Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-281	A. BUILDING: _____ B. WING _____	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MOTHER'S LOVE	1227 WESTMORELAND DRIVE BURLINGTON, NC 27217

(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 An annual and follow up survey was completed on 2/26/25. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents. This facility is licensed for 4 and has a current census of 4. The survey sample consisted of audits of 3 current clients.	V 000		
V 107	27G .0202 (A-E) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQ UIREM ENT S (a) All facilities shall have a written job description for the director and each staff position which: (1)specifies the minimum level of education, competency, work experience and other qualifications for the position; (2) specifies the duties and responsibilities of the position; (3)is signed by the staff member and the supervisor; and (4)is retained in the staff member's file. (b) All facilities shall ensure that the director, each staff member or any other person who provides care or services to clients on behalf of the facility: (1) is at least 18 years of age; (2)is able to read, write, understand and follow directions; (3)meets the minimum level of education, competency, work experience, skills and other qualifications for the position; and (4) has no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry.	V 107	Corrective Measures: Onboarding paperwork will begin within 48 hours of offer acceptance. Employee's file will be updated to be in compliance. Preventive Measures: All educational documents will be obtained before hire date. Who will Monitor: Owner How Often: To ensure compliance, Owner will review the personnel record of incoming staff prior to hire date.	

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kizzy Brown

T IT LE: Owner, QP

(X6) DATE: March 13, 2025

Received by MHL & C 3/14/25

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V 107	Continued From page 1 (c) All facilities or services shall require that all applicants for employment disclose any criminal conviction. The impact of this information on a decision regarding employment shall be based upon the offense in relationship to the job for which the applicant is applying. (d) Staff of a facility or a service shall be currently licensed, registered or certified in accordance with applicable state laws for the services provided. (e) A file shall be maintained for each individual employed indicating the training, experience and other qualifications for the position, including verification of licensure, registration or certification. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to have a complete personnel record affecting one of one audited paraprofessional staff (#1). The findings are: Review on 2/26/25 of the personnel record for staff #1 revealed: -No specific date of hire. -No documentation of educational verification. Interview on 2/26/25 with the Director/Qualified Professional revealed: -Staff #1 had been with her facility for a "little" over a year. -"We just had an accreditation review and all of	V 107		

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V 107	Continued From page 2 the documentation was available for [staff #1]." -She was unable to locate a copy of staff #1's high school diploma. -"I'm just going to have to take the hit for that one." -She confirmed the facility failed to have a complete personnel record for staff #1.	V 107		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQ UIREM ENT S (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation	V 118		

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V 118	Continued From page 3 with a physician. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to keep the MAR current affecting one of three clients (#1). The findings are: Observation on 2/26/25 at approximately 1:27 pm of client #1's medication bin revealed: -There was no Vitamin D3 50 micrograms (mcg) (Bone health), Atorvastatin 20 milligrams (mg) (High Cholesterol), Co-Enzyme Q10 200 mg (Energy) and Omeprazole 20 mg (Heartburn) available for client #1. Review on 2/26/25 of client #1's record revealed: -Admission date of 11/14/24. -Diagnoses of Post-traumatic Stress Disorder, Major Depressive Disorder and Oppositional Defiant Disorder. -She was 16 years old. -Physician's orders dated 11/13/24 for the following medications: Vitamin D3 50 mcg, one tablet daily Atorvastatin 20 mg, one tablet daily Co-Enzyme Q10 200 mg, one capsule daily Omeprazole 20 mg, one capsule daily Review on 2/26/25 of MARs for client #1 revealed: No staff initials to indicate the medication was administered for the following:	V 118	Corrective Measures	All staff will receive supervision training on MAR documentation to correct the deficient area. Training will include the need for accuracy and timeliness.Staff will receive written documentation from prescribing physician for any discontinuance of medicines.	
			Preventive Measures	The MARs will be signed daily by staff administering the medication.Program Manager will be asked to check for any unmarked areas or errors on the MAR daily. Should an error be identified, the error will be corrected before staff leaves the shift. If necessary, supervisor will be contacted and medication errors will be documented as a Level I incident.	
			Who will Monitor	Owner, Program Manager, Pharmacy	
			How Often	All MARs will be audited for completion and accuracy on a weekly basis by Owner or Program Manager.All MARs will be audited by the distributing pharmacy bi-annually	

