			(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					С
		MHL013-251	B. WING		07/17/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
PEACEFU	IL WAYS		C STREET		
		KANNAP	OLIS, NC 28083	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
V 000	INITIAL COMMENTS	;	V 000		
	Four complaints were #NC00230491, NC00 NC00232283), and or unsubstantiated (intal Deficiencies were cited. This facility is license category: 10A NCAC Treatment Staff Secun Adolescents. This facility is license census of 3. The survaudits of 3 current clied.	ke #NC00232206). ed. d for the following service 27G .1700 Residential re for Children or d for 4 and has a current yey sample consisted of ents and 1 former client.			
V 108	(g) Employee training provided and, at a mi following: (1) general organiza (2) training on client delineated in 10A NC 10A NCAC 26B; (3) training to meet to client as specified in to plan; and (4) training in infection bloodborne pathogen (h) Except as permitted. 5602(b) of this Subclient and the subclient as specified in the plan; and the subclient as specified in the subclient a	tion shall be documented. g programs shall be nimum, shall consist of the ational orientation; rights and confidentiality as FAC 27C, 27D, 27E, 27F and the mh/dd/sa needs of the the treatment/habilitation ous diseases and as. ed under 10a NCAC 27G hapter, at least one staff illable in the facility at all is present. That staff	V 108		

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

(X6) DATE TITLE

Division of	of Health Service Regu	ilation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
			D WING		C	
		MHL013-251	B. WING		07/17	7/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE		
			C STREET	,		
PEACEFU	L WAYS					
		KANNAP	OLIS, NC 28083	3		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
TAG	REGULATORT ORT	ESC IDENTIF TING INFORMATION)	TAG	DEFICIENCY)	" NAIL	57.11.2
			+			
V 108	Continued From page	e 1	V 108			
	4					
		nonary resuscitation and				
		h maneuver or other first aid				
	•	nose provided by Red Cross,				
	the American Heart A					
	•	ring airway obstruction.				
	(i) The governing boo					
		nd procedures for identifying,				
	reporting, investigating	ng and controlling infectious				
	and communicable di	iseases of personnel and				
	clients.					
	This Rule is not met	as evidenced by:				
		_				
		ew and interview, the facility				
		ast one staff member who				
	was trained in basic f	` ,				
	cardiopulmonary resu					
		y at all times when a client				
	-	6 audited staff (former staff				
	(FS) #1, staff #3, and	staff #5). The findings are:				
	Review on 6/30/24 of	f (FS) #1's personnel file				
	revealed:					
	-Direct Care Specialis	st.				
	-Hire date of 4/9/25.					
	-Termination date of 7	7/7/25.				
	-American Heart Asso	ociation CPR card dated				
	4/14/25.					
	-No American Heart A	Association FA card				
	1407 anonoan mount	tooodation 17 todia.				
	Review on 7/9/25 of a	staff #3's personnel file				
	revealed:	stan 40 3 personner me				
		ot.				
	-Direct Care Specialis	SI.				
	-Hire date of 6/4/25.					
	-CPR/FA Certificate s	signed by CPR/FA trainer				

Division of Health Service Regulation

dated 3/27/25.

STATE FORM 6899 G6K611 If continuation sheet 2 of 67

Division of Health Service Regulat	ion			FORM	1 APPROVED
	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	MHL013-251	B. WING		1	7/2025
NAME OF PROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STA	TE, ZIP CODE		
PEACEFUL WAYS		T C STREET			
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES JUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	POLIS, NC 28083 ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 108 Continued From page 2 -American Heart Associa 3/27/25No American Heart Ass Review on 7/14/25 of strevealed: -Direct Care SpecialistHire date of 3/19/25CPR/FA Certificate sign dated 6/4/25American Heart Associa 6/4/25No American Heart Associ	ation CPR card dated sociation FA card. aff #5's personnel file ned by CPR/FA trainer ation CPR card dated sociation FA card. FS #1 revealed: le facility. In to 11pm with staff #3. In presentation on the le reson demonstration In a mannequin. In staff #3 revealed: le facility and transported In to 11pm with FS #1. In the computer in a lerson demonstration	V 108			

computer.

portion of the training.

Interview on 7/7/25 with staff #5 revealed:

-Completed CPR/FA training virtually on the

-Did not receive the in person demonstration

-Did not practice CPR on a mannequin.

-Had worked alone in the facility.

STATE FORM 6899 G6K611 If continuation sheet 3 of 67

	n riealth Service Regu		<u> </u>		1	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
						.
		MHL013-251	B. WING	B. WING		, 7/2025
		WIFIE013-231			07/1	112025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		518 EAS	T C STREET			
PEACEFU	L WAYS	KANNAF	OLIS, NC 28083	\		
	CUMMA DV CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
V 108	Continued From page	3	V 108			
V 100	Continued From page	- 3	100			
	Interview on 7/7/25 w	ith the CPR/FA Trainer				
	revealed:					
	-Contracted with the f	facility to provide CPR/FA				
	training.					
		on the same day, but only				
	•	ot the FA cards) from the				
		ciation because it was				
	cheaper.					
	-	with a computer printed FA				
	certificate.	DD/54 : 4 II				
		PR/FA virtually on the				
	computer.					
	-Utilized role playing	when teaching virtual				
	classes.	14 - d do de - a - a - a - a - a - 1111 £ - a				
	-	teddy bear or baby doll" for				
	the demonstration po	rtion during virtual training.				
	Intonvious on 7/14/25	with the Director/Associate				
	Professional revealed					
		uld include an in person				
	component.	did illoldde air ill person				
	-Did not have staff sig	nn in sheets				
	Dia not navo otan ole	yri iii 31133ta .				
\/ 110	27G .0204 Training/S	tunontiaion	V 110			
V 110	Paraprofessionals	supervision	110			
	Faraprofessionals					
	104 NCAC 27G 020	4 COMPETENCIES AND				
		ARAPROFESSIONALS				
		privileging requirements for				
	paraprofessionals.	Principles requirements for				
		s shall be supervised by an				
	associate professiona					
		fied in Rule .0104 of this				
	Subchapter.					
	(c) Paraprofessionals	s shall demonstrate				
		abilities required by the				
	population served.	. ,				
	(d) At such time as a	competency-based				

Division of Health Service Regulation

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DIVISION	n nealth Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
			1		_	
			B WING			
		MHL013-251	B. WING		07/1	7/2025
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE		
	10 715 211 011 001 1 21211					
PEACEFU	L WAYS		C STREET			
		KANNAP	DLIS, NC 28083	3		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	KIATE	DATE
				52.16.2.16.1		
V 110	Continued From page	e 4	V 110			
		s established by rulemaking,				
	then qualified profess	ionals and associate				
	professionals shall de	emonstrate competence.				
	(e) Competence shall	II be demonstrated by				
	exhibiting core skills in	ncluding:				
	(1) technical knowled	dge;				
	(2) cultural awarenes					
	(3) analytical skills;	•				
	(4) decision-making;					
	(5) interpersonal skil					
	(6) communication s					
	(7) clinical skills.	ikilis, aliu				
	` '	dy for each facility shall				
		dy for each facility shall				
		ent policies and procedures				
		individualized supervision				
	plan upon hiring each	i paraprofessional.				
	This Rule is not met	as evidenced by:				
		ew and interview, 1 of 5				
		onals (Licensee/Direct Care				
		emonstrate the knowledge,				
		uired by the population				
	served. The findings a	are.				
	D. d 0/00/05 5	(4b - 1 : /D:				
		the Licensee/Direct Care				
	Specialist's personne					
	-Hire date of 6/28/21.					
	-Evidence Based Pro	tective Interventions-Base				
	Plus (EBPI) 2/3/25.					
	, ,					
	Interview on 7/3/25 w	ith former client (FC) #2				
	revealed:	(- /				
		re Specialist] communicated				

Division of Health Service Regulation

threats to me and [client #3]

STATE FORM 6899 G6K611 If continuation sheet 5 of 67

Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	= IED
					c	,
		MHL013-251	B. WING		07/1	7/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
DE A CEEU		518 EAS	T C STREET			
PEACEFU	L WAYS	KANNAP	OLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETE DATE
V 110	Continued From page	 2 5	V 110			
V 110	-"He (Licensee/Direct me), 'You are coming took everything out of -"I think he wanted m was on the front porc running his mouth." -The licensee/Direct of similar statement to dincident (date unknow) Interview on 7/1/25 w -Locked himself in his "want to go on a com -The Licensee/Direct busted down the door -Told the Licensee/Direct busted down the door -The Licensee/Direct same comment (You forcefully) to [FC #2] unknown)The Licensee/Direct keys to somebody like something" to FC #2. Interviews with client revealed: -Denied hearing the L Specialist make threat licensee at the facility on the front porch (da -Was attempting to deget the clients to go in	t Care Specialist) said (to willingly or forcefully,' and f his pockets." e to come inside (facility). I h because [client #1] was Care Specialist made a client #3 in a separate vn). with client #3 revealed: for room because he did not munity outing. Care Specialist "came and r." rect Care Specialist, "I don't to the willingly or forcefully." Care Specialist made the will come willingly or 2 weeks later (date) Care Specialist handed his e he was going "to do #1 and #4 on 7/1/25 Licensee/Direct Care ats to clients. with the Licensee/Direct Care and all of the clients were ate unknown). eescalate the situation and inside.	V 110			
	-Was attempting to deget the clients to go in	eescalate the situation and				

-I told him you can go "willingly or we can get the

STATE FORM 6899 G6K611 If continuation sheet 6 of 67

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		MHL013-251	B. WING		C 07/17/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
DEAGEEU	I MAYO	518 EAST	C STREET		
PEACEFU	L WAYS	KANNAPO	LIS, NC 28083	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 110	-Client #3 did not war unknown)Had to "bust" the doc -Staff didn't know if he -Talked to client #3 ar Interview on 7/17/25 or Professional revealed -It would not be approto threaten a client to forcefully.	o in (the facility)." the police were not called. It to go to the gym (date or open. It was self-harming. Ind he went to the gym. It with the Director/Associate It woriate for a direct care staff	V 110		
V 112	PLAN (c) The plan shall be assessment, and in p legally responsible per of admission for client receive services beyond (d) The plan shall incompose the projected date of achieved by provision projected date of achieved (2) strategies; (3) staff responsible; (4) a schedule for reannually in consultation responsible person of (5) basis for evaluation outcome achievement (6) written consent of responsible party, or a session of the plan shall be provided in the plan shall be provi	developed based on the artnership with the client or and 30 days. Inde: I that are anticipated to be a of the service and a evement; I view of the plan at least on with the client or legally both; on or assessment of	V 112		

Division of Health Service Regulation

STATE FORM 6899 G6K611 If continuation sheet 7 of 67

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					c	
		MHL013-251	B. WING		07/1	7/2025
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
PEACEFU	L WAYS	518 EAST (KANNAPO	SIREEI LIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 112	Continued From page obtained. This Rule is not met a Based on observation interview, the facility frimplement goals and needs of 1 of 3 audite are: Review on 6/27/25 of -Admission date of 4/-13 years oldDiagnoses of Conduction Trauma and Stressor Deficit Hyperactivity Deficit Hyperactivity Deficit Hyperactivity Deficit Hyperactivity Comprehensive Clinic Addendum dated 3/18	as evidenced by: In, record review and ailed to develop and strategies to meet the Ind clients (#1). The findings Indicate the distraction of the	V 112		RIATE	DATE
	5/7/25 and 6/5/25: "[C	d 10/28/24 and updated lient #1] does not currently nsupervised community				
	Response Improveme 6/30/25 revealed: -5/30/25 "At approxim	the North Carolina Incident ent System from 4/1/25 to lately 6:00 PM, staff begin their scheduled				

Division of Health Service Regulation

chores as outlined in the house routine. [Client

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PRINTED: 07/28/2025 FORM APPROVED

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE S COMPL	
MHL013-251						
		B. WING			17/2025	
NAME OF PR	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
PEACEFUL WAYS			T C STREET			
		POLIS, NC 28083				
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLE DATE
V 112	Continued From page	e 8	V 112			
	task. Staff approache behavior and offer su visibly upset and stat complete the chore. State documented the behavior assisting other clie escalated following a noncompliance. With the home, retrieved a premises, and charge manner. He then use damage household fuverbal de-escalation however, [client #1] ewithout authorization, the street but eventual PM. Staff searched the vehicle for approximation unable to locate the contacted at 9:00 PM.	Staff avior and redirected attention ints. [Client #1's] agitation point deduction for out permission, he exited a metal pole from outside the ed at staff in a threatening d the pole to strike and urniture. Staff attempted techniques and redirection; exited the home again . He remained in view across ally left the area around 8:00 ne neighborhood by foot and ately 45 minutes but were client. Law enforcement was l. At approximately 9:15 PM, [client #1] to the group home				

did without further incident."
-6/3/25 "[Client #1] went AWOL following an incident involving another consumer. The initial incident was de-escalated by staff; however, shortly after, [client #1] became aggressively upset and disregarded staff directives to remain inside the home. [Client #1] exited the residence without staff permission. [Client #1] remained within staff line of sight for approximately 15 to 20

minutes before leaving the visible area. Staff immediately conducted a search for the client both on foot and by vehicle for 45 minutes but

were unsuccessful in locating him. At

client, during which he shared that his emotional outburst was triggered by his friend moving away.

