

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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	<p>INITIAL COMMENTS</p> <p>A complaint and follow up survey was completed on 6/26/25. The complaint was unsubstantiated (intake #NC00229263). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.</p> <p>This facility is licensed for 4 and has a current census of 3. The survey sample consisted of audits of 3 current clients, 1 former clients.</p>	V 000		
V 112	<p>27G .0205 (C-D) Assessment/Treatment/Habilitation Plan</p> <p>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN</p> <p>(c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days.</p> <p>(d) The plan shall include:</p> <p>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;</p> <p>(2) strategies;</p> <p>(3) staff responsible;</p> <p>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;</p> <p>(5) basis for evaluation or assessment of outcome achievement; and</p> <p>(6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.</p>	V 112		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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 112	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a treatment plan was developed based on the assessment and in partnership with the client, a legally responsible person or both within 30 days of admission affecting 3 or 3 clients (#1) and the facility failed to develop and implement goals and strategies to meet the needs of 2 of 3 (#1, #3) clients. The findings are:</p> <p>Review on 6/13/25 of Client #1's record revealed: -Admission 7/8/24. -Age 14. -Diagnosis: Disruptive Mood Dysregulation Disorder. -Comprehensive Clinical Assessment dated 6/4/24 "...has some curiosity about illicit substance use. As he continues in therapy, it will be important to explore potential substance use concerns and provide psychoeducation about substance use prevention." -Child Family Team (CFT) meeting 3/19/25, "...Concerns were raised about potential drug use..." -CFT 4/22/25, "...Client completed substance abuse program but still engages in substance use." -Comprehensive Clinical and Problem Sexual Behavior Evaluation requested by Department of Social Services (DSS) and dated 6/5/25: "</p>	V 112			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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 112	<p>Continued From page 2</p> <p>...According to the residential provider, [client #1] struggles with appropriate peer interaction ...he makes statements that are sexual in nature, and he does not have the opportunity to interact with a positive peer group ...meets criteria for Conduct Disorder ...has watched pornography in the past ...[client #1] said that while on a recent home visit he fondled his 10-year-old sister's vagina while she was sitting in the living room watching TV...said he did ask her not to tell but she did tell their mother after the visit was over ...Although [client #1] said that he has caused no other sexual harm, the current provider has had to separate [client #1] and he is now in a single bedroom because both [client #1] and another resident (client unknown) reported that [client #1] had been propositioning another male resident (unknown) to engage in sex acts and threatening to sexually assault the same resident. As a result, [client #1] is being discharged from the program ..."</p> <p>-Diagnoses updated on 6/5/25 Evaluation to add: Conduct Disorder; Adjustment Disorder with Mood Disturbance; Attention-Deficit Hyperactivity Disorder (ADHD) (by History).</p> <p>-Discharge/Transition Plan dated 5/19/25 and signed by DSS Legal Guardian (LG) and Executive Director/Qualified Professional/Licensee #1 (ED/QP/Licensee #1) on 6/2/25, " ...Expected Discharge Date: 6/15/25 ...The Team is waiting on the outcome of Sexual assault investigation/allegations. We are also waiting on the Psycho Sexual Assessment.</p> <p>-Discharge Notice/Intent to Discharge, 30 day discharge dated 4/28/25 and signed 4/28/25 by the Facility Therapist " ...On April 27, 2025 the client (#1) was involved in a physical altercation with one of his housemates (client #2). While processing actions with both consumers (clients #1, #2), the younger consumer (#2) accused</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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 112	<p>Continued From page 3</p> <p>[client #1] of sexual assaulting him as well. The client (#2) shared that [client #1] often tries to push him in the closet in their room during the night time and often gets behind the client (#2) and humps him from behind while demanding the younger consumer (client #2) to refer to him (client #1) in sexually charged language ..."</p> <p>-Treatment plan dated 6/28/24 and updated 5/15/25 included day program related goals and strategies and did not include a plan with residential goals and strategies for addressing client #1's sexualized behaviors and substance use behaviors in the group home facility.</p> <p>Review on 6/16/25 of client #2's record revealed: -Admitted 10/29/24. -Age 13. -Diagnoses: Generalized Anxiety Disorder; Reaction to Severe Stress, Unspecified; Primary Insomnia 6/19/2024; Attention-Deficit Hyperactivity Disorder, Combined Type; Oppositional Defiant Disorder (ODD). Assessment dated 10/24/24, "...physically aggressive with mother...caused significant damage to his mother's car by throwing a rock..." Treatment plan dated 12/30/24, updated 1/30/25, 3/27/25, "...improve his ability to understand and respect authority figures...work on controlling anger..."