STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601556	A. BUILDING: _____ B. WING _____	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A STEP IN THE RIGHT DIRECTION LLC	2717 BOTANY STREET CHARLOTTE, NC 28216

(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 06/20/2025. The complaint was substantiated (Intake #NC00231409). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Staff Secure for Children or Adolescents. This facility is licensed for 4 and has a current census of 4. The survey sample consisted of audits of 2 current clients and 1 former client.	V 000		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills.	V 110		

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V 110	Continued From page 1 (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record reviews and interviews, 1 of 1 Staff (Staff #1) failed to demonstrate the knowledge skills and abilities required by the population served. The findings are: Review on 06/17/2025 of FC #3's record revealed: -17-years-old. -Admitted 12/09/2023. -Discharged 06/13/2025. -Diagnosed with Major Depressive Disorder, Generalized Anxiety Disorder, Oppositional Defiant Disorder, Unspecified Trauma and Stressor-Related Disorder. -Comprehensive Clinical Assessment dated 02/04/2025 revealed: " ... Her (FC #3) actions indicate difficulty managing anxiety, anger, and frustration, often leading to maladaptive and self-injurious coping mechanisms. [FC #3] was caught emailing unauthorized parties on a school-issued laptop, suggesting possible boundary-testing behavior or attempts to seek external validation or connection outside of approved channels. " Review on 06/17/2025 of Staff #1's personnel record revealed: -Hire date 07/18/2024.	V 110		

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V 110	Continued From page 2 -Client specific training 07/13/2024. -Alternatives to Restrictive Interventions 01/25/2025. Attempted Interviews on 06/18/2025 and 06/19/2025 with FC #3's Department of Social Services (DSS) Guardian was unsuccessful due to no response to phone call prior to survey exit date 06/20/2025. Interview on 06/17/2025 with Client #1 revealed: -" ...I was seated in the van, but I was in the back. So, I really could not see." Interview on 06/17/2025 with Client #2 revealed: -" ...then I see [Staff #1] and [FC #3] try to walk out the door, but [Staff #1] kept closing and holding the door so [FC #3] could not get out of the store until the cops came." Interview on 06/18/2025 with Staff #1 revealed: -"I went into the store and said hi [FC #3] how are you and she just looked at me. She said '[Staff #1], I'm not going back with you', and I said that is fine." -"And that's when she gave the lady money for her items and I said on shoot you got money. I was like, can you buy me something to drink too, and she was like [FC #3], I am not going with y'all." -"She grabbed her bags and tried to go out the door and I said [FC #3] you can't leave right now, and she said why not, and I said because you can't." -"...[FC #3] continued to try to push to get out as well...[FC #3] continued to push the door..." -"I was under the impression that I had to keep eyes on her the entire time, and we did not want her to be AWOL (absent without leave)." -Staff #1 restricted FC #3's ability to exit the store,	V 110		

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V 110	Continued From page 3 which led to further escalation of the 06/11/2025 incident. Interview on 06/17/2025 with Staff #2 revealed: -"[Staff #1] went into the store and was trying to prevent her (FC #3) from leaving until the police came." Interview on 06/20/2025 with the Qualified Professional revealed: -"After locating [FC #3], [Staff #1] and the others advised on what transpired at the store. It was communicated that [Staff #1] stood in front of the door and as [FC #3] was exiting the door she pushed [Staff #1] and both of them fell to the ground." -"We debriefed after, and we advised that our protocol is to contact police when a runaway is sighted. And additionally, before the incident at the store occurred we had advised when they were canvasing that if they saw to not pick her up but to contact the police." -"We will be having training to go over this process to debrief further on how to handle situations (run away situations) should they occur in the future."	V 110		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare	V 132		

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V 132	Continued From page 4 facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure that the Health Care Personnel Registry (HCPR) was notified of all allegations against health care personnel, failed to provide evidence that alleged acts were investigated, and failed to report, within 5 working days, the results of the investigation to the Department. The findings are: Review on 06/17/2025 of the facility's records revealed: -There was no evidence of HCPR notification for the allegation that Staff #1 physically abused Former Client (FC) #3 on 06/11/2025. -There was no evidence of an investigation for	V 132		

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V 132	Continued From page 5	V 132		

the above 06/11/2025 incident.
-There was no evidence that the results of the investigation for the above 06/11/2025 incident were reported to the Department within 5 days.

