STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			_		l R	
		MHL0601482	B. WING		I	7/2025
NAME OF D	ROVIDER OR SUPPLIER	et.	RESS, CITY, STA	TE ZIR CODE	•	
NAME OF FI	ROVIDER OR SUFFLIER		TERS LANE	TE, ZIF GODE		
CHRIST C	HURCH COTTAGE THO	MPSON CHILD & FA	6, NC 28105			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	completed on 5/7/25. substantiated (Intake Deficiencies were cited This facility is licensed category: 10A NCAC Residential Treatmen Adolescents.	#NC00228552). ed. d for the following service 27G .1800 Intensive t for Children and				
		d for 9and has a current rey sample consisted of ents, 2 former clients.				
V 105	27G .0201 (A) (1-7) G	Soverning Body Policies	V 105			
	10A NCAC 27G .0202 POLICIES (a) The governing body facility or service shall written policies for the (1) delegation of man operation of the facility (2) criteria for admiss (3) criteria for dischard (4) admission assess (A) who will perform the (B) time frames for confusion (5) client record management (A) persons authorized (B) transporting record (C) safeguard of record defacement or use by (D) assurance of record authorized users at all (E) assurance of confusion (6) screenings, which	dy responsible for each I develop and implement following: agement authority for the dy and services; ion; ge; ments, including: the assessment; and completing assessment. agement, including: do document; ds; rds against loss, tampering of unauthorized persons; ord accessibility to Il times; and fidentiality of records.				

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
74151 2741	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _			
MHL0601482		MHL0601482	B. WING		R 05/07/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CHRIST C	HURCH COTTAGE THO	MPSON CHILD & FA	TERS LANE S, NC 28105			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLE	ETE
V 105	(B) an assessment of can provide services needs; and (C) the disposition, in recommendations; (7) quality assurance activities, including: (A) composition and a assurance and quality (B) written quality assimprovement plan; (C) methods for moniquality and appropria including delineation utilization of services; (D) professional or clia requirement that staprofessionals and proshall be supervised be that area of service; (E) strategies for imp (F) review of staff quadetermination made to treatment/habilitation (G) review of all fatality were being served in residential programs (H) adoption of stand and programmatic per applicable standards purpose, "applicable means a level of com reference to the prevent of the prev	twhether or not the facility to address the individual's cluding referrals and and quality improvement activities of a quality improvement committee; surance and quality toring and evaluating the teness of client care, of client outcomes and inical supervision, including aff who are not qualified evide direct client services y a qualified professional in roving client care; alifications and a o grant privileges: ties of active clients who area-operated or contracted at the time of death; ards that assure operational erformance meeting of practice. For this standards of practice" petence established with	V 105			

Division of Health Service Regulation

STATE FORM 6899 KY5S11 If continuation sheet 2 of 14

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
							R	
		MHL0601482		B. WING		I	≺ 07/2025	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
CUDICT	UUDCU COTTACE TUOI	MDCON CUILD 8 FA	6722 ST PE	TERS LANE				
CHRIST C	HURCH COTTAGE THO	WPSON CHILD & FA	MATTHEW	S, NC 28105				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE	
V 105	Continued From page	e 2		V 105				
	Continuou i rom page	<i>.</i>						
	This Rule is not met	as evidenced by:						
	Based on record revie	ew and interview, the fa	acility					
	failed to implement a	doption of standards th	at					
	assure operational ar	nd programmatic						
performance meeting applicable standards of								
	practice for therapeut	tic services. The finding	js –					
	are:							
	Review on 5/3/25 of F	Former Client (FC) #4's	3					
	record revealed:							
	- Admission date 2/12	2/25;						
	- Age 15 years;							
	- Diagnoses Attention		_					
		Type; Intermittent Explo	osive					
	Disorder; Dysthymic I							
	- Discharge date 3/28	3/25.						
	Poviou on E/1/25 -f +	ha facility'a Internal						
	Review on 5/1/25 of t	ne facility's Internal october 1, 2024-May 1,	2025					
	revealed:	rolobel I, 2024-IVIAY I,	2020					
		t dated 3/10/25 by the						
	Quality Improvement	-						
		gations: "PQI was notifi	ed via					
		veral complaints made						
	client [FC #4], toward		~ y					
		, [therapist]. The comp	laints					
		լ, լելելերել։ Դոծ ժժութ l to [Supervisor/Qualifie						
	, , ,	Christ Church Superviso						
	client [FC #4], on 3/4/		,					
		Supervisor], also provid	ed an					
		concerns after she me						
	[FC #4].							
		cerns came from [Clini	cal					
	Supervisor's email:							