</p> <p>Review on 6/18/25 of client #3's record revealed: -Admitted 3/5/24. -Age 14. -Diagnoses: ODD; Vision Impairment-Prosthetic Eye. -Assessment dated 3/1/24, "first out of home placement...very defiant...very aggressive and destroys property...exposing himself...masturbates in front of mom..." -Comprehensive Clinical Assessment dated</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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 112	<p>Continued From page 4</p> <p>2/26/24, "...tested with relatively low IQ (Intelligence Quotient) for his age...diagnosed with moderate IDD (Intellectual Disability Disorder) as primary diagnosis...functions at the age of a five year old...struggles with basic like skills...struggles with hygiene...history of inappropriate sexual gestures and comments...display predatory predatory sexual behavior and struggles with impulsive sexualized behaviors...Nexx Phase has to monitor the client with 1:1 staff ratio...recommended to be placed in a higher level of care...a Psychiatric Residential Treatment Facility (PRTF) specializing in sexualized behaviors..."</p> <p>-Treatment plan, 4/1/24, updated 5/15/25, "...respect boundaries..."</p> <p>-Discharged 6/16/25.</p> <p>Attempted interviews on 6/25/25 and 6/26/25 with client #1's DSS LG with no return call prior to survey exit.</p> <p>Attempted interviews on 6/25/25 and 6/26/25 with client #1's LG/mother with no return call prior to survey exit.</p> <p>Interview on 6/26/25 with client #2's LG/mother revealed: -Client #2 had not had therapy at the facility since his admission on 10/29/24. -"...he's (client #2) there (facility) to make him better, to get tools to use when he leaves (discharged).</p> <p>Interview on 6/26/25 with client #3's LG/mother revealed: -Had removed client #3 from the facility and did not plan to return client #3 back to the facility. -Was told by the facility that client #3 needed a higher level of care.</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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 112	<p>Continued From page 5</p> <p>-Did not want to continue to pay room and board while the facility located appropriate placement for client #3.</p> <p>Interview on 6/25/25 with the Day Program Director revealed:</p> <p>-The day program was responsible for the treatment plan and worked within the established goals.</p> <p>-Was the clinical home for the treatment plan for client #1 and client #2.</p> <p>-Client #3 was assessed and was not appropriate for the Day Program.</p> <p>-Was responsible for goals and strategies related to the day program, school and client #1's transition to a higher level of care.</p> <p>-A plan was developed for the day program.</p> <p>-The group home facility participated and provided input to the clients' treatment plans at the day program.</p> <p>-Nexx Phase, LLC staff did not attend the April 2025 CFT meeting for client #1 and therefore the incidents of sexualized behaviors were not presented.</p> <p>-Did not know a reason why the treatment plan was not updated in the May 2025 other than that client #1 was in transition to a higher level of care.</p> <p>-Client #1's sexualized behavior and substance use was "second-hand" information that happened at the group home facility and had not been observed in the day program.</p> <p>-"They (facility) wanted us (day program) to go back and do updates. We can only add stuff (goals and strategies) going forward..."</p> <p>-Client #1's treatment plan was updated monthly as required, but no new goals were added because the goal for the day program was to work toward transition to regular school and a new residential placement with the help of DSS.</p> <p>-The Day Program was updating the annual</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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 112	<p>Continued From page 6</p> <p>treatment plan for client #1 and would have to get signatures.</p> <p>Interview on 6/20/25 with the Associate Professional revealed:</p> <ul style="list-style-type: none"> -The ED/QP/Licensee #1 was responsible for the treatment plan. -She reviewed clients' treatment plans. -Client #1's treatment plan included goals and strategies to address sexualized behaviors, "...ensure they (clients) are not around each other alone...cameras in the house (facility)...have to monitor if one (client) is taking a shower, ensure they are not in the bathroom long and the water is running; neither (clients #1, #2) is left alone..." <p>Interview on 6/23/25 with the Facility Therapist revealed:</p> <ul style="list-style-type: none"> -Was a contracted employee with the facility and only worked a few hours a week. -Had attended some CFT meetings, but did not attend all CFT meetings. -Client #3's sexualized behavior was in his treatment plan, "that's one of his goals, like impulse control..." -Client #1 recently (April 2024) began presenting behaviors that were not present in his initial assessment. -They (Day Program) should have updated the treatment plan (for client #1) in the May (2025) CFT." -Had updated treatment plans if she had clinical responsibility for a client's plan. -The day program was the clinical home and was responsible for client's (#1) treatment plan. -We (facility) participate in treatment planning...the day treatment for each client is responsible for the treatment plan." -The Day program was the clinical home and was 	V 112			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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 112	<p>Continued From page 7</p> <p>responsible for the treatment plan of any client participating in day treatment.