OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	MHL080-222	B. WING		06/09/2025	
ROVIDER OR SUPPLIER	STREET #	ADDRESS, CITY, STATE	, ZIP CODE	·	
OUSING, LLC					
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
INITIAL COMMENTS	3	V 000			
An annual and complaint survey was completed on 6/9/25. The complaint was unsubstantiated (intake #NC00230315). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential					
Treatment Staff Secu Adolescents.	ire for Children or				
census of 3. The surv	vey sample consisted of				
27G .0207 Emergency Plans and Supplies		V 114			
AND SUPPLIES (a) Each facility shall and a disaster plan a these plans available to the county emerge request. The plans sh procedures and route (b) The plans shall be and evacuation proce posted in the facility. (c) Fire and disaster of shall be held at least repeated for each shi Drills shall be conduct simulate the facility's emergencies.	develop a written fire plan nd shall make a copy of ency services agencies upon hall include evacuation es. e made available to all staff edures and routes shall be drills in a 24-hour facility quarterly and shall be ift. cted under conditions that response to fire				
	ROVIDER OR SUPPLIER OUSING, LLC SUMMARY ST (EACH DEFICIENC REGULATORY OR INITIAL COMMENTS An annual and comp on 6/9/25. The comp (intake #NC0023031 This facility is license category: 10A NCAC Treatment Staff Secu Adolescents. The facility is license census of 3. The sum audits of 2 current cli 27G .0207 Emergence 10A NCAC 27G .020 AND SUPPLIES (a) Each facility shall and a disaster plan a these plans available to the county emerge request. The plans shall be and evacuation proce posted in the facility. (c) Fire and disaster shall be held at least repeated for each sh Drills shall be conduc simulate the facility's emergencies. (d) Each facility shall	IDENTIFICATION NUMBER: MHL080-222 ROVIDER OR SUPPLIER STREET / SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS An annual and complaint survey was completed on 6/9/25. The complaint was unsubstantiated (intake #NC00230315). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. The facility is licensed for 4 and currently has a census of 3. The survey sample consisted of audits of 2 current clients and 1 former client. 27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate the facility's response to fire emergencies. (d) Each facility shall have a first aid kit	PF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: MHL080-222 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID INITIAL COMMENTS V 000 An annual and complaint survey was completed on 6/9/25. The complaint was unsubstantiated (intake #NC00230315). Deficiencies were cited. V 000 This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. V 114 10A NCAC 27G .0207 EmERGENCY PLANS AND SUPPLIES V 114 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES V 114 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES V 114 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES V 114 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES V 114 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES V 114 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES V 114 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES V 114 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES V 114 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES Forenon disaster drills in a 24-hour facility shall be held	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: MHL080-222 B. WING OWIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SQUIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SQUIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SQUIMARY STATEMENT OF DEFICIENCIES (RACH DEFICIENCY WARDS TO FERCETURE DUE PY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDER'S PLAN OF C (RACH CORRECTIVE ACT) INITIAL COMMENTS V 000 V 000 INITIAL COMMENTS V 000 An annual and complaint survey was completed on 6/9/25. The complaint was unsubstantiated (intake #NC00230315). Deficiencies were cited. V 000 This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. V 114 10A NCAC 27G .0207 Emergency Plans and Supplies V 114 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES V 114 (a) Each facility shall develop a written fre plan and a disaster plan and shall include evacuation procedures and routes. V 114 (b) The plans shall be made axialable to all staff and evacuation procedures and routes shall be posted in the facility. SUBMENCE Shall be repeated for each shift. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be reposted in the facility. SUBME	pF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:

STATEMEN	of Health Service Regu T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION		E SURVEY PLETED
		MHL080-222	B. WING		06/09/202	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE		06/09/2025	
			RTH LONG STREET			
REVIVE H	IOUSING, LLC	SALISB	URY, NC 28144			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 114	Continued From page	e 1	V 114			
	facility failed to ensur completed at least que each shift. The findin Interview on 6/9/25 w -The facility operated -He had been employ	ews and interviews, the re fire and disaster drills were uarterly and repeated for gs are: vith Staff #1 revealed: with 3 staff shifts;				
	months of July 2024 -No documentation o for the quarter of July -No documentation o	the facility's fire drills for the - December 2024, revealed: f a completed 3rd shift drill / 2024 - September 2024; f a completed 2nd shift drill ober 2024 - December 2024.				
	the months of July 20 revealed: -No documentation o for the quarter of July -No documentation o	the facility's disaster drills for 024 - December 2024 f a completed 3rd shift drill v 2024 - September 2024; f completed 1st or 3rd shift of October 2024 - December				
	-He had been a resid months;	vith Client #1 revealed: lent at the facility for over 4 in fire drills but not a disaster ty.				
	-He was aware that fir required to be comple	vith the Owner revealed: ire and disaster drills were eted quarterly on each shift; sure drills were completed as				

ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL080-222	B. WING		06/	/09/2025
ame of Pi	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
EVIVE H	OUSING, LLC		RTH LONG STREET JRY, NC 28144			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 114	Continued From page	2	V 114			
	required in the future.					
V 118	27G .0209 (C) Medica	ation Requirements	V 118			
	 only be administered order of a person auth drugs. (2) Medications shall clients only when auth client's physician. (3) Medications, inclu- administered only by unlicensed persons tr pharmacist or other lep privileged to prepare at (4) A Medication Adm all drugs administered current. Medications at recorded immediately MAR is to include the (A) client's name; (B) name, strength, at (C) instructions for ad (D) date and time the (E) name or initials of drug. (5) Client requests for checks shall be record 	stration: n-prescription drugs shall to a client on the written horized by law to prescribe be self-administered by horized in writing by the ding injections, shall be licensed persons, or by ained by a registered nurse, egally qualified person and and administer medications. inistration Record (MAR) of d to each client must be kept administered shall be after administration. The following: nd quantity of the drug;				