nighttime hygiene routine and go to bed, which he

[client #1] was redirected to complete his

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Division of	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					С
		MHL013-251	B. WING		07/17/2025
		WITE013-231			07/17/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
DEAGEE	1.14/43/0	518 EAS	C STREET		
PEACEFU	L WAYS	KANNAP	OLIS, NC 28083	3	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE
				BEI IOIENOT)	
V 112	Continued From page	9	V 112		
	. •				
		.m., law enforcement was			
		e with facility policy and			
	protocol, as [Client #1	-			
		without supervision. At			
		.m. the following morning,			
		ed to the home (facility) by			
	police. He was unhar	med upon return.			
	Interview on 7/1/25 w	ith aliant #1 rayaalad:			
		kids (clients) piss me off and			
	I go AWOL."	kids (clients) piss me on and			
	•	5 times" without supervision.			
	_	[local town] to look for			
		bill so I bought myself			
	food."	biii so i bougiit iliyseii			
	-Was gone for about	3 hours each time			
		ny changes to prevent			
	AWOLs.	ly changes to prevent			
	AVIOL3.				
	Interview on 7/2/25 w	rith former staff #1 revealed:			
		e goals or strategies to			
	prevent AWOL behav				
	p. 0 . 0				
	Interview on 7/1/25 w	rith staff #3 revealed:			
		e goals or strategies to			
	prevent AWOL behav	-			
		ade to the treatment plan to			
	prevent AWOL behav				
	•	ep clients who went AWOL			
		we can. We (staff) at least			
	_	lock and if they don't come			
	back in at least 40 mi				
	authorities."				
	Interview on 7/8/25 w	ith the Qualified			
	Professional revealed	• •			
	-Was not sure if client	t #1's treatment plan had			
		to address AWOL behavior.			
	"I would have to chec	k documentation. "He			

(client #1) had a history of AWOL." I want to say

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		TED
					l c	
		MHL013-251	B. WING		1	7/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		518 EAST (C STREET			
PEACEFUL WAYS KANNAPO			LIS, NC 28083	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 112	Continued From page	÷ 10	V 112			
	that there were goals -Had not made revision plan to include goals AWOL behavior. Interview on 7/1/25 an Director/Associate Pr -Client #1 had a histo being admitted to the -Client #1 did not hav prevent AWOL behav - Client #1's treatmen	in place." ons to client #1's treatment and strategies to address and 7/8/25 with the ofessional revealed: ry of AWOL behavior prior to				
V 132	G.S. 131E-256(G) HO Allegations, & Protect	iion	V 132			
	REGISTRY (g) Health care faciliti Department is notified health care personne unknown source, which any act listed in subdit (which includes: a. Neglect or abuse facility or a person to as defined by G.S. 13 as defined by G.S. 13 b. Misappropriation in a health care facilit (b) of this section includer services as defined by G.S. 13 care services as defined by G.S. 13 b. Misappropriation of the services as defined by G.S. 13 b. Misappropriation of the services as defined by G.S. 13 b. Misappropriation of the services as defined by G.S. 13 b. Misappropriation of the services as defined by G.S. 13 b. Misappropriation of the services as defined by G.S. 14 b. Misappropriation of the services as defined by G.S. 15 b. Misappropriation of the services as defined by G.S. 15 b. Misappropriation of the services as defined by G.S. 16 b. Misappropriation of the services as defined by G.S. 16 b. Misappropriation of the services as defined by G.S. 16 b. Misappropriation of the services as defined by G.S. 16 b. Misappropriation of the services as defined by G.S. 16 b. Misappropriation of the services as defined by G.S. 16 b. Misappropriation of the services as defined by G.S. 16 b. Misappropriation of the services as defined by G.S. 16 b. Misappropriation of the services as defined by G.S. 16 b. Misappropriation of the services as defined by G.S. 17 b. Misappropriation of the services as defined by G.S. 18 b. Misappropriation of the services as defined by G.S. 18 b. Misappropriation of the services as defined by G.S. 18 b. Misappropriation of the services as defined by G.S. 18 b. Misappropriation of the services as defined by G.S. 18 b. Misappropriation of the services as defined by G.S. 18 b. Misappropriation of the services as defined by G.S. 18 b. Misappropriation of the services as defined by G.S. 18 b. Misappropriation of the services as defined by G.S. 18 b. Misappropriation of the services as defined by G.S. 18 b. Misappropriation of the services as defined by G.S. 18 b. Misappropriation of the services as defined by	ch appear to be related to ivision (a)(1) of this section. of a resident in a healthcare whom home care services 15E-136 or hospice services 15E-201 are being provided. For the property of a resident 15 y, as defined in subsection 16 uding places where home 16 hed by G.S. 131E-136 or 16 lefined by G.S. 131E-201				

Division of Health Service Regulation

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DIVISION	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			B WING		С
		MHL013-251	B. WING		07/17/2025
NAME OF D	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIR CODE	
TVAIVIL OF T	NOVIDEN ON GOLT EIEN			12, 211 0002	
PEACEFU	IL WAYS		T C STREET		
		KANNAF	OLIS, NC 28083	3	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE
				DEFICIENCY)	
V 132	Continued From page	× 11	V 132		
V 102	Continued From page	- 11	1 102		
	facility or to a patient	or client.			
	e. Fraud against a h	ealth care facility or against			
		whom the employee is			
	providing services).	1 7			
		evidence that all alleged			
		and must make every effort			
	to protect residents fr				
	•	gress. The results of all			
	investigations must be				
	I	e working days of the initial			
	notification to the Dep	partment.			
	T. D				
	This Rule is not met				
		ew and interview, the facility			
		egations or acts of abuse,			
		n, including injuries of an			
		e investigated, failed to			
	make every effort to p	protect clients and failed to			
	ensure the results of	all investigations were			
	reported to the HCPR	R within five working days			
	from the initial notifica	ation to the Department.			
	The findings are:	·			
	Finding #1:				
	3				
	Review on 6/27/25 of	client #1's record revealed:			
	-Admission date of 4/				
	-13 years old.	11/20.			
		ct Disorder, Unspecified;			
		Related Disorder; Attention			
	Deficit Hyperactivity [
	Presentation.	Jisorder, Combined			
	i ieseillauull.				
	Davious on 7/0/05 of	atoff #2's paragonal file			
		staff #3's personnel file			
	revealed:				
	-Direct Care Specialis	st.			
	-Hire date of 6/4/25.				
	-Evidence Based Pro				
	(EBPI)-Base Plus 6/4	/25.			

Division of Health Service Regulation

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
		MHL013-251	B. WING		07/4	, 7/2025
		WIFIE013-231			1 07/1	772025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
DEACEEU	LWAVO	518 EAS	T C STREET			
PEACEFU	L WAYS	KANNAF	OLIS, NC 28083	3		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG REGULATORY OF		LSC IDENTIFTING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIAIE	DAIL
				•		
V 132	Continued From page	e 12	V 132			
	Review on 6/30/25 of	the North Carolina Incident				
		ent System (IRIS) from				
	4/1/25-6/30/25 reveal	. ,				
		at approximately 8:52 PM,				
		/Associate Professional (AP)				
	,	#3) that an altercation had				
		aff (former staff (FS) #1) and				
		ning chores. Staff (#3)				
	reported that law enfo	progression or called.				
	The Qualified Profess	sional (QP) arrived on site				
	within 30 minutes, an	d the Director (Director/AP)				
	followed shortly after.	Police were already				
	present. Upon arrival	, client (#1) was seated on				
	-	surface scratches to the				
		equire medical attention.				
		he yard and reported no				
		tated he was washing dishes				
	,	egan rushing him. When he				
] removed the dish rag from				
	-	lient #1] retrieved the rag				
		g. [FS #1] returned to the nt #1] sprayed her with				
		ed into physical contact,				
	·	d exchanging blows. The				
	conflict moved outdoo					
) was present during the				
		tervene and left the scene				
	when police arrived. I	Both client (#1) and staff (FS				
	#1) were assessed for	or injury by QP and Director				
	/AP."					
	Review on 7/2/25 of v	video #1 recorded by staff #3				
	of the incident on 6/2					
	-Video was 28 secon	<u> </u>				
		S #1 was struggling with				
		and was pulling client #1's				
	hair.					
	-Both of FS #1's hand	ds were holding client #1's	- 1			

Division of Health Service Regulation

hair.

-FS #1 was on top of client #1.

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Division of	of Health Service Regu	ılation				M APPROVED
STATEMEN ⁻	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE S COMPL	
		MHL013-251	B. WING		ı	C 17/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE		
PEACEFU	II WAYS	518 EAS	T C STREET			
ILAGLIC	LIAIO	KANNAI	POLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 132	Continued From page	e 13	V 132			
	telling him "Police are to take your a*s to jai -Client #1 said, "Tell -Staff #3 said, "If she (unintelligible)." -FS #1 got off the sof client #1's hair with b-Staff #3 said, "What oh my God." -Client #1 and FS #1 one another until the - Staff #3 did not atte Review on 7/2/25 of of the incident on 6/2 -Video was 33 secon -FS #1 was on the flowith both handsFS #1 and client #1 one another as FS #7 Client #1's legs as she-Client #1 slapped FS and FS #1 released (1)	her to get the f**k off me." gets off of you what fa, continued to grip and pull oth hands. benefit?" and yelled, "Stop, continued to struggle with video ended. mpt to physically intervene. video #2 recorded by staff #3 6/25 revealed: ds long. for pulling client #1's hair continued to struggle with 1 wrapped her legs around the was pulling his hair. 6 #1 on the right shoulder				

-Staff #3 did not attempt to physically intervene.

[client #1]."

FS #1.

were still both on the floor.

attempted to kick her.

throw it at FS #1's head.

-The video ended.

-An unknown person yelled, "You are on your own

-Client #1 got to his feet and moved away from

-FS #1 grabbed client #1's ankle when client #1

-Staff #3 said,"[Client #1], s**t, stop, stop." -Client #1 grabbed a football and threatened to

Interview on 7/1/25 with client #1 revealed: -On 6/26/25 FS #1 took away the dish rag while

Division of Health Service Regulation

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Division of Health Service Regul	lation			TORWIALTRO	VLD
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	MHL013-251	B. WING		C 07/17/2025	
NAME OF PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
		ST C STREET			
PEACEFUL WAYS	KANNAI	POLIS, NC 28083			
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLE	ETE
-FS #1 "hit me in the s started hitting her bac -"Had a few scratches my arm and forgot we were." - FS #1 "pulled out cheverywhere." - Staff #3 did not physi #1. Interview on 7/1/25 wi -On 6/26/25, client #1 -Heard arguing and satowelFS #1 went to her se "grab her." -FS #1 "pushed" clien -Client #1 and FS #1 "each other pulling hair -They were fighting, wabout 8 minutes. "So outside." -Staff #3 called the law recorded some of the -Staff #3 "stayed for 3 and pulled off (left faction of 6/26/25 there was "physical altercation" #1Staff #3 called the pothing."	and "I pushed her back." stomach or chest so I sk." s on my chest and one on ere the rest of the scratches unks of my hair in little balls ically intervene to stop FS ith client #3 revealed: was cleaning his dishes. aw FS #1 "snatch" the dish at and client #1 tried to it #1. "started tussling-grabbed r, kicking." vrestling on the floor for mehow it ended up w enforcement and altercation. s minutes to talk to the cops cility) and said, she quit."	V 132			

stop."

Interview on 7/2/25 with FS #1 revealed: -On 6/26/25 client #1 was washing dishes and

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Division of Health Service Regu	ulation				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE S COMPLE	
				c	<u>, </u>
	MHL013-251	B. WING		1	7/2025
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE	E, ZIP CODE		
PEACEFUL WAYS	518 EAST	C STREET			
TEAGET GE WATO	KANNAP	OLIS, NC 28083			
PREFIX (EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 132 Continued From page	e 15	V 132			
playing in the sink what is showed" her. She and client #1 a turning off the water is shoved" her. She grabbed client restrain him." They continued to seended up outside on Staff #3 did not help is staff #3 recorded the police. When the police arrivant and "left (facility) is staff #3 would not go the police), "like her as the police), "like her as linear was asking for the told her no." FS #1 "was asking for He told him (client #1 forth" verbally. "I told him (client #1 forth" verbally. "I told him (client #1 forth" verbally. "I told him (client #1 forth" verbally. "The calm down." When Client #1 con for #1 for the water of the water	nen she told him to go to bed. rgued back and forth about until client #1 "pushed and #1 by his hair "trying to struggle with one another and the facility's porch. ne incident and called the rived, staff #3 explained her)." give out any information (to address." with staff #3 revealed: 1 was washing dishes when client #1] to get ready for bed. "started going back and) to do dishes and her (FS ntinued to play in the water, ter off. S #1 with the water and said, e a water fight." t #1 and they both started g." king [FS #1]. I wasn't e."				

recording."

