STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C MHL0601499 B. WING 06/19/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 SKYVIEW ROAD COLLABORATIVE HOPE-SKYVIEW CHARLOTTE, NC 28208 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 000 INITIAL COMMENTS V 000 An complaint and follow up survey was completed on 6-19-25. The complaint was unsubstantiated (Intake# NC00230675). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure For Children Or Adolescents. This facility is licensed for 3 and has a current census of 2. The survey sample consisted of audits of 1 former current client. V 132 G.S. 131E-256(G) HCPR-Notification, V 132 Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home RECEIVED care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 JUL 2 1 2025 are being provided. c. Misappropriation of the property of a **DHSR-MH Licensure Sect** healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. Division of Health Service Regulation

Division of Health Service Regulation

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

(X6) DATE

If continuation sheet 1 of 16

PRINTED: 06/24/2025 **FORM APPROVED** Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C MHL0601499 B. WING 06/19/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 SKYVIEW ROAD COLLABORATIVE HOPE-SKYVIEW CHARLOTTE, NC 28208 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 132 Continued From page 1 V 132 e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure Health Care Personnel Registry (HCPR) was notified of an allegation against facility staff, failed to protect the clients while the investigation was in process and failed to report the results of the investigation within five working days of the investigation. The findings are: Review on 6-11-25 of the North Carolina Incident Response Improvement System (IRIS) from March 26, 2025 to June 11, 2025 revealed: - No documentation of an allegation that on 4-29-25 former client (FC) #1 was awakened out of his sleep during the night by staff #1 and forced to do wall squats and kneel on FC #1's knees for 45 minutes to an hour as punishment for having some behaviors on 4-29-25. Review on 3-21-25 of the facility's incident reports from March 26, 2025, to June 11, 2025 revealed: -No documentation of an allegation that on 4-29-25 former client (FC) #1 was awakened out of his sleep during the night by staff #1 and forced to do wall squats and kneel on FC #1's

knees for 45 minutes to an hour as punishment

for having some behaviors on 4-29-25.

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C MHL0601499 06/19/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 SKYVIEW ROAD COLLABORATIVE HOPE-SKYVIEW CHARLOTTE, NC 28208 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 132 Continued From page 2 V 132 -"I was sleep. He (staff #1) woke me up. I didn't want to get up, it was still night. He (staff #1) said since I didn't want to listen, I wasn't doing what I was suppose to do I was going to do those exercises. I told him to leave me alone then he (staff #1) grabbed me and pushed me to the wall." -"He was trying to make me do the exercise, like squatting on the wall but I wouldn't do them so he made me kneel on my knees against the wall." -"For over an hour (how long he was made to kneel against the wall)." Interview on 6-17-25 with staff #1 revealed: -"I woke [FC #1] a few minutes before everyone else and he went to school and said that I had him up in the middle of the night for an hour or something like that. But that's not how that happened. I woke [FC #1] up about 30 minutes (5am) before everybody (other clients) else. I got him up and I spoke to him about his actions, because his actions were kind of violent towards the female staff the day before." -"I had [FC #1] standing there, talking to him but because he didn't want to do it (stand and listen to staff #1) he (FC #1) was leaning up against the wall. He (FC #1) wasn't standing there but about 5 minutes, less than 5 minutes and he went and got back in the bed. He wasn't doing what I wanted him to do (listen to staff #1) so I let him go back to bed." -Staff #1 did not receive any disciplinary action or suspension from work after the allegation was made. "No, I was not suspended. As far as I

Division of Health Service Regulation

know nothing happened with that."

Professional (QP) revealed:

Interview on 6-12-25 with the Qualified

-"I think it was the later part of April (2025). He said that staff (staff #1) woke him up in the middle

R-C

06/19/2025

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ B. WING MHL0601499

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

COLLABORATIVE HOPE-SKYVIEW

1101 SKYVIEW ROAD

(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	TTE, NC 28208	550000	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLE DATE
V 132	Continued From page 3	V 132		
	of the night and made him stand or kneel on the			
	wall."			
	-"I'm thinking he reported it to school because			
	when I came in later that day (4-30-25) someone			
	from CPS (child protective services) was there (at			
	the facility)."			
	-"I called [staff #1] in the office (4-30-25), asked			
	him what happened, asked him to describe the			
	morning. What he (staff #1) said was he got [FC			
	#1] up early and was talking to him (FC #1) and			
	[FC #1] was leaning up against the wall crying			
	because he wanted to go back to sleep." -"He (staff #1) said he wanted to talk to him (FC			
	#1) so he (staff #1) got him (FC #1) up early so			
	he (FC #1) would have a good day at school. He			
	(staff #1) wanted him (FC #1) to tell him what was			
	going on, why he (FC #1) was acting that way			
	(being belligerent and disrespectful to staff)."			
	-"I did an incident report but to tell you the truth I			
	don't know what happened to it after I did it. I took			
	it to the office (corporate office) and after that I			
	don't know what happened to it."			
-	-Staff #1 was not reported to HCPR. "I don't think			
1	that was (HCPR report for staff #1) because we			
1	brought him in and we talked to him and we went			
(over client rights with him. I don't think that			
	nappened (HCPR report for staff #1)."			
1	nterview on 6-17-25 with the Chief Executive			
(Officer (CEO) revealed:			
-	She was out of the office when the allegation			
V	vas made.			
-	"It was a lot going on during that timeI'm not			
s	sure what was completed and what was not."			
10	nterview on 6-18-25 with the Director of			
	Operations (DO) revealed:			
-	He was out of the office from 5-23-25 to 6-17-25			
0	n medical leave and vacation. He was not aware			
	of the allegation until 6-17-25. "I found out	L d		

