Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060785	A. BUILDING: _____ B. WING _____	C 06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRACLE HOUSE 1	1418 JULES COURT CHARLOTTE, NC 28226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint survey was completed on 6/9/25. The complaint was unsubstantiated (intake #NC00229640). A deficiency was 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 6 and has a current census of 6. The survey sample consisted of audits of 1 current client and 2 former clients.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Patsy M. Camp, TITLE: Executive Director, (X6) DATE: 6/21/25

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement goals and strategies to meet the individual needs of 1 of 3 audited clients (#2). The findings are: Review on 6/9/25 of client #2's record revealed: -Admission date of 2/24/25. -16 years old. -Diagnoses of Major Depressive Disorder, recurrent, moderate; Cannabis Dependence, uncomplicated; Anxiety Disorder, unspecified. -Treatment plan dated 2/6/25 and updated 5/8/25 did not include goals and strategies for preventing AWOL (Absent Without Leave) behavior. Review on 6/5/25 of the North Carolina Response Improvement System (IRIS) from 1/1/25 to 6/5/25 revealed: -3/2/25 Client #2 was AWOL from the facility. -3/8/25 Client #2 was AWOL from the facility. Interview on 6/5/25 with client #2 revealed. -Had gone AWOL twice. -Did not know if he had goals or strategies to address AWOL behavior. Interview on 6/5/25 with the Associate Professional (AP) revealed: -Did not know if client #2's had goals to address	V 112	Please read our current process below: When a consumers goes AWOL, an emergency meeting is called. An AWOL goal is written immediately and the PCP is updated. The Clinical Director follows up with the QP and consumer and monitors updates to make sure that the plan is being implemented. There is a Clinical Team Meeting held each week facilitated by the Clinical Director. The team continues to assess the progress of each consumer.	6/9/25

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V 112	Continued From page 2 AWOL behavior. Interview on 6/9/25 with the Qualified Professional (QP) revealed: -After clients exhibit negative behavior, the treatment plan is updated. -Thought that client #2's goal related to compliance to program rules had been updated to include strategies to prevent AWOL behavior. -Failure to update client #2's treatment plan "must have been an oversight on my part."	V 112		