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
	MHL013-240	A. BUILDING: _____ B. WING _____	R-C 06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSCENDING HEIGHTS, LLC	550 ARCHDALE DRIVE CONCORD, NC 28027 Steven Lanham Steven Lanham (Jun 25, 2025 18:19 EDT)

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V 000	INITIAL COMMENTS A complaint and follow-up survey was completed on 6/6/25. ***The complaint was unsubstantiated*** (intake #NC00230200). **Deficiencies were 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 4. The survey sample consisted of **audits of 4 current clients, 3 former clients**.	V 000	RECEIVED JUN 30 2025 DHSR-MH Licensure Sect	
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 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	V 132		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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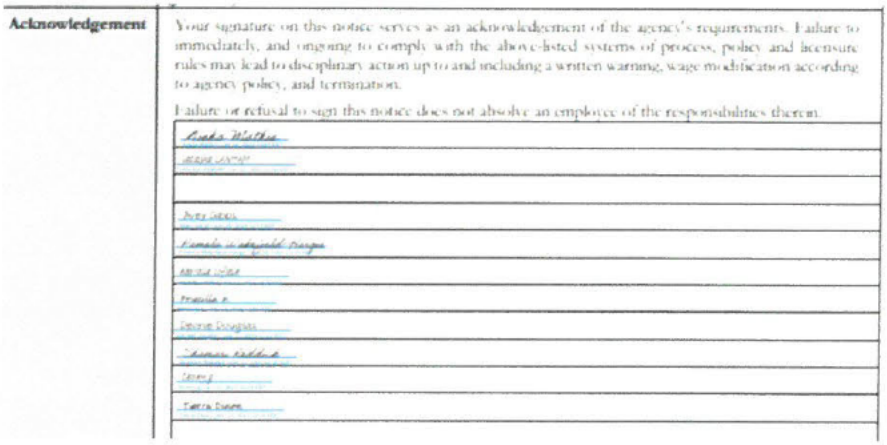
V 132	Continued From page 1 a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be 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 record review and interview, the facility failed to ensure that the North Carolina Health Care Personnel Registry (HCPR) was notified of all allegations against health care personnel within 24 hours, failed to make every effort to protect clients from harm while an investigation was in progress, and failed to report the results of the investigation within five working days of the initial notification. The findings are: Review on 5/22/25 of "Notification of CPS (Child Protective	V 132	**• Measures put in place to correct the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).** **• Measures will be put in place to prevent the problem from occurring again.** **General Staff Meeting Report: 06-12-2025** Staff mtg was completed on 06/12/2025 to review DHSR findings and recommendations. Information included the following: ✓ Professional Development, Refresher & Upcoming Training(s) Incident Report Training: https://drive.google.com/file/d/1YO9adMgSHTV1HAqt4M9PTm9Mr2zEZWG7/view?usp=drive_link NC Healthcare Registry Policy: https://drive.google.com/file/d/1clndRLagNvdcu3HGZxYGil6TxyjaM4az/view?usp=sharing Complaint Intake is available to receive complaints regarding the care and services provided to patients/residents/consumers by health care facilities/agencies/homes licensed by the Division of Health Service Regulation. • Health Care Personnel Investigations reviews and investigates allegations of abuse, neglect, fraud, diversion of drugs, and misappropriation of property against unlicensed health care workers and lists any substantiated finding(s) on the Nurse Aide I Registry and Health Care Personnel Registry for use by health care providers in their hiring process. Client Rights: https://drive.google.com/file/d/1667rD69uHc8UQacse2S1OGKrpdGfengS/view?usp=drive_link  **Acknowledgement** Your signature on this notice serves as an acknowledgement of the agency's requirements. Failure to immediately, and ongoing to comply with the above-listed systems of process, policy and licensure rules may lead to disciplinary action up to and including a written warning, wage modification according to agency policy, and termination. Failure or refusal to sign this notice does not absolve an employee of the responsibilities therein. The agency will continue to follow the protocol for all allegations of abuse, neglect, fraud, diversion of drugs, and misappropriation of property against unlicensed health care workers ***Please Note*** TH did not fail to protect clients from harm while an investigation was in progress. Investigating personnel stated there was no need to remove employee from contact of alleged victim due to victim already being discharged from the facility at the time to notification. **• Who will monitor the situation to ensure it will not occur again: Owner/. Director** **• How often the monitoring will take place: Quarterly** [redacted]	Completed: 06/12/2025 and Quarterly Ongoing

	Services) Involvement" dated 4/1/25 revealed: -"...Allegedly, the female group home staff member (Staff #4) kissed the 17-year-old child (Former Client (FC) #1) on her lips. Female staff (#4) went into the child's (FC #1) room, turned off the lights and undressed and attempted to touch her, child pushed away..." Review on 5/27/25 of FC #1's record revealed: -Age 17. -Admitted 10/24/24. -Diagnoses: Major Depressive Disorder, Mild Intellectual Disabilities, Oppositional Defiant Disorder. -Discharged 3/27/25. -Discharge Summary: -"Discharge Disposition-Since her (FC #1) arrival				

