STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-213	A. BUILDING: _____ B. WING _____	R-C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE 4 THE YOUTH LLC	3001 NASH STREET NW WILSON, NC 27896

(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 March 27, 2025. The complaint was unsubstantiated (intake #NC00228380). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for 4 and currently has a census of 4. The survey sample consisted of audits of 3 current client.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid	V 108		

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techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction.
(i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients.

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure 6 of 6 audited staff (Director/Licensee #1, Program Director/Licensee #2, Qualified Professional (QP), Licensed Professional (LP), staff #1 and staff #4) received training to meet the MH/DD/SA needs of the clients. The findings are:

Review on 03/18/25 and 03/26/25 of client #3's record revealed:
-15 years old.
-Admitted 01/31/24.
-Discharged 03/21/25.
-Diagnoses of Disruptive Mood Dysregulation Disorder, Cannabis Use Disorder, Attention Deficit Hyperactivity Disorder, Adjustment Disorder, Cocaine Use Disorder, Opioid Use Disorder and Amphetamine Use Disorder.

Reviews on 03/18/25 and 03/26/25 of staff #1's personnel record revealed:
-Hire date of 01/19/24.
-No substance abuse training documented.

Reviews on 03/18/25 and 03/26/25 of staff #4's

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personnel record revealed:
-Hire date of 10/1/24.
-No substance abuse training documented.

Reviews on 03/18/25 and 03/26/25 of the QP's personnel record revealed:
-Date of hire 05/31/24.
-No substance abuse training documented.

Reviews on 03/18/25 and 03/26/25 of the LP's personnel record revealed:
-Hire Date: 01/23/25.
-No substance abuse training documented.

Reviews on 03/18/25 and 03/26/25 of the Program Director/Licensee #2's personnel record revealed:
-Hire date of 10/01/23.
-No substance abuse training documented.

Reviews on 03/18/25 and 03/26/25 of the Director/Licensee #1's personnel record revealed:
-Hire date of 10/01/23.
-No substance abuse training documented.

Interview on 03/26/25 the staff #1 stated:
-The facility may have had one training in substance abuse but he could not remember.
-He could recognize if a person had "skin changes, unusual behaviors,self injurious behaviors, be figidty and irate-similar to the stuff you see on tv" as symptoms of substance use.
-He has not had any training in substance abuse.
-He was not familiar with side effects or symptoms of amphetamine, crack or cocaine.

Interview on 03/18/25 could not be completed with staff #4 because she was on medical leave.

Interviews on 03/18/25 and 03/26/25 the QP

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V 108	Continued From page 3 revealed: -She had no training in substance abuse. Interviews on 03/18/25 and 03/26/25 the LP revealed: -She had reviewed all of the client records. -She completed 1 training called Substance Abuse Screening on 03/25/25. -It was about screening adolescents, how to refer them to treatment, motivational interviewing, intervention-readiness to change- determine why they want to use. -She had no substance abuse training on relapse prevention, withdrawal, identifying specific drugs or alcohol use or symptoms that were provided by the facility Interviews on 03/18/25 and 03/26/25 the Program Director/Licensee #2 revealed: -He did not have substance abuse training. -The group home staff did not have substance abuse training. -He understood that the staff needed to be trained to work with clients in the facility with substance use disorders. Interviews on 03/18/25 and 03/26/25 the Director/ Licensee#1 revealed: -He did not have substance abuse training. -The group home staff did not have substance abuse training. -The LP was trained by her job with the school system. -She had her trainings with her at her primary job, she would email them to him. -He understood that the staff needed to be trained. No additional documentation was received prior to exit date.	V 108		

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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. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to develop and implement goals and strategies for 1 of 3 audited clients (#3). The	V 112		