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STATE FORM 6899 KY5S11 If continuation sheet 3 of 14

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
				71. BOILBING.			
		MHL0601482		B. WING		05/07	/2025
NAME OF D	ROVIDER OR SUPPLIER		STREET AND	RESS, CITY, STA	TE ZIR CODE		
NAIVIL OI I	NOVIDEN ON 301 1 EIEN			TERS LANE	II., ZII CODE		
CHRIST C	HURCH COTTAGE THOM	MPSON CHILD & FA		S, NC 28105			
(X4) ID		ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		COMPLETE DATE
V 105	Continued From page	3		V 105			
V 105	- [Therapist] sho computer of a boy wh and emphasized that #4] claimed that [Then him if he did not mana - During a thera when asked about his wanted to go home, a that his childhood was focus on other goals.' - 'The client also Wednesday, the thera and insisted he take a which he refused. The therapist raised her wowalk, but he declined - 'The client repuplaced a piece of mai in an aggressive mana - The following conc [Supervisor/QP] emai - [Therapist] que to change his medicar his perception was insithat's not a reason to It's probably not the mana - The same conconthe computer and were also in [Supervisor - Evidence/Document weekly therapy notes to Thompson. The the indicated that [Therapa a boyfriend killing his mentions that the interawareness about alco	owed him an article on o killed his college girlf could be [FC #4]. 'Clier rapist] told him that worage his anger.' py session with [Theraps goals, [FC #4] stated and the therapist responsion over and he needed to reported that on apist entered the cottage at the the client conveyed that the client conveyed that the client conveyed that the therapist orted that the therapist I from his mother in his ner.' cerns came from It estioned why he requestion and her response it change your medication edication's fault.' cerns regarding the articlient's goal to go homesor/QP] email." Its Reviewed- "There we since [FC #4's] admission of the proposed of the	friend int [FC uld be pist], 'He inded io ge her, he he lap sted from tated, cons. cle ee ere sion bout	V 105			
	_	ist] shared her laptop b	oriefly				
		evealed that [Therapist]				

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STATEMENT	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
VIAD LEWIN (J. CONNECTION	IDENTIFICATION NOWIDER.	A. BUILDING: _		COWI LL TED	
					R	
		MHL0601482	B. WING		05/07/2025	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		6722 ST F	PETERS LANE			
CHRIST C	HURCH COTTAGE THO	MPSON CHILD & FA	VS, NC 28105			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
				DEI IOIENOT)		
V 105	Continued From page	e 4	V 105			
	approached [FC #4] a	a few times, but [FC #4] did				
		his seat. At approximately				
		an be seen dropping a letter				
		d then walking awayQIS				
	reviewed [Therapist]'s					
	• • •	her interactions with clients				
	and staff. She has be					
	communication issue	s with the cottage				
	supervisor, her profes	ssionalism during a CFT				
	(Child Family Team M	leeting) a few months ago,				
	and, most recently, he	er interactions with clients.				
	[Therapist]'s Relias tr	aining transcript shows that				
	•	training on 12/21/23."				
	- Other Actions Taker					
		ved as the therapist from				
	this client's case."					
		on staff/client interviews, it				
	_	herapist] shared an article				
		college student killing his				
	_	cannot be confirmed that				
		statement about this being				
		did not manage his anger.				
		w with [Therapist], it cannot				
		e made the statement hildhood being over. Based				
		erviews, it can be confirmed				
		d her voice while speaking to				
		on a therapeutic walk with				
		•				
	her. Also, according to the Verkada camera footage, [FC #4] can be seen refusing to leave the cottage with [Therapist]. After reviewing					
	Verkada camera footage, [Therapist] can be seen					
	dropping a letter onto [FC #4]'s lap, not					
	aggressively. Based on the interview with					
	[Therapist], it cannot be confirmed that she made					
		ing [FC #4]'s medication.				
	•	4] feel uncomfortable, it was				
	~ -	st] will no longer serve as				
		Clinical Supervisor will				