- Client #1 grabbed a football and threw it at FS #1. "I didn't want to trigger him, so I stopped

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Division o	of Health Service Regu	lation			1 Orav	IAITROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE S COMPLI	
		MHL013-251	B. WING		07/1	7/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
PEACEFU	II WAVE	518 EAS	T C STREET			
PEACEFU	LWAIS	KANNAF	POLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETE DATE
V 132	Continued From page	<u> </u>	V 132			
	- Client #1 threw the fithey "started fighting - "I opened up the dosirens." - "[Client #1] grabbed (FS #1), and they tust-"I told them to put the did." - After the police arrive that the Director/AP as Specialist were on the (facility)." -"I didn't want to help is fighting. It would loon him (client #1)." -"As soon as they (FS tussling, I jumped up Nobody listened so, I -"Later on, I pulled out	football at FS #1's face and again." or (facility) and heard I a stick and attempted to hit sled with the branch (stick)." e branch down, and they red, she let the officers know and Licensee/Direct Care eir way and then " I left or assist when she (FS #1) book like we were ganging up S #1 and client #1) were and told them to calm down. called 911." It my phone to record." the beginning and didn't get				
	- Arrived at the facility already left Started the investigaturing the incident im that FS #1 "did not for putting a client (#1) are "I haven't been able not she (Staff #3) interestant of the staff #3 recorded a with facility staff.	to substantiate whether or ervened." video but did not share it ponded to attempts to reach that she quit."				

-"She (FS #1) won't be back, but I haven't officially given her anything (termination notice) because I haven't gotten her side of the story."

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S COMPLI	
		MHL013-251	B. WING		07/1	7/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE		
PEACEFU	IL WAYS		T C STREET POLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 132	Continued From page	: 17	V 132			
	Specialist revealed: -FS #1 did not "respoincident with client #1 -FS #1 was terminate techniques and the w-Client #1 had some shair pulled out. Client treatmentStaff #3 "claims she "claims she tried to de-"The police said [statyou deescalating whe Staff #3 was "let go" -Staff #3 was "let go" -Staff #3 was in the a started recording and intervene when the veryou are supposed to Finding #2: Review on 6/30/25 of Specialist personnel for Hire date of 6/28/21EBPI-Base Plus 2/3/ Review on 6/24/25 of record revealed: -Admission date of 3/2-17 years oldDischarge date of 6/2-Diagnoses of Post-T Conduct Disorder. Interview on 7/3/25 were likely and clied in the clied in	d for lack of de-escalation rong use of EBPI." superficial scratches and t #1 "declined" medical didn't see anything and escalate." ff #3] had video. How are en you are recording?" because of neglect. rea (of the incident) but failed to deescalate or erbal escalation started. or intervene." the Licensee/Direct Care ille revealed: 25. former client (FC) #2's 23/25. raumatic Stress Disorder, ith FC #2 revealed: re Specialist] communicated				

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Division of Health Service Regula	ation				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE S COMPLE	
	MHL013-251	B. WING		07/1	; 7/2025
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE ZIP CODE		
		C STREET	, 2 3332		
PEACEFUL WAYS	KANNAPO	LIS, NC 28083	3		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 132 Continued From page	18	V 132			
took everything out of I -"I think he wanted me was on the front porch running his mouth." -Reported the incident and his care manager Entity/Managed Care C Care Manager). Interview on 7/1/25 witt -The Licensee/Direct C #2 "You will come willir -"He (Licensee/Direct C keys to somebody like something (to FC #2)." Interview on 7/11/25 wi Manager revealed: -During a phone call or was being mentally about -"FC #2 said there was [Licensee/Direct Care of the deescalate and had to to another area. [Licensee/Direct Care of the deescalate and had to to another area. [Licensee/Direct Care of the allegation on 5/13/2] Interview on 7/9/25 witt Specialist revealed: -Arrived at the facility a on the front porch (date -Was attempting to dee get the clients to go ins -FC #2 "started cursing be here."	his pockets." to come inside (facility). I because [client #1] was to the Complaint Hot Line (Local Management Organization (LME/MCO) th client #3 revealed: Care Specialist said to FC ngly or forcefully". Care Specialist) handed his he was going to do with FC #2's LME/MCO Care in 5/13/25 FC #2 stated he used in the facility. Is an incident going on and Specialist] had to get kids (clients) to move ensee/Direct Care Specialist] we or I will make you scholiect Care Specialist of 25. th the Licensee/Direct Care and all of the clients were e unknown). escalate the situation and side. It is gand said, 'I don't want to willingly or we can get the	V 102			

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DIVISION	n nealth Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			D MINIC		С	
		MHL013-251	B. WING		07/17/2025	
NAME OF D	ROVIDER OR SUPPLIER	STDEET ADI	ORESS, CITY, STA	TE ZID CODE		
NAME OF FI	NOVIDER OR SUFFLIER		, ,	I E, ZIF GODE		
PEACEFU	I WAYS	518 EAST	C STREET			
LAGEIG	LIMA	KANNAPO	LIS, NC 28083	3		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	(- /	E
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE DATE	
				DEFICIENCY)		
V/ 400	0 " 15	40	V 132			
V 132	Continued From page	9 19	V 132			
	-The allegation was n	ot investigated				
	-Was not suspended.					
	-Was not reported to					
	-was not reported to	IIIE HOFK.				
	Intomious on 7/0/05	ith the Diverter/AD verseled.				
		ith the Director/AP revealed:				
		at someone was verbally				
		him, but then when we got				
		ne indicated that his words				
were twisted that no one was verbally abusing						
	him."					
	-FC #2 did not name	the person who he accused				
	of verbally abusing hi	m.				
	-Did not investigate.					
	-"There was nothing t	o investigate "				
	-Did not suspend the					
	Specialist.	Electisee/Direct Gale				
	-	a maticip to the LICDD				
	-Did not report the all	egation to the HCPR.				
V 296	27G .1704 Residentia	al Tx. Child/Adol - Min.	V 296			
	Staffing					
	3					
	10A NCAC 27G .1704	4 MINIMUM STAFFING				
	REQUIREMENTS	i i i i i i i i i i i i i i i i i i i				
		sional shall be available by				
		sional shall be available by				
		direct care staff shall be				
		lity within 30 minutes at all				
	times.	_				
	• •	mber of direct care staff				
	required when childre					
	present and awake is					
	(1) two direct ca	are staff shall be present for				
	one, two, three or fou	r children or adolescents;				
		care staff shall be present				
	for five, six, seven or					
	adolescents; and					
	•	are staff shall be present for				
	• •					
	nine, ten, eleven or tv	verve children or				

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(c) The minimum number of direct care staff

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DIVISION	of Health Service Regu	liation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		MIII 040 054	B WING		C
		MHL013-251	B. WIITO		07/17/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		518 FAS	T C STREET		
PEACEFU	L WAYS		POLIS, NC 28083	•	
			OLIS, NC 20003	•	The state of the s
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	()
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	
17.0		,	IAG	DEFICIENCY)	
V 296	Continued From page	e 20	V 296		
	during child or adoles	scent sleep hours is as			
	follows:	och sieep nouis is as			
		are staff shall be present			
	` ,				
	children or adolescen	ke for one through four			
		are staff shall be present			
		ake for five through eight			
	children or adolescents; and				
		care staff shall be present			
		awake and the third may be			
	•	eleven or twelve children or			
	adolescents.				
		minimum number of direct			
		Paragraphs (a)-(c) of this			
		e staff shall be required in			
	-	he child or adolescent's			
		pecified in the treatment			
	plan.	l barrana ara da ba farrana ara da ara			
		be responsible for ensuring			
		n or adolescents when they			
		cility in accordance with the			
		individual strengths and			
	needs as specified in	the treatment plan.			
	This Rule is not met				
	Based on observation	•			
	interview, the facility	failed to ensure the minimum			
	staff ratio of two staff	for up to 4 adolescents. The			
	findings are:				
	-				
	Review on 6/27/25 of	client #1's record revealed:			

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-Admission date of 4/11/25.

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DIVISION	n Health Service Negu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		MUU 040 054	B. WING		C
		MHL013-251			07/17/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		518 EAST	C STREET		
PEACEFU	L WAYS		OLIS, NC 28083	1	
	CLIMMA DV CT				
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	()
TAG	•	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	
				DEFICIENCY)	
V 296	Continued From page	21	V 296		
. 200	Continued i form page	, 21	1200		
	-13 years old.				
	-Diagnoses of Condu	ct Disorder, Unspecified;			
		Related Disorder; Attention			
	Deficit Hyperactivity D	Disorder, Combined			
	Presentation.				
	-Treatment Plan date	d 10/28/24 and updated			
	5/7/25 and 6/5/25. C	lient #1 "does not currently			
	have access to any u	nsupervised community			
	areas."				
	Review on 6/24/25 of	FC #2's record revealed:			
	-Admission date of 3/	21/25.			
	-17 years old.				
	-Discharge date of 6/2	23/25.			
	-Diagnoses of Post-T	raumatic Stress Disorder,			
	Conduct Disorder.				
	-Treatment plan dated	d 9/4/24 and updated 5/2/25			
	and 6/2/25. FC #2 "d	oes not currently have			
	access to any unsupe	ervised community areas."			
	D : 7/1/05 6				
		client #3's record revealed:			
	-Admission date of 3/	18/25.			
	-15 years old.	15: 1 311: 11			
	•	ct Disorder with Limited			
	•	Moderate; Attention Deficit			
		- Inattentive Presentation;			
		na and Stressor Related			
	Disorder - Adjustmen	t like Disorders with			
	Prolonged Duration.				
	-Treatment Plan date				
		6/24/25 did not include			
	information related to	unsupervised time.			
	Poviou on 7/44/05 - 5	oliont #410 record rove -1 - 4			
		client #4's record revealed:			
	-Admission date of 3/	JU/∠J.			
	-16 years old.	To Cover Office			
	-Diagnoses of Reaction				
	Unspecified; Major De				
	 I reatment plan dated 	d 1/14/25 and updated			

Division of Health Service Regulation

4/21/25, 5/27/25, and 6/23/25. Client #4

STATE FORM 6899 G6K611 If continuation sheet 22 of 67

Division of	of Health Service Regu	ilation				
STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SI	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	:TED
			D MING			
		MHL013-251	B. WING		07/1	7/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
PEACEFU	JL WAYS		T C STREET			
	T		POLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO) BE	(X5) COMPLETE DATE
V 296	Continued From page	e 22	V 296			
		pervision and does not have to community settings at				
	12pm to 1:25pm reve	5 at a community camp from ealed: #4 present with no facility				
	-There was 1 to 2 star -"1 staff is there when -There was "always ju (11pm-7am). -1 or 2 staff transporte	ust" 1 staff on 3rd shift ed clients to and from camp. icks up and 2nd staff is				
	time there was only 1 -There was 1 staff on -"95% of the time ther (4pm to 11pm)."	d to be 2 staff but 95% of the 1." a 3rd shift (11pm to 7am). are was 1 staff on 2nd shift and from camp by 1 staff				
	-Attended camp from later, Monday through were present. -There were usually 2 sometimes less, but " -"A lot of staff are quit -Sometimes 1 staff wa					

Interview on 7/1/25 with client #4 revealed:

STATE FORM 6899 G6K611 If continuation sheet 23 of 67

Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
						•
		MHL013-251	B. WING		1	17/2025
		OTDEET.		TE 710 0005		
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	ATE, ZIP CODE		
PEACEFU	L WAYS		T C STREET	_		
		KANNAF	POLIS, NC 28083	3		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
17.0		,	1710	DEFICIENCY)		
\/ 000	0 " 15		1/ 000			
V 296	Continued From page) 23	V 296			
	-There was "1 to 2" s	taff on shift in the facility.				
	-Attended camp from	7:30am to 4pm or 5pm				
	Monday through Frida	ay. No facility staff were				
	present.					
	-Was "usually" transp	orted by 1 staff.				
		vith former staff #1 revealed:				
	•	elf "onceor a few times."				
		night a couple of times from				
		ıring school). They (clients)				
	are pretty much aslee	•				
	• •	2 (staff) on all shifts."				
		pm or 3pm to 11pm by				
	myself every now and	then."				
	It	:: the at-ff #0				
	Interview on 7/2/25 w					
	•	aff on 3rd shift (11pm to				
	7am).	ow that until I got hired in the				
		025), she was the only staff				
	that worked 2nd shift.					
		tire shift alone, but other				
	staff had.	are stiff alone, but other				
		clients from camp alone.				
	-"1 staff is a safety ris					
	Interview on 7/7/25 w	vith staff #4 revealed:				
	-Worked 11pm to 8an	n.				
	-Had worked 3rd shift					
	-"We are understaffed	d right now."				
	-"When I have had to	do it (work) by myself we				
		someone to come in."				
	-"That shift (3rd) does					
	-Unable to tell the nur	mber of times he worked				
	alone.					
	-Transported the clier	nts to and from camp alone.				
	Interview on 7/7/25 w	vith staff #5 revealed:				
	VIO VV OII 1/1/20 W	iai staii #0 iovodiou.	1	1		1

-"There were a few shifts where I was alone just

in the crossing over (shift change)."