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V 118	Continued From page 4 February 2025- -Vitamin D3 50 mcg on 2/1 thru 2/26 -Atorvastatin 20 mg on 2/7 thru 2/26 -Co-Enzyme Q10 200 mg on 2/7 thru 2/26 -Omeprazole 20 mg on 2/7 thru 2/26 -No documentation to indicate the medication was not available for administration January 2025- -Vitamin D3 50 mcg on 1/1 thru 1/31 -No documentation to indicate the medication was not available for administration Interview on 2/26/25 with client #1 revealed: -Some of her medications were not available because she had to see the doctor to get refills. -She had blood work completed about a week ago in order to get one of those medications refilled. -She had not taken some of those medications for most of the month (February 2025). -She wasn't sure when she would be seeing the doctor in order to have those medications refilled. Interview on 2/26/25 with the Program Manager revealed: -Client #1's February and January 2025 MARs had no staff initials for some of the medications because she ran out of those medications. -Some of client #1's medications were not available because they were waiting on the doctor to write an order to have those medications refilled. -Client #1 required lab work for one of those medications, which they just recently had done this month (February 2025). -She (Program Manager) called the medical office several times and tried to speak with the doctor and/or schedule an appointment to get the medication refilled.	V 118		

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V 118	Continued From page 5 -She was told the doctor was busy or seeing another patient. -Staff did not indicate the medication was not available on the February and January 2025 MARs for client #1. -She confirmed the MARs were not current client #1. Interview on 2/26/25 with the Director/Qualified Professional revealed: -She wasn't aware of some of client #1's medications not being available. -"I know medical appointments for clients can be difficult to make." -"It all boils down to Medicaid, they have to find doctors that accept Medicaid." -She confirmed the MARs were not current client #1.	V 118		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REG IST RY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Health Care Personnel	V 131		

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V 131	Continued From page 6 Registry (HCPR) was accessed prior to employment affecting one of one audited paraprofessional staff (#1). The findings are: Review on 2/26/25 of the personnel record for staff #1 revealed: -No specific date of hire. -No documentation the HCPR was accessed prior to hire. Interview on 2/26/25 with the Director/Qualified Professional revealed: -Staff #1 had been with her facility for a little over a year. -"We just had an accreditation review and all of the documentation was available for [staff #1]." -She recalled doing the HCPR check for staff #1. -She was not sure why the HCPR check was not in staff #1's personnel record. -She confirmed the facility failed to ensure the HCPR was accessed for staff #1 prior to employment.	V 131	Corrective Measures: Onboarding paperwork will begin within 48 hours of offer acceptance. Employee's file will be updated to be in compliance. Preventive Measures: The results of HCPR will be obtained before hire date. Who will Monitor: Owner How Often: To ensure compliance, Owner will review the personnel record of incoming staff prior to hire date.	
V 179	27G .1301 Residential Tx - Scope 10A NCAC 27G .1301 SCOPE (a) The rules of this Section apply only to a residential treatment facility that provides residential treatment, level II, program type service. (b) A residential treatment facility providing residential treatment, level III service, shall be licensed as set forth in 10A NCAC 27G .1700. (c) A residential treatment facility for children and adolescents is a free-standing residential facility which provides a structured living environment within a system of care approach for children or adolescents who have a primary diagnosis of mental illness or emotional disturbance and who	V 179		