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resume that role moving forward. It should be

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	, ,	(X3) DATE SURVEY COMPLETED			
				A. BUILDING: _	-		
		MHL0601482		B. WING		0:	R 5/07/2025
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
			6722 ST PE	TERS LANE			
CHRIST C	HURCH COTTAGE THO	MPSON CHILD & FA		S, NC 28105			
(X4) ID		ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	E APPROPRIATE	COMPLETE DATE
V 105	Continued From page	e 5		V 105			
	noted that between s	taff and the client interv	views				
	the concerns were co		nowo,				
		emails from the Quality					
		list dated 5/6/25 reveale					
		suspended, however, s					
		er clients so she was ison g this time. [FC #4] was					
		g this time. [FC #4] was al Supervisor]. The note					
		•					
	provided from [Clinical Supervisor] also outline the steps taken;						
	- "I apologize, I missp	ooke. [FC #4] was					
	. •	were only a few other					
	_	but they were seen by					
	[Therapist]."						
	Attempted interview of	on 5/6/25 and 5/7/25 wi	th the				
	Legal Guardian of FC	C#4 revealed:					
		the Legal Guardian of I					
		rn call before the exit o	f				
	survey.						
	Interview on 5/5/25 w	vith the Therapist revea	led:				
		d from caseload, "throu	gh a				
	breach of information						
		rapist's computer scree					
		organization she volur	iteers				
	with;	d about the content on t	·ho				
		computer was turned o					
	•	FC #4 watched the vio					
	on the computer;		-				
	! ' '	4 that he would turn out	t like				
	the guy in video who killed his girlfriend;						
	- Denied yelling at FC #4 when she asked him to		im to				
	go for a walk;						
	- Was frustrated with FC #4 when he would not						
	go for a walk;	walk upon roturn place	d a				
		walk, upon return place e arm of the couch FC					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		MHL0601482	B. WING		0:	R 5/07/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
CHRIST C	CHURCH COTTAGE THO	MPSON CHILD & FA	FPETERS LANE EWS, NC 28105			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 105	was sitting on; - "Unintendedly I sho client;" - There was a lot of " #4's medications; - FC #4 stated he wa and use mushrooms stay sane; - Was trained in bias on ethnical boundarie, - Received weekly su Interview on 5/5/25 w revealed: - FC #4 had "issues" him something online girlfriend; - FC #4 was not com Therapist; - Discussed FC #4's Supervisor; - It was decided that Supervisor/QP would about the concerns; - The Therapist yelled go on a walk with her had with her about the FC #4 received a new Interview on 5/7/25 w revealed: - Was the therapist's incident on 3/4/25; - Received a report for Therapist spoke to Fe - As a result of the intention of the intenti	wed my frustrations with the back and forth" about FC inted to leave the country and he needed marijuana to training and extra courses es; upervision for 45 days. With the Supervisor/QP when the Therapist showed e about a guy who killed his fortable with working with the concerns with the Clinical Clinical Supervisor and it speak with the Therapist did at FC #4 for not wanting to re, before a conversation was be previous concerns; ew therapist. With the Clinical Supervisor supervisor at the time of the rom staff about how the C #4; vestigation, meet weekly with to the Therapist from 3/10/25	V 105			