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V 132	Continued From page 2 (10/24/24), [FC #1] has exhibited extreme behaviors on a daily basis to include sexual inappropriateness with peers (other clients), staff, teachers, and school administrators, manipulation, staff splitting, compulsive lying, false claims of sexual assault, property destruction, aggression, profanity, noncompliance, multiple AWOL (absent without leave) attempts, physical assaults, verbal abuse, spitting, staff intimidation, etc. To ensure safety for both [FC #1] and others (staff and clients) in the home (facility), the Resident (FC #1) was discharged from the facility because the resident was physically and verbally aggressive, displayed property destruction, attempted to go awol, and made multiple self-harm attempts and threats." -Course of Treatment ...Since admission (10/24/24) to level three services, the resident has shown constant regression to include instances of property destruction, verbal and physical aggression, attention-seeking behaviors, false allegation of sexual assault [van driver, school officials, residential staff (facility staff)], AWOL attempts, suicidal ideations, and self-harm attempts resulting in multiple hospitalizations ..." Review on 5/22/25 and 6/6/25 of the North Carolina Incident Response Improvement System (IRIS) from 1/1/25-6/6/25 revealed: -No documentation in IRIS and no report to HCPR of FC #1's 4/1/25 allegation of Staff #4 kissing and attempting to touch FC #1. -No documentation of FC #1's allegation of abuse by "van driver, school officials, residential staff (facility staff)" as described in the discharge summary dated 3/27/25. Interview on 5/28/25 with Department of Social Services (DSS) Investigator revealed:	V 132		

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V 132	Continued From page 3	V 132		

-FC#1 had a history making allegations of abuse that had been investigated by DSS in the past year.
-FC #1 had already been discharged from the facility on 3/27/25 and moved to another facility placement.
-FC #1's information about the 4/1/25 allegation of Staff #4 kissing and attempting to touch FC #1, "didn't corroborate with what anyone else (staff, clients) was saying."
-He interviewed facility staff, current clients, FC #1 and FC #1's DSS Social Worker/Legal Guardian (SW/LG) and concluded, based on FC #1 report and reports from staff and clients in the facility, that there was a lack of evidence to substantiate the report of abuse.

Interview on 6/2/25 with FC #1 revealed:
-She had been at the facility for about 2 years and liked it there.
-Did not have any concerns with staff.
-Had been in the hospital (psychiatric) since her IVC and discharge from the facility on 3/27/25. -"Just want to say I was obsess (obsessed). I like her (Staff #4) a lot. I did appreciate her, had love for her in a sense; my love for her is gone; not, I mean, not all the way. I regret what I did and said; I was weird toward her, called her a b****h, I really regret that; wasn't weird, but I was clingy; I got attached too fast."
-Staff #4 had touched her on the chest and tried to kiss her once when she and Staff #4 were alone in the facility (date unknown).
-Was touched by Staff #4 a week before she was discharged on 3/27/25, when she and Staff #4 had fallen asleep on the couch together and were caught by the HM/QP#2, "they [HM/QP#2] were walking in (facility)...and they (HM/QP#2) said 'get up' and she (Staff #4) said 'no, lay back down', and I was confused about who I should listen to; I

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V 132	Continued From page 4 took [Staff #4]'s side because I care about her more. I feel like [HM/QP#2] knew (about the touching)...she (HM/QP#2) thought I was in love with her (Staff #4)." -Was scared to tell anyone because she didn't think she would be believed. Interview on 6/3/25 with client #4 revealed: -FC #1 had left the facility often, police had to go get her, and was not gone more than 30 minutes. -FC #1 liked lying about Staff #4 and would get angry with Staff #4 when she didn't give FC#1 the attention FC #1 wanted. -Staff #4 never acted in a sexual manner toward FC #1 and was never inappropriate. -FC #1 had lied on the van driver and alleged he had touched her. -FC #1 had a crush on the Former QP (FQP) and would ask facility staff to call the FQP. -FC #1 made sexually inappropriate comments about what she would do to Staff #4 and had made similar comments about girls at school. Attempted interview on 6/2/25 contact with FC #1's DSS SW/LG, left voice message with contact information for follow up and there was no contact from DSS SW/LG. There was no return call prior to survey exit. Attempt interview on 6/4/25 with Former Qualified Professional (FQP) was unsuccessful, left voice message with contact information for follow up and there was no contact. There was no return call prior to survey exit. Interview on 6/3/25 with Staff #2 revealed: -"[Staff #4] was always making sure [FC #1] was going in the right direction; she (Staff #4) was good with handling [FC #1] ' s behaviors. -FC #1 had a history of lying and facility staff	V 132		