</p> <p>-The facility did not have a treatment plans for clients based on their initial assessment and failed develop and implement goals and strategies to meet client's (#1, #2) needs.</p> <p>Interview on 6/23/24 with Assistant Director/Licensee #2 revealed:</p> <p>-The day program is the clinical home and keeps client #1's treatment plan.</p> <p>-The Day program was the clinical home and was responsible for the treatment plan of any client participating in day treatment.</p> <p>-Was not able to update the treatment plan with goals and strategies to address client #1's sexualized behavior and substance use because client #1 had not been provided with a related diagnoses.</p> <p>-Client #3 needed a higher level of care, was not formerly diagnosed with IDD, and the facility was working on finding placement.</p> <p>-The facility had begun to facilitate client #3's discharge and placement in February 2025.</p> <p>-"We (facility) don't keep the PCP (Person Center Plan (treatment plan)), [Day Program] keeps the treatment plan, but I understand that they are our (facility) clients."</p> <p>-The facility did not have a treatment plans for clients based on their initial assessment and failed develop and implement goals and strategies to meet client's (#1, #2) needs.</p> <p>Interview on 6/20/25 with the ED/QP/Licensee #1 revealed:</p> <p>-The Day program was the clinical home and was responsible for the treatment plan of any client participating in day treatment.</p> <p>-Client #1 did not have a history of sexualized behavior and substance use at admission.</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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 112	Continued From page 8 -Client #1's treatment plan had a goal and strategies to address substance use. -Helped client #1 get to court ordered drug classes which were completed successfully around February or March 2025. -Worked with the day program to update treatment plans for client #1 and updates were addressed in client #1's CFT meetings. -The day program was responsible for making updates to the treatment plan and the facility provided updates of client #1's behavior. -He thought the treatment plan for client #1 was updated by the Day Program in the May 2025 CFT meeting. -The facility did not have a treatment plans for clients based on their initial assessment and failed develop and implement goals and strategies to meet client's (#1, #2) needs.	V 112		
V 133	G.S. 122C-80 Criminal History Record Check G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT. (a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter. (b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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 133	Continued From page 9 criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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 133	<p>Continued From page 10</p> <p>section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency.</p> <p>(c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant:</p> <ol style="list-style-type: none"> (1) The level and seriousness of the crime. (2) The date of the crime. (3) The age of the person at the time of the conviction. (4) The circumstances surrounding the commission of the crime, if known. (5) The nexus between the criminal conduct of the person and the job duties of the position to be filled. (6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed. (7) The subsequent commission by the person of a relevant offense. <p>The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in</p>	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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 133	Continued From page 11 the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant. (d) Limited Immunity. - A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for: (1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual. (2) Failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section. (e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means;	V 133			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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 133	Continued From page 12 Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5. (f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor. (g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met: (1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10. (2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4;	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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 133	<p>Continued From page 13</p> <p>2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.)</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the criminal history record check was requested within five business days of making the conditional offer of employment affecting 3 of 4 audited staff (House Manager (HM), Assistant Director (AD)/Licensee #2, Executive Director (ED)/Qualified Professional (QP)/Licensee #1). The findings are:</p> <p>Review on 6/17/25 of the HM's personnel record revealed: -Date of Hire: 1/24/23. -Job title: House Manager. -The criminal history background check was completed on 12/1/22.</p> <p>Review on 6/17/25 of the AD/Licensee #2's personnel record revealed: -Date of Hire: 4/22/22. -Job title: Assistant Director/Licensee. -The criminal history background check was completed on 9/10/21.</p> <p>Review on 6/17/25 of the ED/QP/Licensee #1's personnel record revealed: -Date of Hire: 8/14/21. -Job title: Executive Director/Qualified Professional/Licensee. -The criminal history background check was completed on 7/29/21.</p>	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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 133	Continued From page 14 Interview on 6/23/2025 with the ED/QP/Licensee #1 revealed: -The AD/Licensee #2 did the background checks for the employees.	V 133		