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V 112	Continued From page 5 findings are: Review on 03/18/25 and 03/26/25 of client #3's record revealed: -15 years old. -Admitted 01/31/24. -Discharged 03/21/25. -Diagnoses of Disruptive Mood Dysregulation Disorder, Cannabis Use Disorder, Attention Deficit Hyperactivity Disorder, Adjustment Disorder, Cocaine Use Disorder, Opioid Use Disorder and Amphetamine Use Disorder. -Comprehensive Clinical Assessment dated 06/17/24: Presenting Problem..."Clt (client) reports running away from his first group home...Clt endorses multiple high risk behaviors including extensive substance use, running away from group home placement..." Person Centered Plan (PCP) (treatment plan) Update 02/03/25: -Short Term Goal #1: "I want to finish high school." Provider Interventions: "will meet with the consumer a minimum of one time monthly...outlining consumer's (client) development and progress on managing anxiety and frustrations to accomplish his desired goals." -Short Term Goal #3: "to repair my relationship with my friend, that reported me for drug use." Provider Interventions: "will meet with the consumer a minimum of one time monthly for the next 6 months outlining consumer's development and progress on managing anxiety, frustrations and refraining from drug use...will encourage consumer to be active and participate in treatment by attending/participating in scheduled treatment team meetings, doctors appointments and attending school...teach consumer appropriate methods to build healthy relationships with others daily...monitor consumer for the presence and use of drugs daily."	V 112		

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V 112	Continued From page 6 -Short Term Goal #4: "I want to get my car back." Provider Interventions: "will meet with consumer ...outlining consumer's development and progress on managing anxiety and frustrations...will encourage consumer daily to be active and participate in treatment by attending/participating in scheduled treatment team meetings, doctor's appointment and attending school...will daily teach consumer appropriate methods to build healthy relationships with others...increase socialization and effective communication skills." -No updates to Client #3's PCP dated 02/03/25 goals or strategies to address client #3's substance use and elopements on 02/17/25, 03/12/25 and 03/15/25. Review on 03/18/25 of the Child and Family Team Meeting (CFT) Agenda and Minutes: -02/24/25- Attendees: Director, Qualified Professional (QP), Associate Professional (AP), Client #3, Client #3 Department of Social Service (DSS) Legal Guardian, Client #3's Mother and Local Management Entity/Managed Care Organization (LME/MCO) Care Coordinator. The information sharing section for the school noted "Currently suspended". The strategies, goals and other supports sections were left blank. -03/6/25- Attendees: Director, AP, Guardian, Care Coordinator. The information sharing section on the CFT form noted no concerns at the school and no issues at the facility. The strategies, goals and other supports sections were left blank. -No CFT documentation after the 02/17/25 elopement to support recommendations or changes to client #3's treatment or goals to address his elopements. -Urine drug screen completed 03/18/25: Results-Positive for Marijuana.	V 112		

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V 112	Continued From page 7 Review on 03/18/25 of the Licensed Professional (LP) Notes: -02/27/25 Session content: "...reviewed events that occurred between the last group counseling session...problem-solving, emotional regulation, and identifying coping mechanisms to help him navigate these difficulties while maintaining his commitment to staying in school." Review on 03/18/25 of Incident Response Improvement System (IRIS) reports for client #3 revealed: -Client #3 eloped from school on 02/17/25. -Client #3 eloped from the facility on 03/12/25 and 03/15/25. Review on 03/18/25 of the facility's documentation of shift/daily service progress notes for client #3 revealed: -"02/17/25-First Shift-Intervention: Consumer attended school at [Local High School]. Staff received a call from school around 12:30. Staff contacted 9-1-1 to inform them that consumer was missing. Staff and local sheriff department are currently looking for [Client #3] at 2:19 pm" -"02/18/25-First Shift- Intervention: [Director] was notified by [Local High School] that [Client #3] had left school. [Program Director] went to the school to see if he was there and he was not there at 12:40pm. [Director] called the police and reported a missing person report. Law enforcement stayed in contact while searching for [Client #3]. Staff nor police was able to find [Client #3]. [Client #3] showed up at the facility at 6:40pm. [Client #3] stated that he just walked around the community for 6+ hours and he was ok. The local Sheriff department came to confirm that [Client #3] was at the facility." -"03/12/25-First Shift-Intervention: Client had a very rough day after chores he went into his room	V 112		

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V 112	Continued From page 8 then came out into the living room to have a talk about school he was upset and went back to his room. Minutes later he walked to the front door and sorry I need to go blow off some steam staff called the Director and then the police." "-03/12/25-Second Shift-Intervention: Staff discussed with consumer about taking accountability and developing responsibility for his actions in the home and build positive circumstances and focusing on remaining in school and stop being defiant when teachers ask him to something and he does the opposite and gets suspended then doesn't want to follow rules of the home taking accountability for when I arrived on shift other staff stated he had eloped when I asked why he did it the consumer stated I needed to clear my head." "Consumer stated he understood all his interventions but he didn't want to be at the facility so he left but returned on his own like nothing happen; staff reminded consumer of consequences and he couldn't just walk off premises." -"03/15/25- First shift- Intervention: Consumer stated that he just wanted to go home. An hour past by and consumer dashed out the front door. Staff tried to redirect him but he kept going...Assessment of Progress: consumer ran away from house." -"03/16/25- Sun (Sunday) 7p (pm)-7a (am)- Intervention: Consumer was returned to the facility. His social worker dropped him off. Staff asked consumer what was wrong and where did he go. Consumer did not respond and stated that he just wanted to lay down. Assessment of Progress: Consumer was real uninterested when staff was encountering the situation. Consumer slept in front room with staff to make sure he was safe."	V 112		

