STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A	LE CONSTRUCTION (X3	) DATE SURVEY COMPLETED
	MHL011-443	B. WING		R
NAME OF PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST		07/15/2025
ELIADA TREATMENT CENTER		LE, NC 28806		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR 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 COMMEN		V 000		
category: 10A NCA	This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.			
This facility is licenscensus of 8. The suaudits of 3 current	sed for 8 and has a current irvey sample consisted of clients.			
V 132 G.S. 131E-256(G) Allegations, & Prote		V 132		
REGISTRY	EALTH CARE PERSONNEL ities shall ensure that the		Correct: The HCPR required reports shall be submitted by the CCO in reg to this staff member.	
health care personn unknown source, w any act listed in sub (which includes: a. Neglect or abus	ed of all allegations against nel, including injuries of hich appear to be related to division (a)(1) of this section.		Prevent: The PQI Investigations Procedure Form will include a check for HCPR Required Reports and den all allegations against a staff must be reported.	ote
as defined by G.S. as defined by G.S. b. Misappropriation in a health care faci	o whom home care services 131E-136 or hospice services 131E-201 are being provided. In of the property of a resident lity, as defined in subsection cluding places where home		Prevent: The COO will retrain residential staff on the timeline and process for reporting allegations to Pand DSS.	07/30/25 QI
care services as de hospice services as are being provided. c. Misappropriation healthcare facility.	ined by G.S. 131E-136 or defined by G.S. 131E-201 of the property of a gs belonging to a health care		Monitor: Upon completion of a PQI Investigation, the entire PQI team shareview the completed form which shadenote the completion of the HCPR required report.	9/12/25 II

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

TITLE

(X6) DATE

STATE FORM

6899 VV8T11 If continuation sheet 1 of 11

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING	·	COMPLETED	
		MHL011-443	B. WING		R 07/15/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, S	TATE, ZIP CODE		
ELIADA T	REATMENT CENTER		A HOME ROA			
	0.0000		E, NC 28806			
(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 APPROPR DEFICIENCY)	BE COMPLETE	
V 132	Continued From page	1	V 132			
	e. Fraud against a he a patient or client for we providing services). Facilities must have e acts are investigated at to protect residents from investigation is in proginvestigations must be Department within five notification to the Department of a lased on record review facility failed to report a the Health Care Person affecting 1 of 3 audited findings are:  Review on 7/14/25 of S-Title: Youth Mentor.  -Date of Hire: 3/31/25.  Review on 7/14/15 of the revealed:  -No documentation of a allegation of abuse report Social Services (DSS Review on 7/14/25 of the Investigation completed Quality Improvement (Frevealed:  -Date of incident: 6/16/25-There were no listed a linterview on 7/15/25 with revealed:	ealth care facility or against whom the employee is vidence that all alleged and must make every effort on harm while the ress. The results of all reported to the working days of the initial artment.  Is evidenced by: It is evidenced by: It is allegation of abuse to an allegation of abuse to an allegation of abuse to a transfer (Staff #1). The  Staff #1's record revealed:  In efacility incident reports In report to the HCPR for corted the local Department is 7/8/25.  In elicensee Internal is by the Performance and PQI) team dated 6/23/25.	V 132			
	-Confirmed allegation o	f abuse against Staff #1 Client #2 reported 7/8/25.				