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V 132	Continued From page 5 would only interact with FC #1 within sight of the facility cameras or they would only address her from the doorway of FC #1's bedroom without entering. -If FC #1 liked someone, "she (FC #1) would always try to take things further, like asking staff out and when she doesn't ' t get an answer she will lie...she (FC #1) doesn't ' t like rejection and would make things up." -Had never observed anything sexual between Staff #4 and FC #1. -FC #1 liked hugging and staff was helping FC #1 to work on respecting personal space. "We (staff) just dapped (fist bump) her up instead of hugging" because of how long FC #1 would try to extend a hug. -Did not know about IRIS and HCPR or who would be responsible for reporting. Interview on 6/3/25 with Staff #3 revealed: -FC #1 had made "multiple allegations". -If FC #1 got mad or had a crush on someone or was not getting her way, she would say someone sexually assaulted her, hit her and she had made an allegation of assault with client #4's van driver. -Staff was constantly redirecting FC #1 about personal space. -FC #1 liked hugging and staff would give high fives instead of hugging. --Did not know about IRIS and HCPR, but thought QPs or HR/CC were responsible. Interview on 6/4/25 with Staff #4 revealed: -Was named as the perpetrator of abuse by FC #1 and was made aware of FC #1's allegation of abuse (kissing and attempted touching) when the 4/1/25 report came from DSS and the DSS Social Worker Investigator arrived at the facility in April 2025 (dates unknown). -Had never had any intimate or inappropriate	V 132		

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V 132	Continued From page 6 contact with FC #1. -"I'm not sure if they (facility) contacted or made any reports to anything (IRIS, HCPR)." -"The facility did an investigation (April 2025). Once it (FC #1's 4/1/25 allegation of Staff #4 kissing and attempting to touch her) was brought up, it was discussed. [Home Manager (HM/QP#2)] and I were contacted by [Human Resource/Compliance Consultant (HR/CC)] and we discussed house rules, but I don't know what transpired outside of myself, like with other staff members, I can only speak about what happened with me." -QPs and HR/CC were responsible for IRIS and HCPR reporting. -"I was still able to work with TH (Transcending Heights) with no breaks in employment." - "[HR/CC] would be responsible for making reports and doing the investigation." Interview on 6/2/25 with the HM/QP#2 revealed: -Provided supervision to staff. -She and QP#1 were responsible for incident reporting. -Was aware of FC #1's 4/1/25 allegation of Staff #4 kissing and attempting to touch FC #1 and was made aware by DSS on 4/1/25. -"...she (FC #1) stated that staff (#4) tried to sexually assault her, she didn't like it (assault) and she never told anyone, and that's what DSS told me..." -Was not aware of anything intimate or inappropriate going on between FC #1 and Staff #4 and had never observed Staff #4 conduct herself inappropriately with clients. -There was never a time when FC #1 and Staff #4 would have been in the facility alone. -No staff in the facility entered clients' rooms and staff never shut clients' bedroom doors. - Staff had redirected and had addressed in	V 132		

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V 132		V 132		
	Continued From page 7 treatment team meetings that FC #1 had issues respecting boundaries, behavior, profanity and inappropriate comments to staff like, 'hey, you're cute.' -Was aware of FC #1's accusation of sexual assault by van driver that resulted in loss of transportation resource. -Had not made an HCPR report and was not aware if there had been an HCPR report made to address FC #1's 4/1/25 allegation of Staff #4 kissing and attempting to touch FC #1. -There was no facility investigation and Staff #4 was not removed from the schedule because FC #1 had been discharged. -QP #1 was responsible for HCPR reporting and HR/CC was responsible for internal investigation. Interview on 6/2/25 and 6/4/25 with the QP#1 revealed: -Was hired 3/15/25. -Was responsible for completing IRIS reports and HCPR reports. -Knew that allegations of abuse were required to be reported to the HCPR within 24 hours. -"Investigation (date unknown) was done and she (Staff #4) was taken off the schedule until [HR/CC] finished her investigation. I know she (Staff #4) was able to come back once FC #1 was gone from the facility (discharged)." -"I wasn't there when it (Staff #4 allegedly kissing and attempting to touch FC #1) happened." -Was aware that FC #1 had accused (date unknown) the van driver of touching her and the facility lost their use of transportation resource, "...we (staff) talked to her (FC #1) about lying on people when she gets angry." -Was not responsible for the HCPR report because FC #1 had already been discharged from the facility on 3/27/25. -Did not submit report to HCPR once she was			

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V 132	Continued From page 8 made aware sometime during the week of 3/31/25 to 4/4/25 (exact date unknown) of FC #1's 4/1/25 allegation of Staff #4 kissing and attempting to touch FC #1. -Was not sure whether there was a report to HCPR to address FC #1's allegation of Staff #4 kissing and attempting to touch FC #1. Interview on 6/4/25 and 6/6/25 the HR/CC revealed: -Contracted consultant. -Was made aware (April 2025) by DSS SW Investigator of the 4/1/25 report of FC #1's allegation of Staff #4 kissing and attempting to touch FC #1. -Was aware of FC #1's difficulty with boundaries, dishonesty and history of making false accusations of abuse. -Did not submit report in IRIS and did not make an HCPR report. -The QP#1 was responsible for IRIS and HCPR reporting. -She was responsible to make sure the facility followed through and completed IRIS and HCPR reports. -No IRIS and HCPR reports were made because the facility only learned of the DSS report in April 2025 and FC #1 had already been discharged and was no longer a client in the facility -Staff #4 was not removed from the facility schedule pending an investigation. -Was responsible for internal investigation of any allegations. -"I did not do an internal investigation. I did do an interview with [Staff #4], but did not do an internal investigation because DSS was already doing the investigation. I talked with [Staff #4] and got her statement." **This deficiency constitutes a re-cited deficiency**	V 132		