STATE FORM 6899 G6K611 If continuation sheet 24 of 67

Division of	Division of Health Service Regulation						
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:			COMPL	ETED	
			7 50.25 (6				
						;	
		MHL013-251	B. WING		07/1	7/2025	
NAME OF D		CTDEET A	DDDECC CITY CTA	TE 7/D 00DE			
NAIVIE OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE			
PEACEFU	L WAYS		T C STREET				
		KANNAF	OLIS, NC 28083				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	KIATE	DATE	
				52.18.2.16.1,			
V 296	Continued From page	e 24	V 296				
	. •						
	•	ty) 30 minutes maximum					
	alone."						
	Interview on 7/8/25 w						
	Professional (QP) rev						
		staff in the facility on 2nd					
	,	11pm) and 3rd shift (11pm					
	to 8am).						
	-There are no staff wo	orking 1st shift (8am to 4pm					
	or 5pm) Monday thro	ugh Friday because the					
	clients went to camp.						
	-Camp staff provided	supervision while the clients					
	were at camp.						
	•	e camp was staffed or the					
	training they received						
	5 ,						
	Interview on 7/8/25 w	ith the Director/Associate					
	Professional (AP) rev						
		np from 8am until around					
	5pm.						
	•	n all shifts when clients were					
	in the facility.	Tan erinte Wilen ellerite Were					
	,	aff called out of work, there					
		one staff until someone					
	could get there, no m						
	codia get there, no m	ore than 50 minutes.					
	Interview on 7/0/25 w	ith the Licensee/Direct Care					
	Specialist revealed:	iti the Licensee/Direct Care					
	-2 staff worked on all	ahifta					
		gency, [Director/AP] or [QP]					
		minutes away, if we have a					
	call out."						
		rted to camp by 2 staff.					
	-Camp counselors we	•					
	supervision when the	clients were at camp.					
V 366	27G .0603 Incident R	esponse Requirements	V 366				
		,					

10A NCAC 27G .0603

INCIDENT

STATE FORM 6899 G6K611 If continuation sheet 25 of 67

DIVISION	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			D WING		С
		MHL013-251	B. WING		07/17/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE. ZIP CODE	
			T C STREET	,	
PEACEFU	L WAYS				
		KANNAF	POLIS, NC 28083	3	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(*)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	NIATE DATE
				,	
V 366	Continued From page	e 25	V 366		
	DECDONOE DECLU	DEMENTO FOR			
	RESPONSE REQUIF				
	CATEGORY A AND E				
	. ,	3 providers shall develop and			
	implement written pol				
	•	or III incidents. The policies			
	shall require the prov				
	(1) attending to	the health and safety needs			
	of individuals involved	· · · · · · · · · · · · · · · · · · ·			
		the cause of the incident;			
	(3) developing	and implementing corrective			
	measures according	to provider specified			
	timeframes not to exc	ceed 45 days;			
	(4) developing	and implementing measures			
	to prevent similar inci	dents according to provider			
	specified timeframes	not to exceed 45 days;			
	= -	erson(s) to be responsible			
	for implementation of				
	preventive measures				
	-	confidentiality requirements			
		article 2A, 10Å NCAC 26B,			
		3 and 45 CFR Parts 160 and			
	164; and	o and to or ter and too and			
		documentation regarding			
) through (a)(6) of this Rule.			
		requirements set forth in			
	()	Rule, ICF/MR providers			
		ts as required by the federal			
	regulations in 42 CFF	· · · · · · · · · · · · · · · · · · ·			
		requirements set forth in			
	• ,	Rule, Category A and B			
		ICF/MR providers, shall			
		•			
		ent written policies governing			
	•	vel III incident that occurs			
		delivering a billable service			
		on the provider's premises.			
	·	uire the provider to respond			
	by:				
	• •	y securing the client record			
	by:				

Division of Health Service Regulation

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PRINTED: 07/28/2025 FORM APPROVED

Division of Health Service Regulation

DIVISION	of fleatin Service Negu	lation			
STATEMENT	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					C
		MHL013-251	B. WING		07/17/2025
			•		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
PEACEFU	II WAYS	518 EAST	C STREET		
ILAGLIG	LIAIO	KANNAP	OLIS, NC 28083	3	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE
				DEFICIENCY)	
V 366	Continued From page	26	V 366		
, 000	Continued From page	, 20	1 000		
		e client record;			
	(B) making a pl	notocopy;			
		e copy's completeness; and			
		the copy to an internal			
	review team;	are copy to air interrial			
		n meeting of an internal			
	` <i>'</i>	hours of the incident. The			
		shall consist of individuals			
		d in the incident and who			
		for the client's direct care or			
	with direct profession	al oversight of the client's			
	services at the time of	f the incident. The internal			
	review team shall con	nplete all of the activities as			
	follows:				
	(A) review the c	opy of the client record to			
	` '	nd causes of the incident			
		dations for minimizing the			
	occurrence of future in	_			
	, ,	r information needed;			
		n preliminary findings of fact			
		ys of the incident. The			
		f fact shall be sent to the			
	LME in whose catchm	nent area the provider is			
	located and to the LM	IE where the client resides,			
	if different; and				
	(D) issue a final	written report signed by the			
	owner within three mo	onths of the incident. The			
		ent to the LME in whose			
	·	rovider is located and to the			
		resides, if different. The			
	final written report sha				
	identified by the interr				
	-				
		uments pertinent to the			
		ike recommendations for			
	-	ence of future incidents. If			
		d for the report are not			
	available within three	months of the incident, the			
	LME may give the pro	ovider an extension of up to			
		nit the final report: and			

Division of Health Service Regulation

STATE FORM 6899 G6K611 If continuation sheet 27 of 67

Division of	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	
					С	
		MHL013-251	B. WING		07/17/2025	
		WIFIE013-231			07/17/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		518 EAST	C STREET			
PEACEFU	IL WAYS	KANNAP	OLIS, NC 28083	3		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	()	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE	
				DEFICIENCY)		
V 366	Continued From page	e 27	V 366			
		notifying the following:				
	` '	ponsible for the catchment				
		ces are provided pursuant to				
	Rule .0604;					
		nere the client resides, if				
	different;					
		r agency with responsibility				
	for maintaining and u	. •				
		erent from the reporting				
	provider;					
	(D) the Departm					
		legal guardian, as				
	applicable; and					
	(F) any other a	uthorities required by law.				
	This Rule is not met	as evidenced by:				
		ew and interview, the facility				
		ritten policies governing				
		el II incidents and failed to				
	•	ary findings of facts within				
		he incident to the LME. The				
	findings are:	THE INCIDENT TO THE LINE. THE				
	indings are.					
	Review on 6/30/25 of	the North Carolina Incident				
	Response Improveme					
	4/1/25-6/30/25 reveal	-				
		for the allegation by FC #2				
		ect Care Specialist was				
	verbally abusive.	<u>- </u>				
	-No documentation of	f findings of the				
	investigation, correcti					
	measures, and perso					
		rrective and preventative				

measures.

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DIVISION	n rieaitii Service Regu		1		1	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		MHL013-251	B. WING		1	
		IVITEU 13-23			1 07/1	7/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
DE 4 0EE:	I MAYO	518 EAST	C STREET			
PEACEFU	L WAYS	KANNAPO	DLIS, NC 28083	3		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
			1	DEFICIENCY)		
V 366	Continued From page	e 28	V 366			
		· - ·				
	– . – –	"-				
	Interview on 7/3/25 w					
		re Specialist] communicated				
	threats to me and [clie	-				
	,	Care Specialist) said (FC				
		willingly or forcefully,' and				
	took everything out of					
		e to come inside (facility). I				
		h because [client #1] was				
	running his mouth."					
		nt to the Complaint Hot Line				
	and his care manage	,				
	Entity/Managed Care	Organization (LME/MCO)				
	Care Manager).					
		ith client #3 revealed:				
		Care Specialist said to FC				
	#2 "You will come will					
		Care Specialist) handed his				
	keys to somebody like					
	something (to FC #2)	. "				
		with FC #2's LME/MCO Care				
	Manager revealed:					
	• •	on 5/13/25 FC #2 stated he				
	was being mentally a					
		as an incident going on and				
	[Licensee/Direct Care	•				
		o get kids (clients) to move				
	_	ensee/Direct Care Specialist]				
	said, 'You need to mo	ove or I will make you				
	move."					
		e/Direct Care Specialist of				
	the allegation on 5/13	3/25.				
	1t	:41- 41 1 : /D:				
		ith the Licensee/Direct Care				
	Specialist revealed:					
		and all of the clients were				
	on the front porch (da					
	-Was attempting to de	eescalate the situation and				

Division of Health Service Regulation

STATE FORM 6899 G6K611 If continuation sheet 29 of 67

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:	
					С
		MHL013-251	B. WING		07/17/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		518 EAST	C STREET		
PEACEFUL WAYS			LIS, NC 28083		
()(1) ID	SLIMMADV ST.	ATEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CORRECTION	I (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
V 366	Continued From page	e 29	V 366		
	be here." -"I told him you can gepolice to make you go -FC #2 complied and -The allegation was new and was not suspended. Interview on 7/8/25 we -"[FC #2] did report the and mentally abusing on the Child and Famindicated that his wor was verbally abusing -FC #2 did not name of verbally abusing hite." There was nothing the complete and findings, corrective are formally and the staff in relation to the staff in relation to the and findings, corrective are suspended.	o willingly, or we can get the o in." the police were not called. ot investigated. ith the Director/AP revealed: nat someone was verbally him, but then when we got hilly Team meeting he ds were twisted, that no one him." the person who he accused m. ne allegation. to investigate." Director/Licensee or other allegation investigation including and preventative measures, sible for implementation of			
V 367	27G .0604 Incident R	eporting Requirements	V 367		
	level II incidents, exce the provision of billab consumer is on the princidents and level II	REMENTS FOR B PROVIDERS B providers shall report all ept deaths, that occur during le services or while the roviders premises or level III deaths involving the clients rendered any service within acident to the LME			

Division of Health Service Regulation

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DIVISION	n nealth Service Negu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			B. WING		C
		MHL013-251	B. WING		07/17/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		518 FAST	C STREET		
PEACEFU	L WAYS		LIS, NC 28083	1	
		KANNAPC	LIS, NC 20003	•	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
IAG			1/40	DEFICIENCY)	
V 367	Continued From page	e 30	V 367		
	services are provided	within 72 hours of			
	•	ne incident. The report shall			
	_				
	be submitted on a for				
		t may be submitted via mail,			
	-	r encrypted electronic			
	=	nall include the following			
	information:				
		ovider contact and			
	identification informat				
	` '	fication information;			
	(3) type of incid	lent;			
	(4) description	of incident;			
	(5) status of the	e effort to determine the			
	cause of the incident;	and			
	(6) other individ	duals or authorities notified			
	or responding.				
	(b) Category A and B	providers shall explain any			
		e information. The provider			
		ed report to all required			
		ne end of the next business			
	day whenever:				
	•	has reason to believe that			
	information provided				
		g or otherwise unreliable; or			
		obtains information			
		ent form that was previously			
	unavailable.	The form that was proviously			
		providers shall submit,			
		ME, other information			
	obtained regarding th				
	. ,	ords including confidential			
	information;	Alban andhanidiaan ar d			
		other authorities; and			
	. ,	's response to the incident.			
		providers shall send a copy			
		reports to the Division of			
		opmental Disabilities and			
		rvices within 72 hours of			
	becoming aware of th	e incident. Category A			

Division of Health Service Regulation

STATE FORM 6899 G6K611 If continuation sheet 31 of 67

Division of	of Health Service Regu	ilation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	<u>≡</u> TED
			B. WING		C	
		MHL013-251	B. WING		07/1	7/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	ΓΕ, ZIP CODE		
		549 EAST	T C STREET			
PEACEFU	L WAYS					
		KANNAP	OLIS, NC 28083			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		COMPLETE DATE
TAG		ESCIDENTIF TING INFORMATION)	TAG	DEFICIENCY)	NAIL]
				· · · · · · · · · · · · · · · · · · ·		
V 367	Continued From page	e 31	V 367			1
						1
	providers shall send a					1
	_	client death to the Division of				1
		lation within 72 hours of				ı
	becoming aware of th	ne incident. In cases of				ı
	client death within se	ven days of use of seclusion				ı
	or restraint, the provid	der shall report the death				ı
	immediately, as requi	ired by 10A NCAC 26C				1
	.0300 and 10A NCAC	_				1
		B providers shall send a				ı
		E LME responsible for the				ı
		e services are provided.				ı
		ubmitted on a form provided				ı
	I	electronic means and shall				ı
	, ,					ı
	include summary info					ı
	` '	errors that do not meet the				ı
	definition of a level II					ı
	` '	nterventions that do not meet				ı
		el II or level III incident;				ı
		f a client or his living area;				ı
		client property or property in				ı
	the possession of a c	elient;				ı
	(5) the total nur	mber of level II and level III				ı
	incidents that occurre	ed; and				ı
	(6) a statement	t indicating that there have				1
	l .' '	ncidents whenever no				1
	'	red during the quarter that				1
		ria as set forth in Paragraphs				ı
		le and Subparagraphs (1)				1
	through (4) of this Pa					ı
		ragrapii.				ı
						1
						1
						ı
						ı
						ı
						ı
	This Rule is not met	as evidenced by:				1
	Based on interview ar	nd record review, the facility				1