l		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION		SURVEY
l			IDENTIFICATION NOWIBER:	A. BUILDING	G:	СОМ	PLETED
L			MHL0601499	B. WING			R-C / 19/2025
l	NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
	COLLAR	ORATIVE HOPE-SKYVIEW	1101 SKV	/IEW ROAD			
L	OOLLAB	DICATIVE HOPE-SKTVIEW		TE, NC 2820)8		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
	V 132	Continued From page	4	V 132			
		yesterday morning and to that today. " -He is responsible for a reports but there was recomplete IRIS/HCPR resoluted anything like of the office), [CEO] with completing the IRIS/HC This deficiency constituted must be corrected 27G .0603 Incident Resoluted 27G .0603 Incident Resoluted 27G .0603 RESPONSE REQUIRE CATEGORY A AND B Feat (a) Category A and B primplement written policies	submitting IRIS/HCPR no one designated to reports in his absence. this happen again (DO out ll be responsible for CPR reports." utes a re-cited deficiency within 30 days. sponse Requirements INCIDENT EMENTS FOR PROVIDERS providers shall develop and lies governing their	V 132			
		response to level I, II or shall require the provide (1) attending to the of individuals involved in (2) determining the (3) developing an measures according to timeframes not to exceed (4) developing and to prevent similar incide specified timeframes not (5) assigning personal for implementation of the preventive measures; (6) adhering to conset forth in G.S. 75, Article (2 CFR Parts 2 and 3 and 164; and (7) maintaining do	Ill incidents. The policies er to respond by: ne health and safety needs in the incident; ne cause of the incident; id implementing corrective provider specified ed 45 days; id implementing measures into according to provider to exceed 45 days; son(s) to be responsible e corrections and				

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ COMPLETED R-C MHL0601499 06/19/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 SKYVIEW ROAD COLLABORATIVE HOPE-SKYVIEW CHARLOTTE, NC 28208 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 366 Continued From page 5 V 366 (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: obtaining the client record; (A) (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; convening a meeting of an internal (2)review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed:

(C)

issue written preliminary findings of fact

within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides,

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL0601499	B. WING		R-C 06/19/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	ATE, ZIP CODE	1 00/10/2020
COLLAB	ORATIVE HOPE-SKYVIEW	and the second s	/IEW ROAD TE, NC 28208	3	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
	owner within three mo final report shall be se catchment area the property of the catchment and written report shall dentified by the international public documents include all public documents needed available within three mandled within three mandled within three months to submit (3) immediately in the LME resparea where the service Rule .0604; (B) the LME when different; (C) the provider a for maintaining and upon treatment plan, if different provider; (D) the Department (E) the client's legapplicable; and	written report signed by the nths of the incident. The nt to the LME in whose ovider is located and to the resides, if different. The ll address the issues al review team, shall ments pertinent to the recommendations for nce of future incidents. If for the report are not nonths of the incident, the vider an extension of up to the final report; and notifying the following: onsible for the catchment is are provided pursuant to the client resides, if agency with responsibility dating the client's ent from the reporting int; gal guardian, as thorities required by law.	V 366		
	Based on record review facility failed to impleme	and interviews, the			

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3)	DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	1867. 1869	3:		COMPLETED
		MIII 0004 400	B. WING		1	R-C
		MHL0601499	B. WING			06/19/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
COLLAR	ORATIVE HOPE-SKYVIEW	, 1101 SKY\	IEW ROAD			
GOLLAB		CHARLOT	TE, NC 2820	08		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	0/5
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT	TION SHOULD BE	(X5) COMPLETE
TAG	REGULATORT OR E	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO T		DATE
				DEFICIENC	,1)	
V 366	Continued From page	7	V 366			
	findings are:					
	Review on 6-11-25 of	the North Carolina Incident				
	Response Improveme	nt System (IRIS) from		1		
	March 26, 2025, to Jui	ne 11, 2025 revealed:				
	- No level II incident re	port for 4-29-25 that				
	documented former cli	ent (FC) #1 being woke up				
	during the hight by sta	ff #1 and forced to do wall				
	squats and kneel on Fi	C #1's knees for 45				
	minutes to an nour.					
	Review on 6-11-25 of t	he facility's records from				
	March 26, 2025, to Jur	ne 11. 2025 revealed:				
	- No level II incident re					
	documented former clie	ent (FC) #1 being woke up				
	during the night by staf	f #1 and forced to do wall				
	squats and kneel on Fo	C #1's knees for 45				
	minutes to and hour.	The state of the s				
	1-1	_				
	Interview on 6-12-25 w	ith the Qualified				
	Professional (QP) reve	aled:				
	said that staff (staff #1)	part of April (2025). He				
	of the night and made h	woke him up in the middle nim stand or kneel on the				
	wall."	in stand of kneet on the		ž.		
	-"I called [staff #1] in the	e office (4-30-25), asked				
	him what happened, as	ked him to describe the				
	morning. What he (stat	ff #1) said was he got [FC				
		lking to him (FC #1) and				
	[FC #1] was leaning up					
	because he wanted to g					
	-"He (staff #1) said he v	vanted to talk to him (FC				
	#1) so he (staff #1) got	him (FC #1) up early so				
	ne (FC #1) would have	a good day at school. He				
	(staff #1) wanted him (F	C #1) to tell him what was				
	going on, why he (FC #	1) was acting that way				
	(being belligerent and d	isrespectful to staff)."				
	- i did an incident report	but to tell you the truth I				
	it to the office (ned to it after I did it. I took				
	it to the office (corporate	e oπice) and after that I				

