Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ MHL001-281 B. WING 02/26/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1227 WESTMORELAND DRIVE A MOTHER'S LOVE **BURLINGTON, NC 27217** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) V 000 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. Onboarding paperwork will begin within 48 hours of offer acceptance. Corrective V 107 27G .0202 (A-E) Personnel Requirements V 107 Measures Employee's file will be updated to be in 10A NCAC 27G .0202 PERSONNEL compliance. **REO UIREM ENT S** (a) All facilities shall have a written job description for the director and each staff position which: All educational Preventive (1) specifies the minimum level of education, documents will be Measures competency, work experience and other obtained before hire date. qualifications for the position; (2) specifies the duties and responsibilities of the position; Who will (3)is signed by the staff member and the Owner Monitor 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 To ensure compliance. provides care or services to clients on behalf of Owner will review the the facility: How Often personnel record of (1) is at least 18 years of age; incoming staff prior to hire (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.

Division of Health Service Regulation

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

Kizzy Brown

TITLE Owner, QP

ODRS11

(X6) DATE March 13, 2025

If continuation sheet 1 of 19

Received by MHL & C

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(3) DATE SURVEY COMPLETED	
		MHL001-281	B. WING		02/2	6/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
A MOTH	A MOTHER'S LOVE 1227 WES BURLING			ND DRIVE 217		
(X4) ID PREFIX TAG		NT OF DEFICIENCIES NUST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 107	shall require that al applicants for empl conviction. The imp decision regarding upon the offense in which the applicant (d) Staff of a facility currently licensed, accordance with ap services provided. (e) A file shall be memployed indicatin	oyment disclose any criminal act of this information on a employment shall be based relationship to the job for is applying. For a service shall be registered or certified in plicable state laws for the aintained for each individual g the training, experience and for the position, including	V 107			
	failed to have a con affecting one of one staff (#1). The findi Review on 2/26/25 staff #1 revealed: -No specific date of -No documentation Interview on 2/26/2 Professional reveal -Staff #1 had been over a year.	view and interview, the facility inplete personnel record e audited paraprofessional ngs are: of the personnel record for hire. of educational verification. 25 with the Director/Qualified				

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Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL001-281	I-281 B. WING		02/26/2025	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA			
A MOTHER'S LOVE		TMORELAN TON, NC 27				
(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 SHOULI CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		(X5) COMPLETE DATE
V 107	Continued From pa	ge 2	V 107			
	-She was unable to high school diploma -"I'm just going to h one." -She confirmed the	was available for [staff #1]." locate a copy of staff #1's a. nave to take the hit for that facility failed to have a el record for staff #1.				
V 118	V 118 27G .0209 (C) Medication Requirements		V 118			
	only be administered order of a person and drugs. (2) Medications shat clients only when a client's physician. (3) Medications, included administered only builticensed persons pharmacist or other privileged to prepare (4) A Medication Acall drugs administe current. Medication recorded immediat MAR is to include the (A) client's name; (B) name, strength, (C) instructions for (D) date and time the (E) name or initials drug. (5) Client requests checks shall be recorded.	inistration: non-prescription drugs shall ed to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be by licensed persons, or by trained by a registered nurse, r legally qualified person and re and administer medications. Iministration Record (MAR) of red to each client must be kept as administered shall be ely after administration. The				

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Division of Health Service Regulation STATE FORM

QDRS11 If continuation sheet 3 of 19

Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
	MHL001-281 B. WING			02/2	6/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STA	ATE, ZIP CODE		
А МОТН	ER'S LOVE		TMORELAN TON, NC 27			
(X4) ID	SIIMMARV STAT	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				COMPLETE DATE	
V 118	Continued From pa	ge 3	V 118		I	
		view and interviews, the		SU de de Corrective in Measures au re fr au	I staff will receive opervision training on ocumentation to corresticient area. Training clude the need for act and timeliness. Staff will ceive written docume om prescribing physically discontinuance of edicines.	ect the g will ccuracy ll entation
	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 11/14/24Diagnoses of Post-traumatic Stress Disorder, Major Depressive Disorder and Oppositional Defiant DisorderShe was 16 years oldPhysician'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			by m w un Preventive be Measures co th su an	ne MARs will be signe a staff administering the edication. Program Mill be asked to check the marked areas or error e MAR daily. Should be identified, the error prected before staff the eshift. If necessary, approvisor will be contained medication errors to be cumented as a Level cident.	he anager for any ors on an error will be eaves acted will be
					wner, Program Manag narmacy	ger,
	revealed:	ndicate the medication was		CC W How Often Pi be	l MARs will be audite ompletion and accura eekly basis by Owner ogram Manager.All M e audited by the distri narmacy bi-annually	cy on a or IARs will
					1	