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V 132	Continued From page 9 **and must be corrected within 30 days.**	V 132		
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	V 366		

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V 366	Continued From page 10	V 366		
	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 (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			

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V 366	Continued From page 11 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**	V 366	**• Measures put in place to correct the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).** **• Measures will be put in place to prevent the problem from occurring again.** TH will provide "refresher" training to all current residential staff and provide new hire training to ensure all staff are familiar and knowledgeable of the incident response protocols. [See Below] *Incident Reporting-Level 1* **Policy** Transcending Heights LLC requires employees to document all Level I incidents and have documentation available onsite for regular reviews. Level I incidents are NOT to be entered into the IRIS web-based reporting system. **Procedures** The Incident Intake Information Form is the format that is "acceptable to TRANSCENDING HEIGHTS LLC." and is to be used to report all Level 1 incidents. A Level 1 incident is any occurrence that is not consistent with the routine operation of the facility or service or the routine care of a resident and that is likely to lead to adverse effects upon a resident and does not meet the definition of a Level 2 or 3 incidents. For further explanation, please refer to the DHHS Incident and Death Response System Manual developed by DMH available at: http://www.ncdhhs.gov/mhddsas/statspublications/Manuals/incidentmanual2-25-11.pdf A copy of which also may be found in the facility office. Level I incidents include: 1. **Restrictive Interventions**: Any planned use of a restrictive intervention administered appropriately and without discomfort, compliant or injury. **TH Practices Physical Restraints as a LAST RESORT within its facilities and attempts LEAST RESTRICTIVE MEASURES BEFORE THE USE OF RESTRAINTS OR POLICE INTERVENTION.* 2. **Medication Errors**: Any error that a physician or pharmacist has determined does not threaten the resident's health or safety. Providers of periodic services should report an error for resident's who self-administer medications as soon as learning of the incident. a. Wong Dosage Administered b. Wrong Medication Administered c. Wrong Administrative Technique d. Wrong Time (over 1 hour from prescribed time) e. Wrong Person Given Medication f. Missed Dose of Prescribed Medication g. Refused Dose of Prescribed Medication h. Dose Preparation Error i. Loss or Spillage of Medication j. Other Medication Errors 3. **Other Incidents**: Any search of resident's living area or seizure of resident's property. [*This does not include routine "Consent Searches" as described in the agency policy. TH requests that all Incident Intake Information Forms be filed with the agency office by completing the form and submitting it within 24hrs to the Program Director. The Incident Intake Information Form is available in the agency office file cabinet. These forms are to be kept in each resident's record at the agency and be available for review by surveyors if requested. **Reminder:** You MUST contact the Facility Director, HS Manager, and Clinical QP via text/email regarding an incident that results in injury or medical/psychiatric hospitalization immediately. Staff were provided with instruction and training as evidenced below in the staff memo dated March 23, 2025	Completed: 03/23/2025, 06/12/2025 an Quarterly Ongoing

evidenced by:
Based on record reviews and interviews, the facility failed to implement written policies governing their response to level I, II and III incidents. The findings are:

Review on 5/22/25 of "Notification of CPS (Child Protective Services) Involvement" dated 4/1/25 revealed:
-"...Allegedly, the female group home staff member (Staff #4) kissed the 17 year old child (Former Client (FC) #1) on her lips. Female staff (#4) went into the child's (FC #1) room, turned off the lights and undressed and attempted to touch

memo

March 23, 2025

Greetings!

Please allow this memo to serve as an official notice for agency news, policy, and SOP (Systems of Practice).

Important Links

ONLINE Incident Report: **The Document is completed online**

https://docs.google.com/forms/d/e/1FAIpQLSe2JCPyNQpHZ4g70_ZH9CWZ7piZem-:1WWLOTg0ZCDobFFDEg/viewform?usp=preview

Paper Form Incident Report: **The document can be printed and completed**

https://drive.google.com/file/d/1gD-FMau7SaHuOuXXME5-h_gw7U4kw0/view?usp=drive_link

IRIS Manual:
https://drive.google.com/file/d/1ei6OebIA7wt5spyvdDSNH_9qnjAmfuSG/view?usp=sharing

AWOL Protocol: https://drive.google.com/file/d/1-QPSvjEBSc7tW7HYoQgryNdFVG19OIYs/view?usp=sharing

When a resident goes AWOL (absent without leave) follow the procedure outlined below:

1. Immediately begin a timeline of events beginning with the time the resident was identified as AWOL or left the facility without permission. I.e. walks out, runs etc.
2. Immediately notify the Supervisor in charge/ Director by phone/text and email
3. Conduct a search of the surrounding area(s)
4. Notify the police if the search is unsuccessful
   - Identify the missing person's name, date of birth, physical description, last known location, and any relevant medical or behavioral information
   - Provide the AWOL face sheet to police or relevant personnel
5. Notify relevant parties. [*Relevant parties, ex. legal guardians, parents, case manager, social worker, probation officer, identified emergency contact(s)
6. Document all actions taken. [Ex. Searched all areas of the property. I followed the resident as they walked away. Attempted to de-escalate and convince resident to return to the facility]

memo

7. Complete the necessary Incident Report. *Level I incident requires IN-HOUSE REPORT ONLY*

	INCIDENT	LEVEL I	LEVEL II	LEVEL III	Guidelines
	Consumer	Any absence of up to 3 hours over the time specified in the	Any absence greater than 3 hours over the time specified in the individual's service	Amber Alerts	Report all amber and silver alerts

Reports to law enforcement: For the purposes of the DHHS incident system, this includes reports to police, sheriff departments, and magistrates of destructive, aggressive, absences/missing person or potentially dangerous acts by consumers, including self-endangerment. Do not include reports related to a consumer's violation of a probation judgment.