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V 112	Continued From page 9 Interview on 03/18/25 client #3 stated: -He recalled leaving the facility on 03/15/25. He "left because he wanted to." He went "out." -A social worker brought him back to the facility. -He was not in the city of the facility the entire time he was gone. -He walked to multiple houses in the same city as the facility. -He declined to share where he went or who he was with. -When asked about a typical day at the facility he stated "it didn't matter and threw his hands up in air, would not respond to additional questions. Interview on 03/18/25 client #3's DSS Legal Guardian stated: -The Director made her aware of client #3's elopements. -There was no discussion of updating client #3's treatment plan after he eloped on 02/17/25 or 03/12/25 because they were trying to secure other services through substance abuse treatment. -She planned to have client #3 do a drug screen after the 03/12/25 elopement. -The Director gave her notice of discharge after client #3's 03/12/25 elopement. -Client #3 was found at his father's residence in an adjacent county on 03/16/25 and the father's residence which has been associated with drug use. Interview on 03/19/25 the LP stated: -She was not aware of client #3's 02/17/25 elopement from school. -Client #3 told her on 03/13/25 that he had eloped from school on 02/17/25. -She discussed ways that client #3 could cope instead of eloping from the group home and school.	V 112		

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V 112	Continued From page 10 -She reported to the Director on 3/14/25 that "he may run away soon." Interview on 03/19/25 the QP stated: -She participated in CFT meetings and developed client's PCPs. -She was aware that client #3 eloped from school on 02/17/25 and eloped from the facility on 03/12/25 and 03/15/25. -The Director notified her on 03/15/25 "about 2:45pm" that client #3 had eloped. -Client #3 had previously had a goal for elopement and substance abuse however the goal was discontinued because he had no incidents. -After client #3 eloped on 03/12/25 she thought "he might have used drugs." -She counseled Client #3 about elopement but he "felt attacked." -There were no updates to client #3's PCP goals or strategies after he eloped from the facility on 02/17/25. Interview on 03/18/25 and 03/26/25 the Director/Licensee #1 stated: -Client #3 had a coping skills goal with strategies to address substance use and elopement which was discontinued on 09/26/24 because he had no elopement incidents from 01/31/24 thru 08/26/24. -The facility updated client #3's PCP monthly to document progress. There was no updated PCP to address client #3's elopement and substance use for the month of March 2025. -After client #3 eloped on 03/12/25 the Local Management Entity/Managed Care Organization (LME/MCO) Care Manager recommended the enhanced rate services and planned for client #3 to get a drug screen completed to determine if he had been using drugs. -He gave notice of discharge and discussed the	V 112		

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need for a higher level of care with client #3's Guardian and the LME/MCO Care Manager after client #3 eloped on 03/12/25.
-There were no updates to client #3's PCP after he eloped because he discussed the discharge of client #3 after client #3 eloped on 03/12/25.

Review on 03/27/25 of the Plan of Protection dated 03/27/25 and completed by the Director/Licensee #1 and Program Director/Licensee #2 revealed:

"What immediate action will the facility take to ensure the safety of the consumers in your care? Plans for Ensuring Compliance with Immediate Review and Assessment Protocols: 1. Training and Development: Grace for the Youth, LLC will implement a quarterly training program conducted by certified trainers specializing in various substance abuse and mental health diagnoses. This training will be mandatory for all group home staff, including Licensed Professionals (LP), Qualified Professionals (QP), Associate Professionals, and Para Professionals. Regular Oversight: The Director, Lawrence Daniels and Program Director Pierre Dickerson will actively oversee compliance with person-centered plans (PCPs) by conducting weekly chart reviews. They will also participate in weekly supervision meetings with the clinical team to address any issues promptly. 3. Incident Report Review: Weekly incident reports will be evaluated by the group home director to ensure adherence to the current PCPs. This process will help identify any discrepancies or patterns that may require adjustments in client care. 4. Continuous Education: All staff members involved in care planning will be required to complete refresher courses on mental health and substance abuse topics quarterly. This ongoing education will help