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Division of Health Service Regulation

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL001-281		B. WING		02/26/2025		
				NTE, ZIP CODE ND DRIVE	,	·
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETE DATE
V 118	-Omeprazole 20 mg -No documentation was not available for January 2025Vitamin D3 50 mcg -No documentation was not available for Interview on 2/26/2 -Some of her medic because she had to -She had blood wor ago in order to get or refilledShe had not taken for most of the mor -She wasn't sure w doctor in order to h Interview on 2/26/2 revealed: -Client #1's Februal had no staff initials because she ran ou -Some of client #1' available because t to write an order to refilledClient #1 required medications, which this month (Februal -She (Program Man office several times	g on 2/1 thru 2/26 g on 2/7 thru 2/26 00 mg on 2/7 thru 2/26 g on 1/1 thru 1/31 g on 1/1 thru 1/31 g on administration g on 1/1 thru 1/31 g on 1/1 thru 2/26 g on 2/7 thru 2/26 g on				

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL001-281	B. WING		02/2	.6/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
A MOTH	ER'S LOVE		TMORELAN TON, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICI	EMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 5	V 118			
	another patientStaff did not indica available on the Fel MARs for client #1She confirmed the #1. Interview on 2/26/2 Professional reveal -She wasn't aware medications not be -"I know medical a difficult to make." -"It all boils down t doctors that accept	MARs were not current client 25 with the Director/Qualified ed: of some of client #1's ing available. ppointments for clients can be o Medicaid, they have to find				
V 131	Verification G.S. §131E-256 HE REG IST RY (d2) Before hiring h health care facility health care facility e Personnel Registry	HCPR - Prior Employment EALTH CARE PERSONNEL ealth care personnel into a or service, every employer at a shall access the Health Care and shall note each incident oropriate business files.	V 131			
		t as evidenced by: view and interview, the facility Health Care Personnel				

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Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		MHL001-281	B. WING		02/26/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STA	TE, ZIP CODE		
Δ ΜΟΤΗ	ER'S LOVE	1227 WES	TMORELAN	ID DRIVE		
7(1110111		BURLING	TON, NC 27	217		
(X4) ID PREFIX TAG	(EACH DEFICI	EMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X COMP		
V 131	Continued From pa	ge 6	V 131			
	Registry (HCPR) wa employment affect paraprofessional st	is accessed prior to ing one of one audited aff (#1). The findings are:		Corrective Measures	Onboarding paperwork will begin within 48 hours of offer acceptance.	
	staff #1 revealed: -No specific date of hireNo 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 #1She was not sure why the HCPR check was not in staff #1's personnel record.		Corrective	Corrective Measures	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	
	-She confirmed the	facility failed to ensure the d for staff #1 prior to		How Often	To ensure compliance, Owner will review the personnel record of incoming staff prior to date.	
V 179	27G .1301 Residen	tial Tx - Scope	V 179			
	10A NCAC 27G .13 (a) The rules of this residential treatme residential treatme service. (b) A residential treatme licensed as set fort (c) A residential treadolescents is a frewhich provides a stwithin a system of adolescents who have	·				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(XS	S) DATE SURVEY COMPLETED
		MHL001-281	B. WING			02/26/2025
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	•		
A MOTH	ER'S LOVE		TMORELAN TON, NC 27			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE					
V 179	may also have othe (d) Services shall be functioning level of include training in s skills, social skills, a Children or adolesc day treatment facili attend school. (e) Services shall be child or adolescent to return to the natis etting. (f) The residential to	r disabilities. e designed to address the the child or adolescent and elf-control, communication and recreational skills. ents may receive services in a ty, have a job placement, or e designed to support the in gaining the skills necessary ural, or therapeutic home reatment facility shall er individuals and agencies	V 179	Corrective Measures Preventive Measures	The MARs will b staff administer medication.Prog be asked to che unmarked areas MAR daily. Shou identified, the electrocted before shift. If necessarian	documentation efficient area. e written from prescribing y discontinuance e signed daily by ng the fram Manager will ck for any or errors on the ald an error be fror will be e staff leaves the fry, supervisor d and medication
	interviews, the facil other individuals an system of care affer The findings are: Observation on 2/2 of client #1's medic -There was no Vitar (Bone health), Ator (High Cholesterol), (Energy) and Omep available for client	on, record review and ity failed to coordinate with a dagencies within the client's cting one of three clients (#1). 6/25 at approximately 1:27 pm cation bin revealed: min D3 50 micrograms (mcg) vastatin 20 milligrams (mg) Co-Enzyme Q10 200 mg razole 20 mg (Heartburn)		Who will Monitor How Often	staff administer medication.All N audited for com accuracy on a w Owner or Progra MARs will be au	e signed daily by ng the IARs will be oletion and eekly basis by m Manager.All