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3:		LETED
		MHL0601499	B. WING		1	R-C
					06/	19/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COLLABO	ORATIVE HOPE-SKYVIEW		VIEW ROAD			
		CHARLOT	TE, NC 2820	18		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 366	Continued From page	8	V 366			
	don't know what happe	anad to it "				
	don't know what happe	eried to it.				
	Officer revealed: -QP is responsible for reports"I think we have an inc (4-29-25). I will forwar An incident report for 4 being woke up during to forced to do wall squat knees for 45 minutes to received by survey exit	cident report for that d it to you," -29-25 documenting FC #1 the night by staff #1 and s and kneel on FC #1's o and hour was not date. utes a re-cited deficiency				
V 367	27G .0604 Incident Rep	porting Requirements	V 367			
	the provision of billable consumer is on the provincidents and level II de to whom the provider re 90 days prior to the inci responsible for the catc services are provided w becoming aware of the be submitted on a form Secretary. The report n in person, facsimile or e means. The report shalinformation:	PROVIDERS providers shall report all t deaths, that occur during services or while the viders premises or level III eaths involving the clients endered any service within dent to the LME hment area where rithin 72 hours of incident. The report shall provided by the hay be submitted via mail, incrypted electronic				

PRINTED: 06/24/2025 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R-C MHL0601499 B. WING 06/19/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 SKYVIEW ROAD COLLABORATIVE HOPE-SKYVIEW CHARLOTTE, NC 28208 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 367 Continued From page 9 V 367 identification information; client identification information; (2)(3)type of incident: (4)description of incident; (5)status of the effort to determine the cause of the incident; and other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit. upon request by the LME, other information obtained regarding the incident, including: hospital records including confidential (1) information: (2)reports by other authorities; and (3)the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and

Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III

incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) D(ATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	500 000	IG:		MPLETED
		MHL0601499	B. WING			R-C
NAME OF 5						06/19/2025
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
COLLAB	ORATIVE HOPE-SKYVIEW		/IEW ROAD			
(V4) ID	CUMMA DV OTA		TE, NC 282	08		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 367	Continued From page	10	V 367			
	(e) Category A and B report quarterly to the catchment area where The report shall be subly the Secretary via el include summary inform (1) medication edefinition of a level II o (2) restrictive into the definition of a level (3) searches of a seizures of clothe possession of a clie (5) the total numinicidents that occurred (6) a statement in been no reportable incidents have occurred	providers shall send a LME responsible for the services are provided. omitted on a form provided ectronic means and shall mation as follows: rrors that do not meet the r level III incident; erventions that do not meet II or level III incident; a client or his living area; ient property or property in ent; ber of level II and level III ; and indicating that there have dents whenever no d during the quarter that as set forth in Paragraphs and Subparagraphs (1) graph. evidenced by: and interviews, the I critical incidents in the ovement System (IRIS) inagement Entity irganization (MCO)	V 367			
5	services were provided v					
F	Review on 6-11-25 of the	e North Carolina Incident				

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE	SURVEY
1	TOT GOTTLESTION	IDENTIFICATION NUMBER:	A. BUILDIN	G:		PLETED
		MHL0601499	B. WING _			R-C /19/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY	STATE, ZIP CODE	1 00/	119/2023
1		4444 0000	VIEW ROAD	STATE, ZIP CODE		
COLLAB	ORATIVE HOPE-SKYVIEW	Expense Francisco	TE, NC 282	08		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 367	Continued From page	11	V 367			
	Response Improveme March 26, 2025, to Jun-No level II incident redocumented former cliduring the night by starsquats and kneel on Firminutes to an hour. Interview on 6-12-25 w Professional revealed: -"I don't do the IRIS. Coreports) to the office, I'n IRIS." Interview on 6-17-25 w Officer (CEO) revealed-She was out of the office was made but she was called me (4-30-25) and (department of social set [former client (FC) #1]"[Director of Operation: completing the IRIS rep-"It was a lot going on discure what was completed sure what was completed interview on 6-18-25 with Operations (DO) revealed-He was out of the office on medical leave and valof the allegation until 6-yesterday morning and to that today." -He is responsible for suthere was no one design reports in his absence.	int System (IRIS) from the 11, 2025 revealed: port for 4-29-25 that ent (FC) #1 being woke up iff #1 and forced to do wall ic #1's knees for 45 which the Qualified which it is the Chief Executive is the Chief Executive is the Chief Executive is the White Chief Executive is the Chief Executive is	V 367			
	completing the IRIS repo	orts."				