General Staff Meeting Report: 06-12-2025
Staff mtg was completed on 06/12/2025 to review DHSR findings and recommendations. Information included the following:

✓ Professional Development, Refresher & Upcoming Training(s)
Incident Report Training:
https://drive.google.com/file/d/1YO9adMqSHTV1HAqt4M9PTm9Mr2zEZWG7/view?usp=drive_link

NC Healthcare Registry Policy:
https://drive.google.com/file/d/1cIndRLagNvdcu3HGZxYGil6TxyjaM4az/view?usp=sharing
Complaint Intake is available to receive complaints regarding the care and services provided to patients/residents/consumers by health care facilities/agencies/homes licensed by the Division of Health Service Regulation.

- Health Care Personnel Investigations reviews and investigates allegations of abuse, neglect, fraud, diversion of drugs, and misappropriation of property against unlicensed

health care workers and lists any substantiated finding(s) on the Nurse Aide I Registry and Health Care Personnel Registry for use by health care providers in their hiring process.

Client Rights:
https://drive.google.com/file/d/1667rD69uHc8UQacse2S1OGKrpdGfengS/view?usp=drive_link

Acknowledgement	Your signature on this notice serves as an acknowledgement of the agency's requirements. Failure to immediately, and ongoing to comply with the above-listed systems of process, policy and licensure rules may lead to disciplinary action up to and including a written warning, wage modification according to agency policy, and termination. Failure or refusal to sign this notice does not absolve an employee of the responsibilities therein.

- **Who will monitor the situation to ensure it will not occur again: Owner/ Director**
- **How often the monitoring will take place: Quarterly**

[redacted]

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	MHL013-240	A. BUILDING: _____ B. WING _____	R-C 06/06/2025

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V 366	Continued From page 12 her, child pushed away..." Review on 5/27/25 of FC #1's record revealed: -Age 17. -Admitted 10/24/24. -Diagnoses: Major Depressive Disorder, Mild Intellectual Disabilities, Oppositional Defiant Disorder. -Discharged 3/27/25. -Discharge Summary, completed 3/27/25 by Former Qualified Professional (FQP): -"Discharge Disposition-Since her (FC #1) arrival (10/24/24), [FC#1] has exhibited extreme behaviors on a daily basis to include sexual inappropriateness with peers, staff, teachers, and school administrators, manipulation, staff splitting, compulsive lying, false claims of sexual assault, property destruction, aggression, profanity, noncompliance, multiple AWOL (absent without leave) attempts, physical assaults, verbal abuse, spitting, staff intimidation, etc. To ensure safety for both [FC #1] and others in the home, the Resident was discharged from the facility because the resident was physically and verbally aggressive, displayed property destruction, attempted to go awol, and made multiple self-harm attempts and threats." -"Course of Treatment ...Since admission (10/24/24) to level three services, the resident has shown constant regression to include instances of property destruction, verbal and physical aggression, attention-seeking behaviors, false allegation of sexual assault [van driver, school officials, residential staff (facility staff)], AWOL attempts, suicidal ideations, and self-harm attempts resulting in multiple hospitalizations ..." -"Discharge Plan-The resident was IVC'd (involuntarily committed), and [Facility] will support the transition to a higher level of care and/or alternate placement."	V 366		

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V 366	Continued From page 13 -"Discharge Outcome-Discharged-Regression." Review on 5/22/25 and 6/6/25 of the North Carolina Incident Response Improvement System (IRIS) from 1/1/25-6/6/25 revealed: -3/27/25 FC #1 walked away from the facility, threatened self-harm, threatened harm to others in the facility which and her behaviors resulted in call to law enforcement outcome of involuntary commitment. Review on 6/5/25 of the Facility Police Calls for Service Report 1/1/25 through 6/5/25 revealed: -1/5/25, 16:10 (4:10pm), Domestic Assault, [Former Staff #7 (FS#7)], W911, Notes: no signs of suicidal ideology, group home employees are going to work on obtaining IVC paperwork on the juvenile (FC #1). They (facility) were advised that we (law enforcement) are not able to transport her (FC #1) without the IVC paperwork from the mags (magistrate) office; Caller is member of the group home staff (FS #7); No Weapons; 17 YOA (years of age) F/M; mixed female subj (subject) has beat up all of the staff. has spit on the caller (FS #7) and made threats to other reside (clients)." -1/24/25 13:51 (1:51pm), Child Abuse Complaint, Self (facility), Notes: Not on scene. Intake report. -1/24/25, "18:46 (6:46pm), Missing Person [Staff #1], E911, Notes: Upon arrival I spoke with the house manager (HM/QP#2), [HM/QP#2] who stated at approximate 6:15 pm [Former Client #3 (FC#3)] left the residence (facility)...While on site taking notes for the 81 report [FC #3]. She (FC#3) she needed to get away for the moment and went to [fast food restaurant]. [FC#3] stated she would not leave the residence (facility) again and would remain in side; Arrived back home (facility)...19:25 (7:25pm); [FC#3] WF (white female) blonde and blk (black) hair, blk jacket	V 366		