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7.1.12 . 27.111	o. com.zo.zo	15 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	A. BUILDING:			
		MHL001-281	B. WING		02/2	26/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
а мотн	ER'S LOVE	1227 WES	TMORELAN	ID DRIVE		
, (1110111		BURLING	TON, NC 27	217		
(X4) ID PREFIX TAG	(EACH DEFICI	FEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 179	Continued From pa	ge 8	V 179			
	-Admission date of -Diagnoses of Post-Major Depressive D Defiant DisorderShe was 16 years -Physician's orders following medicatic Vitamin D3 50 mcg Atorvastatin 20 mg Co-Enzyme Q10 20 Omeprazole 20 mg Review on 2/26/25 revealed: No staff initials to it administered for the February 2025-Vitamin D3 50 mcg-Atorvastatin 20 mg-Atorvastatin 20 mg-	11/14/24traumatic Stress Disorder, bisorder and Oppositional old. dated 11/13/24 for the ons: , one tablet daily , one tablet daily , one capsule daily , one capsule daily of MARs for client #1 indicate the medication was e following: g on 2/1 thru 2/26 g on 2/7 thru 2/26 00 mg on 2/7 thru 2/26				
	January 2025-					
	-Vitamin D3 50 mc					
		25 with client #1 revealed:				
	because she had to -She had blood wor ago in order to get or refilled. -She had not taken for most of the mor -She wasn't sure w doctor in order to h	cations were not available of see the doctor to get refills. It completed about a week one of those medications as some of those medications of the cate those medications the cate those medications refilled.				
	revealed:	20 Mai alo i logiam Planagei				
	Tovouisu.					

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l · ·	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	MHL001-281		B. WING		02/26/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
A MOTH	ER'S LOVE		TMORELAN TON, NC 27	.= = =		
(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 SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 179	had no staff initials because she ran ou -Some of client #1' available because to write an order to refilledClient #1 required medications, which this month (Februa -She (Program Man office several times doctor and/or sche medication refilledShe was told the danother patient. Interview on 2/26/2 Professional reveal -She wasn't aware medications not be -"I know medical a difficult to make."	ary and January 2025 MARs for some of the medications at of those medications. It of those medications were not hey were waiting on the doctor have those medications lab work for one of those at they just recently had done ary 2025). It is ager) called the medical stand tried to speak with the dule an appointment to get the coctor was busy or seeing 25 with the Director/Qualified ed: of some of client #1's ing available. It is pointments for clients can be of Medicaid, they have to find				
V 366	10A NCAC 27G .06 RESPONSE REQUIF CATEGORY A AND (a) Category A and implement written response to level I, shall require the pre (1) attending of individuals involv (2) determini	REMENTS FOR B PROVIDERS B providers shall develop and policies governing their II or III incidents. The policies ovider to respond by: to the health and safety needs				