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maintain high standards of care and ensure that staff are up-to-date with best practices. 5. Designated Compliance Officers. The QP and LP will be assigned as dedicated compliance officers responsible for overseeing the PCPs and Comprehensive Clinical Assessments (CCAs). They will ensure that all documentation is accurate and that any updates to plans are made in a timely manner. 6. CFT Meetings: For Clients who receive a new diagnosis or have additional clinical needs, the clinical team will organize Child and Family Treatment (CFT) meetings promptly. These meetings will include the client, their guardian, therapists and any relevant support personnel to collaboratively update the person-centered plan with appropriate goals and interventions.7. Annual Review Compliance: Grace 4 the Youth, LLC will ensure that each client's CCA is reviewed and updated annually, or sooner if concerns arise. This proactive approach will help maintain the relevance and effectiveness of the client's treatment plan. 8. All staff will be required to document updates to PCPs diligently. This practice will ensure transparency and accountability in client care planning and adjustments. By implementing these strategies, Grace 4 the Youth, LLC aims to provide a structured and supportive environment that meets the needs of each client wile ensuring compliance with established protocols."

"Describe you plans to make sure the above happens. Grace 4 the Youth, LLC Director, Lawrence Daniels and Program Director, Pierre Dickerson will provide certified trainers in various substance abuse and mental health diagnosis quarterly for all group home staff (Licensed Professional, Associate Professional, Qualified Professional and Para Professional). Director Lawrence Daniels and Program Director, Pierre

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V 112	Continued From page 13 Dickerson will oversee and make sure that all PCP's are in compliance by reviewing charts weekly as well as attending weekly supervision meetings with group home clinical team. Weekly incident reports will be reviewed by group home director to ensure it is aligned with current PCP goals and strategies. Group home directors will require all staff involved in care planning to complete mental and substance refresher courses quarterly. Assign the QP and LP as dedicated compliance officers to oversee PCP's and CCA's.The Director will monitor these plans to make sure that the requirements are met." Client #3 was a 17-year old male that was admitted to the facility on 01/31/24 with diagnoses of Disruptive Mood Dysregulation Disorder, Cannabis use Disorder, Attention Deficit Hyperactivity Disorder, Adjustment Disorder, Cocaine Use Disorder, Opioid Disorder and Amphetamine Use Disorder. Client #3 had three separate elopements between 02/17/25 and 03/15/25. The first elopements client #3 was gone for approximately 3 hours. The second elopement he was gone for approximately 6 hours and the third elopement resulted in an approximately 32 hour overnight absence away from the facility with client #3 being located at his father's residence from whom the DSS Legal Guardian did not feel was a safe option for him to live with and client #3 tested positive for marijuana use after his return to the facility. Client #3's PCP had no goals or strategies to address the recent elopements and substance use. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 112		

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V 131	Continued From page 14	V 131		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (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 reviews and interviews, the facility failed to ensure the Health Care Personnel Registry (HCPR) was accessed prior to hiring facility staff affecting 2 of 6 staff (staff #4 and Qualified Professional (QP). The findings are: Review on 03/18/25 and 03/26/25 of staff #4's personnel record revealed: -Date of hire 10/01/24. -No documentation that the HCPR was accessed. Review on 03/18/25 and 03/26/25 of the QP personnel record revealed: -Date of hire 05/31/24. -No documentation that the HCPR was accessed. Interview with Director/Licensee #1 on 03/18/25 revealed: -He accessed the HCPR prior to employment for facility staff. -He had to redo another personnel file for Staff #4. He had misplaced the original file and the	V 131		

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V 131	Continued From page 15 second file was incomplete with the personnel forms needed. -The HCPR was accessed for the QP but he did not know why it was not in her file. -He understood that the HCPR should be completed prior to the hire date and before the staff worked in the facility. No additional documentation for HCPRs received prior to exit date.	V 131		
V 133	G.S. 122C-80 Criminal History Record Check G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT. (a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter. (b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a	V 133		

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criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed,

