PRINTED: 06/11/2025
FORM APPROVED

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
	MH.080-222	A. BUILDING: _____ B. WING _____	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REVIVE HOUSING, LLC	523 NORTH LONG STREET SALISBURY, NC 28144

(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 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.	V 000		
V 114	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 include evacuation procedures and routes. (b) 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 accessible for use.	V 114	10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES Revive Housing has updated the protocol for drills. Monthly drills will now be conducted for each shift to address the identified issue. Staff will be notified via the home base system when the monthly drills are due. They will be required to perform the drill during their respective shifts and log the details of the drill. A meeting with staff was held on 6/12/2025 to discuss the changes in drill frequency and the documentation procedure. The QP/Director will review the logbooks at the end of each month to ensure staff compliance with the protocol and prevent recurrence of the issue.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Director DATE: 6-20-25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MH L088-222	A. BUILDING _____ B. WING _____	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REVIVE HOUSING, LLC	523 NORTH LONG STREET SALISBURY, NC 28144

(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 114	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure fire and disaster drills were completed at least quarterly and repeated for each shift. The findings are: Interview on 6/9/25 with Staff #1 revealed: -The facility operated with 3 staff shifts; -He had been employed since 3/10/23; -He had participated in fire drills but not a disaster drill. Review on 6/9/25 of the facility's fire drills for the months of July 2024 - December 2024, revealed: -No documentation of a completed 3rd shift drill for the quarter of July 2024 - September 2024; -No documentation of a completed 2nd shift drill for the quarter of October 2024 - December 2024. Review on 6/9/25 of the facility's disaster drills for the months of July 2024 - December 2024 revealed: -No documentation of a completed 3rd shift drill for the quarter of July 2024 - September 2024; -No documentation of completed 1st or 3rd shift drills for the quarter of October 2024 - December 2024. Interview on 6/9/25 with Client #1 revealed: -He had been a resident at the facility for over 4 months; -He had participated in fire drills but not a disaster drill while at the facility. Interview on 6/9/25 with the Owner revealed: -He was aware that fire and disaster drills were required to be completed quarterly on each shift; -He was going to ensure drills were completed as	V 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MH1.080-222	A. BUILDING: _____ B. WING _____	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REVIVE HOUSING, LLC	523 NORTH LONG STREET SALISBURY, NC 28144

(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 114	Continued From page 2 required in the future.	V 114		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118	V 118 27G .0209 (C) Medication Requirements All client records were immediately reviewed by the Qualified Professional (QP) for accuracy and have been updated to include current active medication orders. A house meeting with staff was conducted on 6/12/2025. The meeting addressed the correct protocol for updating the medication record, including the requirement for signatures and procedures to follow when medication is refused, not administered, or discontinued. Staff were explicitly informed that the use of white-out is strictly prohibited under any circumstances. To prevent the recurrence of these issues, the following actions have been implemented: - Weekly MAR checks have been instituted as of 6/12/2025 by the QP to ensure the accuracy of logs. Additionally, end-of-month checks will be performed by the house supervisor or authorized personnel to ensure Revive Housing, LLC complies with Medication Requirements. - All active staff members received medication refresher training, completed as of 6/19/2025, to address the deficiencies cited.	

PRINTED: 06/11/2025
FORM APPROVED
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
	MH.980-222	A. BUILDING _____ B. WING _____	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REVIVE HOUSING, LLC	523 NORTH LONG STREET SALISBURY, NC 28144

(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 118	Continued From page 3 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 (antipsychotic) 25 milligrams (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 every month. -When he asked monthly why he wasn't administered all his medications, staff informed him that he was out. Attempted interviews on 6/5/25, 6/6/25 and	V 118	• Medication record logs have been updated to include more detailed information on administration (medication/admin instructions/date dispensed, etc.).	

PRINTED: 06/11/2025
FORM APPROVED
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
	MH1.080.222	A. BUILDING: _____ B. WING _____	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REVIVE HOUSING, LLC	523 NORTH LONG STREET SALISBURY, NC 28144