Division of Health Service Regulation

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Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	1 ` '	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ובט	
	MHL001-281		B. WING		02/26	5/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
л мотн	ER'S LOVE	1227 WES	TMORELAN	ID DRIVE			
AMOTH	ERSLOVE	BURLING	TON, NC 27	217			
(X4) ID PREFIX TAG	(EACH DEFICI	EMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
V 366	Continued From pa	ge 10	V 366				
	measures accordin timeframes not to e (4) developin to prevent similar in specified timeframe (5) assigning for implementation preventive measure (6) adhering set forth in G.S. 75, 42 CFR Parts 2 and 164; and (7) maintaini Subparagraphs (a) (b) In addition to th Paragraph (a) of thi shall address incide regulations in 42 CI	g to provider specified exceed 45 days; ag and implementing measures incidents according to provider es not to exceed 45 days; person(s) to be responsible of the corrections and es; to confidentiality requirements Article 2A, 10A NCAC 26B, 3 and 45 CFR Parts 160 and ang documentation regarding 1) through (a)(6) of this Rule. He requirements set forth in s Rule, ICF/MR providers ents as required by the federal FR Part 483 Subpart I.		Corrective Measures Preventive Measures	Incidents will be reported and MCO within the 72 hou timeframe.Program Manag receive training on how to an icident report with in IR Within 24 hours of an incid the Owner will follow up won-duty staff member to eincident reports are submi printout of the submission filed within the facility's fili	ur ger will submit RIS. dent, rith the nsure itted.A will be	
	(c) In addition to the Paragraph (a) of this providers, excluding develop and impler their response to a while the provider is or while the client is	e requirements set forth in s Rule, Category A and B g ICF/MR providers, shall ment written policies governing level III incident that occurs s delivering a billable service s on the provider's premises.		Who will Monitor	system. Owner	iiig	
	(A) (B) obtaining (C) making a (D) certifying transferring review team; (2) convening review team within internal review team who were not involven.	ely securing the client record the client record; photocopy; the copy's completeness; and ng the copy to an internal g a meeting of an internal 24 hours of the incident. The m shall consist of individuals ved in the incident and who le for the client's direct care or		How Often	Owner will review IRIS for submission of Level II and reports into IRIS within in hours as incidents occur.	III	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL001-281	B. WING		02/2	26/2025
	PROVIDER OR SUPPLIER	1227 WES	ress, city, sta Stmorelan Ston, nc 27	ND DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICI	EMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 366	with direct professi services at the time review team shall of ollows: (A) review the determine the facts and make recommo occurrence of futur (B) gather ot (C) issue writ within five working preliminary findings LME in whose catch located and to the lif different; and (D) issue a fin owner within three final report shall be catchment area the LME where the clief inal written report identified by the intinclude all public do incident, and shall minimizing the occu all documents need available within thr LME may give the pthree months to su (3) immediat (A) the LME rearea where the serve Rule .0604; (B) the ME (C) for maintaining and	onal oversight of the client's of the incident. The internal omplete all of the activities as e copy of the client record to and causes of the incident endations for minimizing the	V 366			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL001-281	B. WING		02/2	26/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	NTE, ZIP CODE		
A MOTH	HER'S LOVE		TMORELAN TON, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICI	EMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		(X5) COMPLETE DATE
V 366	(D) the Depar (E) the client applicable; and (F) any other This Rule is not more record reviews and implement a policity of the policy of the	tment; 's legal guardian, as authorities required by law. as required. The findings are of client #1's record revealed 11/14/24Diagnoses of Post Disorder, Major Depressive ositional Defiant DisorderShe Review on 2/26/25 of client ed: -Admission date of 10/1/24 djustment Disorder, Anxiety ed, Attention Deficited, Attention Deficited"On Saturday 24 at approximately 3:50 PM at approximately 3:50 PM at #3] left the property without hecked the premises and staffsurrounding area including rks and shopping centers. Staffne of local police department	o o o o o o o o o o o o o o o o o o o			