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V 133	Continued From page 17 except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency. (c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant: (1) The level and seriousness of the crime. (2) The date of the crime. (3) The age of the person at the time of the conviction. (4) The circumstances surrounding the commission of the crime, if known. (5) The nexus between the criminal conduct of the person and the job duties of the position to be filled. (6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed. (7) The subsequent commission by the person of a relevant offense. The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant. (d) Limited Immunity. - A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for:	V 133		

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V 133	Continued From page 18 (1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual. (2) Failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section. (e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders;	V 133		

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V 133	Continued From page 19 Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5. (f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor. (g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met: (1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10. (2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.) This Rule is not met as evidenced by:	V 133		

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V 133	Continued From page 20 Based on record reviews and interviews, the facility failed to ensure the criminal history record check was requested within five business days of making the conditional offer of employment affecting 2 of 6 staff (staff #4 and Qualified Professional (QP). The findings are: Review on 03/18/25 and 03/26/25 of staff #4 personnel record revealed: -Date of hire 10/01/24. -No criminal background check was requested. Review on 03/18/25 and 03/26/25 of the QP personnel record revealed: -Date of hire 05/31/24. -No criminal background check was requested. Interview with the Director/Licensee #1 on 03/18/25 revealed: -He was responsible to request the background checks for all potential staff. -Staff #4 had two files and he had to redo her file because her first file was misplaced with her trainings and her background check. No additional documentation for background checks were received prior to exit date.	V 133		
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	V 366		

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of individuals involved in the incident;
(2) determining the cause of the incident;
(3) developing and implementing corrective 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

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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 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 follows:

(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

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V 366	Continued From page 23 for maintaining and updating the client's treatment plan, if different from the reporting provider; (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 review and interviews, the facility failed to implement written policies governing their response to level II incidents The findings are: No documentation of corrective and preventative measures and persons responsible for implementing corrective and preventative measures to ensure similar incidents did not occur after client #3's elopement on 02/17/25, 03/12/25 and 03/15/25. Interview on 03/19/26 the IRIS representative revealed: -When a facility has a date of 1/1/0001 as the date last submitted it means the report was created but was not officially submitted. Review on 03/18/25 and 03/26/25 of client #3's record revealed: -17 year old male. -Admitted 01/31/24. -Discharged 03/21/25. -Diagnoses of Disruptive Mood Dysregulation Disorder, Cannabis Use Disorder, Attention	V 366		

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V 366	Continued From page 24 Deficit Hyperactivity Disorder, Adjustment Disorder, Cocaine Use Disorder, Opioid Disorder and Amphetamine Use Disorder. Review on 03/18/25 of incomplete Incident Response Improvement System (IRIS) reports for client #3 dated for 02/17/25, 03/12/25 and 03/15/25 revealed: -Incomplete IRIS report dated 1/1/0001 the Client#3 was short termed suspended for 10 days from school for refusing to go to class and eloped from campus. The authorities were contacted on 02/17/25 that included the Guardian of client #3 Department of Social Services, Local Sheriff's Department. The supervisors actions section to include the cause of the incident and preventative measures had not been completed. -Incomplete IRIS report dated 1/01/0001 on 3/12/15 the consumer returned back to his room after taking a shower the Client #3 came out and went into his room. He laid down to watch some television. Client #3 came out and stated 'I am sorry [staff #4] I have to go blow off some steam. He took off walking and was asked to come back. He refused. The supervisors actions section to include the cause of the incident and preventative measures had not been completed. -Incomplete IRIS report dated 1/01/0001 for client #3 on 03/15/25 Client #3 ran out of the group home facility without permission or any warning to staff. The supervisors actions section to include the cause of the incident and preventative measures had not been completed. Interview on 03/19/25 Qualified Professional (QP) revealed: -She completed the incident reports.	V 366		

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V 366	Continued From page 25 -She did not realize the IRIS report was incomplete and was not fully submitted. Interview on 03/19/25 the Associate Professional (AP) revealed: -She assisted the QP with the submission of the IRIS report. -She was never trained on the completion or submission of the IRIS report. Interview on 03/18/25 the Director/Paraprofessional revealed: -Client #3 left the school on 02/17/25 about 12:20pm and returned home on his own the same day about 3:30pm. -Client #3 eloped from the facility on 03/12/25 about 10:12am and returned on his own the same day about 2:11pm -Client #3 eloped from the facility on 03/15/25 about 12:00pm and returned on 03/16/25 about 8:00pm. -The QP and AP were responsible for entering the incident information into IRIS and they were supposed to review and submit it. -He did not realize the report was not fully submitted, due to a section not being completed. -QP had not ensured the report was fully submitted into IRIS. -When he checked client #3's reports in the IRIS, he noticed the supervisor's section was not completed 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	V 367		

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V 367	Continued From page 26 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		

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V 367	Continued From page 27 (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		

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

Interview on 03/19/26 the IRIS representative revealed:
-When a facility has a date of 1/1/0001 as the date last submitted it means the report was created but was not officially submitted.

