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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on 4/8/25. The complaint was substantiated (Intake #NC00227199),The complaint was unsubstantiated (Intake #NC00226649)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 has a current census of 3. The survey sample consisted of audits of 3 current clients.	V 000		
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents;	V 296		

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V 296	Continued From page 1 (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan. This Rule is not met as evidenced by: Based on record reviews, observation and interviews, the facility failed to ensure the required minimum number of two direct care staff were present when three children or adolescents were present and awake. The findings are: Review on 3/20/25 of client #1's record revealed: -An admission date of 2/9/24. -Age 16 years. -Diagnoses of Major Depressive Disorder,Recurrent Moderate; Generalized Anxiety Disorder; Oppositional Defiant Disorder.	V 296		

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V 296	Continued From page 2 Review on 3/20/25 of client #2's record revealed: -An admission date of 2/9/24. -Age 14 years. -Diagnoses of Reactive Attachment Disorder, Conduct Disorder, Fetal Alcohol Syndrome. Review on 3/20/25 of client #3's record revealed: -An admission date of 11/5/24. -Age 9 years. -Diagnoses of Attention Deficit-Hyperactivity Disorder, Oppositional Defiant Disorder, Post-Traumatic Stress Disorder. Observation on 3/30/25 at approximately 2:43pm revealed: -Associate Professional arrived alone to pick up client #1 and client #3 from the day treatment program. Interview on 3/20/25 with client #1 revealed: -"[Staff #3] works the night shift Saturday night to Monday, she works by herself." -Had no concerns with Staff #3's disability (prosthetic leg and use of crutches) since all clients were asleep during her shift. -"Anyone (staff) who is working on night shift works by themselves, [Licensee/Executive Director/Qualified Professional (Licensee/ED/QP), Staff #1, Staff #5]." -"Only one person (staff) drives us (clients) on the van." Interview on 3/13/25 with client #2 revealed: -There are usually 2 staff on shift. -Staff #3 worked the night shift alone, "[Staff #3] is on crutches, she is a very strong woman." -Had no concerns about Staff #3's working alone, "we're (clients) all sleeping."	V 296		

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V 296	Continued From page 3 Interview on 3/20/25 with client #3 revealed: -"Everyone (staff) on night shift works alone." -"Only one person (staff) drives us (clients) to school." Interview on 3/14/25 with the Department of Social Services Investigator revealed: -"I have been there (facility) and there was only one staff there. On 2/4/25 [Staff #1] was there. Another staff and the Licensee (Licensee/ED/QP) arrived while I was there (facility, 2/4/25). I think she (Staff #1) called him (Licensee/ED/QP)." -"When I visited (facility) on 3/4/25 at supper...there was [Staff #1] there making supper (for clients), getting meds (medications), and I didn't see or hear another staff person (in the facility)." Interview on 3/14/25 with Former Staff #6 revealed: -"[Staff #3] worked on night shift by herself; they (clients) slept but if anything went on (crisis) they (clients) would have gotten away (ran away), it is a level 3 facility...a handicapped person, on 3rd shift, working alone." -"We (staff) are trained for restraints, but what was [Staff #3] going to do if she were by herself; how is that even possible?" Interview on 4/7/25 with Staff #1 revealed: -"There are usually 2 staff working; having only one staff, it has happened. I can't tell you the day." -"If somebody (staff) calls in or they (facility) are short staffed, it has happened (one staff). They (facility) have problems filling in the gaps." -"No one (staff) works with [Staff #3]; she works alone and is handicap, and someone should because she walks with two crutches and wouldn't be able to do anything if something	V 296		

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happens."
-"No one (staff) works with third (shift), they (staff) work alone, whoever (staff) works third works alone."
-Had been in the facility during the day when there was only one staff, "that would be when they (staff) were not able to get noone (staff to cover shift)."
-New staff had worked alone while completing training.

Attempted interview on 3/21/25 and 4/4/25 with Staff #2 was unsuccessful. Left voice messages each attempt, but did not receive a returned call.

Interview on 3/20/25 with Staff #3 revealed:
-"I work third shift on Saturday and Sunday only, unless they (facility) need me."
-"No other staff works with me; I check on them (clients) while they're sleep."
-"I take them to school on Monday morning; no other staff ride with me when I take them to school."
-"If I work during the day shift, there's someone working with me, and one person's working at night, because the girls (clients) are sleep."
-"I walk with crutches, I was told I would never walk again after my accident. Just because I walk on crutches doesn't mean I can't do anything. I can't carry stuff, but I can do just about anything anyone else can do.
-"I haven't had any problems. If I need assistance, there are numbers I can call for help."
-Had not had an occasion to need assistance or help.

