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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
		MHL080-227	B. WING		R 07/28/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
PINE STR	EET 2	4145 PINI			
		SALISBU	RY, NC 28147		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
V 000	INITIAL COMMENTS		V 000		
	An annual and follow on 7/28/25. Deficience	up survey was completed ies were cited.			
	category: 10A NCAC	d for the following service 27G .5600C Supervised Developmental Disability.			
		d for 2 and currently has a vey sample consisted of ents.			
V 536	27E .0107 Client Right Int.	nts - Training on Alt to Rest.	V 536		
	to restrictive intervent (b) Prior to providing disabilities, staff inclu employees, students demonstrate compete completing training in other strategies for cr which the likelihood o or injury to a person o property damage is p	plement policies and size the use of alternatives cions. services to people with ding service providers, or volunteers, shall ence by successfully communication skills and reating an environment in firmminent danger of abuse with disabilities or others or revented.			
	based on state compound compliance and demonstrate (d) The training shall include measurable testing (vibehavior) on those of	s shall establish training etencies, monitor for internal constrate they acted on data be competency-based, earning objectives, written and by observation of ojectives and measurable e passing or failing the			

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

DIVISION	n rieaith Service Regu	1	1		ı	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			B WINC		R	
		MHL080-227	B. WING		07/2	8/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE		
TO THE OT THE	TO VIDER OR OUT FILE			, 2.11 0002		
PINE STR	EET 2	4145 PINE				
		SALISBUI	RY, NC 28147			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RIATE	DATE
				DEI IOIENCI)		
V 536	Continued From page	1	V 536			
	. •					
	(e) Formal refresher	training must be completed				
	by each service provi	der periodically (minimum				
	annually).					
	(f) Content of the trai	ning that the service				
		nploy must be approved by				
	the Division of MH/DI					
	Paragraph (g) of this	•				
	0	strate competence in the				
	following core areas:	strate competence in the				
		and understanding of the				
	· ·	_				
	people being served;					
	` ,	and interpreting human				
	behavior;					
	` ,	the effect of internal and				
		at may affect people with				
	disabilities;					
		or building positive				
	relationships with per					
	` ,	cultural, environmental and				
	organizational factors	that may affect people with				
	disabilities;					
	(6) recognizing	the importance of and				
	assisting in the perso	n's involvement in making				
	decisions about their	life;				
	(7) skills in ass	essing individual risk for				
	escalating behavior;	-				
		tion strategies for defusing				
		tentially dangerous behavior;				
	and	,g,				
		navioral supports (providing				
	• •	h disabilities to choose				
	activities which direct					
	behaviors which are u					
	(h) Service providers	,				
		al and refresher training for				
		ai and refresher training for				
	at least three years.	tion about include:				
	` '	tion shall include:				
		ated in the training and the				
	outcomes (pass/fail);					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:	
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		MHL080-227	B. WING		07/28/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	E, ZIP CODE	
PINE STR	EET 2		NE STREET		
		SALISB	URY, NC 28147		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
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TAG	REGOLATORTOR	EGO IDENTII TING INI GRAVATION,	TAG	DEFICIENCY)	WATE
V 536	Continued From page	e 2	V 536		
	(B) when and v	vhere they attended; and			
	(C) instructor's				
		n of MH/DD/SAS may			
		ocumentation at any time.			
	(i) Instructor Qualific	-			
	Requirements:	G			
	•	all demonstrate competence			
	by scoring 100% on t	esting in a training program			
	aimed at preventing,	reducing and eliminating the			
	need for restrictive in	terventions.			
	(2) Trainers shall demonstrate competence				
	by scoring a passing grade on testing in an				
	instructor training program.				
	(3) The training				
		nclude measurable learning			
		le testing (written and by			
		ior) on those objectives and			
		to determine passing or			
	failing the course.				
	` '	t of the instructor training the			
	service provider plans				
	' '	sion of MH/DD/SAS pursuant			
	to Subparagraph (i)(5	instructor training programs			
	• •	3 . 3			
	shall include but are not limited to presentation of: (A) understanding the adult learner;				
		r teaching content of the			
	course;	r teaching content of the			
	•	r evaluating trainee			
	performance; and	:			
	T	ion procedures.			
		all have coached experience			
		ogram aimed at preventing,			
	• • • • • • • • • • • • • • • • • • • •	ting the need for restrictive			
		one time, with positive			
	review by the coach.	•			
	_	all teach a training program			
		reducing and eliminating the			
		terventions at least once			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL080-227	B. WING		07/28	3/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PINE STR	EET 2	4145 PINE	STREET Y, NC 28147			
040.15	SLIMMADV ST	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	N	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 536	Continued From page	e 3	V 536			
	annually. (8) Trainers shainstructor training at le (j) Service providers documentation of initi training for at least th (1) Docume (A) who particip outcomes (pass/fail); (B) when and v (C) instructor's (2) The Division request and review th (k) Qualifications of (1) Coaches sharequirements as a train (2) Coaches share course which is b (3) Coaches share competence by competrain-the-trainer instruction (I) Documentation share for trainers.	all complete a refresher east every two years. shall maintain fal and refresher instructor free years. entation shall include: lated in the training and the where attended; and frame. In of MH/DD/SAS may his documentation any time. Coaches: fall meet all preparation finer. fall teach at least three times eing coached. fall demonstrate foliction of coaching or faction. fall be the same preparation				
	facility failed to ensur #2) completed annua restrictive intervention	ews and interview, the e 2 of 3 audited staff (#1 and I training on alternatives to ns. The findings are:				
	keview on 7/25/25 of	staff #1's personnel record	1			