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION		E SURVEY PLETED
			A. BOILDIN	J		R-C
		MHL0601499	B. WING			6/19/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
COLLAB	ORATIVE HOPE-SKYVIEW		IEW ROAD	••		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	TE, NC 282			
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 367	Continued From page	12	V 367			
	This deficiency constit and must be corrected	utes a re-cited deficiency within 30 days.				
V 500	27D .0101(a-e) Client	Rights - Policy on Rights	V 500			
	assures the implement G.S. 122C-65, and G.S. (b) The governing bod implement policy to ass (1) all instances abuse, neglect or exploreported to the County Services as specified ir G.S. 7A, Article 44; and (2) procedures an instituted in accordance practice when a medical present serious risk to the Particular attention shall neuroleptic medications (c) In addition to those 10A NCAC 27E .0102(1) each facility shall develop that identifies: (1) any restrictive prohibited from use with (2) in a 24-hour facunder which staff are profit to the restrictive interventions of the restrictive interventions of the restrictions of client (1) and (d) are addentify:	INTERVENTIONS by shall develop policy that ation of G.S. 122C-59, S. 122C-66. by shall develop and sure that: of alleged or suspected bitation of clients are Department of Social of G.S. 108A, Article 6 or sure with sound medical ation that is known to the client is prescribed. If be given to the use of social of G.S. 108A, article 6 or sure with sound medical ation that is known to the client is prescribed. If be given to the use of social of G.S. 108A, article 6 or sure with sound medical ation that is known to the client is prescribed. If the given to the use of social of G.S. 108A, article 6 or sure with sound medical ation that is known to the client is prescribed. If the given to the use of social of G.S. 108A, article 6 or sure with sound medical in the client is prescribed. If the given to the use of social of G.S. 108A, article 6 or sure with sound medical in the client is prescribed. If the given to the use of social of G.S. 108A, article 6 or sure with sound medical in the client is prescribed. If the given to the use of social of G.S. 108A, article 6 or sure with sound medical in the client is prescribed. If the given to the use of social of G.S. 108A, article 6 or sure with sound medical in the client is prescribed. If the given to the use of social of G.S. 108A, article 6 or sure with sound medical in the client is prescribed. If the given to the use of social of G.S. 108A, article 6 or sure with sound medical in the client is prescribed. If the given to the use of social of G.S. 108A, article 6 or sure with social of G.S. 108A, article 6 or sure with social of G.S. 108A, article 6 or sure with social of G.S. 108A, article 6 or sure with social of G.S. 108A, article 6 or sure with social of G.S. 108A, article 6 or sure with social of G.S. 108A, article 6 or sure with social of G.S. 108A, article 6 or sure with social of G.S. 108A, article 6 or sure with social of G.S. 108A, article 6 or sure with social of G.S. 108A, article 6 or sure with social of G.S. 108A, article 6 or sure with social of G.S.				

PRINTED: 06/24/2025 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ R-C MHL0601499 B. WING 06/19/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 SKYVIEW ROAD COLLABORATIVE HOPE-SKYVIEW CHARLOTTE, NC 28208 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 500 Continued From page 13 V 500 (2)the individual responsible for informing the client; and (3)the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E): the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3)the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure all incidents of alleged abuse were reported to the County Department of

Division of Health Service Regulation

revealed:

Social Services (DSS). The findings are:

Review on 6-11-25 of the facility's record

-No documentation to support County DSS notification for the allegation that on 4-29-25 former client (FC) #1 was awakened out of his sleep during the night by staff #1 and forced to do

	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DAT	E SURVEY
/ / / / / / / / / / / / / / / / / / / /	VOI CONNECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G:		IPLETED
		MHL0601499	B. WING _			R-C
NAME OF	PROVIDER OR SUPPLIER				1 06	6/19/2025
				STATE, ZIP CODE		
COLLAB	BORATIVE HOPE-SKYVIEW	Part Article Reportation	VIEW ROAD ITE, NC 282			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIENCY	'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 500	Continued From page	14	V 500			
V 500	wall squats and kneel minutes to an hour as some behaviors on 4-2 Review on 6-11-25 of the Response Improvement March 26, 2025 to Junning The Norman Commentation of a DSS regarding an alleg former client (FC) #1 wall squats and kneel of minutes to an hour as properly some behaviors on 4-2 Interview on 6-12-25 was Professional/QP reveal and on't do that (report responsibility. [Chief Operation of the professional of the pro	on FC #1's knees for 45 punishment for having 29-25. the North Carolina Incident at System (IRIS) from e 11, 2025 revealed: a report made to the local gation that on 4-29-25 ras awakened out of his by staff #1 and forced to do on FC #1's knees for 45 bunishment for having 9-25. ith the Qualified ed: to DSS). That's not my berating Officer(COO)] or (DO) does the reporting ened (report made to	V 500			
	sure what was complete	ed and what was not."				
	Interview on 6-18-25 wit -He was out of the office on medical leave and va of the allegation until 6-' yesterday morning and I to that today."	th the revealed: from 5-23-25 to 6-17-25 facation. He was not aware 17-25. "I found out was doing the follow up is happen again (DO out be responsible for				

PRINTED: 06/24/2025 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R-C B. WING MHL0601499 06/19/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 SKYVIEW ROAD **COLLABORATIVE HOPE-SKYVIEW** CHARLOTTE, NC 28208 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 500 Continued From page 15 V 500 This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.

Plan of Correction

Plan of Correction form

To:

Division of Health Service Regulation Mental Health Licensure and Certification Section Facility Name: Collaborative Hope-Sky view MHL Number: 060-1499 Rule Violation/Tag/Citation Level: (Administrative Action and Crosses) 10A NCAC 27G .0304 V512 FOR Serious Abuse and neglect for a Type A1 citation.