Interview on 4/8/25 with the Licensed Professional/Licensed Clinical Mental Health Counselor Associate revealed:
-Usually 2 staff working on shifts.

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V 296	Continued From page 5 -Had never observed 1 staff working alone. -Was not aware that Staff #3 had a disability or that she was working third shift alone, "She is gone by the time I get , but I would say that is a valid concern" as it related to a crisis. -"There was an occasion when I arrived (at the facility) and there was only one staff on the shift, and then before I left, another staff showed up; I can't identify a specific time (date), but there was never an entire shift when I saw someone (staff) working alone." Interview on 3/21/25 with the Associate Professional revealed: -The facility was short staffed and only 1 staff worked on third shift. -Staff #3 was the only staff that worked alone, "depending on the time; overnight there is just one staff; it's (schedule) staggered" and if anyone is working alone it's not for the whole shift. -Clients were asleep during the third shift and there had been no problems. -Two staff worked during day "unless someone is late or unable to make the shift and we have to find other staff." -When staff transported clients, "there is usually two (staff); drop offs (school) in the morning sometimes its one." -"Finding reliable, trustworthy staff is the biggest concern; trying to find consistency (with staff) has been the hard part." Interview on 4/7/25 with the Associate Professional revealed: -Was responsible for staffing each shift. -"There's usually two (staff on shift), but like I said if we have people who miss their shift or emergencies, we scramble to get people in to cover shifts."	V 296		

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V 296	Continued From page 6 Attempted review of staff schedules on 4/7/25 was unsuccessful due to not receiving prior to exiting this survey. Interview on 3/13/25 with the Licensee/ED/QP revealed: -Shifts are 8am to 8pm and 8pm to 8am. -"[Staff #3] walks with crutches every so often because she has a fake leg. She was (working) with another staff and the clients we have currently have behaviors that are more manageable; they (clients) have more attitudes. She (Staff #3) mostly works the overnight shift when the girls (clients) are sleep." -"I have staff that come in about 2:30pm that pick up the girls (clients from school) and then they (other staff) will come in." -"Different staff work that shift (third) with [Staff #3]." -There had been no incidents or crisis. Interview on 4/8/25 with the Licensee/ED/QP revealed: -Facility was short staffed and was working to hire and train new staff. -Was not aware there needed to be 2 staff on every shift. -Was not aware 2 staff needed to be on shift with a new staff in training. -Had been in transition (since November/December 2024) with staff turnover and had difficulty getting coverage for each shift. -Would ensure there were 2 staff on every shift.	V 296		
V 364	G.S. 122C- 62 Additional Rights in 24 Hour Facilities § 122C-62. Additional Rights in 24-Hour Facilities.	V 364		

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V 364	Continued From page 7 (a) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-61, each adult client who is receiving treatment or habilitation in a 24-hour facility keeps the right to: (1) Send and receive sealed mail and have access to writing material, postage, and staff assistance when necessary; (2) Contact and consult with, at his own expense and at no cost to the facility, legal counsel, private physicians, and private mental health, developmental disabilities, or substance abuse professionals of his choice; and (3) Contact and consult with a client advocate if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each adult client may exercise these rights at all reasonable times. (b) Except as provided in subsections (e) and (h) of this section, each adult client who is receiving treatment or habilitation in a 24-hour facility at all times keeps the right to: (1) Make and receive confidential telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over therapies; (3) Communicate and meet under appropriate supervision with individuals of his own choice upon the consent of the individuals; (4) Make visits outside the custody of the facility unless: a. Commitment proceedings were initiated as the result of the client's being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the	V 364		

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respondent was found not guilty by reason of insanity or incapable of proceeding;
b. The client was voluntarily admitted or committed to the facility while under order of commitment to a correctional facility of the Division of Adult Correction of the Department of Public Safety; or
c. The client is being held to determine capacity to proceed pursuant to G.S. 15A-1002;
A court order may expressly authorize visits otherwise prohibited by the existence of the conditions prescribed by this subdivision;
(5) Be out of doors daily and have access to facilities and equipment for physical exercise several times a week;
(6) Except as prohibited by law, keep and use personal clothing and possessions, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002;
(7) Participate in religious worship;
(8) Keep and spend a reasonable sum of his own money;
(9) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes; and
(10) Have access to individual storage space for his private use.
(c) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-57 and G.S. 122C-59 through G.S. 122C-61, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to have access to proper adult supervision and guidance. In recognition of the minor's status as a developing individual, the minor shall be provided opportunities to enable him to mature physically, emotionally, intellectually, socially, and vocationally. In view of the physical, emotional, and intellectual immaturity of the minor, the

