

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-417	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 03/17/2025
NAME OF PROVIDER OR SUPPLIER BEYOND BELIEF FAMILY SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 309 1ST STREET MOUNT HOLLY, NC 28120		
(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 295	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to employ an Associate Processional (AP) who provided services to the facility on a full time basis. The findings are: Review on 3-7-25 of the AP's personnel record revealed: -Date of Hire: 6-3-24. -Bachelor of Science. -Signed job description (6-20-24): "The Residential Associate Professional is a full time employee who meets or exceeds the requirements of an associate professional as set forth in 10A NCAC 27G .0104(1) provides direct care for consumers of age 10 to 18 years old." Interview on 3-11-25 with the House Manager revealed: -"No I don't see her (AP) often. She (AP) had only been working a little bit because her mother has been sick. She only comes (to work at the facility) a couple times a month when she can." -"Is that position (AP) suppose to be full time? [Director/Licensee] she's a new provider. She is still learning all of this (rules for managing the facility)." Interview on 3-17-25 with the AP revealed: -"Yes", she is the AP. -"No,"she does not supervise any staff. "No," Does not participate in CFTs or any team meetings. "I don't do any of that, nothing clinical." -"I basically just check in to see how the girls (clients) are doing."	V 295			

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V 295	Continued From page 2 -"Not often (in the facility) , maybe once a week, about 5 hours a week. I'm part time, very part time. I've never worked full time. I have always worked part time. I was not hired to be full time. I have a full time job already." -"It may say that (job description) but I have never worked full time there (at the facility)." Interview on 3-14-25 with the Director/Licensee revealed: -She hired the AP. -"Well, I'm a new provider. I wasn't aware of that rule (AP has to be full time)."	V 295		
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	V 296	we have staffed to ensure and maintain 2 staff at all times.	

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BEYOND BELIEF FAMILY SERVICES LLC

**309 1ST STREET
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V 296	Continued From page 3 children or adolescents; (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 review, interviews and observation, the facility failed to ensure the minimum staff ratio of two staff for up to four children or adolescents. The findings are: Observation on 3-7-25 between 4pm and 7pm revealed: -One staff (staff #1) on shift with clients #1, #2 and #3 present in the facility. Review on 3-7-25 of am email from the Director	V 296		

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V 296	Continued From page 4 revealed: "[staff #1] is there and will be there until 9pm and another staff is coming in for tonight at 630/7 to cover the night. Do i have to have 2 staff at night with 3 girls being that they are sleeping?" Interview on 3-7-25 with staff #1 revealed: -No one was schedule to work with her that day (3-7-25). "I'm the only one scheduled today. It's usually two staff scheduled to work on second shift. This is the first time I've worked by myself." -"Only one staff works on 3rd shift." Interview on 3-7-25 with the Director/Licensee revealed: -The facility runs two shifts. Day shift ran 7am to 7pm and night shift ran 7pm to 7am with two staff working 7am to 7pm. -"There is usually two staff on 7am to 7pm shift and one staff on 7pm to 7am shift. " -"I've got a call to another staff to come in. She should be there in about 30 minutes." -"I wasn't aware that we needed two staff on third shift since the girls (clients) were asleep. I make sure there are two staff on third shift from now own."	V 296			
V 299	27G .1707 Res.Tx. Child/Adol - Pers Permit in Facility 10A NCAC 27G .1707 PERSONS PERMITTED IN THE FACILITY (a) Only admitted children or adolescents, legally responsible persons, staff, other family and friends identified in the treatment plan, and others permitted by the facility director shall be permitted on the premises. (b) Individuals other than those specified in Paragraph (a) of this Rule are prohibited from	V 299			

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V 299	Continued From page 5 entering the facility except in instances of emergency or as permitted by law. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure only adolescents admitted, legal guardians, staff and other family identified in the treatment plan were permitted in the facility. Affecting 3 of 3 clients. (clients #1, #2 and #3). The findings are: Observation on 3-7-25 between 4 and 4:45pm revealed: -A teenage girl identified by staff #1 as a neighbor and friend of client #1 was in the facility,. -The neighbor was in the facility approximately 30 to 45 minutes and socialized and watched Television with clients #1, #2 and #3. Interview on 3-7-25 with client #1 revealed: -"We (client #1 and neighbor) go to the same school. She lives down the street." -"Yeah, just a couple of times, maybe three times (neighbor has been to the facility).". Interview on 3-7-25 with staff #1 revealed: -"She (neighbor) doesn't live here. She's here visiting [client #1]. She's a friend of [client #1], she lives across the street. They (client #1 and the neighbor) go to school together." -Director/Licensee was aware that the neighbor visited. "Yeah all of that has already been worked out (permission had been granted for the neighbor to visit client #1). I think [Director/Licensee] talked to her (neighbors) parents and got permission for her to come over."	V 299	we have implemented not to allow anyone on premises outside of staff and consumers unless it is written approval and proper checks have been done through dhhs.		