Division of Health Service Regulation

STATE FORM 6899 KY5S11 If continuation sheet 7 of 14

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			7 20125			R
		MHL0601482	B. WING		05	5/07/2025
NAME OF P	ROVIDER OR SUPPLIER	STREE	FADDRESS, CITY, STA	TE, ZIP CODE		
		6722 S	T PETERS LANE	,		
CHRIST	CHURCH COTTAGE THOM	MPSON CHILD & FA MATTH	HEWS, NC 28105			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	E APPROPRIATE	COMPLETE DATE
V 105	Continued From page	. 7	V 105			
	Therapist; - Was assigned FC #4 - FC #4 declined to file Therapist; - Did not report the Therapist Worker Licensure Box	e a complaint on the nerapist to the Social				
V 367	27G .0604 Incident R	eporting Requirements	V 367			
	level II incidents, excethe provision of billable consumer is on the princidents and level II of to whom the provider 90 days prior to the in responsible for the caservices are provided becoming aware of the besubmitted on a for Secretary. The report in person, facsimile of means. The report in formation: (1) reporting providentification information: (2) client identification information: (3) type of incidentification of the cause of the incident; (6) other individion responding. (b) Category A and B missing or incomplete	REMENTS FOR PROVIDERS Providers shall report all pet deaths, that occur during le services or while the roviders premises or level III deaths involving the clients rendered any service within ricident to the LME tchment area where within 72 hours of le incident. The report shall im provided by the t may be submitted via mail, r encrypted electronic hall include the following lovider contact and lion; fication information; lent; of incident; leffort to determine the				