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V 364	Continued From page 9 24-hour facility shall provide appropriate structure, supervision and control consistent with the rights given to the minor pursuant to this Part. The facility shall also, where practical, make reasonable efforts to ensure that each minor client receives treatment apart and separate from adult clients unless the treatment needs of the minor client dictate otherwise. Each minor client who is receiving treatment or habilitation from a 24-hour facility has the right to: (1) Communicate and consult with his parents or guardian or the agency or individual having legal custody of him; (2) Contact and consult with, at his own expense or that of his legally responsible person and at no cost to the facility, legal counsel, private physicians, private mental health, developmental disabilities, or substance abuse professionals, of his or his legally responsible person's choice; and (3) Contact and consult with a client advocate, if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each minor client may exercise these rights at all reasonable times. (d) Except as provided in subsections (e) and (h) of this section, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to: (1) Make and receive telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Send and receive mail and have access to writing materials, postage, and staff assistance when necessary; (3) Under appropriate supervision, receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however	V 364		

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visiting shall not take precedence over school or therapies;
(4) Receive special education and vocational training in accordance with federal and State law;
(5) Be out of doors daily and participate in play, recreation, and physical exercise on a regular basis in accordance with his needs;
(6) Except as prohibited by law, keep and use personal clothing and possessions under appropriate supervision, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002;
(7) Participate in religious worship;
(8) Have access to individual storage space for the safekeeping of personal belongings;
(9) Have access to and spend a reasonable sum of his own money; and
(10) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes.
(e) No right enumerated in subsections (b) or (d) of this section may be limited or restricted except by the qualified professional responsible for the formulation of the client's treatment or habilitation plan. A written statement shall be placed in the client's record that indicates the detailed reason for the restriction. The restriction shall be reasonable and related to the client's treatment or habilitation needs. A restriction is effective for a period not to exceed 30 days. An evaluation of each restriction shall be conducted by the qualified professional at least every seven days, at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's record. Restrictions on rights may be renewed only by a written statement entered by the qualified professional in the client's record that states the reason for the renewal of the restriction. In the case of an adult client who has not been adjudicated incompetent,

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V 364	Continued From page 11 in each instance of an initial restriction or renewal of a restriction of rights, an individual designated by the client shall, upon the consent of the client, be notified of the restriction and of the reason for it. In the case of a minor client or an incompetent adult client, the legally responsible person shall be notified of each instance of an initial restriction or renewal of a restriction of rights and of the reason for it. Notification of the designated individual or legally responsible person shall be documented in writing in the client's record. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure privacy. The findings are: Observation at approximately 1:44 pm on 3/13/25 revealed: -Cameras were located in the back upper right corner of the staff office, in the common area, and facing the front vestibule and hallway of the facility. Interview on 3/20/25 and 4/8/25 with client #1 revealed: -"They (Staff) listen to all our (clients) phone calls." -"The therapy sessions with [Licensed Professional/Licensed Clinical Mental Health Counselor Associate (LP/LCMHCA)] are not private, he (Licensee/Executive Director/Qualified Professional (Licensee/ED/QP)) listens and the door is kept open; that's why I ask her (LP/LCMHCA) if we can take a walk or something."	V 364		

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V 364	Continued From page 12 -All telephone calls were monitored and had to be placed on speaker so staff could listen. -"I'm never able to talk to my social worker (legal guardian) without someone (staff) listening in; he (Licensee/ED/QP) opens our mail, too. My calls with my grandfather are supposed to be on speaker." Attempted interview on 3/20/25 and 4/8/25 with Client #2 who was not in the facility. She was at school (3/20/25) and visiting with family out of town (4/8/25). Interview on 3/20/25 and 4/8/24 with client #3 revealed: -Therapy sessions were done in the staff office where there was a camera and the office door was left open. -All calls to family were monitored. -The call was placed on speaker and staff was present to listen on each call, "they (staff) sits right beside you when you're on the phone." Interview on 3/14/25 with the Department of Social Services (DSS) Investigator revealed: -"My only concern would be that staff talk over clients while they're on the phone with parents." -[Client #3]'s guardian (mother) expressed concern that [Former Staff #3] would talk over kids (clients) when they were on the phone." Interview on 4/7/25 with client #3's DSS Legal Guardian revealed: -"She's (client #3) not able to speak confidentially, when she talks on the phone she has to go to common area, we'll hear staff or other clients talking in the back (background)." -"She's (client #3) not allowed to be in her room to have a private conversation, they read her mail before she gets it. She's not at will (free) to say	V 364		