In lieu of mailing the form, you may e-mail the completed electronic form to:

Provider Name:	Collaborative Hope	Phone:	
Provider Contact		Fax:	
Person for follow-up:		rax.	
		Email:	
Address:		B	
Finding	7700 Research Dr., Ste 105 Charlotte, NC 28262	Provider # 10131556	3120
rinding	Corrective Action Steps	Responsible Party	Timeline
1) 132 G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where	We acknowledge that this deficiency has been previously cited and must be fully addressed within 30 days. The corrective actions previously implemented remain in effect; however, in response to this recurrence, the agency has taken additional steps to strengthen compliance with all applicable statutes and rules. With the enhanced administrative oversight and the continuation of previously implemented corrective actions, the agency is confident these measures will lead to improved adherence to regulatory requirements and prevent recurrence of this issue. Implemented Corrective Action Steps: 1. Specifically, a reorganization of the administrative structure has been completed to introduce an added layer of oversight. The Administrative Officer (AO) will now be directly involved in all investigative and reporting procedures related to allegations,	CEO/ED Administrative Officer	Implementation Date: August 1, 2025 Projected Completion Date: Immediately and ongoing
home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility.	incidents, and infractions. While the Executive Director (ED) and Director of Operations (DO) will continue their responsibilities in these matters, the AO will review all reports and establish clear timelines to ensure timely and		

d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.

This Rule is not met as evidenced by:
Based on record review and interview, the
facility failed to ensure Health Care
Personnel Registry (HCPR) was notified
of an allegation against facility staff,
failed to protect the clients while the
investigation was in process and failed to
report the results of the investigation
within five working days of the
investigation.

The findings are:

Review on 6-11-25 of the North Carolina Incident Response Improvement System (IRIS) from March 26, 2025 to June 11, 2025 revealed:

- No documentation of an allegation that on 4-29-25 former client (FC) #1 was awakened out of his sleep during the night by staff #1 and forced to do wall squats and kneel on FC #1's knees for 45 minutes to an hour as punishment for having some behaviors on 4-29-25.

Review on 3-21-25 of the facility's incident reports from March 26, 2025, to June 11, 2025 revealed:

-No documentation of an allegation that on 4-29-25 former client (FC) #1 was awakened out of his sleep during the night accurate notification to the Health Care Personnel Registry (HCPR), protection of clients during investigations, and reporting of findings within the required five working days.

by staff #1 and forced to do wall squats and kneel on FC #1's knees for 45 minutes to an hour as punishment for having some behaviors on 4-29-25. Interview on 6-12-25 with FC #1 revealed: -"I was sleep. He (staff #1) woke me up. I didn't want to get up, it was still night. He (staff#1) said since I didn't want to listen, I wasn't doing what I was suppose to do I was going to do those exercises. I told him to leave me alone then he (staff #1) grabbed me and pushed me to the wall." -"He was trying to make me do the exercise, like squatting on the wall but I wouldn't do them so he made me kneel on my knees against the wall." -"For over an hour (how long he was made to kneel against the wall)." Interview on 6-17-25 with staff #1 revealed: -"I woke [FC #1] a few minutes before everyone else and he went to school and said that I had him up in the middle of the night for an hour or something like that. But that's not how that happened. I woke [FC #1] up about 30 minutes (5am) before everybody (other clients) else. I got him up and I spoke to him about his actions. because his actions were kind of violent towards the female staff the day before." -"I had [FC #1] standing there, talking to him but because he didn't want to do it (stand and listen to staff #1) he (FC #1) was leaning up against the wall. He (FC #1) wasn't standing there but about 5 minutes, less than 5 minutes and he went and got back in the bed. He wasn't doing what I wanted him to do (listen to staff #1) so I let him go back to bed." -Staff #1 did not receive any disciplinary

action or suspension from work after the			1
allegation was made. "No, I was not			
suspended. As far as I know nothing	^		1
happened with that."	*		1
			1
Interview on 6-12-25 with the Qualified			1
Professional (QP) revealed: of the night			1
and made him stand or kneel on the			
wall."			
-"I'm thinking he reported it to school			
because when I came in later that day (4-			
30-25) someone from CPS (child			
protective services) was there (at			
the facility)."			
-"I called [staff #1] in the office (4-30-			
25), asked him what happened, asked him			
to describe the morning. What he (staff			
#1) said was he got [FC#1] up early and			
was talking to him (FC #1) and			
[FC #1] was leaning up against the wall			
crying because he wanted to go back to			
sleep."			
-"He (staff #1) said he wanted to talk to			
him (FC#1) so he (staff #1) got him (FC			
#1) up early so he (FC #1) would have a			
good day at school. He (staff #1) wanted			
him (FC #1) to tell him what was			
going on, why he (FC #1) was acting that			
way(being belligerent and disrespectful to			
staff)."			
-"I did an incident report but to tell you			
the truth I don't know what happened to it			
after I did it. I took it to the office			
(corporate office) and after that I			
don't know what happened to it."			
-Staff #1 was not reported to HCPR. "I			-
don't think that was (HCPR report for			
staff #1) because we brought him in and			
we talked to him and we went over client			
rights with him. I don't think that	ľ		
happened (HCPR report for staff #1)."			
Interview on 6-17-25 with the Chief			
Executive Officer (CEO) revealed:			
zacoure officer (CEO) revealed:			