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	MHL080-222	B. WING		06	/09/2025
ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE,	, ZIP CODE		
	523 NOF	RTH LONG STREET			
OUSING, LLC	SALISB	URY, NC 28144			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
Continued From page	3	V 118			
Based on observation interviews, the facility medications were adr order of a physician a	n, record reviews and failed to ensure ninistered on the written nd failed to keep the MAR				
-An admission date of -An age of 13; -Diagnoses included I Disorder, Attention De (ADHD), Conduct Dis Defiance Disorder (OI -Physician orders date (antipsychotic) 25 mill by mouth (po) daily 8: (antidepressant) 10 m 8:00am and Clonidine .1mg, take 1 tablet po -Physician order date	f 2/1/25; Post Traumatic Stress eficit Hyperactivity Disorder order and Oppositional DD); ed 6/9/25 for Risperidone ligrams (mg), take 1 tablet :00am, Escitalopram ng, take 1 tablet po daily e Hydrochloride (ADHD) o in the morning 8:00am; d 5/27/25 for				
-He was ordered to be morning and for the p only been administere -He had been out of a medications for a cou -He wasn't administer medications for a cou -When he asked mon	e administered 4 pills every ast couple of days, he had ed 3; it least one of his ple of days; red at least one of his ple of days every month. thly why he wasn't				
	ROVIDER OR SUPPLIER DUSING, LLC SUMMARY ST/ (EACH DEFICIENC) REGULATORY OR I Continued From page This Rule is not met a Based on observation interviews, the facility medications were adr order of a physician a current affecting 2 of a #2). Review on 6/9/25 of C -An admission date of -An age of 13; -Diagnoses included I Disorder, Attention De (ADHD), Conduct Dis Defiance Disorder (O -Physician orders data (antipsychotic) 25 mill by mouth (po) daily 8: (antidepressant) 10 m 8:00am and Clonidine .1mg, take 1 tablet po -Physician order date Dextroamphetamine (po daily 8:00am. Interview on 6/9/25 w -He was ordered to be morning and for the p only been administer He wasn't administer medications for a cou -When he asked mon administered all his m	IDENTIFICATION NUMBER: IDENTIFICATION IDENTIFICATION	IDENTIFICATION NUMBER: A. BUILDING: MHL080-222 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE SUMMARY STATEMENT OF DEFICIENCIES 523 NORTH LONG STREET CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 3 V 118 This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to ensure medications were administered on the written order of a physician and failed to keep the MAR current affecting 2 of 2 surveyed clients (#1 and #2). Review on 6/9/25 of Client #1's record revealed: -An admission date of 2/1/25; -An age of 13; -Diagnoses included Post Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder (ADHD), Conduct Disorder and Oppositional Defiance Disorder (ODD); -Physician orders dated 6/9/25 for Risperidone (antiopersestint) 10 mg, take 1 tablet by mouth (po) daily 8:00am, Escitalopram (antidepressant) 10 mg, take 1 tablet po daily 8:00am and Clonidine Hydrochloride (ADHD) .1mg, take 1 tablet po in the morning 8:00am; -Physician order dated 5/27/25 for Dextroamphetamine (ADHD) 20mg, take 1 tablet po daily 8:00am. Interview on 6/9/25 with Client #1 revealed: -He was ordered to be administered 4 pills every morning and for the past couple of days, he had only been administered 3; -He had been out of at least one of his medications for a couple of days; -He wasn't administered at least one of his medications for a couple of days; -He wasn't administered at least one of his medications for a couple of days; -When he asked monthly why he wasn't administered all his medications, staff	F CORRECTION IDENTIFICATION NUMBER: A BUILDING: MHL080-222 B: WING COVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE DUSING, LLC 523 NORTH LONG STREET SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to ensure medications were administered on the written order of a physician and failed to keep the MAR current affecting 2 of 2 surveyed clients (#1 and #2). Review on 6/9/25 of Client #1's record revealed: -An admission date of 2/1/25; -An admission date of 2/1/25; -An age of 13; -Diagnoses included Post Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder (ADHD), Conduct Disorder and Oppositional Defance Disorder (ADHD) Image, Take 1 tablet po daily 8:00am; -Physician order dated 5/27/25 for Destroam matinistered 4 pills every morning and for the past couple of days; -He was ordered to be administered 4 pills every morning and for the past couple of days; -He was ordered to be administered 4 pills every morning and for the past couple of days; -He was ordered to be administered 4 pills every morning and for the past couple of days; -He was ordered to be administered 4	F CORRECTION IDENTIFICATION NUMBER: A BUILDING: COM MHL080-222 B. WING 06 COVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE 523 NORTH-LONG STREET SUMMARY STATEMENT OF DEFICIENCED BY FULL SALISBURY, NC 2814 PREVIDER'S PLAN OF CORRECTIVE, AND REVIDER'S PLAN OF CORRECTIVE, AND REVIDENCED TO THE APPROPRIATE DEFICIENCY MUST BE PRECEDED BY FULL PREFIX Continued From page 3 V 118 PREFIX CROSS-REPERCED TO THE APPROPRIATE DEFICIENCY Continued From page 3 V 118 V 118 PREFIX CROSS-REPERCED TO THE APPROPRIATE DEFICIENCY Continued From page 3 V 118 V 118 PREFIX CROSS-REPERCED TO THE APPROPRIATE DEFICIENCY Continued From page 3 V 118 V 118 PREFIX CROSS-REPERCED TO THE APPROPRIATE DEFICIENCY Continued From page 3 V 118 This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to ensure medications were administered on the written order of a physician and failed to keep the MAR current affecting 2 of 2 surveyed clients (#1 and #2). PREFIX PREFIX Review on 6/9/25 of Client #1's record revealed: -An age of 13: -Diagnose included Post Traumatic Stress Dis

STATEMEN	of Health Service Regu	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL080-222	B. WING		06	/09/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
REVIVE H	IOUSING, LLC		TH LONG STREET			
		SALISBU	JRY, NC 28144			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETI DATE
V 118	Continued From page	e 4	V 118			
	6/9/25, with Client #1 successful as reques ignored.					
	for the month of June -No documentation for Risperidone, Escitalo Hydrochloride or Dex	or 6/8/25 and 6/9/25 that				
	Observation on 6/9/2 for Client #1 revealed Escitalopram were no					
	pharmacy utilized by -Risperidone for Clier up on 5/7/25; -Risperidone for Clier had not been picked -Escitalopram for Clier up on 5/10/25;	nt #1 was previously picked nt #1 was refilled 6/7/25 and up; ent #1 was previously picked ent #1 was refilled today and				
	-An admission date o -An age of 17; -Diagnoses included ADHD, Generalized A and Cannabis Use Di -Physician orders dat (ADHD) 70mg, take 1 8:00am, Saphris (anti tablet po daily 8:00am (antidepressant) 20m 8:00am, Aripiprazole	Conduct Disorder, ODD, Anxiety Disorder, Insomnia sorder; ed 4/29/25 for Vyvanse capsule po every morning psychotic) 10mg, take 1 n, Fluoxetine g, take 1 capsule po daily (antipsychotic) 20mg, take 1 azodone (insomnia) 150mg,				

