STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601499	A. BUILDING: _____ B. WING _____	R-C 06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLABORATIVE HOPE-SKYVIEW	1101 SKYVIEW ROAD CHARLOTTE, NC 28208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An 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 000		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client.	V 132	RECEIVED JUL 21 2025 DHSR-MH Licensure Sect	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kanita Driggins CEO — TITLE: CEO — (X6) DATE: 7/14/2025

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V 132	Continued From page 1 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. Interview on 6-12-25 with FC #1 revealed:	V 132		

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V 132	Continued From page 2 -"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 know nothing happened with that." 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	V 132		

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V 132	Continued From page 3 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 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 happened (HCPR report for staff #1)." Interview on 6-17-25 with the Chief Executive Officer (CEO) revealed: -She was out of the office when the allegation was made. -"It was a lot going on during that time...I'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	V 132		

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V 132	Continued From page 4 yesterday morning and I was doing the follow up to that today. " -He is responsible for submitting IRIS/HCPR reports but there was no one designated to complete IRIS/HCPR reports in his absence. -"Should anything like this happen again (DO out of the office), [CEO] will be responsible for completing the IRIS/HCPR reports." This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 132		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.	V 366		

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V 366	Continued From page 5 (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: (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,	V 366		

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V 366	Continued From page 6 if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to implement written policies governing their response to level II incidents. The	V 366		

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V 366	Continued From page 7 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 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	V 366		

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V 366	Continued From page 8 don't know what happened to it." Interview on 6-17-25 with the Chief Executive Officer revealed: -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 #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 was not received by survey exit date. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and	V 367		

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V 367	Continued From page 9 identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy 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).	V 367		

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V 367	Continued From page 10 (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. 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	V 367		

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V 367	Continued From page 11 Response Improvement System (IRIS) 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 an hour. Interview on 6-12-25 with the Qualified Professional revealed: -"I don't do the IRIS. Once I take it (incident reports) to the office, I'm not sure who does the IRIS." Interview on 6-17-25 with the Chief Executive Officer (CEO) revealed: -She was out of the office when the allegation was made but she was informed by staff. "[QP] called me (4-30-25) and told me DSS (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 time...I'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."	V 367		

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V 367	Continued From page 12 This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 367		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions;	V 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601499	A. BUILDING: _____ B. WING _____	R-C 06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLABORATIVE HOPE-SKYVIEW	1101 SKYVIEW ROAD CHARLOTTE, NC 28208

(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 500	Continued From page 13 (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure all incidents of alleged abuse were reported to the County Department of Social Services (DSS). The findings are: Review on 6-11-25 of the facility's record revealed: -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	V 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601499	A. BUILDING: _____ B. WING _____	R-C 06/19/2025

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(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 500	Continued From page 14 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 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. 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)] or [Director of Operations (DO) does the reporting (DSS)." -"I don't think that happened (report made to DSS)." Interview on 6-17-25 with the revealed: -"[DO] is responsible for making the report to DSS." -"It was a lot going on during that time...I'm not 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."	V 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601499	A. BUILDING: _____ B. WING _____	R-C 06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLABORATIVE HOPE-SKYVIEW	1101 SKYVIEW ROAD CHARLOTTE, NC 28208

(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 500	Continued From page 15 This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 500		

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:**	[redacted]
Provider Contact Person for follow-up:	[redacted]	**Fax:**	
		Email:	
Address:	9700 Research Dr., Ste 105 Charlotte, NC 28262	**Provider #**	10131556

Finding	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 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.	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. **<u>Implemented Corrective Action Steps:</u>** 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, 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	CEO/ED [redacted] Administrative Officer	Implementation Date: August 1, 2025 Projected Completion Date: Immediately and ongoing

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 allegation was made. "No, I was not suspended. As far as I know nothing happened with that." Interview on 6-12-25 with the Qualified Professional (QP) revealed: 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 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 happened (HCPR report for staff #1)." Interview on 6-17-25 with the Chief Executive Officer (CEO) revealed:			