Review on 03/18/25 of the Incident Response Improvement System (IRIS) revealed:
-No submitted reports for Client #3's elopement from 02/17/25, 03/12/25 and 03/15/25.

Review on 03/18/25 and 03/26/25 of client #3's record revealed:
-16 years old.
-Admitted 01/31/24.
-Discharged 03/21/25.
-Diagnoses of Disruptive Mood Dysregulation Disorder, Cannabis Use Disorder, Attention Deficit Hyperactivity Disorder, Adjustment Disorder, Cocaine Use Disorder, Opioid Use Disorder and Amphetamine Use Disorder.

Review on 03/18/25 of the facility's copy of incomplete Incident Response Improvement System (IRIS) reports for client #3 revealed:

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V 367	Continued From page 29 -Incomplete IRIS report dated 1/1/0001 for client #3. "Date of Incident: 02/17/25. Time of Incident: 12:30pm. Date Provider Learned of Incident 02/17/25 Date provider learned of Incident 02/12/25. Incident comments: Consumer was short termed suspended for 10 days from school for refusing to go to class and walked off campus..." -Incomplete IRIS report dated 1/01/0001: "Date of Incident: 03/12/25. Time of Incident: 10:15am. Date Provider Learned of Incident 03/12/25. Time of Incident 10:15am. Date Provider Learned of Incident 03/12/25. Incident comments: The consumer [Client #3] was discussing with a staff member [Staff #4] about school..." The consumer returned to his room...he was taking a shower...consumer came out went into his room and laid down to watch some television then about 10 minutes later he came out and stated " I am sorry [Staff #4] I have to go blow off some steam and took off walking...Staff asked him to come back and if he needed to talk let them talk about it... the consumer kept on walking." -Incomplete IRIS report dated 1/01/00 for client #3. "Date of Incident: 03/15/25. Time of Incident: 3:45pm. Date Provider Learned of Incident 03/15/25. Incident comments: 03/17/25- Consumer ran out of the group home facility without permission or any warning to staff." Interview on 03/19/25 the Qualified Professional (QP) revealed: -She completed the incident report the on 03/15/25 with the Associate Professional (AP). -She trained online for the IRIS system. -She received a report number for the 03/15/25 incident for elopement. -She did not realize the incident report was	V 367		

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V 367	Continued From page 30 incomplete when submitted in IRIS and the LME/MCO had no record of the incomplete report. Interview on 03/19/25 the AP revealed: -She assisted the QP with the submission of the IRIS report. Interview on 03/18/25 the Director revealed: -The QP and AP were responsible to enter the incident information into IRIS and they were supposed to review and submit the report the Local Management Entity/Managed Care Organization (LME/MCO). -He did not realize the report was not fully submitted into IRIS and incomplete to the LME/MCO, due to a section not being completed. -The QP had not ensured the report was fully submitted into IRIS and that the report was not successfully submitted to the LME. -He would make sure the IRIS reports are completed with future incidents and reported to the LME within 72 hours. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 367		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers,	V 536		

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V 536	Continued From page 31	V 536		

employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented.
(c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered.
(d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
(e) Formal refresher training must be completed by each service provider periodically (minimum annually).
(f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.
(g) Staff shall demonstrate competence in the following core areas:
(1) knowledge and understanding of the people being served;
(2) recognizing and interpreting human behavior;
(3) recognizing the effect of internal and external stressors that may affect people with disabilities;
(4) strategies for building positive relationships with persons with disabilities;
(5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;
(6) recognizing the importance of and

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assisting in the person's involvement in making decisions about their life;
(7) skills in assessing individual risk for escalating behavior;
(8) communication strategies for defusing and de-escalating potentially dangerous behavior; and
(9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).
(h) Service providers shall maintain documentation of initial and refresher training for at least three years.
(1) Documentation shall include:
(A) who participated in the training and the outcomes (pass/fail);
(B) when and where they attended; and
(C) instructor's name;
(2) The Division of MH/DD/SAS may review/request this documentation at any time.
(i) Instructor Qualifications and Training Requirements:
(1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.
(2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.
(3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
(4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant

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to Subparagraph (i)(5) of this Rule.
(5) Acceptable instructor training programs shall include but are not limited to presentation of:
(A) understanding the adult learner;
(B) methods for teaching content of the course;
(C) methods for evaluating trainee performance; and
(D) documentation procedures.
(6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach.
(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.
(8) Trainers shall complete a refresher instructor training at least every two years.
(j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.
(1) Documentation shall include:
(A) who participated in the training and the outcomes (pass/fail);
(B) when and where attended; and
(C) instructor's name.
(2) The Division of MH/DD/SAS may request and review this documentation any time.
(k) Qualifications of Coaches:
(1) Coaches shall meet all preparation requirements as a trainer.
(2) Coaches shall teach at least three times the course which is being coached.
(3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.
(l) Documentation shall be the same preparation

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V 536	Continued From page 34 as for trainers. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 4 of 6 audited staff (staff #1 ,Qualified Professional (QP), Program Director/Licensee #2 , Director/ Licensee #1) received annual training in seclusion, physical restraint, and isolation time out. The findings are: Review on 03/18/25 of staff #1's personnel record revealed: -Hire date of 01/19/24. -Nonviolent Crisis Intervention Plus (NCI Plus) training expired on 02/03/25 in alternatives to restrictive interventions. Interview on 03/26/25 staff #1 stated: -He had previously trained in NCI Plus but could not remember when. Review on 03/18/25 of the QP's personnel record revealed: -Hire date of 05/31/24. -There was no documented NCI Plus training in alternatives to restrictive interventions. Interview on 03/19/25 the QP revealed: -She had been trained in NCI Plus. -The staff received certificates after NCI Plus training. -That her NCI Plus training should be up to date.	V 536		

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V 536	Continued From page 35 -The Director/Licensee #1 and Program Director/Licensee #2 made sure the NCI Plus is up to date. Review on 03/18/25 of the Program Director/Licensee's #2 personnel record revealed: -Hire date of 10/01/23. -NCI Plus training expired on 02/03/25 in alternatives to restrictive interventions. Interview on 03/18/25 the Program Director/Licensee #2 revealed: -The Director had the responsibility to ensure NCI trainings were scheduled and completed. -He did not realize the NCI Plus trainings were expired. -He would make sure that the NCI Plus trainings would be updated. Review on 03/18/25 of the Director/Licensee #1's personnel record revealed: -Hire date of 10/01/23. -NCI Plus training expired on 02/03/25 in alternatives to restrictive interventions. Interview on 03/18/25 Director revealed: -It was his responsibility to make sure the NCI Plus trainings were scheduled staff. -He renewed training once every month or upon availability. -He would make sure that the NCI Plus training would be updated.	V 536		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND	V 537		

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V 537	Continued From page 36 ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions;	V 537		

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V 537	Continued From page 37 (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out.	V 537		

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V 537	Continued From page 38 (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor	V 537		

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V 537	Continued From page 39 training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure of 4 of 6 audited staff (staff #1, Qualified Professional (QP), Program Director/Licensee #2 and Director/ Licensee #1) received annual training in seclusion, physical restraint, and isolation time out. The findings are: Review on 03/18/25 of staff #1's personnel record revealed: -Hire date of 01/19/24. -Nonviolent Crisis Interventions Plus (NCI Plus) training expired on 02/03/25 in seclusion, physical restraint, and isolation time out. Interview on 03/26/25 staff #1 stated:	V 537		

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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 537	Continued From page 40 -He had previously trained in NCI Plus could not remember when. Review on 03/18/25 of the QP's personnel record revealed: -Hire date of 05/31/24. -There was no documented NCI Plus training in seclusion, physical restraint, and isolation time out. Interview on 03/19/25 the QP revealed: -She had been trained in NCI Plus. -The staff received certificates for NCI Plus after training. -That her NCI Plus training should be up to date. -The Director/Licensee #1 and Program Director/Licensee #2 made sure the NCI Plus was up to date for all staff. Review on 03/18/25 of the Program Director/Licensee #2's personnel record revealed: -Hire date of 10/01/23. -NCI Plus training expired on 02/03/25 in seclusion, physical restraint, and isolation time out. Interview on 03/18/25 the Program Director/Licensee #2 revealed: -The Director/Licensee #1 had the responsibility and made sure NCI Plus trainings were completed. -He did not realize the trainings were expired. -He would make sure that the NCI Plus trainings would be updated. Review on 03/18/25 of the Director/Licensee #1's personnel record revealed: -Hire date of 10/01/23. -NCI Plus Training expired on 02/03/25 in seclusion, physical restraint, and isolation time	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-213	A. BUILDING: _____ B. WING _____	R-C 03/27/2025