Division of Health Service Regulation STATE FORM

6899

If continuation sheet 5 of 9

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE COMP	SURVEY LETED
		MHL080-222	B. WING		06/	09/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
REVIVE H	OUSING, LLC					
			URY, NC 28144			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED B)		ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From page	e 5	V 118			
	6/9/25, with Client #1	on 6/5/25, 6/6/25 and 's guardian were not ts to return calls were				
	for the month of June -No documentation for Vyvanse, Saphris, Flu were administered or administered; -Documentation of pr Trazodone; -Documentation of in	or 6/8/25 and 6/9/25 that uoxetine and Aripiprazole why they weren't n (as needed) for itials on 6/1/25, 6/3/25 and e was administered at				
	today that he had not required; -He was busy and un documented the MAF Owner today; -He thought Trazodor	aware by the facility Owner a documented the MARs as able to find a pen but had Rs after talking with the				
	-He was not aware th MAR's; -He was going to ens	with the Owner revealed: here was a problem with the nure that the MAR's were d and medications were red.				
	Due to the failure to a medication administra determined if clients as ordered by the phy	ation, it could not be received their medications				

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		MHL080-222	B. WING		06/09/2025	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
REVIVE H	OUSING, LLC	523 NOF	TH LONG STREET			
		SALISBI	URY, NC 28144			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 296	Continued From page	9 6	V 296			
V 296	27G .1704 Residentia Staffing	al Tx. Child/Adol - Min.	V 296			
	telephone or page. A able to reach the facil times. (b) The minimum nur required when childre present and awake is (1) two direct ca one, two, three or fou (2) three direct for five, six, seven or adolescents; and (3) four direct ca nine, ten, eleven or tw adolescents. (c) The minimum nur during child or adoless follows: (1) two direct ca and one shall be awa children or adolescen (2) two direct ca and both shall be awa children or adolescen	sional shall be available by a direct care staff shall be ity within 30 minutes at all mber of direct care staff n or adolescents are as follows: are staff shall be present for r children or adolescents; care staff shall be present eight children or are staff shall be present for velve children or mber of direct care staff cent sleep hours is as are staff shall be present ke for one through four ts; are staff shall be present ake for five through eight				
	 asleep for nine, ten, e adolescents. (d) In addition to the care staff set forth in I Rule, more direct care the facility based on t 	awake and the third may be eleven or twelve children or minimum number of direct Paragraphs (a)-(c) of this e staff shall be required in he child or adolescent's pecified in the treatment				

STATEMEN	of Health Service Regu r OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL080-222	B. WING		06/09/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
REVIVE H	OUSING, LLC		RTH LONG STREET			
			URY, NC 28144			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
V 296	supervision of childre are away from the fac child or adolescent's needs as specified in This Rule is not met	I be responsible for ensuring on or adolescents when they cility in accordance with the individual strengths and the treatment plan.	V 296			
	interviews, the facility minimum staff ratio o adolescents. The find Observations on 6/9 10:00am - 12:00pm r	f two staff for up to 4				
	-An admission date of -An age of 13; -Diagnoses included Disorder, Attention D	Client #1's record revealed: of 2/1/25; Post Traumatic Stress eficit Hyperactivity Disorder, d Oppositional Defiance				
	-He was aware there staff with him while a -Client #1 was suspe week so it was an em	rd shift but was filling in on				

ID PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COM	SURVEY PLETED
		MHL080-222	B. WING		06	/09/2025
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	•	
EVIVE H	OUSING, LLC		RTH LONG STREET URY, NC 28144			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
V 296	Continued From page Interview on 6/9/25 w -He was aware there when clients were pro times; -It was a struggle find		V 296			