Division of Health Service Regulation

STATE FORM 6899 KY5S11 If continuation sheet 8 of 14

MALGO PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6722 ST PETERS LANE MATTHEWS, NO 28105 MATTHEWS, NO 28105 PREFIX TAQ V 367 Continued From page 8 report recipients by the end of the next business day whenever: (1) The provider has reason to believe that information required or the incident, including: (1) Less provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required or the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (4) 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. (4) 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. Including the incident category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Requisition 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 10 A NCAC 26C 0.300 and 10 A NCAC 27E 0.104(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 in comments.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER CHRIST CHURCH COTTAGE THOMPSON CHILD & FA MATTHEWS, NC. 23105 WATCH CONTINUED TO BE PROVIDER PROVIDERS PLAN OF CORRECTION (SCAPE CHORNEY) (EACH DEPICIENCY MUST BE PRECEDED BY FULL PREFIX TAG) WASTO Continued From page 8 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 LECONS but her 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 had ready of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall seven the death immediately, as required by 10A NCAC 28C 0.300 and 10A NCAC 27E 0.104(C)(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					_			>
CHRIST CHURCH COTTAGE THOMPSON CHILD & FA CAN D			MHL0601482		B. WING			
(XA) ID SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE	NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
(A) ID SUMMARY STATEMENT OF DEFICIENCIES DE PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MAY 18 OF RECECUE DB Y PULL TAG (RECULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 8 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 ports 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 send a report quarterly to the LME responsible for the catchiment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall	0115105.0			6722 ST PE	TERS LANE			
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 8 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 Regulation within 72 hours of becoming aware of the incident, In cases of client death within seven days of use of seculsion 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 by the Secretary via electronic means and shall	CHRIST C	HURCH COTTAGE THON	IPSON CHILD & FA	MATTHEW	S, NC 28105			
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 0.300 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	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FU		PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF	OULD BE	COMPLETE
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 Ill 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 Ill incident 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 10 A NCAC 26C .0300 and 10 A 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	V 367	Continued From page	· 8		V 367			
(1) medication errors that do not meet the definition of a 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;	V 367	report recipients by the day whenever: (1) the provider information provided information provided information provided information provided information provided information; (2) the provider required on the incided unavailable. (c) Category A and B upon request by the Lobtained regarding the (1) hospital receinformation; (2) reports by one (3) the provider (4) Category A and B of all level III incident Mental Health, Develor Substance Abuse Serbecoming aware of the providers shall send a incidents involving a complete Health Service Regulates becoming aware of the client death within service includes and 10A NCAC (e) Category A and B report quarterly to the catchment area where The report shall be subly the Secretary via equinclude summary information of a level II of (2) restrictive in the definition of a	the end of the next busing that reason to believe to the report may be gor otherwise unreliable obtains information and form that was previous providers shall submit, and, other information the incident, including: ords including confident ther authorities; and is response to the incident providers shall send a reports to the Division of providers shall send a reports to the Division of providers within 72 hours of the incident. Category A is copy of all level III calcient death to the Division of the incident. In cases of yen days of use of sections within 72 hours of the incident. In cases of yen days of use of sections within 72 hours of the incident. In cases of yen days of use of sections within 72 hours of the incident. In cases of yen days of use of sections within 72 hours of the incident. In cases of yen days of use of sections within 72 hours of the incident. In cases of yen days of use of sections within 72 hours of the incident. In cases of yen days of use of sections within 72 hours of the incident of the incident of the incident of the incident; the incident; the incident; the incident; the incident incident incident incident; the incident incide	that e; or usly tial ent. copy of id if usion of usion th ne ided nall the meet	V 367			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			_			R
		MHL0601482	B. WING		05	/07/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE		
CHRIST C	HURCH COTTAGE THO	MPSON CHILD & FA	PETERS LANE WS, NC 28105			
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	PRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	COMPLETE DATE
V 367	Continued From page	e 9	V 367			
	the possession of a c (5) the total null incidents that occurre (6) a statement been no reportable in incidents have occurr meet any of the criter	mber of level II and level III ed; and t indicating that there have cidents whenever no red during the quarter that ia as set forth in Paragraphs e and Subparagraphs (1)				
	failed to report all critic Response Improvement the Local Manageme Care Organization (Matches and Parket 1988). Catchment areas where within 72 hours of beautiful free findings are: Review on 5/3/25 of Freeord revealed: - Admission date 2/12 - Age 15 years; - Diagnoses Attention Disorder, Combined Disorder; Dysthymic Inc. Discharge date 3/28	ew and interview the facility ical incidents in the Incident ent System (IRIS) and notify int Entity (LME)/Managed ICO) responsible for the ere services were provided coming aware of the incident ed clients (Former Client #4). Former Client (FC) #4's 2/25; In Deficit Hyperactivity Type; Intermittent Explosive Disorder; 3/25.				
	Review on 5/1/25 of t Investigations from O	he facility's Internal ctober 1, 2024-May 1, 2025				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
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040.15	CHMMADV CT	TATEMENT OF DEFICIENCIES		, 	PROVIDER'S PLAN OF CO		()(5)