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V 299	Continued From page 6 Interviews on 3-14-25 with the Director/Licensee revealed: -"The girls (clients) are not allowed visitors unless they are social workers, guardians or family that have been approved by the clients team." -"I have not approved any visitors in the home. That is not in our policy and the staff have been told this. They were told when they were hired by going over the policy and procedures and in staff meetings."	V 299			
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective 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	V 366			

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V 366	Continued From page 7 Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or 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	V 366			

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V 366	Continued From page 8 (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to implement written policies governing their response to level II incidents. The findings are:	V 366	we have implemented sending out staff emails PRN, training, and monthly staff meetings to discuss how to properly monitor and report any level II or level III incidents and ensuring that responsible parties such as house manager QP/AP, Director are properly notifying	

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V 366	Continued From page 9 Review on 3-7-25 of the facility's incident reports from December 1, 2024 to March 7, 2025 revealed: -No documentation of an incident on 1-10-25 were FC #6 was absent without leave (AWOL) from the facility for an unknown number of hours. --No documentation of an incident occurring on 2-11-25 involving client #1 and FC#4 getting into a physical altercation and the police were called to the facility. The altercation resulted in injury to FC #4 and and staff #2. FC #4 was transported to the hospital for treatment for a swollen eye, face and nose. No documentation to support the above incidents had been evaluated to: -Attended to the health and safety needs of individuals involved in the incident. -Determined the cause of the incident. -Developed and implemented corrective measures according to provider specified timeframes not to exceed 45 days. -Developed and implemented measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days. -Assigned person(s) to be responsible for implementation of the corrections and preventive measures. Review on 3-7-25 of the North Carolina Incident Response Improvement System (IRIS) from December 1, 2024 to March 7, 2025 revealed: -No documentation of an incident on 1-10-25 were FC #6 was absent without leave (AWOL) from the facility for an unknown number of hours.. Interview on 3-14-25 with the Therapist revealed: -"I can't remember the exact date (of FC #6's AWOL). I learned of the incident during a therapy session. She (FC#6) said that she was mad at	V 366	The LME and completing IRIS as needed.		

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V 366	Continued From page 10 staff (unknown staff) because they were trying to make her go to her room and she didn't want to go so she ran away (AWOL). I'm not sure of all the details. How long she was gone and all that. I do know that her (FC #6) mother found her and called her social worker and her social worker brought her back to the home (facility)." Interview on 3-7-25 with the Director revealed: -"She just didn't want to be here (at the facility) so she left (AWOL)." -"Yes, we completed an incident report. I'm not sure of the date I will look back at the incident report." -Documentation for FC #6's AWOL was not provided by survey exit.	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;	V 367			

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V 367	Continued From page 11 (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: (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	V 367			

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V 367	Continued From page 12 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. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure all level II incidents were reported to the Local Management Entity (LME)/Managed Care Organization (MCO) within 72 hours of learning of the incident. The findings are: Review on 3-7-25 of the facility's incident reports for December 1, 2025 to March 7, 2025 revealed: -No documentation of an incident on 1-10-25	V 367	The director/owner, QP and house manager will monitor via staff meetings, on staff observations, and camera reviews to ensure we are following compliance and doing our due diligence to avoid further occurrences.		

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V 367	Continued From page 13 were FC #6 was absent without leave (AWOL) from the facility for an unknown number of hours. -No documentation of an incident occurring on 2-11-25 involving client #1 and FC#4 getting into a physical altercation and the police were called to the facility. The altercation resulted in injury to FC #4 and and staff #2. FC #4 was transported to the hospital for treatment for a swollen eye, face and nose." Review on 3-7-25 of the North Carolina Incident Response Improvement System (IRIS) from December 1, 2024 to March 7, 2025 revealed: -No documentation of an incident on an unknown date of FC #6 being absent without leave (AWOL) from the facility. -No documentation of an incident occurring on 2-11-25 involving client #1 and FC#4 getting into a physical altercation and the police were called to the facility. The altercation resulted in injury to FC #4 and and staff #2. FC #4 was transported to the hospital for treatment for a swollen eye, face and nose." Interview on 3-7-25 with client #1 revealed: -"[FC #4] had a phone. We are not allowed to have a phone and she blamed it on me. She was saying things in front of staff to make me look like I had something. At first I didn't say anything because I wasn't going to rat (tell staff about the phone) her out but then she got meaner and meaner. She was trying to make me mad so I would fight her. So I said, ok [FC #4] how about your phone? She threw it in the trash can and lied and said she didn't have a phone. Then she ran up in my face and I fought her. [staff #2] brook it up (the fight). Then she started hitting [FC #5]. I don't even know why she was fighting [FC #5] because [FC #5] didn't have anything to do with it (the phone fight)."	V 367		

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**309 1ST STREET
MOUNT HOLLY, NC 28120**

(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 367	Continued From page 14 Interview on 3-14-25 with the Therapist revealed: -"I can't remember the exact date. I learned of the incident during a therapy session. She said that she was mad at staff (unknown staff) because they were trying to make her go to her room and she didn't want to go so she ran away. I'm not sure of all the details. How long she was gone and all that. I do know that her (FC #6) mother found her and called her social worker and her social worker brought her back to the home (facility)." Interview on 3-7-25 with the Director revealed: -"She (FC #6) just didn't want to be here (at the facility) so she left." -"Yes, we completed an incident report. I'm not sure of the date I will look back at the incident report." -"An incident report of the incident was not received by survey exit. -"She was responsible for completing the IRIS reports. -"She did not complete IRIS reports for the above incidents.	V 367		