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7.110 1 27.111	AND FEAR OF CONNECTION		A. BUILDING:			
MHL001-281		B. WING		02/2	26/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
A MOTH	ER'S LOVE		TMORELAN			
		BURLING	TON, NC 27			
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 366	Continued From pa	ge 13	V 366			
	with the necessary	information"				
	Review on 2/26/25	of the North Carolina (NC)				
	Incident Response revealed:	Improvement System (IRIS)				
	-There was no leve	l II incident report submitted				
		ients #1 and #3 running away d 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 mea					
		25 with the Program Manager				
	revealed: -Clients #1 and #3	ran away from the facility in				
	December 2024.					
	-Staff called the po incident.	lice department during that				
	-She would normally write up the incident and email it to the Program Coordinator with their former agency.					
	-The Program Coor	dinator with the former				
		he incident into IRIS. facility failed to implement a				
		eir response to Level II				
	· ·	25 with the Director/Qualified				
	Professional reveal	ed:				
		e incident with clients #1 and om the facility in December				
	2024.	•				
	-The Program Coor	dinator with the former				

Division of Health Service Regulation

			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
MHL001-281		B. WING			02/26/2025		
ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE				
ER'S LOVE							
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		
Continued From pa	ge 14	V 366					
IRISShe confirmed the policy governing the incidents as require	facility failed to implement a eir response to Level II ed.						
and must be correc	ted within 30 days.						
27G .0604 Inciden	t Reporting Requirements	V 367					
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			Corrective Measures	and MCO wir timeframe.P receive train	thin the 72 h Program Man ning on how t	our ager will o submit	
incidents and level to whom the providence of the responsible for the services are providence of the services are providence of the submitted on a formal of the services. The report of the services of the submitted on a formal of the services of the serv	II deaths involving the clients er rendered any service within incident to the LME catchment area where ed within 72 hours of the incident. The report shall form provided by the ort may be submitted via mail, or encrypted electronic		Preventive Measures	the owner w on-duty staf incident rep printout of th	rill follow up f member to orts are subr he submissio	with the ensure nitted.A on will be	
inf or m ation:			Who will Monitor	Owner			
identification inform (2) client iden (3) type of inc (4) description (5) status of the inciden (6) other indion responding.	nation; ntification information; cident; on of incident; the effort to determine the nt; and viduals or authorities notified		How Often	submission reports into	of Level II ar IRIS within i	nd III n 72	
	Continued From paragency was responsible for the provision of bill consumer is on the incidents and level to whom the provided becoming aware of be submitted on a final services are provided becoming aware of be submitted on a final services are provided becoming aware of be submitted on a final services are provided becoming aware of be submitted on a final services are provided becoming aware of be submitted on a final services are provided becoming aware of be submitted on a final services are provided becoming aware of be submitted on a final services are provided becoming aware of be submitted on a final services are provided becoming aware of be submitted on a final services are provided becoming aware of be submitted on a final services are provided becoming aware of be submitted on a final services are provided becoming aware of be submitted on a final services are provided becoming aware of the services are provided becomin	ROVIDER OR SUPPLIER STREET ADD 1227 WES BURLING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 14 agency was responsible for putting incidents into IRISShe 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. 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	ROVIDER OR SUPPLIER REP'S LOVE REP'S LOVE REPS LOVE SUMMARY STATEMENT OF DEFICIENCIES (LEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 14 agency was responsible for putting incidents into IRISShe 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. 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 provider sendered 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 provider 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 on authorities notified or responding.	A BUILDING: MHLOO1-281 BUNING ROVIDER OR SUPPLIER STREET ADDRESS, CITY. STATE, ZITP CODE 1227 WESTMORELAND DRIVE BURLINGTON, NC 27217 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 14 agency was responsible for putting incidents into IRISShe confirmed the facility failed to implement a policy governing their response to Level III incidents as required. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days. 27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers premises or level III 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.	A BUILDING: MHLOO1-281 BER'S LOVE SUMMARY STATEMENT OF DEFICIENCES EACH DEFICIENCY MUST BE PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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 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 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) satus of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding.	A BUILDING: MHL001-281 B. WING O2/22 ROWIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1227 WESTMORELAND DRIVE BURLINGTON, NC 27217 SUMMARY STATEMENT OF DEFICIENCIES (EACH OBFICIENCY MUST BE PRECEDED BY FUIL (EACH CORRECTION FOR USE) DEFICIENCY MUST BE PRECEDED BY FUIL (EACH CORRECTIVE ACTION SHOULD BE CROSS-ARE FOR ETCH CONTROL OF USE DEFICIENCY MUST BE PRECEDED BY FUIL (EACH CORRECTIVE ACTION SHOULD BE CROSS-ARE FOR ETCH CORRECTION AND CONTROL OF USE DEFICIENCY OF TAG	