V 296	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	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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	<p>Continued From page 15</p> <p>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.</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure the minimum staff ratio of two staff for up to 4 adolescents. The findings are:</p> <p>Observations on 6/13/25 from approximately 3:20pm - 3:51pm revealed:</p> <ul style="list-style-type: none"> -Client #1 and client #1's Department of Social Services Legal Guardian (DSS LG) were standing next to DSS LG's car, parked on the street outside for facility, and they were waiting for the facility staff to arrive. -Client #1 and DSS LG were talking when Staff #4 arrived at the facility. -Staff #4 waited outside the facility for other facility clients and staff to arrive. -Client #2 arrived at the facility. -The DSS LG left the facility. -Staff #4 was the only staff at the facility with 2 clients (#1, #2). 	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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	<p>Continued From page 16</p> <p>-Staff #4 continued to wait outside the facility, in the facility's front yard area, and would not enter the facility until an additional facility staff member arrived.</p> <p>-Staff #1 arrived at the facility, unlocked the facility and allowed Staff #4, client #1 and client #2 to enter the facility.</p> <p>Review on 6/13/25 of Client #1's record revealed: -An admission date of 7/8/24. -An age of 14. -Diagnosis: Disruptive Mood Dysregulation Disorder.</p> <p>Review on 6/13/25 of Client #2's record revealed: -An admission date of 10/29/24. -An age of 13. -Diagnoses: Generalized Anxiety Disorder; Reaction to Severe Stress, Unspecified; Primary Insomnia; Attention-Deficit Hyperactivity Disorder, Combined Type; Oppositional Defiant Disorder.</p> <p>Review on 6/13/25 of Client #3's record revealed: -An admission date of 3/5/24. -An age of 14. -Diagnoses: Oppositional Defiant Disorder; Vision Impairment-Prosthetic Eye. -Discharged on 6/16/25.</p> <p>Interview on 6/13/25 with client #1 revealed: -"There's always at least one staff. [Staff #4] comes around 1pm to 3pm and leaves around 11pm, then [Staff #1] comes in around 11pm until we (clients) leave for school." -Staff #1 worked alone. -One staff worked on weekends.</p> <p>Interview on 6/13/25 with client #2 revealed: -Usually 2-3 staff worked when clients are awake. -Unsure what staff worked while he slept.</p>	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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	<p>Continued From page 17</p> <p>-House Manager (HM) worked alone, "because he can handle things; he can handle us."</p> <p>Unable to interview client #3 because he was on a home visit.</p> <p>Attempted interviews on 6/25/25 and 6/26/25 with client #1's DSS LG with no return call prior to survey exit.</p> <p>Attempted interviews on 6/25/25 and 6/26/25 with client #1's LG/mother with no return call prior to survey exit.</p> <p>Interview on 6/26/25 with client #2's LG/mother revealed: -Had been at the facility when there was one staff (dates unknown). -"When I dropped off [client #2] on Sundays (evening) there would only be one staff (House Manager (HM)) there (facility)."</p> <p>Interview on 6/25/25 with Former Staff #5 revealed: -"Usually two, sometimes 3 staff on shift." -Never a time when there was one staff, "only time that would happen was if someone was relieved to do something, like I might go to the store." -Two staff when clients were transported.</p> <p>Attempted interview on 6/20/25 with Staff #1 with no return call prior to survey exit.</p> <p>Attempted interview on 6/20/25 with Staff #2 with no return call prior to survey exit.</p> <p>Interview on 6/23/25 with Staff #3 revealed: -At least 2 staff on each shift and might also be at the facility on weekends.</p>	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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	<p>Continued From page 18</p> <p>-Was not aware of staff working on shift alone.</p> <p>Interview on 6/13/25 with Staff #4 revealed: -Aware there was supposed to be a 2nd staff with him while in the facility.</p> <p>Attempted interview on 6/25/25 with the HM was unsuccessful because he was unable to talk, agreed to call back and there was no return call prior to survey exit.</p> <p>Interview on 6/23/25 with the Facility Therapist revealed: -Provided therapy to clients 2-3 days a week in the facility. -Had seen 2 staff working and had never seen only one staff on shift.</p> <p>Interview on 6/20/25 with the Associate Professional revealed: -Worked 3pm to 10pm weekdays and 9am to 4pm on weekends. -"Always two staff and a QP (Qualified Professional), the house manager will also be there (facility) sometime."