Division of Health Service Regulation

failed to report all Level II incident reports to the

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					С	
		MHL013-251	B. WING		07/17/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PEACEFU	IL WAYS	518 EAST (STREET			
		KANNAPO	LIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 367	Continued From page	e 32	V 367			
	Organization (MCO)	e services are provided coming aware of the				
	Response Improveme	the North Carolina Incident ent System (IRIS) revealed: for the allegation by FC #2 ect Care Specialist was				
	Interview on 7/3/25 with FC #2 revealed: -"[Licensee/Direct Care Specialist] communicated threats to me and [client #3]." -"He (Licensee/Direct Care Specialist) said (to FC#2), 'You are coming willingly or forcefully,' and took everything out of his pockets." -"I think he wanted me to come inside (facility). I was on the front porch because [client #1] was running his mouth." -Reported the incident to the Complaint Hot Line and his LME/MCO Care Manager.					
	#2 "You will come will	Care Specialist said to FC ingly. Care Specialist) handed his e he was going to do				
	Manager revealed: -During a phone call of was being mentally all -FC #2 "said there was [Licensee/Direct Care deescalate and had to	as an incident going on and e Specialist] had to o get kids (clients) to move ensee/Direct Care Specialist]				

Division of Health Service Regulation

STATE FORM 6899 G6K611 If continuation sheet 33 of 67

Division of	of Health Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SI COMPLE		
		MUI 042 254	B. WING		C 07/4	
		MHL013-251			07/1	7/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	E, ZIP CODE		
PEACEFU	L WAYS		ST C STREET POLIS, NC 28083			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTION	N.	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 367	Interview on 7/9/25 w Specialist revealed: -Arrived at the facility on the front porch (da -Was attempting to de get the clients to go ir -FC #2 "started cursir be here." -"I told him you can gpolice to make you go -FC #2 complied and -The allegation of was -Was not suspended. Interview on 7/8/25 w -"[FC #2] did report the and mentally abusing on the CFT meeting here twisted that no chim."	e/Direct Care Specialist of b/25. ith the Licensee/Direct Care and all of the clients were ate unknown). escalate the situation and aside. ng and said, 'I don't want to be willingly, or we can get the b in." the police were not called.	V 367			
	of verbally abusing hi -Was responsible for abuseDid not investigate"There was nothing t -Did not submit the in becoming aware of the	m. investigating allegations of o investigate." cident within 72 hours of				
V 500	27D .0101(a-e) Client	Rights - Policy on Rights I POLICY ON RIGHTS	V 500			

RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that

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Division of Health Service Regulation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			B WING		С
		MHL013-251	B. WING		07/17/2025
NAME OF D	ROVIDER OR SUPPLIER	STDEET A	DDRESS, CITY, STA	TE ZID CODE	
NAME OF T	TOVIDER OR SOLT LIER			TE, ZII GODE	
PEACEFU	L WAYS		T C STREET		
		KANNAI	POLIS, NC 28083	3	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX	*	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI	RIATE DATE
				DEFICIENCY)	
V 500	Continued From page	e 34	V 500		
		ntation of G.S. 122C-59,			
	G.S. 122C-65, and G	.S. 122C-66.			
	(b) The governing bo	ody shall develop and			
	implement policy to a	ssure that:			
		s of alleged or suspected			
		oloitation of clients are			
		y Department of Social			
		in G.S. 108A, Article 6 or			
	G.S. 7A, Article 44; a				
		and safeguards are			
		ice with sound medical			
		ication that is known to			
		o the client is prescribed.			
		nall be given to the use of			
	neuroleptic medicatio				
		se procedures prohibited in			
		2(1), the governing body of			
	each facility shall dev	elop and implement policy			
	that identifies:				
	(1) any restricti	ve intervention that is			
	prohibited from use w	vithin the facility; and			
	(2) in a 24-hou	r facility, the circumstances			
	under which staff are	prohibited from restricting			
	the rights of a client.	-			
	(d) If the governing be	ody allows the use of			
	() 3	ns or if, in a 24-hour facility,			
		ent rights specified in G.S.			
		re allowed, the policy shall			
	identify:	is anomou, the policy shall			
	•	ed restrictive interventions or			
	allowed restrictions;	of 100th of the vention of			
		al responsible for informing			
	` '	ai responsible for illioitilling			
	the client; and	mmdumes f			
	• •	cess procedures for an			
	involuntary client who				
	restrictive intervention				
		ventions are allowed for use			
	within the facility, the				
	develop and impleme	ent policy that assures			

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				c		
		MHL013-251 B. WING		1	7/2025	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
PEACEFU	L WAYS		C STREET			
			OLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 500	Continued From page	e 35	V 500			
	which includes: (1) the designal has been trained and competence to use reprovide written author restrictive intervention renewed for up to a traccordance with the traccordance	ns when the original order is otal of 24 hours in ime limits specified in 10A				
	This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure all instances of alleged or suspected abuse, neglect or exploitation were reported to the county department of social services (DSS). The findings are: Finding #1: Review on 6/27/25 of client #1's record revealed: -Admission date of 4/11/2513 years oldDiagnoses of Conduct Disorder, Unspecified; Trauma and Stressor Related Disorder; Attention Deficit Hyperactivity Disorder, Combined Presentation.					
	Review on 7/9/25 of s revealed:	staff #3's personnel file				

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-Direct Care Specialist.

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			P WINC		С	
		MHL013-251	B. WING		07/17/2	2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
PEACEFU	L WAYS		C STREET			
			DLIS, NC 28083	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE 0	(X5) COMPLETE DATE
V 500	Continued From page	e 36	V 500			
	-Hire date of 6/4/25. -Evidence Based Pro (EBPI)-Base Plus 6/4	tective Interventions /25.				
	altercation between F Client #1. Staff #3 vio and neglected to to pr physically intervening Finding #2 details, FC	g #1 details regarding the former Staff (FS) #1 and dee taped the altercation rotect Client #1 by not during the altercation. C#2 alleged the ect communicated threats to				
	Response Improvemed 4/1/25-6/30/25 reveal -"On June 26, 2025, at the Director (Director) was notified by staff (occurred between staclient (#1) during every reported that law enformation of the Qualified Profess within 30 minutes, an (Director/Associate Pafter. Police were alrectient (#1) was seated surface scratches to trequire medical attenty yard and reported no he was washing disher ushing him. When he removed the dish rag [Client #1] retrieved the cleaning. [FS #1] reture [Client #1] sprayed here.	ed: at approximately 8:52 PM, l'Associate Professional) #3) that an altercation had off (former staff (FS) #1) and ning chores. Staff (#3) brocement had been called. sional (QP) arrived on site d the Director rofessional) followed shortly leady present. Upon arrival, d on the porch with visible whe chest, which did not tion. Staff (FS #1) was in the injuries. [Client #1] stated les when staff (FS #1) began le didn't comply, [FS #1] from him and sat down. The rag and resumed le with water, which all contact, including pushing				

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was present during the incident but did not

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					С	
		MHL013-251	B. WING		07/17/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE		
NAME OF T	TOVIDER OR SOLT LIER		C STREET	KIE, ZII GODE		
PEACEFU	L WAYS		OLIS, NC 28083	3		
	OUR MAR DV OT		<u> </u>			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		Ε
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP		
				DEFICIENCY)		
V 500	Continued From page	e 37	V 500			
		scene when police arrived.				
		FS #1 and Client #1 were				
		y QP (Qualified Professional)				
	(AP))."	r/Associate Professional				
	(Al)).					
	Interview on 7/8/25 w	rith the Director/AP revealed:				
		on 6/26/25 and staff #3 had				
	already left.					
	-Started the investiga	tion immediately.				
	-"I don't want to say it	was abuse but it was				
	wrong."					
	-Staff #3 recorded a v	video, but did not share it				
	with facility staff.					
	-Staff #3 had not resp	oonded to attempts to reach				
	her.					
	-"[Staff #3] indicated t	•				
	-"I was going to officia	ally terminate ner." to substantiate whether or				
	not she intervened."	to substantiate whether or				
		be back, but I haven't				
		ything (termination notice)				
		tten her side of the story."				
		investigation of neglect by				
		protect client #1 from abuse.				
	-Did not report staff #					
	•					
	Interview with the Lice	ensee/Direct Care				
	Specialist:					
		didn't see anything and				
	"claims she tried to de					
	•	ff #3] had video. How are				
		en you are recording?"				
	-Staff #3 was "let go"	•				
		rea (of the incident) but				
	_	failed to deescalate or erbal escalation started.				
	-"You are supposed to					

-An investigation of neglect by staff #3 for failing

to protect client #1 from abuse was not

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
			D MINO	B. WILLO		
		MHL013-251	B. WING		07/17	//2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
PEACEFU	L WAYS		C STREET			
			OLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 500	Continued From page	e 38	V 500			
	completed. -Staff #3 was not repo	orted to DSS.				
	Finding #2:					
	Review on 6/30/25 of Specialist's personne -Hire date of 6/28/21. -EBPI-Base Plus 2/3/					
	Review on 6/24/25 of former client (FC) #2's record revealed: -Admission date of 3/21/2517 years oldDischarge date of 6/23/25Diagnoses of Post-Traumatic Stress Disorder, Conduct Disorder.					
	threats to me and [clicular-"He (Licensee/Direct #2), 'You are coming took everything out of -"I think he wanted mass on the front porcirunning his mouth." -Reported the incident and his care manager	re Specialist] communicated ent #3]." Care Specialist) said (to FC willingly or forcefully,' and f his pockets." e to come inside (facility). I h because [client #1] was				
	Manager revealed: -During a phone call of was being mentally al -"FC #2 said there was [Licensee/Direct Care	as an incident going on and				

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Division	of Health Service Regu	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			_		
					С
		MHL013-251	B. WING		07/17/2025
	20,4050 00 01,001,150	0.70.57	DDE00 0171/ 071	TE 710 0005	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
PEACEFU	I WAVE	518 EAS	C STREET		
FLACEIO	LWAIS	KANNAP	OLIS, NC 28083	S	
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I (X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	(- /
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE DATE
				DEFICIENCY)	
14.500	<u> </u>		14.500		
V 500	Continued From page	e 39	V 500		
	to another area. Il ice	ensee/Direct Care Specialist]			
	said, 'You need to mo				
	move."	ve or i will make you			
		/Direct Care Specialist of			
		e/Direct Care Specialist of			
	the allegation on 5/13	3/25.			
		ith the Licensee/Direct Care			
	Specialist revealed:				
		and all of the clients were			
	on the front porch (da	ate unknown).			
	-Was attempting to de	eescalate the situation and			
	get the clients to go ir	nside.			
		ng and said, 'I don't want to			
	be here."	.9			
		o willingly or we can get the			
	police to make you go				
		the police were not called.			
	-The allegation was n				
	-Was not suspended.				
	-Allegation was not re	eported to DSS.			
		rith the Director/AP revealed:			
		nat someone was verbally			
	and mentally abusing	him, but then when we got			
	on the Child and Fam	nily Team meeting he			
	indicated that his work	ds were twisted that no one			
	was verbally abusing				
		the person who he accused			
	of verbally abusing hi				
	-Did not investigate.				
	-"There was nothing t	to investigate "			
	-Did not report the alle	egation to DSS.			
V 512	27D .0304 Client Righ	nts - Harm, Abuse, Neglect	V 512		
	404 NOAC 07D 600	4 DDOTEOTION 50014			
	10A NCAC 27D .0304				
		SLECT OR EXPLOITATION			
		protect clients from harm,			
	abuse, neglect and ex	xploitation in accordance			

Division of Health Service Regulation

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Division of Health Service Regulation						
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		E SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COM	PLETED
						С
		MHL013-251	B. WING		07	7/17/2025
		MITEO 10-201				71772023
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
PEACEFU	II WAVE	518 EAS	T C STREET			
FLACLIO	LWAIS	KANNAP	POLIS, NC 28083	3		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 512	Continued From page	e 40	V 512			
	sort of abuse or negle 27C .0102 of this Cha (c) Goods or services purchased from a clie established governing (d) Employees shall necessary to repel or aggressive client and governing body policy is necessary depends characteristics of the and physical and mer of aggressiveness disintervention procedur Subchapter 10A NCA (e) Any violation by a	s shall not be sold to or ent except through g body policy. use only that degree of force recurs a violent and I which is permitted by y. The degree of force that s upon the individual client (such as age, size intal health) and the degree splayed by the client. Use of res shall be compliance with AC 27E of this Chapter. an employee of Paragraphs Rule shall be grounds for				
		ew and interview, 1 of 4 o protect 1 of 3 current				
	-Admission date of 4/ -13 years old. -Diagnoses of Condu	oct Disorder, Unspecified; Related Disorder; Attention				
	Review on 7/9/25 of s revealed:	staff #3's personnel file				

Division of Health Service Regulation

-Direct Care Specialist.