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V 366	Continued From page 14 and furry slides, oversized jackets, walking towards [local restaurant], time lapse 20mins (minutes)." -2/8/25, 15:43 (3:43pm), Missing Person Child, [FS#8], W911, Notes: Juvenile (FC #3)left in the care of para professional [Staff #9], who stated she will be transporting the juvenile to [County] for further evaluation and placement, [FC #3]; Notified 2/8/25, 15:48 (3:48pm) twrds (towards) shopping center black hoodie, navy blue baby yoda pajama pants, [sneaker brand] shoes blk and gry (grey) bag, and red crossbody purse left on foot client ran away, 15 year old white female [FC#3]." -3/21/25, "22:57 (10:27pm), Check Welfare, [Staff #6], Notes:...One female juvenile (FC #1); Prisoner in custody, 23:01 (11:01pm); Back at the home (facility) but needs transport her to hospital; heavy set female short Mohawk hair style [FC #1] 17 yo (year old); Female jumped out the window, subject have a 73 episode (mental distress)." - 3/25/25, "19:15 (7:15pm), General Disturbance [QP#1], Notes: I located [FC #1] on the ramp of [interstate highway]. She voluntarily got in my car and returned to the group home where I turned her over to staff. [FC #1] state she was not going to hurt herself and just wanted to leave for a while. She stated she would remain at the group home for the evening (19:59, 7:59pm); On [interstate highway]...female flagged me down...walking...caller lost sight, caller in a gray [make/model]; history of self harm trying to walk in between cars short haircut heavy set female green shorts and purple jacket...female trying to run off group home no known weapons [FC #1] 17 yo female." -4/2/25, "9:45am, Child Abuse Complaint, Self; Notes: DSS (Department of Social Services) report; 3/27/25 18:56 (6:56pm) Mental Commitment, Notes: [FC #1]..."	V 366		

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V 366	Continued From page 15	V 366		

Reviews on 5/22/25 of the facility's records 2/1/25 through 5/22/25 revealed :
-There was no documentation of level I, II, or III incidents.
-No documentation of internal investigation. -No documentation that the facility attended to the health and safety needs of the individuals involved in the incident, determined the cause of the incident, developed and implemented corrective measures, developed and implemented measures to prevent similar incidents, and assigned person(s) to be responsible for implementation of the corrections and preventive measures.

Attempt interview on 6/4/25 with Former Qualified Professional (FQP) was unsuccessful, left voice message with contact information for follow up and there was no contact. There was no return call prior to survey exit.

Interview on 6/4/25 with Staff #4 revealed: -Was made aware on 4/1/25 by DSS of the allegation by FC #1 that Staff #4 kissed and had attempted to touch FC #1.
-Had reported escalation of client behaviors beginning around 3/21/25 and had reported her concerns (March 2025) about FC #1's inappropriate behaviors to the facility.
-Was not sure if facility had documented incidents of FC #1's behaviors. "I know what was discussed (staff) was that she was on her 30 days (behavior contract) and her behavior on a whole was being monitored."
-"We (facility) keep an incident reporting log in the facility. I believe these things (FC #1's behaviors) were documented."
-Had never written an incident report.
-"From my understanding, she (FQP) completed

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V 366	Continued From page 16 the incident reports...I provided her any information she may need." -Was not sure if there were any incidents documented. -Was not aware if a report was completed in IRIS for FC #1's 4/1/25 allegation of Staff #4 kissing and attempting to touch FC #1. -She had not been taken off the facility schedule pending an internal investigation. -There had been no internal investigation completed by the facility. Interview on 6/2/25 with the Home Manager/QP#2 revealed: -Qualified Professional (QP). -She and QP #1 were responsible for reporting incidents. -Knew that FC #1 had issues respecting boundaries, behavior, profanity and inappropriate comments to staff ('hey, you're cute') that had been redirected by staff and addressed in team meetings. -An IRIS report had been submitted for the 3/27/25 incident resulting in FC #1 being involuntarily committed. -Was not aware if there had been a report submitted in IRIS and HCPR for FC #1's 4/1/25 allegation of Staff #4 kissing and attempting to touch FC #1. -There had been no investigation and Staff #4 was not taken off shift because FC #1 had been discharged when the facility became aware of FC #1's 4/1/25 allegation of Staff #4 kissing and attempting to touch FC #1. Interview on 6/2/25 and 6/4/25 with the QP#1 revealed: -Hired on 3/15/25. -Had been told (facility) that FC #1 had been having a lot of behaviors and was on a 30 day	V 366		