</p> <p>Interview on 6/18/25 with the Assistant Director/Licensee #2 revealed: -There was always 2-3 staff present in the facility.</p> <p>Interview on 6/13/25 with the Executive Director/QP/Licensee #1 revealed: -Aware there was supposed to be 2 staff when clients were present in the facility at all times. -"We (facility) try to keep the best ratios as possible...there are times when there are 3-4 staff...especially with this sexualized behavior...there is staff times that overlap; we try to keep it 2 staff to every 2 groups of kids (clients)."</p>	V 296			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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 19 -"We (facility) try not to have staff alone, but it may happen if someone is late..."	V 296		
V 364	G.S. 122C- 62 Additional Rights in 24 Hour Facilities § 122C-62. Additional Rights in 24-Hour Facilities. (a) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-61, each adult client who is receiving treatment or habilitation in a 24-hour facility keeps the right to: (1) Send and receive sealed mail and have access to writing material, postage, and staff assistance when necessary; (2) Contact and consult with, at his own expense and at no cost to the facility, legal counsel, private physicians, and private mental health, developmental disabilities, or substance abuse professionals of his choice; and (3) Contact and consult with a client advocate if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each adult client may exercise these rights at all reasonable times. (b) Except as provided in subsections (e) and (h) of this section, each adult client who is receiving treatment or habilitation in a 24-hour facility at all times keeps the right to: (1) Make and receive confidential telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over therapies; (3) Communicate and meet under appropriate	V 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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 364	Continued From page 20 supervision with individuals of his own choice upon the consent of the individuals; (4) Make visits outside the custody of the facility unless: a. Commitment proceedings were initiated as the result of the client's being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found not guilty by reason of insanity or incapable of proceeding; b. The client was voluntarily admitted or committed to the facility while under order of commitment to a correctional facility of the Division of Adult Correction of the Department of Public Safety; or c. The client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; A court order may expressly authorize visits otherwise prohibited by the existence of the conditions prescribed by this subdivision; (5) Be out of doors daily and have access to facilities and equipment for physical exercise several times a week; (6) Except as prohibited by law, keep and use personal clothing and possessions, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Keep and spend a reasonable sum of his own money; (9) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes; and (10) Have access to individual storage space for his private use. (c) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-57 and G.S. 122C-59 through G.S. 122C-61, each minor client who is receiving treatment or habilitation in a	V 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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 364	<p>Continued From page 21</p> <p>24-hour facility has the right to have access to proper adult supervision and guidance. In recognition of the minor's status as a developing individual, the minor shall be provided opportunities to enable him to mature physically, emotionally, intellectually, socially, and vocationally. In view of the physical, emotional, and intellectual immaturity of the minor, the 24-hour facility shall provide appropriate structure, supervision and control consistent with the rights given to the minor pursuant to this Part. The facility shall also, where practical, make reasonable efforts to ensure that each minor client receives treatment apart and separate from adult clients unless the treatment needs of the minor client dictate otherwise.</p> <p>Each minor client who is receiving treatment or habilitation from a 24-hour facility has the right to:</p> <p>(1) Communicate and consult with his parents or guardian or the agency or individual having legal custody of him;</p> <p>(2) Contact and consult with, at his own expense or that of his legally responsible person and at no cost to the facility, legal counsel, private physicians, private mental health, developmental disabilities, or substance abuse professionals, of his or his legally responsible person's choice; and</p> <p>(3) Contact and consult with a client advocate, if there is a client advocate.</p> <p>The rights specified in this subsection may not be restricted by the facility and each minor client may exercise these rights at all reasonable times.