(IRIS) from March 26, 2025, to June 11, 2025	A reorganization of the administrative structure has been completed to strengthen		
Review on 6-11-25 of the North Carolina Incident Response Improvement System	Corrective Action Steps:		the IRIS system
the facility failed to implement written policies governing their response to level II incidents. The findings are:	these measures will lead to improved adherence to regulatory requirements and prevent recurrence of this issue.		Immediately upon filling the AO position training will begin on the use of
This Rule is not met as evidenced by: Based on record review and interviews,	administrative oversight and the continuation of previously implemented corrective actions, the agency is confident		This will be ongoing with no completion date.
CATEGORY A AND B PROVIDERS	however, in response to this recurrence, the agency has taken additional steps to strengthen compliance with all applicable statutes and rules. With the enhanced		Projected Completion Date:
2) 366 27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR	We acknowledge that this deficiency has been previously cited and must be fully addressed within 30 days. The corrective actions previously implemented remain in effect,	k -CEO/ED Administrative Officer	Implementation Date: August 1, 2025
This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	W		
responsible for completing the IRIS/HCPR reports."			
reports in his absence"Should anything like this happen again (DO out of the office), [CEO] will be			
IRIS/HCPR reports but there was no one designated to complete IRIS/HCPR			
yesterday morning and I was doing the follow up to that today. " -He is responsible for submitting			
later part of April (2025). He said that staff (staff #1) woke him up in the middle			
6-17-25 on medical leave and vacation. He was not aware of the allegation until 6-17-25. "I found out-"I think it was the			
Interview on 6-18-25 with the Director of Operations (DO) revealed: -He was out of the office from 5-23-25 to			
timeI'm not sure what was completed and what was not."			
allegation was made"It was a lot going on during that			
-She was out of the office when the			T

revealed:

- No level II incident report for 4-29-25 that

documented former client (FC) #1 being woke up during the night by staff #1 and forced to do wall squats and kneel on FC #1's knees for 45 minutes to an hour. Review on 6-11-25 of the facility's records from March 26, 2025, to June 11, 2025 revealed:

- No level II incident report for 4-29-25 that

documented former client (FC) #1 being woke up during the night by staff #1 and forced to do wall squats and kneel on FC #1's knees for 45 minutes to and hour. Interview on 6-12-25 with the Qualified Professional (QP) revealed:

-"I think it was the later part of April (2025). He said that staff (staff #1) woke him up in the middle of the night and made him stand or kneel on the wall." -"I called [staff #1] in the office (4-30-25), asked him what happened, asked him to describe the morning. What he (staff #1) said was he got [FC #1] up early and was talking to him (FC #1) and [FC #1] was leaning up against the wall crying because he wanted to go back to sleep."-"He (staff #1) said he wanted to talk to him (FC #1) so he (staff #1) got him (FC #1) up early so he (FC #1) would have a good day at school. He (staff #1) wanted him (FC #1) to tell him what was going on, why he (FC #1) was acting that way (being belligerent and disrespectful to staff)."I did an incident report but to tell you the truth I don't know what happened to it after I did it. I took it to the office (corporate office) and after that I don't know what happened to it." Interview on 6-17-25 with the Chief

Executive Officer revealed:

oversight and ensure full implementation of written policies regarding the response to Level II incidents. As part of this restructuring. the Administrative Officer (AO) has been assigned a key role in overseeing all incident reporting processes. The AO will now be responsible for reviewing and verifying that all Level II incidents are promptly documented in accordance with agency policy and state requirements, including timely entry into the North Carolina Incident Response Improvement System (IRIS). The Executive Director (ED) and Director of Operations (DO) will maintain their current roles, but the AO will monitor compliance with reporting timelines and ensure appropriate follow-up is completed. This change is designed to ensure that no Level II incident, such as the one involving Former Client #1, is missed, mishandled, or left unreported.

2. A reorganization of the administrative structure will be implemented to strengthen oversight and ensure consistent implementation of written policies related to Level II incident response. While the Qualified Professional (QP) is knowledgeable about the requirements for completing incident reports in a timely manner, this recent finding demonstrates the need for additional accountability and oversight; therefore, the QP will receive additional refresher and in-service trainings.

Previous Corrective Action Steps:

1. Biweekly Staff Meetings and Written
Notification of Reporting Protocols
Collaborative Hope will conduct mandatory
biweekly staff meetings to review state-mandated
reporting procedures, documentation practices, and
client rights. A written protocol outlining these
responsibilities will be distributed to all staff. These

4		
-QP is responsible for completing incident reports. -"I think we have an incident report for that (4-29-25). I will forward it to you," An incident report for 4-29-25 documenting FC #1being woke up during the night by staff #1 and forced to do wall squats and kneel on FC #1'sknees for 45 minutes to and hour was not received by survey exit date.	investigations, including ensuring client protection. 2. Individual and Group Supervision by the Qualified Professional (QP) The QP will conduct individual and group supervisory meetings to coach staff on their responsibilities regarding incident reporting and the	
3) 367 27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A	We acknowledge that this is a re-cited deficiency and accept full responsibility for the failure to report all required critical incidents in the North Carolina Incident Response Improvement System (IRIS) and to notify the	Implementation Date: August 1, 2025, update agency P&P
AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that	organization (LME/MCO) within 72 hours of becoming aware of the incident, as mandated by 10A NCAC 27G	DO, ED and QP
occur during the provision of billable services or while the consumer is on the provider's premises or level III incidents	While the Qualified Professional (OP) is knowledgeable	AO upon hire
and level II deaths involving the clients to	about incident documentation and reporting protocols, the agency identified gaps in internal processes that led to this	QP Projected Completion Date:

whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where

services are provided within 72 hours of becoming aware of the incident. The report shall

be submitted on a form provided by the Secretary. The report may be submitted via mail,

in person, facsimile or encrypted electronic

means. The report shall include the following

information:

- (1) reporting provider contact and identification information;
- (2) client identification information;
- (3) type of incident:
- (4) description of incident;
- (5) status of the effort to determine the cause of the incident; and
- (6) other individuals or authorities notified

or responding.

- (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:
- (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or
- (2) the provider obtains information required on the incident form that was previously unavailable.
- (c) Category A and B providers shall submit,

upon request by the LME, other information obtained regarding the incident, including:

oversight, including unclear delegation of responsibility and lack of a contingency plan during the Director of Operations' (DO) extended absence.