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V 366	Continued From page 17 contract. -"We (facility) lost our transportation because [FC #1] accused him (van driver) of touching her (March 2025) and we (staff) talked to her about lying on people when she gets angry. We were able to get transportation (van) back after [FC #1]'s discharge." -Did not recall that the facility had internal level I incident reports. -"When I came she (FC #1) had just come back from IVC because she had busted out a window (facility)...went to hospital on 3/27 (2025), I met her on 3/24 (2025) when she was coming back from the hospital (IVC)." -Was responsible for completing IRIS reports. -Did not submit incident report in IRIS and did not report to HCPR once she was made aware of the abuse (Staff #4 kissing and attempting to touch FC #1) allegation, "I didn't do one (incident report). I'm confused why would I do an incident report or report it (4/1/25 allegation) if she (FC #1) said it (allegation) after she was discharged?" -"I did an incident report when the client was IVCed (involuntarily committed) 3/27 (2025), it's in the system, I completed it in IRIS." -Had not submitted any other level II or III reports in IRIS for behaviors as described in FC #1's 3/27/25 discharge summary. -Did not have documentation of incident reports to correspond with police service calls to the facility (1/1/25 to 6/5/25). Interview on 6/4/25 and 6/6/25 the HR/CC revealed: -Contracted consultant. -Responsible for overseeing reporting of incidents. -Was not aware that QP#1 had not provided internal incidents documentation prior to survey exit.	V 366		

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V 366	Continued From page 18 -Was not aware of police reports (1/1/25 through 6/5/25). -Was not aware if level 1, II, II reports were documented for incidents of FC #1's behavior as described in the 3/27/25 discharge summary. .-Did not submit incident reports and was not responsible for submitting IRIS reports. -Was not aware of the 4/1/25 report of FC #1's allegation of Staff #4 kissing and attempting to touch FC #1 until DSS came to the facility in April 2025. -The QPs were responsible for IRIS reports, "...I would receive a copy to keep track and make sure the follow through is taken care of (IRIS and HCPR completed). I provide them (facility) with the information, then follow up to make sure it is done." -Acknowledged she did not complete a thorough investigation to attend to the health and safety needs of the individuals involved in the incident, determine the cause of the incident, develop and implement corrective measures, develop and implement measures to prevent similar incidents, and assign person(s) to be responsible for implementation of the corrections and preventive measures. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	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	V 367		

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V 367	Continued From page 19 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; (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	V 367		

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	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 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.			

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	MHL013-240	A. BUILDING: _____ B. WING _____	R-C 06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSCENDING HEIGHTS, LLC	550 ARCHDALE DRIVE CONCORD, NC 28027

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to report all level II and III incidents in the Incident Response Improvement System (IRIS) and notify the Local Management Entity (LME)/Managed Care Organization (MCO) responsible for the catchment area where services as required. The findings are:

Review on 5/22/25 of "Notification of CPS (Child Protective Services) Involvement" dated 4/1/25 revealed:
-"...Allegedly, the female group home staff member (Staff #4) kissed the 17 year old child (Former Client (FC) #1) on her lips. Female staff (#4) went into the child's (FC #1) room, turned off the lights and undressed and attempted to touch her, child pushed away..."

Review on 5/27/25 of FC #1's record revealed:
-Age 17.
-Admitted 10/24/24.
-Diagnoses: Major Depressive Disorder, Mild Intellectual Disabilities, Oppositional Defiant Disorder.
-Discharged 3/27/25.
-Discharge Summary, completed 3/27/25 by Former Qualified Professional (FQP):
-"Discharge Disposition-Since her (FC #1) arrival (10/24/24), [FC #1] has exhibited extreme behaviors on a daily basis to include sexual inappropriateness with peers, staff, teachers, and school administrators, manipulation, staff splitting, compulsive lying, false claims of sexual assault, property destruction, aggression, profanity, noncompliance, multiple AWOL (absent without leave) attempts, physical assaults, verbal abuse, spitting, staff intimidation, etc. To ensure

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safety for both [FC #1] and others in the home, the Resident was discharged from the facility because the resident was physically and verbally aggressive, displayed property destruction, attempted to go awol, and made multiple self-harm attempts and threats."
-"Course of Treatment ...Since admission (10/24/24) to level three services, the resident has shown constant regression to include instances of property destruction, verbal and physical aggression, attention-seeking behaviors, false allegation of sexual assault [van driver, school officials, residential staff (facility staff)], AWOL attempts, suicidal ideations, and self-harm attempts resulting in multiple hospitalizations ...
-Discharge Plan-The resident was IVC'd (involuntarily committed), and [Facility] will support the transition to a higher level of care and/or alternate placement.
-Discharge Outcome-Discharged-Regression."

Review on 5/22/25 and 6/6/25 of the North Carolina Incident Response Improvement System (IRIS) from 1/1/25-6/6/25 revealed:
-3/27/25 FC #1 walked away from the facility, threatened self-harm, threatened harm to others in the facility which and her behaviors resulted in call to law enforcement outcome of involuntary commitment.