</p> <p>(d) Except as provided in subsections (e) and (h) of this section, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to:</p> <p>(1) Make and receive telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the</p>	V 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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 364	Continued From page 22 receiving party; (2) Send and receive mail and have access to writing materials, postage, and staff assistance when necessary; (3) Under appropriate supervision, receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over school or therapies; (4) Receive special education and vocational training in accordance with federal and State law; (5) Be out of doors daily and participate in play, recreation, and physical exercise on a regular basis in accordance with his needs; (6) Except as prohibited by law, keep and use personal clothing and possessions under appropriate supervision, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Have access to individual storage space for the safekeeping of personal belongings; (9) Have access to and spend a reasonable sum of his own money; and (10) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes. (e) No right enumerated in subsections (b) or (d) of this section may be limited or restricted except by the qualified professional responsible for the formulation of the client's treatment or habilitation plan. A written statement shall be placed in the client's record that indicates the detailed reason for the restriction. The restriction shall be reasonable and related to the client's treatment or habilitation needs. A restriction is effective for a period not to exceed 30 days. An evaluation of each restriction shall be conducted by the qualified professional at least every seven days,	V 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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 364	<p>Continued From page 23</p> <p>at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's record. Restrictions on rights may be renewed only by a written statement entered by the qualified professional in the client's record that states the reason for the renewal of the restriction. In the case of an adult client who has not been adjudicated incompetent, in each instance of an initial restriction or renewal of a restriction of rights, an individual designated by the client shall, upon the consent of the client, be notified of the restriction and of the reason for it. In the case of a minor client or an incompetent adult client, the legally responsible person shall be notified of each instance of an initial restriction or renewal of a restriction of rights and of the reason for it. Notification of the designated individual or legally responsible person shall be documented in writing in the client's record.</p> <p>This Rule is not met as evidenced by: Based on interviews, the facility failed to ensure privacy. The findings are:</p> <p>Interview on 6/13/25 and 6/27/25 with client #1 revealed: -Phone calls were made from 7pm to 8:15pm. -Staff monitors clients telephone calls, "they (staff) listen to calls...they call the number, then they put the phone on speaker." -"The call has to be on speaker and staff is close by, we get a fifteen minute call unless we're on restriction, then we get five minutes."</p> <p>Interview on 6/13/25 with client #2 revealed:</p>	V 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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 364	<p>Continued From page 24</p> <p>- "We can only call our legal guardian at 7pm. We have to get permission to use the phone and staff listens."</p> <p>Unable to interview client #3 because he was on a home visit.</p> <p>Attempted interviews on 6/25/25 and 6/26/25 with client #1's Department of Social Services Legal Guardian (DSS LG) with no return call prior to survey exit.</p> <p>Attempted interviews on 6/25/25 and 6/26/25 with client #1's LG/mother with no return call prior to survey exit.</p> <p>Interview on 6/26/25 with client #2's LG/mother revealed: - Staff puts the telephone calls on speaker phone. - "I felt like I can't talk to him because it feels like everyone (staff) is listening to you. I just wait for him (client #2) to come home to talk with him about anything..."</p> <p>Attempted interview on 6/20/25 with Staff #1 with no return call prior to survey exit.</p> <p>Attempted interview on 6/20/25 with Staff #2 with no return call prior to survey exit.</p> <p>Interview on 6/23/25 with Staff #3 revealed: - "Staff dials (phone number), waits for person to pick up to verify (who was called), hand phone to the client and monitor client's conversation..."</p> <p>Interview on 6/23/25 with the Facility Therapist revealed: - "Staff monitor phone calls."</p> <p>Interview on 6/20/25 with the Associate</p>	V 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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 364	Continued From page 25 Professional revealed: -"We (staff) are right there (with clients) and make calls for them." -"We (staff) sit with them (clients) and monitor while they are on the phone talking; basically for all phone calls..." Interview on 6/24/25 with the Assistant Director/Licensee #1 revealed: -Client telephone time is at 7pm. -Telephone calls were placed on speaker so staff can monitor. -Other facility clients are not present when a client is on the phone. -"Staff has to hear for safety reasons, all parents are not parents and we have heard parents giving kids instructions on how to be interviewed for evaluations." -"...we dial the numbers on the list (approved callers) and no one is called if they are not on that list."	V 364		