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Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
					l c	
		MHL013-251	B. WING		07/17/2025	
		11112010-201			1 0//1/	72023
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	re, zip code		
PEACEFU	I WAVS	518 EAS	T C STREET			
PEACEFU	LWAIS	KANNAF	POLIS, NC 28083			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	DATE
V 512	Continued From page	e 41	V 512			
	-Hire date of 6/4/25.					
	-Evidence Based Pro	tective Interventions				
	(EBPI)-Base Plus 6/4					
	(LDI I)-Dase I lus 0/4	125.				
	Review on 6/30/25 of	the North Carolina Incident				
		ent System (IRIS) from				
	4/1/25-6/30/25 reveal	- , ,				
		at approximately 8:52 PM,				
		Associate Professional				
	`	staff (#3) that an altercation				
		n staff (former staff (FS) #1)				
	and client (#1) during	evening chores. Staff (#3)				
	reported that law enfo	procement had been called.				
	The Qualified Profess	sional (QP) arrived on site				
	within 30 minutes, an	d the Director (Director/AP)				
	followed shortly after.					
		, client (#1) was seated on				
	•	surface scratches to the				
		equire medical attention.				
	` '	he yard and reported no				
		tated he was washing dishes				
	, ,	egan rushing him. When he				
] removed the dish rag from				
	-	lient #1] retrieved the rag				
		g. [FS #1] returned to the				
		nt #1] sprayed her with ed into physical contact,				
		d exchanging blows. The				
	conflict moved outdoo	0 0				
) was present during the				
		tervene and left the scene				
		Both client (#1) and staff (FS				
	=	or injury by QP and Director				
	/AP."	, , ,				
	Review on 7/2/25 of v	video #1 recorded by staff #3				
	of the incident on 6/26					

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-Video was 28 seconds long.

-In the living room, FS #1 was struggling with client #1 on the sofa and was pulling client #1's

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Division (of Health Service Regu	ulation			FORM	1 APPROVED
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S COMPLE	
		MHL013-251	B. WING		07/1) 7/2025
NAME OF P	PROVIDER OR SUPPLIER	STREET A'	DDRESS, CITY, STAT	TE, ZIP CODE		
DEACEE	II MAVA	518 EAS	T C STREET			
PEACEFU	JL WATS	KANNAP	POLIS, NC 28083	<u> </u>		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 512	Continued From page	e 42	V 512			
	hairFS #1 was on top of -Staff #3 was yelling a telling him "Police are to take your a*s to jai -Client #1 said, "Tell -Staff #3 said, "If she (unintelligible)." -FS #1 got off the sof client #1's hair with be -Staff #3 said, "What oh my God." -Client #1 and FS #1 one another until the - Staff #3 did not attel Review on 7/2/25 of v of the incident on 6/20 -Video was 33 second-FS #1 was on the flowith both hands.	at client #1 to stop and e coming and they are going il." her to get the f**k off me." e gets off of you what fa, continued to grip and pull both hands. benefit?" and yelled, "Stop, continued to struggle with video ended. empt to physically intervene. video #2 recorded by staff #3 16/25 revealed:				

one another as FS #1 wrapped her legs around Client #1's legs as she was pulling his hair. -Client #1 slapped FS #1 on the right shoulder

and FS #1 released Client #1's hair. -FS#1 then kicked client #1's head while they were still both on the floor.

-An unknown person yelled, "You are on your own [client #1]."

-Client #1 got to his feet and moved away from

-FS #1 grabbed client #1 ankle when client #1 attempted to kicked her.

-Staff #3 said,"[Client #1], s**t, stop, stop."

-Client #1 grabbed a football and threatened to throw it at FS #1's head.

Division of Health Service Regulation

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Division of	<u>of Health Service Regu</u>	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			B. WING		C
		MHL013-251	B. WING		07/17/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		518 FAS	T C STREET		
PEACEFU	L WAYS		POLIS, NC 28083	3	
			OLIS, NC 28083		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(- /
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	
1710		,	1,10	DEFICIENCY)	
			1,,-,-		
V 512	Continued From page	e 43	V 512		
	-Staff #3 did not atten	npt to physically intervene.			
	-The video ended.	inpt to priyologily intervente.			
	THE VIGOS CHASA.				
	Interview on 7/1/25 w	ith client #1 revealed:			
		ok away the dish rag while			
	he was doing dishes.	on away the dien rag willie			
		and "I pushed her back."			
	-FS #1 "hit me in the	•			
	started hitting her bac				
	-"Had a few scratches on my chest and one on my arm and forgot were the rest of the scratches				
	were."	ere the rest of the scratches			
		nunks of my hair in little balls			
	everywhere."	idiks of my half in little balls			
		ically intervene to stop FS			
	#1.	ically litterverie to stop F3			
	#1.				
	Interview on 7/1/25 w	ith client #3 revealed:			
		was cleaning his dishes.			
		aw FS #1 "snatch" the dish			
	towel.	aw F5 #1 Shatch the dish			
		eat and client #1 tried to			
	"grab her."	at and chefit #1 thed to			
	· ·	.+ 44			
	-FS #1 "pushed" clien				
		"started tussling-grabbed			
	each other pulling hai				
		vrestling on the floor for			
	about 8 minutes. "So outside."	menow it ended up			
	-Staff #3 called the la	w enforcement and			
	recorded some of the				
	_	3 minutes to talk to the cops			
	and pulled off (left fac	cility) and said, she quit."			
	1t	:411: #4			
	Interview on 7/1/25 w				
	-On 6/26/25 there wa				
	•	between client #1 and FS			
	#1.				

-Staff #3 called the police and "filmed the whole

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Division of	Division of Health Service Regulation					
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
		MHL013-251	B. WING			7/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		518 EAS	T C STREET			
PEACEFUL WAYS KANI			OLIS, NC 28083	1		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 512	Continued From page	÷ 44	V 512			
		FS #1 and Client #1) to				
	playing in the sink wh - She and client #1 ar turning off the water ushoved" her She grabbed client # restrain him." - They continued to stended up outside on the staff #3 did not help Staff #3 recorded the police When the police arripart and "left (facility).	was washing dishes and en she told him to go to bed. gued back and forth about intil client #1 "pushed and #1 by his hair "trying to truggle with one another and the facility's porch. e incident and called the ved, staff #3 explained her " ive out any information (to				
	FS #1 "was asking [cl He told her no." -FS #1 and Client #1 forth" verbally"I told him (client #1) #1) to calm down." - When Client #1 cont FS #1 turned the wate - Client #1 sprayed F3 "Do you want to have	I was washing dishes when ient #1] to get ready for bed. "started going back and to do dishes and her (FS tinued to play in the water, er off. S #1 with the water and said, a water fight." #1 and they both started				

strangers."

-"I called the police."

-"[Client #1] was choking [FS #1]. I wasn't recording at this time."

- FS #1 and Client #1 "continued to fight like

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Division of Health Service Regulation						
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SU COMPLE	
		MUI 042 254	B. WING		C	7/2025
		MHL013-251	5		07/17	7/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
DEACEE	II WAYS	518 EAST	C STREET			
PLACEIC	PEACEFUL WAYS KANNAF					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 512	Continued From page	÷ 45	V 512			
	- FS #1 was "pulling of came out." - Client #1 grabbed a #1. "I didn't want to the recording." - Client #1 threw the fitthey "started fighting. - "I opened up the dosirens." - "[Client #1] grabbed (FS #1), and they tus. -"I told them to put the did." - After the police arrive that the Director/AP a Specialist were on the (facility)." -"I didn't want to help is fighting. It would be on him (client #1)." -"As soon as they (FS tussling, I jumped up Nobody listened so, I."Later on, I pulled outling." Interview on 7/8/25 we harrived at the facility already left. - Started the investigated during the incident im that FS #1 "did not for putting a client (#1) are "I haven't been able not she (Staff #3) interview on the control of the control of the part on the part on the porch."	football and threw it at FS rigger him, so I stopped football at FS #1's face and again." or (facility) and heard a stick and attempted to hit sled with the branch (stick)." e branch down, and they red, she let the officers know and Licensee/Direct Care eir way and then " I left or assist when she (FS #1) book like we were ganging up and told them to calm down. called 911." It my phone to record." the beginning and didn't get with the Director/AP revealed: It was a factor of the control of th				

- Staff #3 had not responded to attempts to reach

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Division of Health Service Regulation						
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SI COMPLE	
		MHL013-251	B. WING		O7/1	; 7/2025
NAME OF D	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	TE ZIR CODE	1 0	
NAME OF T	TOVIDER OR SOLT EIER		C STREET	11, 211 GODE		
PEACEFUL WAYS KANNAP			OLIS, NC 28083			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 512	Continued From page	e 46	V 512			
	Interview 7/9/25 with Specialist revealed: -FS #1 did not "respoincident with client #1 -FS #1 was terminate techniques and the w-Client #1 had some shair pulled out. Client treatmentStaff #3 "claims she "claims she tried to de-"The police said [staryou deescalating whe-Staff #3 was "let go" -Staff #3 was in the a started recording and	ially terminate her." be back, but I haven't ything (termination notice) tten her side of the story." the Licensee/Direct Care and appropriately" during the on 6/26/25. and for lack of de-escalation arong use of EBPI." superficial scratches and t #1 "declined" medical didn't see anything and eescalate." ff #3] had video. How are en you are recording?" because of neglect. area (of the incident) but I failed to deescalate or erbal escalation started.				
	7/14/25 written by the -"What immediate act ensure the safety of t -The QP or a designal conduct informal chec within the next 24 hou address any concerns emotional support. The consumer's chartAll direct care staff, 0 complete refresher tra and exploitation within -The Director/AP will	ck-ins with each consumer urs to ensure they feel safe, s, and identify needs for nis will be documented in the QPs, and supervisors will aining on abuse, neglect,				

STATE FORM 6899 G6K611 If continuation sheet 47 of 67

DIVISION	n nealth Service Negu	ialion			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			B. WING		C
		MHL013-251	D. WING		07/17/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE. ZIP CODE	
			C STREET	,	
PEACEFU	L WAYS				
		KANNAPO	LIS, NC 28083		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
TAG	REGULATORT OR E	ESC IDENTIFY TING INFORMATION)	TAG	DEFICIENCY)	IAIL SILL
V 512	Continued From page	e 47	V 512		
	If::6:				
		volved in or suspected of			
		glect they will be removed			
		contact while the matter is			
	_	l be adjusted using available			
	relief or PRN (as need				
		. Termination of employee			
	involved (termination	completed July 7th).			
	-Starting immediately	, brief team huddles at the			
	start and end of each	shift will be used to review			
	safety concerns, ensu	ure all assigned duties are			
		v staff to raise any issues			
	impacting consumer of	_			
	-The House Manager				
	•	next two weeks to observe			
	staff-consumer intera				
		ride immediate coaching if			
	concerns arise.	ide immediate coderning in			
		to make sure the above			
	happens.	to make suite the above			
		nt each consumer check-in			
	in their chart. Any issu				
	•				
		clinical team and addressed			
		Facility Director will review			
	documentation to ens				
		the IRIS report/Health Case			
	, ,	e reflective of the additional			
	staff being implicated				
	-The QP or Director w	•			
		e attendance rosters. Topics			
	will include definitions	G .			
	,	procedures, and prevention			
		e will be documented, and			
	-	nd sign-in sheets will be			
	stored in staff records	s for verification.			
	Any future incidents v	vill trigger immediate staffing			
	adjustments per polic				
		op (scheduling software) will			
		and end-of-shift huddles.			
		reminders and provide			

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space within the app for staff to record any

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Division of Health Service Regulation

STATEMENT OF D		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF CO	PRRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		MHL013-251	B. WING		C 07/17/2025
NAME OF PROVID	DER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
DEACEEIII WA	AV6	518 EAST	C STREET		
PEACEFUL WA	415	KANNAPO	LIS, NC 28083	3	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETE
con -A s will sup Wai the Fact Rev Pro Dire "Whens -All con and -Th reprinci add -If s con inci con inverselie sup sus 202 (ter Clie Uns Dise 202 phy #1's	standardized "Walk be used to record pervision practices, alkthroughs will occur next two weeks. Light Director for conview on 7/15/25 of prection dated 7/15/25 of prection by Julian Director will updated and the staff member. Specific staff are involved to include all stated and the staff member of precipied to the negligible of PRN staff to reprecipied. Staff will be remination. Staff involved precipied the same of precipied t	be monitored weekly. tthrough Observation Log" staff-consumer interactions, and any coaching provided. ur throughout the week for ogs will be reviewed by the mpliance." the amended Plan of 25 written by the on will the facility take to ne consumers in your care? Ps, and supervisors will unining on abuse, neglect, ly 24th, 2025. ate the June 26, 2025, IRIS aff implicated in the abuse as updated July 14, 2025 to volved in or suspected of glect in the June 26, 2025 emoved from direct le the matter is be adjusted using available maintain adequate olived in the incident were day as the incident June 26, employee involved	V 512		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
74101 2741 01	CONTRACTION	ISERTI IO/RIGITATIONISER.	A. BUILDING: _		33	
			P WING		С	
		MHL013-251	B. WING		07/17/2025	
NAME OF PRO	OVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
PEACEFUL	WAYS	518 EAST	C STREET			
I LAGLI GL		KANNAPO	DLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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	
V 512 (Continued From page	49	V 512			
# r f	#1 from abusing client recorded the incident, further escalated the o to client #1's calls for constitutes a Type A1	t #1, rather, she video made comments that crisis, and did not respond				
_	27E .0107 Client Righ Int.	ts - Training on Alt to Rest.	V 536			
	to restrictive intervention (b) Prior to providing disabilities, staff include employees, students of demonstrate competer completing training in other strategies for crowhich the likelihood of or injury to a person we property damage is property damage in property damage is property damage in property damage is property damage in property damage is property damage is property damage in pro	plement policies and size the use of alternatives ons. services to people with ding service providers, or volunteers, shall nice by successfully communication skills and eating an environment in a fimminent danger of abuse with disabilities or others or evented. It is shall establish training etencies, monitor for internal enstrate they acted on data to ecompetency-based, earning objectives, written and by observation of jectives and measurable passing or failing the eraining must be completed der periodically (minimum				