Review on 6/5/25 of the Facility Police Calls for Service Report 1/1/25 through 6/5/25 revealed: -1/5/25, 16:10 (4:10pm), Domestic Assault, [Former Staff #7 (FS#7)], W911, Notes: no signs of suicidal ideology, group home employees are going to work on obtaining IVC paperwork on the juvenile (FC #1). They (facility) were advised that we (law enforcement) are not able to transport her (FC #1) without the IVC paperwork from the mags (magistrate) office; Caller is member of the

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V 367	Continued From page 23 group home staff (FS #7); No Weapons; 17 YOA (years of age) F/M; mixed female subj (subject) has beat up all of the staff. has spit on the caller (FS #7) and made threats to other reside (clients)." -1/24/25 13:51 (1:51pm), Child Abuse Complaint, Self (facility), Notes: Not on scene. Intake report. -1/24/25, "18:46 (6:46pm), Missing Person [Staff #1], E911, Notes: Upon arrival I spoke with the house manager (HM/QP#2), [HM/QP#2] who stated at approximate 6:15 pm [Former Client #3 (FC#3)] left the residence (facility)...While on site taking notes for the 81 report [FC #3]. She (FC#3) she needed to get away for the moment and went to [fast food restaurant]. [FC#3] stated she would not leave the residence (facility) again and would remain in side; Arrived back home (facility)...19:25 (7:25pm); [FC#3] WF (white female) blonde and blk (black) hair, blk jacket and furry slides, oversized jackets, walking towards [local restaurant], time lapse 20mins (minutes)." -2/8/25, 15:43 (3:43pm), Missing Person Child, [FS#8], W911, Notes: Juvenile (FC #3) left in the care of para professional [Staff #9], who stated she will be transporting the juvenile to [County] for further evaluation and placement, [FC #3]; Notified 2/8/25, 15:48 (3:48pm) twrds (towards) shopping center black hoodie, navy blue baby yoda pajama pants, [sneaker brand] shoes blk and gry (grey) bag, and red crossbody purse left on foot client ran away, 15 year old whit female [FC#3]." -3/21/25, "22:57 (10:27pm), Check Welfare, [Staff #6], Notes:...One female juvenile (FC #1); Prisoner in custody, 23:01 (11:01pm); Back at the home (facility) but needs transport her to hospital; heavy set female short Mohawk hair style [FC #1] 17 yo (year old); Female jumped out the window, subject have a 73 episode (mental distress)."	V 367		

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-3/25/25, "19:15 (7:15pm), General Disturbance [QP#1], Notes: I located [FC #1] on the ramp of [interstate highway]. She voluntarily got in my car and returned to the group home where I turned her over to staff. [FC #1] state she was not going to hurt herself and just wanted to leave for a while. She stated she would remain at the group home for the evening (19:59, 7:59pm); On [interstate highway]...female flagged me down...walking...caller lost sight, caller in a gray [make/model]; history of self harm trying to walk in between cars short haircut heavy set female green shorts and purple jacket...female trying to run off group home no known weapons [FC #1] 17 yo female."
-4/2/25, "9:45am, Child Abuse Complaint, Self; Notes: DSS (Department of Social Services) report; 3/27/25 18:56 (6:56pm) Mental Commitment, Notes: [FC #1]..."

Reviews on 5/22/25 of the facility's records 2/1/25 through 5/22/25 revealed:
-No level II or III incidents reported.
-No documentation of internal investigations for level II, and III from 3/1/25 through 6/6/25.

Attempt interview on 6/4/25 with Former Qualified Professional (FQP) was unsuccessful, left voice message with contact information for follow up and there was no contact. There was no return call prior to survey exit.

Interview on 6/4/25 with Staff #4 revealed: -
Was not responsible for submitting reports in IRIS.
-Had never written or submitted an incident report.
-QPs were responsible for submitting reports in IRIS.

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V 367	Continued From page 25 Interview on 6/2/25 with the Home Manager/QP#2 revealed: -Qualified Professional (QP). -She and QP #1 were responsible for reporting incidents. -Was unable to provide the facility's internal incident reports. -Was not aware if there had been a report submitted in IRIS for FC #1's 4/1/25 allegation of Staff #4 kissing and attempting to touch FC #1. Interview on 6/2/25 and 6/4/25 with the QP#1 revealed: -Was responsible for submitting incidents in IRIS. -Had submitted IRIS report for FC #1's IVC on 3/27/25 and had not submitted any other level II and III reports to IRIS. -Was not aware she needed to submit report in IRIS and HCPR for FC #1's 4/1/25 allegation of Staff #4 kissing and attempting to touch FC #1. -Had not submitted any other level II or III reports in IRIS for FC #1 behaviors as described in FC #1's 3/27/25 discharge summary. -Did not have documentation of incident reports to correspond with police service calls to the facility (1/1/25 to 6/5/25). Interview on 6/4/25 and 6/6/25 the Human Resources/Compliance Consultant revealed: -Contracted consultant. -Responsible for overseeing the reporting of incidents. -Did not submit report in IRIS and was not responsible for submitting IRIS reports. -"Generally the QP (QP#1) would be responsible, I would receive a copy to keep track and make sure the follow-through is taken care of...I provide them (facility) with the information, then follow up to make sure it is done." -Was not aware of incidents from police report	V 367		

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V 367	Continued From page 26 (1/1/25 through 6/5/25). -Was not aware that QP#1 had not provided internal incidents documentation prior to survey exit. **This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.**	V 367		

Signature: Steven Lanham
Steven Lanham (Jun 25, 2025 18:19 EDT)

Email: faruqam31073@gmail.com

Title: CEO