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V 364	Continued From page 13	V 364		

what's going on; the only way we've (parents) gotten information from her (client #3) was during her home visits.
-"I was told by staff (anonymous) that he (Licensee/ED/QP) creepily watches the cameras and staff (anonymous) has said they don't want to speak freely because of retaliation. I visually saw this when I was using a staff's (anonymous) phone to talk to him (Licensee/ED/QP) because I was having trouble reaching him. The staff (anonymous) had to turn their back to the camera (facility) or whisper so he (Licensee/ED/QP)wouldn't be able to hear. They (staff) have to get out of earshot of the outside cameras to talk outside."

Interview on 4/7/25 with Staff #1 revealed:
-Had no concerns about cameras in facility as a safety measure and felt clients were able to speak freely.
-Had monitored clients' telephone calls as it was the facility's policy.
-Telephone calls are made in the common area.

Interview on 4/8/25 with the LP/LCMHCA revealed:
-Was aware of the camera in the staff office and she had always met clients with the office door closed.
-Was not comfortable meeting for therapy in clients' bedrooms.
-Clients were given the choice to meet in the staff office or take a walk.
-Would discuss alternative meeting spaces for therapy with Licensee/ED/QP.
-"Calls to family are monitored. I will be in the office (staff office), and staff and client on the phone are in the common area. One of the girls (clients) is a pacer (client #2), so when she (client #2) walks by the office I can hear the person on

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V 364	Continued From page 14 the other line, the phone is on speaker. I can't always hear the other person, but I can hear [client #2]. I guess the walls are thin." -"[Client #1]'s calls with her grandfather have to be monitored per her social worker (DSS Legal Guardian) and are on speaker phone. Pretty sure, fairly certain that [client #3]'s calls are not on speaker, her calls are a specific time. I want to say they're not speaker, but I don't know that for certain." -Had addressed privacy issues with her licensed supervisor and planned to discuss further with supervisor and with Licensee/ED/QP. -Planned to speak with Licensee/ED/QP about client privacy and alternative meeting spaces for client privacy (therapy). Interview on 4/8/25 with the Licensee/ED/QP revealed: -Had staff to monitor client phone calls to "make sure they (clients) don't get agitated" and, if necessary the call would be interrupted, if needed due to client agitation. -"I tell staff they are not to intervene (during the call); their (clients) guardians are aware." -Had opened and reviewed clients' mail before giving it to them. -Would review the policy and update client treatment plans as needed. -Had removed the camera from the staff office (4/8/25).	V 364		
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	V 366		

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V 366	Continued From page 15 response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective 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	V 366		

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V 366	Continued From page 16 review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or 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;	V 366		

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V 366	Continued From page 17 (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (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 reviews and interviews the facility failed to implement written policies for level I and II incidents and failed to issue written preliminary findings of facts within five working days of the incident to the LME. The findings are: Review on 3/20/25 of client #3's record revealed: -An admission date of 11/5/24. -Age 9 years. -Diagnoses of Attention Deficit-Hyperactivity Disorder, Oppositional Defiant Disorder, Post-Traumatic Stress Disorder. Review on 3/13/25 of the facility's incident reports from 1/1/25 to 3/13/25 revealed: -No documentation of client #3's aggressive behaviors, kicking staff (Staff #1) and kicking the walls in her bedroom on 3/4/25 which resulted in Staff #1 performing a restraint. Review on 3/13/25 of the North Carolina Incident Response Improvement System (IRIS) from	V 366		