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DIVIDIOTI	or riealth Service Negu	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			B WING		C
		MHL013-251	B. WING		07/17/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		518 EAST	C STREET		
PEACEFU	IL WAYS		DLIS, NC 28083	3	
	0.00.00.00				
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(- /
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
	0 " 15	50	V/ 520		
V 536	Continued From page	9 50	V 536		
	provider wishes to em	nploy must be approved by			
	the Division of MH/DI	D/SAS pursuant to			
	Paragraph (g) of this	•			
		strate competence in the			
	following core areas:				
		and understanding of the			
	people being served;	and anderstanding of the			
		and interpreting human			
	behavior;	and interpreting numan			
	,	the effect of internal and			
		it may affect people with			
	disabilities;	it may affect people with			
		or building positivo			
	(4) strategies for relationships with per	or building positive			
		cultural, environmental and			
	disabilities;	that may affect people with			
		the importance of and			
	assisting in the perso decisions about their	n's involvement in making life;			
		essing individual risk for			
	escalating behavior;				
	_	tion strategies for defusing			
		tentially dangerous behavior;			
	and				
	(9) positive beh	navioral supports (providing			
		n disabilities to choose			
	activities which direct				
	behaviors which are u				
	(h) Service providers	,			
		al and refresher training for			
	at least three years.	5			
	1	tion shall include:			
	\ /	ated in the training and the			
	outcomes (pass/fail);				
		where they attended; and			
	(C) instructor's				
		n of MH/DD/SAS may			
		ocumentation at any time.			

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DIVISION	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			P WING		С
		MHL013-251	B. WING		07/17/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE	
			, ,	,	
PEACEFU	L WAYS		T C STREET		
		KANNAF	OLIS, NC 28083	3	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(-/
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	JAIL DAIL
				,	
V 536	Continued From page	e 51	V 536		
	. •				
	(i) Instructor Qualification	ations and Training			
	Requirements:				
		all demonstrate competence			
	by scoring 100% on to	esting in a training program			
	aimed at preventing,	reducing and eliminating the			
	need for restrictive int	terventions.			
	(2) Trainers sha	all demonstrate competence			
		grade on testing in an			
	instructor training pro				
	(3) The training	•			
		nclude measurable learning			
		le testing (written and by			
	•	ior) on those objectives and			
		to determine passing or			
	failing the course.	to determine passing or			
		t of the inetructor training the			
		t of the instructor training the			
	service provider plans				
	• •	sion of MH/DD/SAS pursuant			
	to Subparagraph (i)(5				
		instructor training programs			
		not limited to presentation of:			
	. ,	ng the adult learner;			
	(B) methods for	r teaching content of the			
	course;				
	(C) methods fo	r evaluating trainee			
	performance; and				
	(D) documentat	ion procedures.			
	(6) Trainers sha	all have coached experience			
	teaching a training pro	ogram aimed at preventing,			
	reducing and eliminat	ting the need for restrictive			
	interventions at least	one time, with positive			
	review by the coach.	•			
	•	all teach a training program			
		reducing and eliminating the			
		terventions at least once			
	annually.				
	•	all complete a refresher			
	instructor training at le				
	(j) Service providers				
	(1) Service broviders	onan mannalli	1	1	

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Division of	<u>of Health Service Regu</u>	ılation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					С
		MHL013-251	B. WING		07/17/2025
					1 0
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	
PEACEFU	I WAYS		T C STREET		
·	LVAIO	KANNAP	POLIS, NC 28083	3	
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE DATE
V 536	Continued From page	e 52	V 536		
	documentation of initi	ial and refresher instructor			
	training for at least the				
		entation shall include:			
	(A) who particip	pated in the training and the			
	outcomes (pass/fail);				
	` '	where attended; and			
	(C) instructor's				
	` '	n of MH/DD/SAS may			
	(k) Qualifications of (nis documentation any time.			
	` '	nall meet all preparation			
	requirements as a tra				
		nall teach at least three times			
	the course which is be	eing coached.			
	` '	nall demonstrate			
	competence by comp				
	train-the-trainer instru				
	'''	nall be the same preparation			
	as for trainers.				
	This Rule is not met				
		ew and interviews, the			
	_	re 1 of 5 audited staff (former			
		strated competence in			
		tive interventions. The			
	findings are:				
		f FS #1's personnel file			
	revealed:				
	-Direct Care Specialis	st.			
	-Hire date of 4/9/25.				

-Termination date of 7/7/25.

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Division of	Division of Health Service Regulation						
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SU COMPLE		
		MHL013-251	B. WING		O7/17	7/2025	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	FE, ZIP CODE			
		518 EAS	T C STREET				
PEACEFU	L WAYS	KANNAF	POLIS, NC 28083				
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 536	Continued From page	÷ 53	V 536				
	-Evidence Based Pro (EBPI)-Base Plus 4/1						
	Review on 6/30/25 of the North Carolina Incident Response Improvement System (IRIS) from 4/1/25-6/30/25 revealed: -"On June 26, 2025, at approximately 8:52 PM, the Director (Director/Associate Professional (AP) was notified by staff (#3) that an altercation had						
	client (#1) during ever reported that law enfo	aff (former staff (FS) #1) and ning chores. Staff (#3) orcement had been called. sional (QP) arrived on site					
	within 30 minutes, and followed shortly after.	d the Director (Director/AP)					
	the porch with visible	surface scratches to the equire medical attention.					
		he yard and reported no tated he was washing dishes					
		egan rushing him. When he I] removed the dish rag from					
	_	lient #1] retrieved the rag g. [FS #1] returned to the					
		nt #1] sprayed her with ed into physical contact,					
		d exchanging blows. The					
	separatedStaff (#3)) was present during the tervene and left the scene					
	when police arrived. E	Both client (#1) and staff (FS or injury by QP and Director					
	Review on 7/2/25 of v of the incident on 6/26 -Video was 28 second						

hair.

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-In the living room, FS #1 was struggling with client #1 on the sofa and was pulling client #1's

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Division of Fleatin Service Regu	ilation		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	MHL013-251	B. WING	C 07/17/2025
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STATE, ZIP CODE	
	518 EAST (CSTREET	

PEACEF	JL WAYS	T C STREET POLIS, NC 28083		
(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 536	Continued From page 54	V 536		
	-Both of FS #1's hands were holding client #1's hair. -FS #1 was on top of client #1. -Staff #3 was yelling at client #1 to stop and telling him "Police are coming and they are going to take your a*s to jail." -Client #1 said, "Tell her to get the f**k off me." -Staff #3 said, "If she gets off of you what (unintelligible)." -FS #1 got off the sofa, continued to grip and pull client #1's hair with both hands. -Staff #3 said, "What benefit?" and yelled, "Stop, oh my God." -Client #1 and FS #1 continued to struggle with one another until the video ended. - Staff #3 did not attempt to physically intervene. Review on 7/2/25 of video #2 recorded by staff #3 of the incident on 6/26/25 revealed: -Video was 33 seconds long. -FS #1 was on the floor pulling client #1's hair with both hands. -FS #1 and client #1 continued to struggle with one another as FS #1 wrapped her legs around Client #1's legs as she was pulling his hair. -Client #1 slapped FS #1 on the right shoulder and FS #1 released Client #1's head while they were still both on the floor. -An unknown person yelled, "You are on your own [client #1]." -Client #1 got to his feet and moved away from FS #1. -FS #1 grabbed client #1's ankle when client #1 attempted to kick her. -Staff #3 said, "[Client #1], s**t, stop, stop." -Client #1 grabbed a football and threatened to throw it at FS #1's head. -Staff #3 did not attempt to physically intervene. -The video ended.			

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Division o	of Health Service Regu	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
		MHL013-251	B. WING		07/1	; 7/2025
NAME OF PE	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	-	
PEACEFU	L WAYS		C STREET			
		KANNAP	OLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 536	Continued From page	÷ 55	V 536			
	to FS #1 dated 7/7/25 Director/Associate Pro-"This letter serves as termination of your en Ways Residential Ser immediately." -"Following a recent in altercation between your our facility, an interconducted. The findin determined that you wituation and failed to established protocols de-escalation techniquiolated our safety poat significant risk." Interview on 7/1/25 w-On 6/26/25 FS #1 to be was doing dishesFS #1 "pushed me" astarted hitting her bace-"Had a few scratches my arm and forgot we were." - FS #1 "pulled out cheverywhere." - Staff #3 did not physi#1. Interview on 7/1/25 w-On 6/26/25, client #1 - Heard arguing and satowel.	ofessional (AP) revealed: s formal notice of the imployment with Peaceful vices, effective incident involving an ourself and a client residing inal investigation was igs of this investigation were the aggressor in the adhere to the agency's including approved ues. Your actions directly dicies and placed the client ith client #1 revealed: ok away the dish rag while and "I pushed her back." stomach or chest so I ck." s on my chest and one on ere the rest of the scratches hunks of my hair in little balls ically intervene to stop FS ith client #3 revealed: was cleaning his dishes. aw FS #1 "snatch" the dish eat and client #1 tried to				

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Division of	of Health Service Regu	lation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL013-251	B. WING		C 07/17/2025
NAME OF PR	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE	,
PEACEFU	L WAYS		T C STREET OLIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 536	each other pulling hai -They were fighting, wabout 8 minutes. "So outside." -Staff #3 called the lar recorded some of the -Staff #3 "stayed for 3 and pulled off (left factories) and pulled the police off factories) and pulled factories and substantial pulled factories and s	"started tussling-grabbed ir, kicking." wrestling on the floor for omehow it ended up we enforcement and a altercation. If minutes to talk to the copsicility) and said, she quit." with client #4 revealed: It is an argument and a between client #1 and FS colice and "filmed the whole FS #1 and Client #1) to with FS #1 revealed: It was washing dishes and hen she told him to go to bed. It is any if the facility's porch. It is incident and called the ived, staff #3 explained her ived, staff #3 explained her	V 536	DEFICIENCY)	
	Interview on 7/2/25 w	vith staff #3 revealed:			

-On 6/26/25, Client #1 was washing dishes when FS #1 "was asking [client #1] to get ready for bed.

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Division o	of Health Service Regu	ulation			FORM	1 APPROVED
STATEMENT OF DEFICIENCIES (X1		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		MHL013-251	B. WING		1	7/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STA	TE, ZIP CODE		
		518 EAS	T C STREET			
PEACEFU	L WAYS	KANNAI	POLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPL		(X5) COMPLETE DATE
V 536	Continued From page	e 57	V 536			
	He told her no."					
		"started going back and				
	forth" verbally.	0 0				
	` ,	to do dishes and her (FS				
	#1) to calm down."					
	- When Client #1 con FS #1 turned the water	tinued to play in the water,				
		S #1 with the water and said,				
	"Do you want to have					
		t #1 and they both started				
	"pushing and shoving					
		king [FS #1]. I wasn't				
	recording at this time.	."				
	-"I called the police."	"continued to fight like				
	strangers."	continued to light like				
	•	client #1's hair. Some of it				
	came out."					
		football and threw it at FS				
		rigger him, so I stopped				
	recording."	factball at FC #41a face and				
	they "started fighting	football at FS #1's face and				
	- "I opened up the do	•				
	sirens."	c. (.acy) and noard				
	- "[Client #1] grabbed	I a stick and attempted to hit				
		sled with the branch (stick) "				

(FS #1), and they tussled with the branch (stick)."
-"I told them to put the branch down, and they did."

- After the police arrived, she let the officers know that the Director/AP and Licensee/Direct Care Specialist were on their way and then " I left (facility)."

-"I didn't want to help or assist when she (FS #1) is fighting. It would look like we were ganging up on him (client #1)."

-"As soon as they (FS #1 and client #1) were tussling, I jumped up and told them to calm down. Nobody listened so, I called 911."

-"Later on, I pulled out my phone to record."