Review on 06/16/2025 of the North Carolina Incident Response Improvement System (IRIS) from 03/15/2025 - 06/15/2025 revealed:
-There was no HCPR notification for Staff #1's alleged physical abuse of FC #3 incident dated 06/11/2025.
-There was no investigation for the above 06/11/2025 incident.
-There was no evidence that the results of the investigation was reported within 5-day to the Department for the above 06/11/2025 incident.

Interview on 06/17/2025 with the Qualified Professional (QP) revealed:
-"We did not report to HCPR."
-"We did interviews with the clients and staff."
-"She (Staff #1) continued to work that night. She has not worked since. We suspended her until the investigation is complete."

Interview on 06/20/2025 with the QP revealed:
-"As it relates to abuse and the allegation, the staff and the clients were interviewed regarding the situation and the IRIS report was completed."
-"[Licensee] has the written information but could not provide the information because she was on vacation."
-"In the future, we will ensure that any allegation against staff will be reported within 24 hours."
-"In the future, as it relates internal investigations, we will ensure that we have information available for applicable parties as needed."

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V 300	Continued From page 6	V 300		
V 300	27G .1708 Residential Tx. Child/Adol - Trans or dischg 10A NCAC 27G .1708 TRANSFER OR DISCHARGE (a) The purpose of this Rule is to address the transfer or discharge of a child or adolescent from the facility. (b) A child or adolescent shall not be discharged or transferred from a facility, except in case of emergency, without the advance written notification of the treatment team, including the legally responsible person. For purposes of this Rule, treatment team means the same as the existing child and family team or other involved persons as set forth in Paragraph (c) of this Rule. (c) The facility shall meet with existing child and family teams or other involved persons including the parent(s) or legal guardian, area authority or county program representative(s) and other representatives involved in the care and treatment of the child or adolescent, including local Department of Social Services, Local Education Agency and criminal justice agency, to make service planning decisions prior to the transfer or discharge of the child or adolescent from the facility. (d) In case of an emergency, the facility shall notify the treatment team including the legally responsible person of the transfer or discharge of the child or adolescent as soon as the emergency situation is stabilized. (e) In case of an emergency, notification may be by telephone. A service planning meeting as set forth in Paragraph (c) of this Rule shall be held within five business days of an emergency transfer or discharge.	V 300		

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V 300	Continued From page 7 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to coordinate service planning decisions prior to the transfer or discharge of the child or adolescent from the facility affecting 1 of 1 Former Clients (FC #3). The findings are. Review on 06/17/2025 of FC #3's record revealed: -17-years-old. -Admitted 12/09/2023. -Discharged 06/13/2025. -Diagnosed with Major Depressive Disorder, Generalized Anxiety Disorder, Oppositional Defiant Disorder, Unspecified Trauma and Stressor-Related Disorder. -Comprehensive Clinical Assessment dated 02/04/2025 revealed: " ...During the assessment, she exhibited signs of frustration and moodiness but was appropriately dressed for the occasion. [FC #3]'s team expressed concerns regarding her limited progress in treatment, noting increased defiance, manipulative behaviors, and verbal aggression towards others. These behaviors have been persistent, indicating difficulties with emotional regulation and compliance with authority figures. She denied suicidal and homicidal ideation however staff reports incidents of [FC #3] engaging in self-harming behaviors Since arriving at A Step in the Right Direction (ASITRD) group home, [FC #3] presents with a pattern of escalating emotional dysregulation and concerning behaviors that have persisted over a sustained period of time. Her actions indicate difficulty managing anxiety, anger, and frustration, often leading to maladaptive and self-injurious coping mechanisms. [FC #3] was caught emailing	V 300		

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V 300	Continued From page 8	V 300		

unauthorized parties on a school-issued laptop, suggesting possible boundary-testing behavior or attempts to seek external validation or connection outside of approved channels. "
-There was no emergency CFT (Child and Family Team) documentation to facilitate and coordinate FC #3's discharge after the facility amended the initial 30-day notice agreement.

Attempted Interviews on 06/18/2025 and 06/19/2025 with FC #3's Department of Social Services (DSS) Guardian was unsuccessful due to no response to phone call prior to survey exit date 06/20/2025.

Interview on 06/16/2025 with the Qualified Professional (QP) revealed:
-"She (FC #3) is not coming back to our facility."
-"We did 30 days (notice) on 05/07/2025 with a formal discharge date of 06/05/2025."
-"We agreed to keep to until the new provider could take her ..."