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V 367	Continued From page 10			V 367			
	revealed:						
	revealed: - Investigation Report Quality Improvement - The Complaint Allegemail on 3/7/25 of sectient [FC #4], toward Residential Therapist were initially reported Professional (QP)], Calient [FC #4], on 3/4, Supervisor [Clinical Semail with consistent [FC #4] The following cort Supervisor's] email: - [Therapist] show the computer of a boy where and emphasized that [FC #4] claimed that [The him if he did not man - During a therat when asked about his wanted to go home, at that his childhood ward emphasized that wanted to go home, at that his childhood ward emphasized that wanted to go home, at that his childhood ward emphasized that wanted to go home, at that his childhood ward emphasized that wanted to go home, at that his childhood ward emphasized to go home, at the control of the cont	october 1, 2024-May 1, at dated 3/10/25 by the Specialist (QIS); gations: "PQI was notificated as the Christ Church to [Supervisor]. The complet to [Supervisor] also provide concerns after she metaled him an article on the killed his college girll to could be [FC #4]. 'Clie trapist] told him that wor age his anger.' apy session with [Thera is goals, [FC #4] stated and the therapist responses over and he needed to the special state of the special state of the second second him an article on the killed his college girll told him that wor age his anger.'	ed via by laints ed or by ed an t with cal her [FC uld be pist], 'He nded				
	focus on other goals 'The client als	.' o reported that on					
		apist entered the cottag	ge				
	_	a therapeutic walk with	-				
	which he refused. The client conveyed that the						
	therapist raised her voice, insisting he take the						
	walk, but he declined again, and she left.'						
	- 'The client rep	orted that the therapist					
	placed a piece of mail from his mother in his lap		lap				
	in an aggressive mar						
	-The following con [Supervisor/QP] ema						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
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			WAITHEAN	7, 140 20103			
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					DEFICIENCY)	
V 367	Continued From page	<u> </u>		V 367			
		estioned why he reques					
	_	ation and her response					
		sensitive. [Therapist] st					
		change your medication	ons.				
	It's probably not the n						
		cerns regarding the arti					
		client's goal to go home	е				
	were also in [Supervi	•					
		ts Reviewed- "There we s since [FC #4's] admiss					
			SIOH				
	to Thompson. The therapy note from 3/4/25 indicated that [Therapist] shared an article about						
	a boyfriend killing his		bout				
	,	ent behind this was to ra	aise				
	awareness about alco		aisc				
		da footage from 3/4/25					
	_	pist] shared her laptop b	riefly				
	with [FC #4] during th		,				
		evealed that [Therapist	1				
	_	a few times, but [FC #4]	•				
		his seat. At approximat					
		an be seen dropping a l					
	onto [FC #4]'s lap and	d then walking away0	QIS				
	reviewed [Therapist]'s	s previous coaching					
	sessions, focusing or	n her interactions with c	lients				
	and staff. She has be	en coached on					
	communication issue	s with the cottage					
		ssionalism during a CF					
		/leeting) a few months a					
		er interactions with clie					
		aining transcript shows	that				
	•	E training on 12/21/23."					
	- Other Actions Taken: "Effective 3/7/25,						
	[Therapist] was removed as the therapist from		m				
	this client's case."		_ :1				
	- Conclusion "Based on staff/client interviews, it						
	was confirmed that [Therapist] shared an article with [FC #4] about a college student killing his						
		college student killing n t cannot be confirmed th					
	, •						
	[Therapist] made the	statement about this be	eing				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED								
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NAIVIE OF PI	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
CHRIST CHURCH COTTAGE THOMPSON CHILD & FA												
MATTHEWS, NC 28105												
(X4) ID												
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				DEFICIENCY)								
1/ 007	0 " 15	40	1/ 007									
V 367	Continued From page	e 12	V 367									
	IFC #41 one day if he	did not manage his anger.										
		w with [Therapist], it cannot										
	be confirmed that she											
		hildhood being over. Based										
		erviews, it can be confirmed										
	that [Therapist] raised her voice while speaking to											
		on a therapeutic walk with										
	her. Also, according t	o the Verkada camera										
	footage, [FC #4] can	be seen refusing to leave										
	the cottage with [The	rapist]. After reviewing										
		age, [Therapist] can be seen										
	dropping a letter onto [FC #4]'s lap, not aggressively. Based on the interview with [Therapist], it cannot be confirmed that she made the statement regarding [FC #4]'s medication. Due to making [FC #4] feel uncomfortable, it was											
	- · · · · · · · · · · · · · · · · · · ·	st] will no longer serve as										
	his therapist. Interim Clinical Supervisor will resume that role moving forward. It should be noted that between staff and the client interviews, the concerns were consistent." Review on 5/1/25 of the IRIS reports from October 1, 2024- May 1, 2025 revealed: - No incident report for the alleged emotional abuse incident on 3/4/25 with FC #4.											
	Review on 5/6/25 of emails from the Quality Improvement Specialist dated 5/6/25 revealed: - [Therapist] was not suspended, however, she did not have any other clients so she was isolated from client care during this time. [FC #4] was reassigned to [Clinical Supervisor]. The notes I provided from [Clinical Supervisor] also outline											
the steps taken; - "I apologize, I misspoke. [FC #4] was reassigned and there were only a few other clients in the cottage but they were seen by												
					 							
[Therapist]."												
[ι ιισιαριοτ].												

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Interview on 5/7/25 with the Chief Performance

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6722 ST PETERS LANE MATTHEWS, NC 28105 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 13 Quality Officer revealed: - Reviewed criteria for level 2 incident reports and didn't realize an IRIS report needed to be STREET ADDRESS, CITY, STATE, ZIP CODE 6722 ST PETERS LANE MATTHEWS, NC 28105 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE) V 367 V 367	ALS I ENT OF SOUNEOHOR													
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Quality Officer revealed: - Reviewed criteria for level 2 incident reports and didn't realize an IRIS report needed to be	PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE COMPLÉTE CROSS-REFERENCED TO THE APPROPRIATE DATE								
	V 367	Quality Officer reveal - Reviewed criteria fo	led: or level 2 incident reports an		V 367									

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