STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-443	A. BUILDING: _____ B. WING _____	R 07/15/2025

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ELIADA TREATMENT CENTER	882 ELIADA HOME ROAD ASHEVILLE, NC 28806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual, follow up and complaint survey was completed on July 15, 2025. The complaint were substantiated (Intake #NC00232481). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for 8 and has a current census of 8. The survey sample consisted of audits of 3 current clients.	V 000		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client.	V 132	Correct: The HCPR required reports shall be submitted by the CCO in regard to this staff member. Prevent: The PQI Investigations Procedure Form will include a check box for HCPR Required Reports and denote all allegations against a staff must be reported. Prevent: The COO will retrain residential staff on the timeline and process for reporting allegations to PQI and DSS. Monitor: Upon completion of a PQI Investigation, the entire PQI team shall review the completed form which shall denote the completion of the HCPR required report.	7/15/25 9/12/25 07/30/25 9/12/25

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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V 132	Continued From page 1 e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report an allegation of abuse to the Health Care Personnel Registry (HCPR) affecting 1 of 3 audited staff (Staff #1). The findings are: Review on 7/14/25 of Staff #1's record revealed: -Title: Youth Mentor. -Date of Hire: 3/31/25. Review on 7/14/15 of the facility incident reports revealed: -No documentation of a report to the HCPR for allegation of abuse reported the local Department of Social Services (DSS) 7/8/25. Review on 7/14/25 of the Licensee Internal Investigation completed by the Performance and Quality Improvement (PQI) team dated 6/23/25 revealed: -Date of incident: 6/16/25-6/17/25. -There were no listed allegations of abuse. Interview on 7/15/25 with the local DSS worker revealed: -Confirmed allegation of abuse against Staff #1 involving Client #1 and Client #2 reported 7/8/25.	V 132		

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V 132	Continued From page 2 Interview on 7/15/25 with the Quality Assurance Manager revealed: -Was a member of the PQI team. -PQI team was responsible for reporting to the HCPR for allegations of abuse against employees. -Was not aware of an allegation of abuse prior to 7/8/25. -HCPR was not completed for allegation of abuse against Staff #1 reported to the local DSS on 7/8/25. -HCPR was not completed due to "a series of miscommunications, (PQI) did not communicate effectively as a team." -Aware of the requirement for HCPR reporting, "...we dropped the ball honestly (not reporting to the HCPR for allegation of abuse against Staff #1 reported 7/8/25)." Interview on 7/15/25 with the Chief Compliance Officer revealed: -Was a member of the PQI team. -PQI team was responsible for reporting to the HCPR for allegations of abuse against employees. -Was not aware of an allegation of abuse prior to 7/8/25. -HCPR was not completed for allegation of abuse against Staff #1 reported to the local DSS on 7/8/25. -"...was rushing (completing internal investigation) since the incident had already been delayed." -Will make sure to use her checklist for processing incidents moving forward to ensure required departments are notified of any allegation of abuse upon being made aware. -Will update the incident investigation form to include to refer back to incident processing checklist to ensure all steps are taken.	V 132		

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V 132	Continued From page 3 Interview on 7/15/25 with the Chief Operating Officer revealed: -PQI team responsible for notifying the HCPR for allegations of abuse against employees. -Will ensure clear systematic overview of who is following up and the step by step process reviewing the incidents and processes involved.	V 132		
V 293	27G .1701 Residential Tx. Child/Adol - Scope 10A NCAC 27G .1701 SCOPE (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility. (b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to a community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting. (e) Services shall be designed to: (1) include individualized supervision and structure of daily living; (2) minimize the occurrence of behaviors	V 293	Correction: The guardian shall be notified in regard to the allegation by the CCO. Prevention: The PQI Investigation Procedure Form shall be updated to include a step to inform all guardians of all students involved in an investigation. Monitor: The PQI Investigation Procedure Form shall be shared with the entire PQI team upon its completion and shall denote that guardian notification has been completed.	7/9/25 9/12/25 9/12/25

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V 293	Continued From page 4 related to functional deficits; (3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting. (f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to coordinate with individuals within the client's system of care for 1 of 3 current clients (Client #1). The findings are: Review on 7/14/25 of Client #1's record revealed: -Age: 12. -Date of admission: 6/5/25. -Diagnoses: Personality Disorder, Major Depressive Disorder, and Anxiety Disorder. -No documentation of facility notification to guardian for incident on 6/16/25 and 6/17/25. -Child Family Team meeting dated 7/7/25: -Guardian was not notified of incident dated	V 293		