Interview on 06/20/2025 with the QP revealed:
-"[FC #3] was placed on 30-day notice and after the incident (on 06/11/2025) was transported to the hospital."
-"So, because her 30 days had expired and she posed a health and safety concern to ASITRD, we held an emergency CFT (Child and Family Team) for [FC #3] and determined that she would not be back to the ASITRD."
-"ASITRD located placement for her, but she (FC #3) would not be able to transition to that place until the first week of July (2025)."
-"...We do realize that leaving her in the hospital is not ideal, but we will try to do what is in the best interest of the child."

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V 366	Continued From page 9	V 366		
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 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	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 366	Continued From page 10 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 (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	V 366		

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V 366	Continued From page 11 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 and Level III incidents. The findings are: Review on 06/16/2025 of the North Carolina Incident Response Improvement System (IRIS) from 03/15/2025 - 06/15/2025 revealed: -Level II: Former Client (FC) #3's aggressive behavior and unplanned absence for more than 3 hours that required police contact incident dated 06/11/2025. -Level III: There was no IRIS report submitted for the allegation that Staff #1 physically abused FC #3 incident dated 06/11/2025.	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 366	Continued From page 12 Review on 06/17/2025 of the facility records revealed: There was no documentation to support that the above recorded incidents had been evaluated to: -Determined the cause of the incident. -Assigned person to be responsible for implementation of the corrective and/or preventive measures. Interview on 06/20/2025 with the Qualified Professional revealed: -"As it relates, to documenting how to prevent this from happening this from happening in the future, we will ensure include details on to prevent any incident from happening in the future."	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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 367	Continued From page 13 (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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	MHL0601556	A. BUILDING: _____ B. WING _____	06/20/2025

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V 367	Continued From page 14 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 report Level III incidents in the Incident Response Improvement System (IRIS) within 24 hours of becoming aware of the incident. The findings are: Review on 06/16/2025 of the North Carolina Incident Response Improvement System (IRIS) from 03/15/2025 - 06/15/2025 revealed: -There was no IRIS report submitted for the allegation that Staff #1 physically abused Former	V 367		

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V 367	Continued From page 15 Client (FC) #3 on 06/11/2025. Review on 06/17/2025 of an IRIS Report submitted on 06/14/2025 for FC #3 revealed: -The incident occurred on 06/11/2025. -The incident report was completed on 06/14/2025 (72 hours after the incident). -The facility learned about the incident on 06/11/2025. -Consumer Behaviors: Aggressive Behavior and unplanned absence for more than 3 hours that required police contact. -Incident Information: "NO" specified for Allegation against staff and/or facility. -HCPR Facility Allegation section was "NOT" completed. -The resident abuse box was "NOT" checked. -Staff #1 was "NOT" identified or accused of resident abuse. -Provider Comments: "...[FC #3] pushed staff as she was exiting the door and both [FC #3] and staff fell while going out the door ... She then went to a neighbor's house and police were contacted. Reportedly, [FC #3] painted a false narrative to the neighbors and was able to obtain money and use their phone to make contact with her friends and family members. " -There were no additional updates to the report after 06/14/2025. Interview on 06/20/2025 with the Qualified Professional revealed: -"Regarding the allegation of abuse, when completing the IRIS report for this incident, under the consumer behavior section the details of the incident and all information that we had at the time was included in the report as it relates to the allegation against staff." -"We completed another IRIS report on 6/19/2025, regarding the details of the allegations	V 367		

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V 367	Continued From page 16 against staff and this report included the HCPR requirements." -"In the future, as it relates to any allegation against staff, A Step In The Right Direction, will ensure that allegations are reported within 24 hours."	V 367		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S.	V 500		

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V 500	Continued From page 17 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure all incidents of alleged abuse are reported to the County Department of Social Services (DSS). The findings are: Review on 06/17/2025 of the facility records revealed:	V 500		

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V 500	Continued From page 18 -There was no notification to the Local County DSS for Staff #1's alleged physical abuse of Former Client (FC) #3 incident dated 06/11/2025. Interview on 06/17/2025 with the Qualified Professional (QP) revealed: -"I did not report it to [Local County] CPS (Child Protective Services)." Interview on 06/20/2025 with the QP revealed: -"We reported it to her (FC #3) social worker, but we were not aware that we needed to report to local DSS." -"Going forward, if there are allegations against staff we will ensure that we report any allegation to the assigned DSS as well local DSS."	V 500		