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	:	COMPLETED	
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		MHL011-443	B. WING		07/15/2025	
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TO AMIL OF T	NOVIDER OR SOFFEIER		DRESS, CITY, ST DA HOME ROA			
ELIADA T	REATMENT CENTER		E, NC 28806			
(X4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	<del></del>			
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V 132	Continued From page	2	V 132			
	Interview on 7/15/25 v	vith the Quality Assurance				
	Manager revealed:	with the Quality Assurance				
	-Was a member of the	POI team				
		sible for reporting to the		9		
	HCPR for allegations					
	employees.					
	-Was not aware of an	allegation of abuse prior to				
	7/8/25.	<ul> <li>■ 10000000</li></ul>				
	-HCPR was not compl	eted for allegation of abuse				
		ed to the local DSS on				
	7/8/25.					
		eted due to "a series of				
		PQI) did not communicate				
	effectively as a team."	and for LICDD and the				
		nent for HCPR reporting, honestly (not reporting to				
		n of abuse against Staff #1				
	reported 7/8/25)."	n or abuse against Stail #1				
	Interview on 7/15/25 w Officer revealed:	ith the Chief Compliance				
	-Was a member of the	PQI team.				
		sible for reporting to the				
	HCPR for allegations of	of abuse against				
	employees.					
	-Was not aware of an allegation of abuse prior to 7/8/25.					
		eted for allegation of abuse				
	against Staff #1 reporte 7/8/25.	ed to the local DSS on				
		eting internal investigation)				
	since the incident had a					
	-Will make sure to use					
		oving forward to ensure				
	required departments a					
	allegation of abuse upo					
	-Will update the incider					
	include to refer back to					
	checklist to ensure all s	верь аге такеп.				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE SU	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	LETED
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NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
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	ASHEVI					
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETE DATE
V 132	Continued From page	3	V 132			
	Interview on 7/15/25 w Officer revealed: -PQI team responsible allegations of abuse a -Will ensure clear syst following up and the st	with the Chief Operating  for notifying the HCPR for gainst employees.  ematic overview of who is	, , , , ,			
V 293	27G .1701 Residential	Tx. Child/Adol - Scope	V 293			
	children or adolescents free-standing residenti intensive, active theraginterventions within a shall not be the primar who is not a client of the (b) Staff secure means awake during client sleshall be continuous as this Section.  (c) The population seradolescents who have mental illness, emotion substance-related diso co-occurring disorders disabilities. These children or addrequire the following:  (1) removal from community-based residecilitate treatment; and (2) treatment in a (e) Services shall be de (1) include indivistructure of daily living;	nent staff secure facility for s is one that is a all facility that provides peutic treatment and system of care approach. It y residence of an individual ne facility. Se staff are required to be seep hours and supervision set forth in Rule .1704 of each of the secure		Correction: The guardian shall be notified in regard to the allegation the CCO.  Prevention: The PQI Investigation Procedure Form shall be updated include a step to inform all guardia all students involved in an investig Monitor: The PQI Investigation Procedure Form shall be shared vithe entire PQI team upon its completion and shall denote that guardian notification has been completed.	to ans of gation.	7/9/25 9/12/25

PRINTED: 07/16/2025 **FORM APPROVED** Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL011-443 07/15/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 882 ELIADA HOME ROAD **ELIADA TREATMENT CENTER** ASHEVILLE, NC 28806 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 293 Continued From page 4 V 293 related to functional deficits; ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; assist the child or adolescent in the acquisition of adaptive functioning in self-control. communication, social and recreational skills; and 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:

Division of Health Service Regulation

-Age: 12.

-Date of admission: 6/5/25.

Review on 7/14/25 of Client #1's record revealed:

-Guardian was not notified of incident dated

-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:

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	TATE, ZIP CODE			
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ELIADA I	REATMENT CENTER	ASHEVILL	E, NC 28806				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
V 293	Continued From page	5	V 293				
	6/16/25 and 6/17/25.						
	0/10/20 and 0/17/20.						
	Quality Improvement ( revealed: -Date of incident: 6/16 -There were no listed a	ed by the Performance and PQI) team dated 6/23/25 /25-6/17/25. allegations of abuse.					
	revealed:	vith the local DSS Worker					
		of abuse against Staff #1					
	involving Client #1 rep						
	revealed:	rith Client #1's guardian  Client #1 while on a home  legation of abuse.					
		ith Therapist #1 revealed: 1's guardian of incident 7/25.					
	Manager revealed: -Was not sure why Clie made aware of the alle -"I thought she (Client:	ent #1's guardian was not gation of abuse. #1) had been made aware gassumption that she was					
	Officer revealed: -"I should of notified [C use my checklist of pro-"was rushing (compl since the incident had a-Will make sure to use	eting internal investigation) already been delayed." her checklist for oving forward to ensure					