Division of Health Service Regulation

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Division c	<u>of Health Service Regu</u>	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					С
		MHL013-251	B. WING		07/17/2025
NAME OF PE	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE	
TO THE OT THE	to vibert of tool i eleft		C STREET	12, 211 0002	
PEACEFU	L WAYS		OLIS, NC 28083	•	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE
17.500			1,4500		
V 536	Continued From page	e 58	V 536		
		the beginning and didn't get			
	the part on the porch.	."			
	Inton (in.), on 7/0/05	rith the Director/AP revealed:			
		on 6/26/25 and staff #3 had			
	already left.	y on 0/20/20 and stail #0 had			
		ation into FS #1's actions			
	•	mediately and concluded			
		llow de-escalation protocol			
	putting a client (#1) at				
	not she (Staff #3) inte	to substantiate whether or			
		video but did not share it			
	with facility staff.				
	- Staff #3 had not res	ponded to attempts to reach			
	her.				
	- "[Staff #3] indicated- "I was going to offici	•			
	-"She (FS #1) won't b				
		ything (termination notice)			
		tten her side of the story."			
		ensee/Direct Care Specialist			
	revealed: -FS #1 did not "respo	nd appropriately" during the			
	incident with client #1				
	-"She (FS #1) was ter				
		ues and the wrong use of			
	EBPI."				
	075 0400 000 1501		,		
V 537	-	hts - Training in Sec Rest &	V 537		
	ITO				
	10A NCAC 27E .0108	3 TRAINING IN			
		CAL RESTRAINT AND			
	ISOLATION TIME-OU	JT			
	(a) Seclusion, physic	cal restraint and isolation			

time-out may be employed only by staff who have

been trained and have demonstrated

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PRINTED: 07/28/2025 FORM APPROVED

Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SUR	
			A. BUILDING: _			
			B WING		C	
		MHL013-251	B. WING		07/17/2	2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
DEACEEU	LWAVO	518 EAST	C STREET			
PEACEFU	L WATS	KANNAP	OLIS, NC 28083	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 537	Continued From page	e 59	V 537			
	competence in the nr	oper use of and alternatives				
		Facilities shall ensure that				
	=	ploy and terminate these				
		ned and have demonstrated				
	competence at least a					
	(b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the					
	training is completed					
	demonstrated.	and competence is				
		r taking this training is				
		etence by completion of				
		, reducing and eliminating				
	the need for restrictive					
		be competency-based,				
	include measurable le					
		vritten and by observation of				
	,	ojectives and measurable				
	methods to determine course.	e passing or failing the				
		training must be completed				
	* *	der periodically (minimum				
	annually).	doi ponedidany (miniman				
	(f) Content of the trai	ning that the service				
		ploy must be approved by				
	the Division of MH/DI	D/SAS pursuant to				
	Paragraph (g) of this					
		ng programs shall include,				
	but are not limited to,					
	` '	formation on alternatives to				
	the use of restrictive i					
		on when to intervene				
	others);	nent danger to self and				
		n safety and respect for the				

Division of Health Service Regulation

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Division of	ivision of Health Service Regulation							
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED			
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NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE				
		518 EAS	T C STREET					
PEACEFU	L WAYS	KANNAF	OLIS, NC 2808	3				
040.15	CLIMMADV CT	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	J 0.50			
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(- /			
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR				
				DEFICIENCY)				
V 537	Continued From page	260	V 537					
V 331	Continued From page	: 00	V 337					
	rights and dignity of a	II persons involved (using						
	concepts of least rest	rictive interventions and						
	incremental steps in a							
	-	or the safe implementation						
	of restrictive intervent							
		mergency safety						
	interventions which in							
	assessment and monitoring of the physical and psychological well-being of the client and the safe							
	use of restraint throughout the duration of the							
	restrictive intervention;							
	(6) prohibited procedures;							
		trategies, including their						
	importance and purpo							
		tion methods/procedures.						
	(h) Service providers							
		al and refresher training for						
	at least three years.	ar arra remeener training re-						
	_	tion shall include:						
		ated in the training and the						
	outcomes (pass/fail);	ated in the training and the						
	,,	where they attended; and						
	(C) instructor's							
		n of MH/DD/SAS may						
		ocumentation at any time.						
	(i) Instructor Qualification	_						
	Requirements:	ag						
	*	all demonstrate competence						
		esting in a training program						
		reducing and eliminating the						
	need for restrictive int							
		all demonstrate competence						
		esting in a training program						
		eclusion, physical restraint						
	and isolation time-out							
		all demonstrate competence						
		grade on testing in an						
	instructor training pro	-						
	(4) The training							
	(4) 1116 ((a)) (119	j Silali D e						

STATE FORM 6899 G6K611 If continuation sheet 61 of 67

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 518 EAST C STREET KANNAPOLIS, NC 28083 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAGK TAGK COntinued From page 61 Competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures.	MHL013-251 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 518 EAST C STREET KANNAPOLIS, NC 28083 (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) V 537 Continued From page 61 Competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course;	MHL013-251 MHL013-251 MHL013-251 B. WING	MHL013-251 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PEACEFUL WAYS STREET ADDRESS, CITY, STATE, ZIP CODE 518 EAST C STREET KANNAPOLIS, NC 28083 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 537 Continued From page 61 competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the	MHL013-251 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PEACEFUL WAYS STREET ADDRESS, CITY, STATE, ZIP CODE STREET KANNAPOLIS, NC 28083 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 537 Continued From page 61 competency-based, include measurable learning V 537 Competency-based, include measurable learning	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PEACEFUL WAYS STREET ADDRESS, CITY, STATE, ZIP CODE STREET EXAMNAPOLIS, NC 28083 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES KANNAPOLIS, NC 28083 (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE A. BUILDING: D. C O7/17/2025 CC O7/17/2025	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY	STATEMENT	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		
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of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule.	of seclusion, physical restraint and isolation	\	(D) documentation procedures.	approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures.	observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures.	MHL013-251 MHL013-251 MHL013-251 STREET ADDRESS, CITY, STATE, ZIP CODE PEACEFUL WAYS S18 EAST C STREET KANNAPOLIS, NC 28083 ((A) ID PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TAG COMPLETE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY DEFICIENCY V 537 Continued From page 61 Competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures.		annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR.					
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Division of Health Service Regulation

outcome (pass/fail);

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
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		MHL013-251	B. WING		1	7/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
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	CLIMMADY CT		LIS, NC 28083			
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V 537	(C) instructor's (2) The Division review/request this do (I) Qualifications of C (1) Coaches sh requirements as a tra (2) Coaches sh times, the course whi	where they attended; and name. In of MH/DD/SAS may ocumentation at any time. It coaches: It all meet all preparation iner. It all teach at least three och is being coached. It all demonstrate all times or occording or oction. It all be the same	V 537			
	failed to ensure annu- measurable testing by seclusion, physical re- was completed for 3 of staff (FS) #1, staff #3 ensure that staff dem- restrictive intervention #1 and staff #3). The Review on 6/30/24 of revealed: -Direct Care Specialis -Hire date of 4/9/25. -Termination date of 7 -Evidence Based Pro (EBPI)-Base Plus 4/1	ew and interview, the facility al training, including y observation of behavior, in straint and isolation time-out of 6 audited staff (former, and staff #4) and failed to constrated competency in as for 2 of 6 audited staff (FS findings are: FS #1's personnel file st.				

Division of Health Service Regulation

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Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
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		MHL013-251	B. WING		07/17/2025	
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V 537	Continued From page	e 63	V 537			
	revealed:					
	-Direct Care Specialis	st.				
	-Hire date of 6/4/25.					
	-EBPI-Base Plus 6/4/	25.				
	Review on 7/9/25 of s	staff #4's personnel file				
	revealed:	•				
	-Direct Care Specialis	st.				
	-Hire date of 3/10/25.					
	-EBPI-Base Plus 3/12/25.					
	Interview on 7/2/25 with FS #1 revealed:					
	-Was trained on EBP					
	-Was not trained phys	sically on restraints or				
	blocks.					
		person training for EBPI.				
	_	'let them (clients) have their				
	moments and ignore	them."				
	7/0/05					
	Interview on 7/2/25 w					
	-EBPI training was co					
	_	n that class. It was me and				
	a guy talking."	sically on restraints or				
	-vvas not trained priys	sically of restraints of				
	-"It did concern me th	nat it was a zoom link				
		class). These boys (clients)				
	,	to hurt us. We were not				
	properly trained."	S Hart do. The Word Hot				
	F. 26 5					
	Interview on 7/7/25 w	vith staff #4 revealed:				
		ortion of EBPI training was				
	virtual via Zoom.	3				
		the in person (restrictive				
	interventions) yet. W					
	instructor."	5				
	-"My restraint experie	ence was from a prior group				
	home."					

Interview on 7/11/25 with the EBPI trainer

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SUI COMPLET	
			_		c	
		MHL013-251	B. WING		07/17	/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PEACEFU	I WAVE	518 EAST 0	STREET			
PEACEFU	LWAIS	KANNAPOI	LIS, NC 28083	}		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 537	Continued From page	e 64	V 537			
	revealed: -Prevention portion of virtually through Zoon -The prevention portion demonstrations by the restraintsConducted an in-pertraining teach the phy -The in-person restrict usually completed the or within the next weet-The EBPI-Base Plus trainee received both restrictive portions of	in the training completed in. In on of the training includes a instructor of blocks and inson restrictive intervention in the sical techniques. It is intervention training is a day after the Zoom training is a cartificate indicated that the interventative and interventative and interventative and include an in-person include an in-person in techniques.				
V 539	10A NCAC 27F .0102 ENVIRONMENT (a) Each client shall It (1) an atmosph uninterrupted sleep di hours, consistent with provided and the type (2) accessible a for at least limited per determined inappropr habilitation team. (b) Each client shall It his room, or his portion with respect to choice	pe provided: ere conducive to uring scheduled sleeping the types of services being of clients being served; and areas for personal privacy,	V 539			

Division of Health Service Regulation

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Division of Health Service Regulation		liation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
			7 20.22			
						;
		MHL013-251	B. WING		07/1	7/2025
NAME OF D	ROVIDER OR SUPPLIER	STDEET AS	DRESS, CITY, STA	TE 710 CODE		
NAME OF PI	ROVIDER OR SUPPLIER			KIE, ZIP GODE		
PEACEFU	I WAYS	518 EAS	C STREET			
,		KANNAP	OLIS, NC 2808:	3		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PRÉFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				DEFICIENCY)		
V 539	Continued From page	- 65	V 539			
	Continuou i rom page	3 00				
	restrictions on this fre	edom shall be carried out in				
	accordance with gove	erning body policy.				
	This Rule is not met	as evidenced by:				
		n and interview, the facility				
	failed to ensure there was an atmosphere conductive to uninterrupted sleep during					
	scheduled sleeping hours and accessible areas for personal privacy affecting 1 of 4 audited					
	clients former client (I	FC) #1). The findings are:				
	Observation on 7/7/0/	T in the facility of				
	Observation on 7/7/25					
	approximately 1pm re					
	-	ge shelves was assessable				
	by walking through Fo					
		room/storage room was				
	locked.					
	Interview on 7/3/25 w					
	-	ne with the closet/staff				
	bathroom (staff bathro	oom/storage closet). Meds				
	(medications) were st	tored there."				
	-"Sometimes staff bro	ought clients into the closet				
	(staff bathroom/storag	ge closet) to give meds."				
	•	them (clients) in my room. It				
	is a safety issue."	, ,				
		through FC #1's bedroom				
	to the staff bathroom/	, -				
		ght. They did not knock."				
	battiloom, even at me	gnt. They did not knook.				
	Interview on 7/2/25 w	vith staff #2 revealed:				
	-Medications were sto					
	bathroom/storage clo					
		C #2's room to get to the				
	staff bathroom/storag	je closet.				

Division of Health Service Regulation

Interview on 7/7/7 with staff #4 revealed:

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Division of	Division of Health Service Regulation					
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE S COMPLI	
		MHL013-251	B. WING		07/1	; 7/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STAT	E, ZIP CODE		
PEACEFU	IL WAYS		C STREET OLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 539	get to the staff bathro-Clients were not allow (staff bathroom/storage-Utilized the staff bathworking 3rd shift (11p-"I make a noise and coming." -"I try to be quiet if he Interview on 7/7/25 w-Had to go through Fostaff bathroom/storage-"We were supposed go through to the bather "He (FC #2) never sea through is room)." Interview on 7/8/25 were supposed go through to the bather "He (FC #2) never sea through is room)." Interview on 7/8/25 were recalled the bathroom as the staffer FC didn't have "any it through his room to go bathroom/storage cloen the staff bathroom the staff bathroom the staff bathroom/storage cloen the staff bathroom th	go through FC #2's room to om/storage closet. wed to use that bathroom ge closet). proom/storage closet when m to 8am). let him (FC #2) know I am is sleeping." ith staff #5 revealed: C #2's bedroom to get to the e closet. to knock on door and ask to proom." aid no (we could not go ith the Qualified is accessed through FC #2's bathroom/storage closet." ssues" with staff going et to the staff set. ith the Director/Associate is torage closet was used to be locked up such chemicals. wed in the staff set. staff bathroom/storage	V 539	DEFICIENCY)		

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