-She was out of the office when the allegation was made. -"It was a lot going on during that time...I'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-"I think it was the later part of April (2025). He said that staff (staff #1) woke him up in the middle yesterday morning and I was doing the follow up to that today. " -He is responsible for submitting IRIS/HCPR reports but there was no one designated to complete IRIS/HCPR reports in his absence. -"Should anything like this happen again (DO out of the office), [CEO] will be responsible for completing the IRIS/HCPR reports." This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.			
2) 366 27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS 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 II incidents. 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	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. **<u>Corrective Action Steps:</u>** 1. A reorganization of the administrative structure has been completed to strengthen	K[redacted]-CEO/ED Administrative Officer	Implementation Date: August 1, 2025 Projected Completion Date: This will be ongoing with no completion date. Immediately upon filling the AO position training will begin on the use of the IRIS system

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. <u>Previous Corrective Action Steps:</u> 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		

-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 #1 being 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.	sessions will focus on staff duties during 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 HCPR process. Each staffmember will review case scenarios and sign an **attestation** affirming understanding of the five-day reporting requirement and protocols for client safety. 3. **Administrative Oversight and HCPR Compliance Assurance** The facility administrator will ensure that all allegations involving abuse, neglect, or any act defined in G.S. 131E-256(a)(1) are: • **Immediately reported** to the HCPR • Investigated with documentation of interim **protective measures** taken for client safety • The results of the investigation are submitted to DHHS **within five working days** Submissions will be tracked and logged under the administrator's purview. 4. **Incident Review and Quality Assurance Audits** A monthly QA audit will be conducted on all incident reports to ensure timely HCPR notification, proper protective action for clients, and timely completion of investigations. Any deviations will trigger immediate		
3) 367 27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the provider's premises or level III incidents and level II deaths involving the clients to	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 appropriate Local Management Entity/Managed Care Organization (LME/MCO) within 72 hours of becoming aware of the incident, as mandated by 10A NCAC 27G .0604. While the Qualified Professional (QP) is knowledgeable about incident documentation and reporting protocols, the agency identified gaps in internal processes that led to this	[redacted]s Administrative Officer Director of Operations- [redacted] Quality Assurance professional [redacted]-QP	Implementation Date: August 1, 2025, update agency P&P Immediate training for DO, ED and QP Training will begin for AO upon hire 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 information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter	findings to the CEO and ED to ensure all Level II and III incidents are captured and submitted within 72 hours. A quarterly summary will also be compiled and submitted to the LME/MCO as required under section (e) of the rule, if applicable. 5. **Policy Revision:** The agency's Incident Reporting Policy and Procedures Manual will be revised to reflect all changes noted above, including designated roles, timelines, reporting channels, backup procedures, and documentation requirements for both IRIS and the LME/MCO.		

that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record 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 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. Interview on 6-12-25 with the Qualified Professional revealed: -"I don't do the IRIS. Once I take it (incident reports) to the office, I'm not sure who does the IRIS." Interview on 6-17-25 with the Chief Executive Officer (CEO) revealed: -She was out of the office when the			

allegation was made but she was informed by staff. "[QP] called me (4-30-25) and told me DSS (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 time...I'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.			
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	[redacted] Administrative Officer I[redacted]tions- M[redacted] C[redacted]e p[redacted]	Implementation Date: August 1, 2025 Projected Completion Date: August 1, 2025 and ongoing

(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: o Clearly designate **primary** and **alternate staff** responsible for reporting all suspected abuse, neglect, or exploitation to DSS within 24 hours of awareness. o Require documentation of all DSS contacts, including date/time, reporter, and response received. o Include a step-by-step **decision-making and reporting flowchart** for clarity and consistency. **3. Clarified Role Assignments** • **Reassignment of DSS Reporting Responsibility:** o The **Director of Operations (DO)** remains the primary contact for DSS reporting. o In the DO's absence, the **Chief Executive Officer (CEO)** or the **Administrative Officer (AO)** is authorized and responsible	[redacted]	

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. <u>Staff Training and Competency Validation</u>** • **Mandatory Staff Retraining:** All administrative and clinical staff, including the QP, DO, AO, and CEO, will complete refresher training on: ○ G.S. 108A and G.S. 7A statutory requirements. ○ DSS reporting timelines and documentation. ○ 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. **5. <u>Oversight and Quality Assurance</u>** • **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. ○ 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 revealed: -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. 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. 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)] or [Director of Operations (DO) does the reporting (DSS)." -"I don't think that happened (report made to DSS)." Interview on 6-17-25 with the revealed:			

-"[DO] is responsible for making the report to DSS." -"It was a lot going on during that time...I'm not 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.			