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V 366	Continued From page 18 1/1/25 to 3/13/25 revealed: -No submission of an incident report of client #3's aggressive behaviors, kicking staff (Staff #1) and kicking the walls in her bedroom on 3/4/25 which resulted in Staff #1 performing a restraint. Interview and observation on 4/8/25 at approximately 3:46pm with client #3 revealed: -She was angry with her mom and Staff #1 on 3/4/25. -"I was in my room, I was kicking the walls in my room, kicking her (Staff #1). -I was restrained, she (Staff #1) folded my arms like this and was pulling them tight, it was real tight. It lasted about 10 minutes." -Client #3 demonstrated how the hold was performed, with Staff #1 facing the client, client's arms criss-crossed across the front of client's body and Staff #1 was holding client's hands down on the sides of client's body. -"He (Licensee/Executive Director/Qualified Professional (Licensee/ED/QP)) yelled at me already so I don't want him to know; I don't want him to yell at me again." Interview on 4/7/25 with client #3's mother revealed: -Was aware of the details of the 3/4/25 incident between staff #1 and client #3 that resulted in restraint. -"...she (client #3) was mad at me and they (facility) gave her a consequence. I had planned to take her dress shopping for an (upcoming) event. The incident started at day treatment (3/4/25) and because of her behavior there (day treatment), I told her 'I'm not taking you shopping this weekend' and that's why she was mad. That's the only time I'm aware she has been physically aggressive with staff. She kicked staff (staff #1), was kicking her walls."	V 366		

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V 366	Continued From page 19 Interview on 4/7/25 with Staff #1 revealed: -Recalled the 3/4/25 incident of aggression with client #3, -"I didn't pay it no attention because she's little, yes she kicked me but she's nine (years old); she has tantrums..." -"She (client #3) was already upset, her mom had told her 'no' and she got mad and took it out on me." -"When she (client #3) has incidences of yelling, kicking and screaming it's because she doesn't get her way. I just put her in a little bear hug and carried her to her room. You know how you just hold their hands. I was standing behind her, her hands were on her side; it was just a couple of minutes." -"[Client #3's Mother] knows about the incident (3/4/25)." -"They (Associate Professional (AP) and Licensee/ED/QP) document it, I don't document it." Interview on 4/8/25 with the Licensed Professional/Licensed Clinical Mental Health Counselor Associate revealed: -There had been no incidents at the facility in the past 3 months. -Had not witnessed incidents of aggression or destruction of property with clients. -Was not aware of the incident (3/4/25) with client #3 kicking staff (#1) and restraint by Staff #1. -"...she (client #3) has, we'll call it, outbursts, tantrums but never an incident that she kicked a staff, not that was mentioned to me...I should be aware." Interview on 3/21/25 with the AP revealed: -No incidents or restraints in the last 3 months.	V 366		

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V 366	Continued From page 20 Further interview on 4/7/25 with the AP revealed: -"We don't really have big incidents, like aggressive behavior or destruction of property." -Staff would report incidents in the daily shift notes. -Incidents would be documented in the daily note. -"Like when a client (#3) kicked staff (#1) (3/4/25), that should be in the shift note." -Did not know if an incident report had been submitted, " I don't think she (Staff #1) did a level one report; I would have to look. I can call her (Staff #1), find those notes and send them..." -Did not know where to document incidents. -Did not receive incident report before exiting the survey. Interview on 4/8/25 with Licensee/ED/QP revealed: -Shift staff reported incidents to Licensee/ED/QP or AP. -Was responsible for completing and submitting incident reports, along with AP. -Was aware of the 3/4/25 incident with client #3 and Staff #1. -"I don't feel like I yell, but I am from New York and my voice may be loud and could be perceived as yelling, that's why I also did the de-escalation training. When I'm stern, they (clients) may perceive that I am yelling, but I don't feel like I'm raising my voice. I'm being stern." -Was not aware a restraint had been performed by Staff #1. -Staff #1 did not report that a restraint had been performed during the 3/4/25 incident. -The facility had not follow up with client #3 and attended to her health and safety needs. -Had not documented level I incident report and had not submitted a level II report in IRIS in required timeframe. -Did not complete the level I incident report or	V 366		

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V 366	Continued From page 21 3/4/25 incident until 4/7/25. -No documentation an investigation was completed. -There was no documentation preliminary findings of fact within 5 working days of knowledge of the incident. -Did not know he had to submit the preliminary findings of fact within 5 working days of knowledge of the incident. -Did not document of findings of the investigation, corrective and preventative measures, and person(s) responsible for implementation of corrective and preventative measures.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident;	V 367		

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V 367	Continued From page 22 (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: (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	V 367		

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V 367	Continued From page 23 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. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure a Level II incident report was submitted to the Local Management Entity/Managed Care (LME/MCO) Organization within 72 hours. The findings are: Review on 3/20/25 of client #3's record revealed: -An admission date of 11/5/24. -Age 9 years. -Diagnoses of Attention Deficit-Hyperactivity Disorder, Oppositional Defiant Disorder, Post-Traumatic Stress Disorder. Review on 3/13/25 of the facility's incident reports	V 367		