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V 293	Continued From page 5 6/16/25 and 6/17/25. Review on 7/14/25 of the Licensee Internal Investigation completed by the Performance and Quality Improvement (PQI) team dated 6/23/25 revealed: -Date of incident: 6/16/25-6/17/25. -There were no listed allegations of abuse. Interview on 7/15/25 with the local DSS Worker revealed: -Confirmed allegation of abuse against Staff #1 involving Client #1 reported 7/8/25. Interview on 7/15/25 with Client #1's guardian revealed: -Was first informed by Client #1 while on a home visit on 7/7/25 of the allegation of abuse. Interview on 7/15/25 with Therapist #1 revealed: -Did not notify Client #1's guardian of incident dated 6/16/25 and 6/17/25. Interview on 7/15/25 with the Quality Assurance Manager revealed: -Was not sure why Client #1's guardian was not made aware of the allegation of abuse. -"I thought she (Client #1) had been made aware (of allegation of abuse), assumption that she was made aware." Interview on 7/15/25 with the Chief Compliance Officer revealed: -"I should of notified [Client #1's] guardian, didn't use my checklist of processing incidents." -"...was rushing (completing internal investigation) since the incident had already been delayed." -Will make sure to use her checklist for processing incidents moving forward to ensure required departments are notified of any	V 293		

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V 293	Continued From page 6 allegation of abuse upon being made aware. -Will update the incident investigation form to include to refer back to incident processing checklist to ensure all steps are taken. Interview on 7/15/25 with the Chief Operating Officer revealed: -The staff an allegation of abuse was reported to would notify the Client's therapist and the PQI team. -No one told Client #1's therapist or their guardian about the allegation of abuse. -Will ensure clear systematic overview of who is following up and the step by step process reviewing the incidents and processes involved.	V 293		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information;	V 367	Correct: IRIS reports for all students involved in this investigation shall be completed and submitted by the QAM. Prevent: The PQI Investigation Procedure Form shall be updated to include a step for completing all required IRIS reports. Prevent: The COO will retrain residential staff on the timeline and process for reporting allegations to PQI and DSS. Monitor: Upon completion of an investigation, the completed form shall be shared with the entire PQI team and denote that the IRIS reports have been completed.	7/15/25 9/12/25 7/30/25 9/12/25

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V 367	Continued From page 7 (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the	V 367		

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V 367	Continued From page 8 catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report level II incidents in the Incident Response Improvement System (IRIS) within 72 hours of becoming aware of the incident. The findings are: Review on 7/14/25 of Client #1's record revealed: -Age: 12. -Date of admission: 6/5/25. -Diagnoses: Personality Disorder, Major Depressive Disorder, and Anxiety Disorder.	V 367		

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V 367	Continued From page 9 Review on 7/14/25 of Client #2's record revealed: -Age: 16. -Date of admission: 2/25/25. -Diagnoses: Disruptive Mood Dysregulation Disorder, and Attention Deficit Hyperactivity Disorder, combined type. Review on 7/14/25 of IRIS revealed: -No documentation of level II IRIS report for allegation of abuse reported to the local Department of Social Services (DSS) on 7/8/25 involving Client #1 and #2. Review on 7/14/25 of the Licensee Internal Investigation completed by the Performance and Quality Improvement (PQI) team dated 6/23/25 revealed: -Date of incident: 6/16/25-6/17/25. -There were no listed allegations of abuse. Interview on 7/15/25 with the local DSS Worker revealed: -Confirmed allegation of abuse against Staff #1 involving Client #1 and Client #2 reported 7/8/25. Interview on 7/15/25 with the Quality Assurance Manager revealed: -Was a member of the PQI team. -PQI team was responsible for reporting level II incidents in IRIS. -Was not aware of an allegation of abuse prior to 7/8/25. -Level II incident was not completed in IRIS for the allegation of abuse against Staff #1 reported to the local DSS on 7/8/25. -Level II incident was not completed in IRIS for the allegation of abuse against Staff #1 involving Client #1 and Client #2 due to "a series of miscommunications, (PQI) did not communicate effectively as a team."	V 367		

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V 367	Continued From page 10 -Aware of the requirement for incident reporting in IRIS, "...we dropped the ball honestly (Level II incident was not completed in IRIS for the allegation of abuse against Staff #1 involving Client #1 and Client #2)." Interview on 7/15/25 with the Chief Compliance Officer revealed: -Was a member of the PQI team. -PQI team was responsible for reporting level II incidents in IRIS. -Was not aware of an allegation of abuse prior to 7/8/25. -Level II incident was not completed in IRIS for the allegation of abuse against Staff #1 involving Client #1 and Client #2 reported to the local DSS on 7/8/25. -"...was rushing (completing internal investigation) since the incident had already been delayed." -Will make sure to use her checklist for processing incidents moving forward to ensure required departments are notified of any allegation of abuse upon being made aware. -Will update the incident investigation form to include to refer back to incident processing checklist to ensure all steps are taken. Interview on 7/15/25 with the Chief Operating Officer revealed: -PQI team responsible for reporting level II incidents in IRIS for allegations of abuse against employees. -Level II incident was not completed in IRIS for the allegation of abuse against Staff #1 involving Client #1 and Client #2 reported to the local DSS on 7/8/25. -Will ensure clear systematic overview of who is following up and the step by step process reviewing the incidents and processes involved.	V 367		