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
MHL001-281		B. WING		02/26/2025	
NAME OF PROVIDER OR SUPPLIER	STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
A MOTHER'S LOVE		TMORELAN TON, NC 27			
PREFIX (EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 367 Continued From page	15	V 367			
missing or incomplete shall submit an update report recipients by the day whenever: (1) the provider information provided is erroneous, misleading (2) the provider required on the incider unavailable. (c) Category A and B pupon request by the LI obtained regarding the (1) hospital recoinf or mation; (2) reports by ot (3) the provider (d) Category A and B pof all level III incident Mental Health, Develo Substance Abuse Serve becoming aware of the providers shall send a incidents involving a contident of the client death within sever or restraint, the providimmediately, as required to 1000 and 1000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 mation; (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;				

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	
7.1.12 / 27.11	IDENTIFICATION TO THE		A. BUILDING:			
MHL001-281		B. WING		02/26/2025		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STA	TE, ZIP CODE		
А МОТН	ER'S LOVE		TMORELAN			
6	CUMMA DV CTAT		TON, NC 27			0(5)
(X4) ID PREFIX TAG	(EACH DEFICI	TEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 367	Continued From pa	ge 16	V 367			
	the definition of a let (3) searches (4) seizures of the possession of a (5) the total rincidents that occu (6) a statement been no reportable incidents have occumeet any of the crit	evel II or level III incident; of a client or his living area; of client property or property in client; number of level II and level III rred; and ent indicating that there have incidents whenever no urred during the quarter that teria as set forth in Paragraphs ule and Subparagraphs (1)				
	facility failed to ensithe Local Managem Organization (LME/where services are becoming aware of Review on 2/26/25-Admission date of Diagnoses of Post-Major Depressive Defiant Disorder. -She was 16 years Review on 2/26/25-Admission date of Diagnoses of Adjusting	views and interviews, the sure incidents were reported to nent Entity/Managed Care MCO) for the catchment area provided within 72 hours of the incident. The findings are: of client #1's record revealed: 11/14/24traumatic Stress Disorder, visorder and Oppositional old. of client #3's record revealed: 10/1/24. stment Disorder, Anxiety ed, Attention Deficit				

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
MHL001-281		B. WING		02/2	02/26/2025		
A MOTHER'S LOVE 1227 WEST			DRESS, CITY, STATE, ZIP CODE STMORELAND DRIVE STON, N.C. 27217				
PRÉFIX (EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	ION SHOULD BE HE APPROPRIATE			
-She was 17 years Review on 2/26/2 dated 12/28/24 re-"On Saturday, De approximately 3:5 left the property we checked the premisurrounding area and shopping centrof local police depwith the necessar Review on 2/26/2 Incident Responsive revealed: -There was no level by the facility for offrom the facility and called by staff. Interview on 2/26/2 revealed: -Clients #1 and #December 2024Staff called the princidentShe would normate amail it to the Proformer agencyThe Program Codagency would put she wasn't sure wand #3 running awashe confirmed the above incident to	PROVIDER OR SUPPLIER HER'S LOVE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 2024Staff called the police department during that incidentShe would normally write up the incident and email it to the Program Coordinator with their former agencyThe Program Coordinator with the former agency would put the incident into IRISShe wasn't sure why the incident with client #1 and #3 running away was not in IRISShe confirmed the facility failed to report the above incident to LME/MCO within 72 hours. Interview on 2/26/25 with the Director/Qualified						

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ECONSTRUCTION	(X3) DATE SURVEY COMPLETED		
MHL001-281		B. WING		02/26/2025		
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	•	
A MOTHER'S LOVE 1227 WES						
(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 SHOULI CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		(X5) COMPLETE DATE
V 367	F PROVIDER OR SUPPLIER STREET ADDRES 1227 WESTN BURLINGTO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		V 367			

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