To ensure full and sustained compliance with this rule, the following corrective actions have been implemented:

1. Clarification and Reassignment of Reporting Duties:

A written protocol will be developed and implemented to clearly designate the roles and responsibilities for completing and submitting all Level II and III incident reports. Effective within 30 days of hire, the Administrative Officer (AO) will be formally assigned to oversee all incident report submissions in IRIS and to the LME/MCO, including in the absence of the DO. The AO will serve as the alternate IRIS administrator to ensure continuity in reporting.

2. Backup Coverage Protocol:

A formal backup protocol will be instituted. In the event of an extended absence by the DO or any other responsible party, the AO or the Chief Executive Officer (CEO) will assume full responsibility for completing and submitting incident reports within regulatory timeframes. This will be documented in the agency's updated Incident Reporting Policy.

3. Training and Competency Verification:

All relevant administrative and clinical staff, including the QP, CEO, AO, and DO, will complete refresher training on 10A NCAC 27G .0604 requirements, including IRIS submission timelines and procedures. Staff competency will be verified through a post-training quiz and supervised walkthrough of an IRIS submission.

4. Ongoing Monitoring and Quality Assurance:

A monthly internal audit process has been established. The AO will review all incident logs, cross-check them with IRIS entries, and report

Training completion fate for DO, ED, and QP August 10, 2025

(1) hospital records including confidential findings to the CEO and ED to ensure all Level II information: and III incidents are captured and submitted within (2) reports by other authorities; and 72 hours. A quarterly summary will also be (3) the provider's response to the incident. compiled and submitted to the LME/MCO as (d) Category A and B providers shall send required under section (e) of the rule, if applicable. a copy of all level III incident reports to the Division of Mental Health. 5. Policy Revision: Developmental Disabilities and Substance The agency's Incident Reporting Policy and Abuse Services within 72 hours of Procedures Manual will be revised to reflect all becoming aware of the incident. Category changes noted above, including designated roles, A providers shall send a copy of all level timelines, reporting channels, backup procedures, III incidents involving a client death to and documentation requirements for both IRIS and the Division of Health Service Regulation the LME/MCO. within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident: (2) restrictive interventions that do not meet the definition of a level II or level III incident: (3) searches of a client or his living area; (4) seizures of client property or property the possession of a client; (5) the total number of level II and level incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter

that		T
meet any of the criteria as set forth in		
Paragraphs		
(a) and (d) of this Rule and		
Subparagraphs (1)		
through (4) of this Paragraph.		
S ()		
This Rule is not met as evidenced by:		
Based on record review and interviews,		
the		
facility failed to report all critical		
incidents in the		
Incident Response Improvement System		
(IRIS)		
and notify the Local Management Entity		
(LME)/Managed Care Organization		
(MCO)		
responsible for the catchment areas where		
services were provided within 72 hours of		
becoming aware of the incident. The		
findings are:		
Review on 6-11-25 of the North Carolina		
Incident Response Improvement System		
(IRIS) from March 26, 2025, to June 11,		
2025 revealed:		
- No level II incident report for 4-29-25	i	
that	1	
documented former client (FC) #1 being	1	
woke up during the night by staff #1 and	1	
forced to do wall squats and kneel on FC		
#1's knees for 45	J	
minutes to an hour.	l	
Interview on 6-12-25 with the Qualified		
Professional revealed:		
-"I don't do the IRIS. Once I take it	1	
(incident		
reports) to the office, I'm not sure who		
does the		
IRIS."		
Interview on 6-17-25 with the Chief		
Executive Executive		
Officer (CEO) revealed:	1	
-She was out of the office when the		
and mas out of the office when the		

4) 500 27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66.	The facility failed to ensure that an allegation of abuse on 4-29-25 involving former client (FC) #1 was reported to the County Department of Social Services (DSS), as required by law. This constitutes a re-cited deficiency and must be corrected within 30 days. This agency understands the critical importance of protecting client rights and ensuring timely and appropriate reporting of all suspected abuse. With the completion and implementation of this corrective action plan, we are confident that systems will	Administrative Officer I tions-	Implementation Date: August 1, 2025 Projected Completion Date: August 1, 2025 and ongoing
(department of social services) was there about [former client (FC) #1]. -"[Director of Operations/DO] is responsible for completing the IRIS reports." -"It was a lot going on during that timeI'm not sure what was completed and what was not." Interview on 6-18-25 with the Director of Operations (DO) revealed: -He was out of the office from 5-23-25 to 6-17-25 on medical leave and vacation. He was not aware of the allegation until 6-17-25. "I found out yesterday morning and I was doing the follow up to that today." -He is responsible for submitting IRIS reports but there was no one designated to complete IRIS reports in his absence. -"Should anything like this happen again (DO out of the office), [CEO] will be responsible for completing the IRIS reports." This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.			
allegation was made but she was informed by staff. "[QP] called me (4-30-25) and told me DSS			

- (b) The governing body shall develop and implement policy to assure that:
- (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are

reported to the County Department of Social

Services as specified in G.S. 108A, Article 6 or

G.S. 7A, Article 44; and

(2) procedures and safeguards are instituted in accordance with sound medical

practice when a medication that is known to

present serious risk to the client is prescribed.

Particular attention shall be given to the use of

neuroleptic medications.

- (c) In addition to those procedures prohibited in
- 10A NCAC 27E .0102(1), the governing body of

each facility shall develop and implement policy

that identifies:

- (1) any restrictive intervention that is prohibited from use within the facility; and
- (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting

the rights of a client.