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revealed:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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		MHL080-227	B. WING		07/28/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE		
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PINE STR	EET 2		RY, NC 28147			
			T, NC 20147			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 536	Continued From page	e 4	V 536			
	- A hire date of 2/13/2 - His training in altern interventions expired - He had not updated restrictive intervention Review on 7/25/25 of revealed: - A hire date of 1/17/2 - No initial training in interventions.	24. atives to restrictive 2/13/25. his training in alternatives to ns. staff #2's personnel record				
V 537	restrictive intervention 8/7/25.	ns class scheduled for	V 537			
	ISOLATION TIME-OU (a) Seclusion, physicitime-out may be employen trained and have competence in the procedures. Staff authorized to emprocedures are retrained and the procedures are retrained to procedures are retrained to prior to providing disabilities whose treating to provide the procedures are retrained by the prior to providing disabilities whose treating the providers of the providers of the providers are retrained by the p	CAL RESTRAINT AND JT cal restraint and isolation loyed only by staff who have e demonstrated oper use of and alternatives Facilities shall ensure that aploy and terminate these ned and have demonstrated annually. direct care to people with atment/habilitation plan terventions, staff including aployees, students or olete training in the use of estraint and isolation time-out se interventions until the				

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DIVISION O	it Health Service Regu	liation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
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		MHL080-227	B. Will 6		07/28/2025	
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		4145 PIN	IE STREET			
PINE STRE	EET 2		JRY, NC 28147			
			JK1, NO 20147	T		
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				DEFICIENCY)		
			1,,,,,,			
V 537	Continued From page	e 5	V 537			
	demonstrated.					
		r taking this training is				
		etence by completion of				
		, reducing and eliminating				
	the need for restrictiv					
		be competency-based,				
	include measurable le					
		written and by observation of				
		ojectives and measurable				
	•	e passing or failing the				
	course.	s pageing or raining the				
	(e) Formal refresher training must be completed					
		der periodically (minimum				
	annually).	der periodically (minimum				
	(f) Content of the train	ining that the service				
		ploy must be approved by				
	the Division of MH/DI					
	Paragraph (g) of this	•				
	0 . (0)	ng programs shall include,				
	but are not limited to,					
		formation on alternatives to				
	the use of restrictive i					
		on when to intervene				
		nent danger to self and				
	others);	ioni danger te con and				
	,,	n safety and respect for the				
		all persons involved (using				
		trictive interventions and				
	incremental steps in a					
		or the safe implementation				
	of restrictive intervent					
		emergency safety				
	interventions which in					
		nitoring of the physical and				
		ing of the client and the safe				
		ghout the duration of the				
	restrictive intervention					
	(6) prohibited p					
		strategies, including their				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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		MHL080-227	B. WING		1	8/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
PINE STR	EET 2		STREET			
		SALISBU	RY, NC 28147			
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 537	Continued From page	e 6	V 537			