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	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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 366	Continued From page 26 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 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:	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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 366	<p>Continued From page 27</p> <p>(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;</p> <p>(B) gather other information needed;</p> <p>(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</p> <p>(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 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</p> <p>(3) immediately notifying the following:</p> <p>(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;</p> <p>(B) the LME where the client resides, if different;</p> <p>(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;</p> <p>(D) the Department;</p> <p>(E) the client's legal guardian, as applicable; and</p> <p>(F) any other authorities required by law.</p>	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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 366	<p>Continued From page 28</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to implement written policies governing their response to Level I incidents as required. The findings are:</p> <p>Review on 6/17/25 of Former client (FC) #5's record revealed: -An admission date of 2/18/25. -Age 16. -Diagnoses: Oppositional Defiant Disorder; Attention-Deficit Hyperactivity Disorder, combined type; Cannabis Use Disorder, Mild; Adjustment Disorder; Unspecified Anxiety Disorder. -Discharge Summary signed by Executive Director/Qualified Professional/Licensee #2 (ED/QP/Licensee #2) and dated 4/1/25: "Reason for Immediate Discharge:...(Client #1) has been suspended from school due being caught using substances in the schools bathroom...is accessing illegal substances and bringing it into the home (home)...has shared his vape pins filled with marijuana to a younger peer (unknown) in the home....communicated several threats to staff. Safety Concerns: ...The use of substance use and introducing such substances to younger peers..." -Discharged 4/1/25.</p> <p>Review on 6/16/25 of client #1's record revealed: -An admission date of 7/8/24. -Age 14. -Diagnosis: Disruptive Mood Dysregulation</p>	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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 366	<p>Continued From page 29</p> <p>Disorder.</p> <p>-Comprehensive Clinical Assessment dated 6/4/24 "...has some curiosity about illicit substance use. As he continues in therapy, it will be important to explore potential substance use concerns and provide psychoeducation about substance use prevention."</p> <p>-Child Family Team (CFT) meeting 3/19/25, "...Concerns were raised about potential drug use..."</p> <p>-CFT 4/22/25, "...Client completed substance abuse program but still engages in substance use.</p> <p>Review on 6/13/25 and 6/18/25 of facility's incident reports from 4/1/25 to 6/13/25 revealed:</p> <p>-4/1/25 the House Manager administered a random drug test to client #1 that resulted in a positive marijuana result.</p> <p>-4/4/25 FC #5 reported use of marijuana vape on the school bus (4/4/25) and Former Staff (FS) #5 confiscated the vape.</p> <p>-No level I incident report for FS #5 confiscating a marijuana vape from FC #5 and client #1's admission of having a nicotine vape confiscated from FS #5 in April 2025.</p> <p>-No level I, II incident report for client #2's LG/mother's report of client #2 AWOL (away without leave) to the local supermarket (March/April 2025).</p> <p>-No level 1 incident reports of FC #5's substance use, sharing vapes with peers or introducing substances to younger peers as described in FC #5's discharge summary.</p> <p>Interview on 6/27/25 with client #1 revealed:</p> <p>-Had a vape in April that he had gotten from FC #5, "I got it from [FC#5], he got it from someone at his school."</p> <p>-FC #5 had possession of the vape "on the</p>	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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 366	<p>Continued From page 30</p> <p>weekend (date unknown)", it was in FC #5's bedroom "...hid it in the middle of his (FC #5) clothes in his basket."</p> <p>-FC #5 gave client #1 the vape (date unknown) and client #1 hit the vape in the "pocket of my coat (bedroom closet)."</p> <p>-Had used the vape with a "nicotine product; [product brand name]" and then threw it out of his bedroom window; " it was out there on the ground for a day and a half."</p> <p>-"[FS #5] and the DSS LG for client, asked if client #1 had a vape, "I told him I threw it (vape) out the window."</p> <p>-Client #1 took FS #5 and the DSS LG outside the facility and they found the vape client #1 had thrown out the window.</p> <p>-FS #5 checked to see if the vape working and FS #5 destroyed the vape.</p> <p>-"They (facility) did a drug test that came back positive for marijuana, but I didn't do anything (marijuana)."</p> <p>Unable to interview client #3 because he was on a home visit.</p> <p>Attempted interviews on 6/25/25 and 6/26/25 with client #1's DSS LG with no return call prior to survey exit.</p> <p>Attempted interviews on 6/25/25 and 6/26/25 with client #1's LG/mother with no return call prior to survey exit.</p> <p>Interview on 6.26/25 with client #2's LG/mother revealed:</p> <p>-Was not aware of vapes in the facility .</p> <p>-"[Client #2] said one boy (unknown) was vaping at school."