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V 537	Continued From page 41 out. Interview on 03/18/25 Director/Licensee #1 revealed: -He had the responsibility and made sure NCI Plus trainings were completed for all staff. -He renewed training once every month or upon availability for facility staff. -He would make sure that the NCI Plus training would be updated.	V 537		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview the facility was not maintained in a clean, attractive and orderly manner. The findings are: Observation on 03/19/25 at approximately 10:13am revealed: Living Room Area: -The ceiling fan had 1 of 4 light bulbs that did not work. Kitchen Area: -The light bulb above the stove did not work. -The entire microwave was filled with dried liquid residue splatters. Room 1 shared by Client #3 and Client #4: -The brown carpet was soiled with a dark residue	V 736		

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V 736	Continued From page 42 over the entire carpet with small pieces of paper and lint of various sizes. Room 2 shared by Client #1 and Client #2: -The ceiling fan had 1 of 4 light bulbs that did not work. -The brown carpet was soiled with a dark residue over entire carpet with small pieces of paper and lint of various sizes. Hallway Bathroom: -The knob for the hot water on the left side of sink was broken and did not work when turned on the water did not come out. -There was a light green residue on the sink fixture that covered the front area of fixture. Vacant Bedroom 3: - Multiple areas on the entire carpet were soiled with a dark residue and various size pieces of dark colored unknown particles of various sizes covered the entire floor. -The entire room had baseboards in multiple areas with white paint scrapes that showed the darker paint underneath that were approximately 3 to 5 inches. Bathroom in vacant bedroom #3: -The mirror hanging on the door was covered with a white film residue and could not show a clear reflection in mirror. Interview on 03/27/25 the Program Director revealed: -The carpet was cleaned by a professional every three months. -The carpet was cleaned a week after the survey, "I can't remember the exact date the carpet was cleaned." -Staff was reminded to have the clients eat at the	V 736		

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V 736	Continued From page 43 dining room table instead of their room. -The light bulbs that did not work will be changed. Interview on 03/27/25 the Director revealed: -A professional shampooed and cleaned the carpet every three months. -The carpet was cleaned a week after the last survey in the month October 2024. -The house keeper cleaned twice a month. She cleaned on the 03/04/25 and 03/21/25. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		
V 784	27G .0304(d)(12) Therapeutic and Habilitative Areas 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (d) Indoor space requirements: Facilities licensed prior to October 1, 1988 shall satisfy the minimum square footage requirements in effect at that time. Unless otherwise provided in these Rules, residential facilities licensed after October 1, 1988 shall meet the following indoor space requirements: (12) The area in which therapeutic and habilitative activities are routinely conducted shall be separate from sleeping area(s). This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure the area in which therapeutic and habilitative activities were separate from sleeping areas. The findings are: Review on 3/18/25 of client #3's record revealed:	V 784		

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V 784	Continued From page 44 -15 years old. -Admitted 01/31/24. -Discharged 03/21/25. -Diagnoses of Disruptive Mood Dysregulation Disorder, Cannabis Use Disorder, Attention Deficit Hyperactivity Disorder, Adjustment Disorder, Cocaine Use Disorder, Opioid Use Disorder and Amphetamine Use Disorder. Review on 03/18/25 of facility documentation revealed client #3 had eloped from the facility on 03/15/25 and returned to the facility 03/16/25 at approximately 8:00pm. Interview on 3/18/25 Client #3 declined to answer some questions. He became disengaged, throwing hands up in air, would not answer questions and just looking around. Interview on 3/18/25 the Director/Licensee #1 stated: -Client #3 eloped from the facility on 3/15/25 about 12:00pm and returned on 3/16/25 about 8:00pm. -The Program Director and staff #4 had worked at the facility overnight on 3/16/25 when client #3 slept in the living room. -Client #3 slept only slept in the living room overnight on 03/16/25 on a cot. -He "felt more comfortable with [client #3] in the living room" because of the elopement situation. -He had client #3 sleep in the "front room" so staff could monitor him to prevent him from eloping again.	V 784		