(d) If the governing body allows the use of

restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify:

(1) the permitted restrictive interventions or

allowed restrictions; (2) the individual

be implemented to ensure full compliance with 10A NCAC 27D .0101 and the underlying statutes.

1. Immediate Corrective Measures

DSS Notification (Retroactive):

The agency will submit a formal notification to DSS regarding the 4-29-25 incident involving FC #1. Documentation of this report will be retained in the client's file and in the facility's incident log to demonstrate corrective follow-up.

Internal Review of All Past Allegations (Last 6 Months):

A retrospective review of all incident and behavior logs from the last 6 months will be completed to confirm that no other unreported allegations of abuse occurred. Any findings requiring DSS reporting will be promptly addressed.

2. Policy and Procedure Revisions

- Update Abuse/Neglect Reporting Policy: The agency's policy on Client Rights and Abuse/Neglect Reporting will be revised to:
 - Clearly designate primary and alternate staff responsible for reporting all suspected abuse, neglect, or exploitation to DSS within 24 hours of awareness.
 - Require documentation of all DSS contacts, including date/time, reporter, and response received.
 - Include a step-by-step decision-making and reporting flowchart for clarity and consistency.

3. Clarified Role Assignments

- Reassignment of DSS Reporting Responsibility:
 - The Director of Operations (DO) remains the primary contact for DSS reporting.
 - In the DO's absence, the Chief Executive Officer (CEO) or the Administrative Officer (AO) is authorized and responsible

responsible for informing the client; and

- (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions.
- (e) If restrictive interventions are allowed for use

within the facility, the governing body shall

develop and implement policy that assures

compliance with Subchapter 27E, Section .0100.

which includes:

(1) the designation of an individual, who has been trained and who has

demonstrated

competence to use restrictive interventions, to

provide written authorization for the use of

restrictive interventions when the original order is renewed for up to a total of 24 hours in

accordance with the time limits specified in 10A

NCAC 27E .0104(e)(10)(E):

(2) the designation of an individual to be responsible for reviews of the use of restrictive

interventions: and

(3) the establishment of a process for appeal for the resolution of any

disagreement

over the planned use of a restrictive intervention.

This Rule is not met as evidenced by: Based on record reviews and interviews, the

facility failed to ensure all incidents of alleged

abuse were reported to the County Department of Social Services (DSS). The findings are:

- for fulfilling DSS reporting requirements without delay.
- This structure will be documented in both policy and internal communication protocols.

4. Staff Training and Competency Validation

Mandatory Staff Retraining:

All administrative and clinical staff, including the QP, DO, AO, and CEO, will complete refresher training on:

- o G.S. 108A and G.S. 7A statutory requirements.
- o DSS reporting timelines and documentation.
- o The agency's updated incident reporting and client rights policies.

Competency Verification:

Staff understanding will be validated through a post-training quiz and scenario-based exercises. Training records are maintained on-site and will be available for review

Oversight and Quality Assurance

- Internal Audit Schedule (Implemented): The AO will conduct monthly audits of all incident reports to verify:
 - Proper DSS reporting when required.
 - Timeliness and completeness of documentation.
 - o Staff compliance with reporting policies.

Quarterly Compliance Review:

The CEO will lead a quarterly compliance meeting to review all abuse/neglect cases and DSS communications, ensuring oversight and accountability from the top level of governance.

Review on 6-11-25 of the facility's record			T
revealed:			1
-No documentation to support County			
DSS			
notification for the allegation that on 4-			
29-25			
former client (FC) #1 was awakened out			
of his			
sleep during the night by staff #1 and			
forced to do wall squats and kneel on FC			
#1's knees for 45			
minutes to an hour as punishment for			
having			
some behaviors on 4-29-25.			
Daview on 6 11 25 Cd 37 4 5			
Review on 6-11-25 of the North Carolina			
Incident Response Improvement System			
(IRIS) from March 26, 2025 to June 11,			
2025 revealed:			
-No documentation of a report made to			
the local			
DSS regarding an allegation that on 4-29-			
25			
former client (FC) #1 was awakened out			
of his			
sleep during the night by staff #1 and			
forced to do wall squats and kneel on FC			
#1's knees for 45			
minutes to an hour as punishment for			
having			
some behaviors on 4-29-25.			
25-110 STIM (1018 OH 27-23.			
Interview on 6-12-25 with the Qualified			
Professional/QP revealed:			
-"I don't do that (report to DSS). That's			
not my			
responsibility. [Chief Operating			
Officer(COO) - Division of the control of the contr			
Officer(COO)] or [Director of Operations			
(DO) does the reporting (DSS)."			
-"I don't think that happened (report made			
to		1	
DSS)."		1	
Interview on 6-17-25 with the revealed:			
	1		1

I "IDO] : '11 C 1: 1		
-"[DO] is responsible for making the		T
report to	1	
DSS."]	
-"It was a lot going on during that		
timeI'm not	1	
sure what was completed and what was		
not."		
Interview on 6-18-25 with the revealed:		
-He was out of the office from 5-23-25 to		
6-17-25 on medical leave and vacation.		
He was not aware of the allegation until		
6-17-25. "I found out yesterday morning		
and I was doing the follow up to that		
today."		
-"Should anything like this happen again		
(DO out of the office), [CEO] will be		
responsible for		
making the report to DSS."		
This deficiency constitutes a re-cited		
deficiency and must be corrected within		
30 days.		