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V 367	Continued From page 24 from 1/1/25 to 3/13/25 revealed: -No documentation of client #3's aggressive behaviors, kicking staff (Staff #1) and kicking the walls in her bedroom on 3/4/25 which resulted in Staff #1 performing a restraint. Review on 3/13/25 of the North Carolina Incident Response Improvement System (IRIS) from 1/1/25 to 3/13/25 revealed: -No submission of an incident report of client #3's aggressive behaviors, kicking staff (Staff #1) and kicking the walls in her bedroom on 3/4/25 which resulted in Staff #1 performing a restraint. Interview and observation on 4/8/25 at approximately 3:46pm with client #3 revealed: -She was angry with her mom and Staff #1 on 3/4/25. -"I was in my room, I was kicking the walls in my room, kicking her (Staff #1). -I was restrained, she (Staff #1) folded my arms like this and was pulling them tight, it was real tight. It lasted about 10 minutes." -Client #3 demonstrated how the hold was performed, with Staff #1 facing the client, client's arms criss-crossed across the front of client's body and Staff #1 was holding client's hands down on the sides of client's body. -"He (Licensee/Executive Director/Qualified Professional (Licensee/ED/QP)) yelled at me already so I don't want him to know; I don't want him to yell at me again." Interview on 4/7/25 with client #3's mother revealed: -Was aware of the details of the 3/4/25 incident between staff #1 and client #3 that resulted in restraint. -"...she (client #3) was mad at me and they (facility) gave her a consequence. I had planned	V 367		

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V 367	Continued From page 25 to take her dress shopping for an (upcoming) event. The incident started at day treatment (3/4/25) and because of her behavior there (day treatment), I told her 'I'm not taking you shopping this weekend' and that's why she was mad. That's the only time I'm aware she has been physically aggressive with staff. She kicked staff (staff #1), was kicking her walls." Interview on 4/7/25 with Staff #1 revealed: -Recalled the 3/4/25 incident of aggression with client #3, -"I didn't pay it no attention because she's little, yes she kicked me but she's nine (years old); she has tantrums..." -"She (client #3) was already upset, her mom had told her 'no' and she got mad and took it out on me." -"When she (client #3) has incidences of yelling, kicking and screaming it's because she doesn't get her way. I just put her in a little bear hug and carried her to her room. You know how you just hold their hands. I was standing behind her, her hands were on her side; it was just a couple of minutes." -"[Client #3's Mother] knows about the incident (3/4/25)." -"They (Associate Professional (AP) and Licensee/ED/QP) document it, I don't document it." Interview on 4/8/25 with the Licensed Professional/Licensed Clinical Mental Health Counselor Associate revealed: -There had been no incidents at the facility in the past 3 months. -Had not witnessed incidents of aggression or destruction of property with clients. -Was not aware of the incident (3/4/25) with client #3 kicking staff (#1) and restraint by Staff #1.	V 367		

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V 367	Continued From page 26 -"...she (client #3) has, we'll call it, outbursts, tantrums but never an incident that she kicked a staff, not that was mentioned to me...I should be aware." Interview on 3/21/25 with the AP revealed: -No incidents or restraints in the last 3 months. Further interview on 4/7/25 with the AP revealed: -"We don't really have big incidents, like aggressive behavior or destruction of property." -Staff would report incidents in the daily shift notes. -Incidents would be documented in the daily note. -"Like when a client (#3) kicked staff (#1) (3/4/25), that should be in the shift note." -Did not know if an incident report had been submitted, " I don't think she (Staff #1) did a level one report; I would have to look. I can call her (Staff #1), find those notes and send them..." -Did not know where to document incidents. -Did not receive incident report before exiting the survey. Interview on 4/8/25 with Licensee/ED/QP revealed: -Shift staff reported incidents to Licensee/ED/QP or AP. -Was responsible for completing and submitting incident reports in IRIS, along with AP. -Was aware of the 3/4/25 incident with client #3 and Staff #1. -"I don't feel like I yell, but I am from New York and my voice may be loud and could be perceived as yelling, that's why I also did the de-escalation training. When I'm stern, they (clients) may perceive that I am yelling, but I don't feel like I'm raising my voice. I'm being stern." -Was not aware a restraint had been performed by Staff #1.	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-399	A. BUILDING: _____ B. WING _____	R-C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 367	Continued From page 27 -Staff #1 did not report that a restraint had been performed during the 3/4/25 incident. -Had had not submitted a level II report in IRIS. -Planned to submit incident report in IRIS.	V 367		