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V 179	Continued From page 7 may also have other disabilities. (d) Services shall be designed to address the functioning level of the child or adolescent and include training in self-control, communication skills, social skills, and recreational skills. Children or adolescents may receive services in a day treatment facility, have a job placement, or attend school. (e) Services shall be designed to support the child or adolescent in gaining the skills necessary to return to the natural, or therapeutic home s etting. (f) The residential treatment facility shall coordinate with other individuals and agencies within the client's system of care. This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to coordinate with other individuals and agencies within the client's system of care affecting one of three clients (#1). The findings are: Observation on 2/26/25 at approximately 1:27 pm of client #1's medication bin revealed: -There was no Vitamin D3 50 micrograms (mcg) (Bone health), Atorvastatin 20 milligrams (mg) (High Cholesterol), Co-Enzyme Q10 200 mg (Energy) and Omeprazole 20 mg (Heartburn) available for client #1. Review on 2/26/25 of client #1's record revealed:	V 179	Corrective Measures	All staff will receive supervision training on MAR documentation to correct the deficient area. Staff will receive written documentation from prescribing physician for any discontinuance of medicines.	
			Preventive Measures	The MARs will be signed daily by staff administering the medication.Program Manager will be asked to check for any unmarked areas or errors on the MAR daily. Should an error be identified, the error will be corrected before staff leaves the shift. If necessary, supervisor will be contacted and medication errors will be documented as a Level I incident.	
			Who will Monitor	Owner, Program Manager, Pharmacy	
			How Often	The MARs will be signed daily by staff administering the medication.All MARs will be audited for completion and accuracy on a weekly basis by Owner or Program Manager.All MARs will be audited by the distributing pharmacy bi-annually	

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V 179	Continued From page 8 -Admission date of 11/14/24. -Diagnoses of Post-traumatic Stress Disorder, Major Depressive Disorder and Oppositional Defiant Disorder. -She was 16 years old. -Physician's orders dated 11/13/24 for the following medications: Vitamin D3 50 mcg, one tablet daily Atorvastatin 20 mg, one tablet daily Co-Enzyme Q10 200 mg, one capsule daily Omeprazole 20 mg, one capsule daily Review on 2/26/25 of MARs for client #1 revealed: No staff initials to indicate the medication was administered for the following: February 2025- -Vitamin D3 50 mcg on 2/1 thru 2/26 -Atorvastatin 20 mg on 2/7 thru 2/26 -Co-Enzyme Q10 200 mg on 2/7 thru 2/26 -Omeprazole 20 mg on 2/7 thru 2/26 January 2025- -Vitamin D3 50 mcg on 1/1 thru 1/31 Interview on 2/26/25 with client #1 revealed: -Some of her medications were not available because she had to see the doctor to get refills. -She had blood work completed about a week ago in order to get one of those medications refilled. -She had not taken some of those medications for most of the month (February 2025). -She wasn't sure when she would be seeing the doctor in order to have those medications refilled. Interview on 2/26/25 with the Program Manager revealed:	V 179		

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V 179	Continued From page 9 -Client #1's February and January 2025 MARs had no staff initials for some of the medications because she ran out of those medications. -Some of client #1's medications were not available because they were waiting on the doctor to write an order to have those medications refilled. -Client #1 required lab work for one of those medications, which they just recently had done this month (February 2025). -She (Program Manager) called the medical office several times and tried to speak with the doctor and/or schedule an appointment to get the medication refilled. -She was told the doctor was busy or seeing another patient. Interview on 2/26/25 with the Director/Qualified Professional revealed: -She wasn't aware of some of client #1's medications not being available. -"I know medical appointments for clients can be difficult to make." -"It all boils down to Medicaid, they have to find doctors that accept Medicaid."	V 179		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective	V 366		

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V 366	Continued From page 10 measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or	V 366	Corrective Measures	Incidents will be reported to IRIS and MCO within the 72 hour timeframe.Program Manager will receive training on how to submit an icident report with in IRIS.	
			Preventive Measures	Within 24 hours of an incident, the Owner will follow up with the on-duty staff member to ensure incident reports are submitted.A printout of the submission will be filed within the facility's filing system.	
			Who will Monitor	Owner	
			How Often	Owner will review IRIS for the submission of Level II and III reports into IRIS within in 72 hours as incidents occur.	

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V 366	Continued From page 11 with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as f ollows : (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;	V 366		

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V 366	Continued From page 12 (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement a policy governing their response to Level II incidents as required. The findings are: Review on 2/26/25 of client #1's record revealed: -Admission date of 11/14/24. -Diagnoses of Post-traumatic Stress Disorder, Major Depressive Disorder and Oppositional Defiant Disorder. -She was 16 years old. Review on 2/26/25 of client #3's record revealed: -Admission date of 10/1/24. -Diagnoses of Adjustment Disorder, Anxiety Disorder-Unspecified, Attention Deficit Hyperactivity Disorder. -She was 17 years old. Review on 2/26/25 of an in-house incident report dated 12/28/24 revealed: -"On Saturday, December 28, 2024 at approximately 3:50 PM, [client #1] and [client #3] left the property without permission. Staff checked the premises and staff searched the surrounding area including neighborhoods, parks and shopping centers. Staff contacted the [Name of local police department] and provided dispatch	V 366		