(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 118	Continued From page 4 6/9/25, with Client #1's guardian were not successful as requests to return calls were ignored. Review on 6/9/25 at 10:56am of Client #1's MAR for the month of June 2025 revealed: -No documentation for 6/8/25 and 6/9/25 that Risperidone, Escitalopram, Clonidine Hydrochloride or Dextroamphetamine were administered or why they weren't administered. Observation on 6/9/25 at 11:00am medications for Client #1 revealed Risperidone and Escitalopram were not available. Interview on 6/9/25 with a representative from the pharmacy utilized by the facility revealed: -Risperidone for Client #1 was previously picked up on 5/7/25; -Risperidone for Client #1 was refilled 6/7/25 and had not been picked up; -Escitalopram for Client #1 was previously picked up on 5/10/25; -Escitalopram for Client #1 was refilled today and had not been picked up; Review on 6/9/25 of Client #2's record revealed: -An admission date of 6/13/23; -An age of 17; -Diagnoses included Conduct Disorder, ODD, ADHD, Generalized Anxiety Disorder, Insomnia and Cannabis Use Disorder; -Physician orders dated 4/29/25 for Vyvanse (ADHD) 70mg, take 1 capsule po every morning 8:00am, Saphris (antipsychotic) 10mg, take 1 tablet po daily 8:00am, Fluoxetine (antidepressant) 20mg, take 1 capsule po daily 8:00am, Aripiprazole (antipsychotic) 20mg, take 1 tablet po daily and Trazodone (insomnia) 150mg, take 1 tablet po nightly 8:00pm.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MH1.088-222	A. BUILDING: _____ B. WING _____	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REVIVE HOUSING, LLC	523 NORTH LONG STREET SALISBURY, NC 28144

(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 118	Continued From page 5 Attempted interviews on 6/5/25, 6/6/25 and 6/9/25, with Client #1's guardian were not successful as requests to return calls were ignored. Review on 6/9/25 at 11:05am of Client #2's MAR for the month of June 2025 revealed: -No documentation for 6/8/25 and 6/9/25 that Vyvanse, Saphris, Fluoxetine and Aripiprazole were administered or why they weren't administered; -Documentation of prn (as needed) for Trazodone; -Documentation of initials on 6/1/25, 6/3/25 and 6/4/25 that Trazodone was administered at 8:00am instead of 8:00pm. Interview on 6/9/25 with Staff #2 revealed: -He had been made aware by the facility Owner today that he had not documented the MARs as required; -He was busy and unable to find a pen but had documented the MARs after talking with the Owner today; -He thought Trazodone was able to be administered anytime during the day as needed. Interview on 6/9/25 with the Owner revealed: -He was not aware there was a problem with the MAR's; -He was going to ensure that the MAR's were completed as required and medications were administered as ordered. Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080-222	A. BUILDING _____ B. WING _____	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REVIVE HOUSING, LLC	523 NORTH LONG STREET SALISBURY, NC 28144

(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 296	Continued From page 6 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; (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.	V 296	10A NCAC 27G .1704 Minimum Staffing Requirement Revive Housing schedules two employees for each shift. On 6/12/2025, the QP and Director reviewed the notification requirements for employees who cannot attend or will be late to their shift, ensuring that two staff members are present on every shift. Employees will continue to use the home base system to notify all staff members if someone is late or absent. If an employee cannot find coverage for their shift, they must inform the QP/Director immediately. The QP/Director have initiated random shift visits to monitor compliance with the required staffing levels. These random shift visits will continue for the next 2-3 months to ensure compliance and prevent the recurrence of the issue.	

PRINTED: 06/11/2025
FORM APPROVED
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
	MH1880-222	A. BUILDING _____ B. WING _____	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REVIVE HOUSING, LLC	523 NORTH LONG STREET SALISBURY, NC 28144

(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 296	Continued From page 7 (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 observations, record review and interviews, the facility failed to ensure the minimum staff ratio of two staff for up to 4 adolescents. The findings are: Observations on 6/9/25 from approximately 10:00am - 12:00pm revealed Staff #1 and Client #1 were the only individuals present at the facility. 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, Conduct Disorder and Oppositional Defiance Disorder. Interview on 6/9/25 with Staff #1 revealed: -He was aware there were supposed to be a 2nd staff with him while at the facility with Client #1; -Client #1 was suspended from day camp last week so it was an emergency; -He usually worked 3rd shift but was filling in on 1st to supervise Client #1.	V 296		

PRINTED: 06/11/2025
FORM APPROVED
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
	MH1080222	A. BUILDING: _____ B. WING _____	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REVIVE HOUSING, LLC	523 NORTH LONG STREET SALISBURY, NC 28144

(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 298	Continued From page 8 Interview on 6/9/25 with the Owner revealed: -He was aware there was supposed to be 2 staff when clients were present in the facility at all times; -It was a struggle finding staff to fill in since it was unexpected that Client #1 was suspended from day camp.	V 298		