V 337	importance and purpo (8) documental (h) Service providers documentation of initial at least three years. (1) Documental (A) who participoutcomes (pass/fail); (B) when and vocation outcomes (pass/fail); (B) when and vocation outcomes (pass/fail); (C) instructor's (2) The Division review/request this docation of the docation of the docation outcomes (pass/fail); (I) Instructor Qualification review/request this docation outcomes (pass/fail); (I) Trainers shall by scoring 100% on the teaching the use of sea and isolation time-out (and isolation time-out (b) and isolation time-out (competency-based, in objectives, measurable methods failing the course. (I) The training proceed of the docation of the d	ose; and cion methods/procedures. shall maintain al and refresher training for tion shall include: ated in the training and the where they attended; and name. In of MH/DD/SAS may ocumentation at any time. Action and Training all demonstrate competence testing in a training program reducing and eliminating the terventions. In all demonstrate competence esting in a training program reducing and eliminating the terventions. In all demonstrate competence esting in a training program reducing and eliminating the terventions. In all demonstrate competence esting in a training program reclusion, physical restraint it. In all demonstrate competence grade on testing in an an an area. In shall be include measurable learning le testing (written and by iter) on those objectives and ite determine passing or the first functor training the is to employ shall be sion of MH/DD/SAS pursuant.	V 337			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		MHL080-227	B. WING		07/28/2025	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
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PINESIK	EE1 Z	SALISBU	RY, NC 28147			
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 537	Continued From page	e 7	V 537			
	course; (C) evaluation of	r teaching content of the				
	` '	ion procedures. all be retrained at least				
	()	strate competence in the use				
		restraint and isolation				
		in Paragraph (a) of this				
		all be currently trained in				
		all have coached experience				
	in teaching the use of	f restrictive interventions at positive review by the				
	(10) Trainers sha	all teach a program on the ventions at least once				
	annually.					
		all complete a refresher				
	instructor training at le (k) Service providers					
	•	al and refresher instructor				
	training for at least the					
		tion shall include:				
	(A) who particip outcome (pass/fail);	ated in the training and the				
		vhere they attended; and				
	(C) instructor's					
		n of MH/DD/SAS may				
	•	ocumentation at any time.				
	(I) Qualifications of C					
	` '	all meet all preparation				
	requirements as a tra					
	` '	nall teach at least three				
	times, the course whi	cn is being coached. iall demonstrate				
	(3) Coaches sh competence by comp					
	train-the-trainer instru					
	(m) Documentation s					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		MHL080-227	B. WING		07/28/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	FE, ZIP CODE	
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	OLIMA BY OT		JRY, NC 28147		TION
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETE
V 537	Continued From page	e 8	V 537		
	preparation as for tra	iners.			
	facility failed to ensur restrictive intervention (#1 and #2). The find	ews and interview, the e staff completed training in his for 2 of 3 audited staff ings are: f staff #1's personnel record			
	2/13/25.	ctive interventions expired			
	revealed: - A hire date of 1/17/2 - No initial training in	restrictive interventions. with the Licensee revealed: ff #2 had a restrictive			
V 736	10A NCAC 27G .030 EXTERIOR REQUIR (c) Each facility and imaintained in a safe,	EMENTS	V 736		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C		(X3) DATE COMI	SURVEY PLETED	
		A. BUILDING:			R	
	MHL080-227	B. WING		07	//28/2025	
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATI	E, ZIP CODE			
PINE STREET 2		IE STREET				
		JRY, NC 28147				
PREFIX (EACH DEFICIENCY MU	IENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 736 Continued From page 9 This Rule is not met as a Based on observations a was not maintained in a sorderly manner. The findid Observation on 7/28/25 at of the exterior front door. Interview on 7/28/25 with Professional revealed: The bush to the left of the covered the front door "put don't use the front porch, get that cut down."	and interviews, the facility safe, attractive, and ings are: at approximately 2:03 pm revealed: the front door partially the Qualified the front door partially robably because we	V 736				

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