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(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 366	Continued From page 13 with the necessary information..." Review on 2/26/25 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed: -There was no level II incident report submitted by the facility for clients #1 and #3 running away from the facility and the police department being called by staff. -There was no documentation to determine: The cause of the incident; If the facility developed and implemented corrective measures according to the provider specified timeframes not to exceed 45 days; no measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days and assigning person(s) to be responsible for implementation of the corrections and preventive measures. Interview on 2/26/25 with the Program Manager revealed: -Clients #1 and #3 ran away from the facility in December 2024. -Staff called the police department during that incident. -She would normally write up the incident and email it to the Program Coordinator with their former agency. -The Program Coordinator with the former agency would put the incident into IRIS. -She confirmed the facility failed to implement a policy governing their response to Level II incidents as required. Interview on 2/26/25 with the Director/Qualified Professional revealed: -She was aware the incident with clients #1 and #3 running away from the facility in December 2024. -The Program Coordinator with the former	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-281	A. BUILDING: _____ B. WING _____	02/26/2025

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V 366	Continued From page 14 agency was responsible for putting incidents into IRIS. -She confirmed the facility failed to implement a policy governing their response to Level II incidents as required. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR 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 inf or m ation: (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	V 367	Corrective Measures: Incidents will be reported to IRIS and MCO within the 72 hour timeframe.Program Manager will receive training on how to submit an icident report with in IRIS Preventive Measures: Within 24 hours of an incident, the owner will follow up with the on-duty staff member to ensure incident reports are submitted.A printout of the submission will be filed within the facility's filing system. Who will Monitor: Owner How Often: Owner will review IRIS for the submission of Level II and III reports into IRIS within in 72 hours as incidents occur.	

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V 367	Continued From page 15 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: (1) hospital records including confidential inf or m ation ; (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	V 367		

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V 367	Continued From page 16 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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure incidents were reported to the Local Management Entity/Managed Care Organization (LME/MCO) for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are: Review on 2/26/25 of client #1's record revealed: -Admission date of 11/14/24. -Diagnoses of Post-traumatic Stress Disorder, Major Depressive Disorder and Oppositional Defiant Disorder. -She was 16 years old. Review on 2/26/25 of client #3's record revealed: -Admission date of 10/1/24. -Diagnoses of Adjustment Disorder, Anxiety Disorder-Unspecified, Attention Deficit Hyperactivity Disorder.	V 367		

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V 367	Continued From page 17 -She was 17 years old. Review on 2/26/25 of an in-house incident report dated 12/28/24 revealed: -"On Saturday, December 28, 2024 at approximately 3:50 PM, [client #1] and [client #3] left the property without permission. Staff checked the premises and staff searched the surrounding area including neighborhoods, parks and shopping centers. Staff contacted the [Name of local police department] and provided dispatch with the necessary information..." Review on 2/26/25 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed: -There was no level II incident report submitted by the facility for clients #1 and #3 running away from the facility and the police department being called by staff. Interview on 2/26/25 with the Program Manager revealed: -Clients #1 and #3 ran away from the facility in December 2024. -Staff called the police department during that incident. -She would normally write up the incident and email it to the Program Coordinator with their former agency. -The Program Coordinator with the former agency would put the incident into IRIS. -She wasn't sure why the incident with client #1 and #3 running away was not in IRIS. -She confirmed the facility failed to report the above incident to LME/MCO within 72 hours. Interview on 2/26/25 with the Director/Qualified Professional revealed: -She was aware the incident with clients #1 and	V 367		

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V 367	Continued From page 18 #3 running away from the facility in December 2024. -The Program Coordinator with the former agency was responsible for putting incidents into IRIS. -She was not sure why the incident with clients #1 and #3 was not in IRIS. -"I just have to eat that citation." -She confirmed the facility failed to report the above incident to LME/MCO within 72 hours. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 367		