OR I  Continued From page and symptoms of sec alcoholism and drug a - No documentation of education.  Interview on 1/15/25 v #5 revealed: - Hired as a group face - Became a therapist - Had no credentials t counseling; - Caseload had 8 clie substance abuse; - "I felt thrown in the p Interview on 1/6/25 at Director revealed: - Started new position - Realized there were are not qualified to pr - Stopped several sta therapist services to o - Have hired new staf few days to few week	MHL0601379  OVIDER OR SUPPLIER  RECOVERY CENTER, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 6  and symptoms of secondary complications due to alcoholism and drug addiction;  No documentation of required continuing education.  Interview on 1/15/25 with the Primary Therapist #5 revealed:  Hired as a group facilitator  Became a therapist in October 2024;  Had no credentials to provide substance abuse counseling;  Caseload had 8 clients being treated for substance abuse;  "I felt thrown in the position."  Interview on 1/6/25 and 1/15/25 with the Clinical	MHL0601379  OVIDER OR SUPPLIER  STREET ADDRESS, CITY, STA  11403 NORTH TRYON ST CHARLOTTE, NC 28262  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 6  and symptoms of secondary complications due to alcoholism and drug addiction; No documentation of required continuing education.  Interview on 1/15/25 with the Primary Therapist #5 revealed: Hired as a group facilitator Became a therapist in October 2024; Had no credentials to provide substance abuse counseling; Caseload had 8 clients being treated for substance abuse; - "I felt thrown in the position."  Interview on 1/6/25 and 1/15/25 with the Clinical Director revealed: - Started new position on 1/6/25; - Realized there were staff providing services they are not qualified to provide; - Stopped several staff from providing primary therapist services to clients; - Have hired new staff that will start in the new few days to few weeks to meet the requirements	MHL0601379  STREET ADDRESS, CITY, STATE, ZIP CODE  11403 NORTH TRYON STREET CHARLOTTE, NC 28262  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  CROSS-REFERENCED TO THE APPROPE DEFICIENCY)  Interview on 1/15/25 with the Primary Therapist #5 revealed:  - Hired as a group facilitator - Became a therapist in October 2024; - Had no credentials to provide substance abuse counseling;  - Caseload had 8 clients being treated for substance abuse; - "I felt thrown in the position."  Interview on 1/6/25 and 1/15/25 with the Clinical Director revealed: - Started new position on 1/6/25; - Realized there were staff providing services they are not qualified to provide; - Stopped several staff from providing primary therapist services to clients; - Have hired new staff that will start in the new few days to few weeks to meet the requirements	

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