</p> <p>-Was not told by the facility about client #2 AWOL, "[Client #2] had to tell me."</p>	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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 366	<p>Continued From page 31</p> <p>Interview on 6/25/25 with FS #5 revealed: -Recalled the April 2025 incidents with confiscating vapes from FC #5 with marijuana and client #1 with nicotine. -FS #5 had gotten a vape from FC #5 "sometime in April (2025), he (FC #5) was high (under the influence)...eyes were open and then his eyes almost closed. I know it was marijuana because I looked up the type (brand) of vape..." -Had found vapes on FC #5 on more than one occasion (unknown dates). -FC #5 was buying vapes from someone at his school. -FC #5 and client #1 had both failed drug tests that were submitted. -Client #1 told FS #5 where to find the vape, "it was in the back yard (of the facility) in a tree stump. I got it, took pictures of it and then I destroyed it." -Placed client #1 on a 3 day restriction, because client #1 "confessed" to owning the vape and it was "a nicotine vape." -"I showed the picture (April 2025) to [Assistant Director (AD)/Licensee #2 and ED/QP/Licensee #1], which is my higher ups." -"That incident (client #1) happened in April (2025), and I wrote the incident report, and it clearly states what happened."</p> <p>Attempted interview on 6/20/25 with Staff #1 with no return call prior to survey exit.</p> <p>Attempted interview on 6/20/25 with Staff #2 with no return call prior to survey exit.</p> <p>Interview on 6/23/25 with Staff #3 revealed: -Had never seen or heard and was not aware that vapes had been found in the facility. -Was not aware that FC #5 had a vape in the</p>	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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 366	<p>Continued From page 32</p> <p>facility.</p> <p>-Was aware that the staff thought FC #5 was smoking at school, "never smelled smoke or caught him (FC #5) smoking."</p> <p>-Was not aware a random drug test was administered to client #1 in April 2025.</p> <p>-The staff who witnessed an incident was responsible for writing the incident report.</p> <p>Interview on 6/26/25 with Staff #4 revealed:</p> <p>-Was not aware of vapes in the facility.</p> <p>-Was not aware of staff confiscating vapes.</p> <p>-Had a "minor issue" 6/19/25 with client #1 "inappropriately touching kids (peers) feet while at the pool."</p> <p>-Client #1 was "grabbing on their (peers) feet...made them (peers) feel uncomfortable" and Staff #4 typed up an incident report.</p> <p>-Recalled that there was an incident on 6/17/25 or 6/18/25 when client #1 returned from a home visit with sunburn and "[HM] wrote an incident (report)."</p> <p>Interview on 6/16/25 with the Home Manager (HM) revealed:</p> <p>-Was responsible for reviewing incident reports submitted by staff.</p> <p>-Did not recall any incidents that involved clients having vapes.</p> <p>-Had only done a drug test with client #1 after the AD/Licensee #2 got permission from client #1's DSS LG.</p> <p>Attempted interview on 6/25/25 with the HM was unsuccessful because he was unable to talk, agreed to call back and there was no return call prior to survey exit.</p> <p>Interview on 6/16/25, 6/23/25 and 6/27/25 with the AD/Licensee #2 revealed:</p>	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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 366	<p>Continued From page 33</p> <ul style="list-style-type: none"> -After the 4/1/25 drug screen client #1 was referred to and completed substance abuse treatment." -The facility was granted permission by client #1's DSS LG to drug test because the HM thought client #1 was "acting weird." -Had not caught clients smoking or using vapes. -There had been no vapes found in the facility. -"Do we suspect they (clients) have vapes? Absolutely; Do they tell us they have vapes? Absolutely....have never seen them (vape) and they (clients) lie so much about having vapes." -Was not aware FS #5 had found a vape in the facility on 4/4/25, although there was an incident report. -Had asked staff about the presence of vapes in the facility (after 6//25), "...it (finding vapes) could have happened on other occasions and they (staff) didn't put in incidents (reports)." -Had not submitted incident report because she was not aware and staff had not reported that vapes had been found in the facility. -The HM was responsible for reviewing all incident reports for the facility that were turned in by staff. <p>Interview on 6/20/25 with the ED/QP/Licensee #2 revealed:</p> <ul style="list-style-type: none"> -HM conducted a drug screen with client #1 because "he (HM) had observed [client #1]'s eyes were red..." -Client #1's drug test came back positive for marijuana, "because they do those vapes." -Once client #1 tested positive (marijuana), "he swore he didn't do anything." -Thought client #1 was "smuggling" vapes in to the facility. -Was made aware in April 2025 by staff that client #1 "got caught" with a vape in April 2025, "it should have been an incident report..." 	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 06/26/2025
NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012		
(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 366	Continued From page 34 -Client #1's DSS LG was made aware, "not sure why staff wouldn't have done an incident report." -Was not aware of other incidences when vapes were found in the facility, but "suspected clients have had them."	V 366			