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		MHL011-443	B. WING		07/15/2025	/15/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
ELIADA T	REATMENT CENTER		A HOME ROA .E, NC 28806				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
V 293	allegation of abuse up-Will update the incide include to refer back to checklist to ensure all Interview on 7/15/25 v Officer revealed: -The staff an allegation would notify the Client teamNo one told Client #1' about the allegation of -Will ensure clear syst following up and the si	oon being made aware. ent investigation form to o incident processing steps are taken.  with the Chief Operating n of abuse was reported to 's therapist and the PQI steps therapist or their guardian abuse. ematic overview of who is	V 293				
V 367	27G .0604 Incident Re 10A NCAC 27G .0604 REPORTING REQUIR	INCIDENT REMENTS FOR	V 367	Correct: IRIS reports for all stude		5	
CATEGORY A AND B PROVIDERS  (a) Category A and B providers shall report level II incidents, except deaths, that occur the provision of billable services or while to consumer is on the providers premises or incidents and level II deaths involving the to whom the provider rendered any service 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 be submitted on a form provided by the Secretary. The report may be submitted in person, facsimile or encrypted electronic means. The report shall include the followinformation:  (1) reporting provider contact and identification information;  (2) client identification information;	providers shall report all pot deaths, that occur during esservices or while the poviders premises or level III eaths involving the clients		involved in this investigation shall completed and submitted by the C Prevent: The PQI Investigation Procedure Form shall be updated include a step for completing all re	to 9/12/25			
	cident to the LME chment area where within 72 hours of incident. The report shall in provided by the may be submitted via mail, encrypted electronic all include the following vider contact and		IRIS reports.  Prevent: The COO will retrain residential staff on the timeline and process for reporting allegations to and DSS.  Monitor: Upon completion of an investigation, the completed form see that the IRIS reports have be completed.	7/30/25 PQI Shall and			

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	:	COMP	LETED	
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ELIADA T	REATMENT CENTER		DA HOME RO	-			
			LE, NC 28806				
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V 367	Continued From page	7	V 367				
	(3) type of incid	ent:					
	(4) description of						
	TOTAL STATE OF THE PARTY OF THE	effort to determine the					
	cause of the incident;						
		uals or authorities notified					
	or responding.						
		providers shall explain any					
		information. The provider					
		ed report to all required					
		e end of the next business					
	day whenever:	haa					
		has reason to believe that					
	information provided in	or otherwise unreliable; or					
		obtains information		1			
		nt form that was previously					
	unavailable.	it form that was proviously					
	(c) Category A and B	providers shall submit.					
	upon request by the LI						
	obtained regarding the						
		rds including confidential					
	information;						
		her authorities; and				1	
		response to the incident.					
		providers shall send a copy					
		eports to the Division of					
	- Salar Maria and Article - In an experience of the property of the control of th	omental Disabilities and ices within 72 hours of					
	becoming aware of the						
	providers shall send a					- 1	
		ent death to the Division of				- 1	
	Health Service Regulat					ı	
	becoming aware of the	incident. In cases of					
	client death within seve	en days of use of seclusion					
	or restraint, the provide	er shall report the death					
	immediately, as require						
	.0300 and 10A NCAC 2						
	(e) Category A and B p						
	report quarterly to the L	ME responsible for the					
						1	

**FORM APPROVED** Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R B. WING MHL011-443 07/15/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 882 ELIADA HOME ROAD **ELIADA TREATMENT CENTER** ASHEVILLE, NC 28806 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) V 367 Continued From page 8 V 367 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: restrictive interventions that do not meet (2) 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.

Division of Health Service Regulation

-Date of admission: 6/5/25.

-Diagnoses: Personality Disorder, Major Depressive Disorder, and Anxiety Disorder.

MHL011-443  B. WING RODO  RT/15/2025  MME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP GODE  SUMMARY STATEMENT OF DEPOISHOURS  BY ELLADA HOME ROAD  ASHEVILLE, NC 2886  DISTRICT ADDRESS PLAN OF CORRECTION  (EACH DEPRICENCY WIDST BE PRECEDED BY PLLL  REQUILATORY OR LS DENTIFYING INFORMATION)  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, and Intention Officit Hyperactivity Disorder, combined type.  Review on 7/14/25 of the Licensee Internal Investigation of abuse reported to the local Department of Social Services (DSS) on 7/8/25 involving Client #1 and Client #2 reported 7/8/25,  -There were no listed allegations of abuse.  Interview on 7/15/25 with the Quality Assurance Manager revealed:  -Vas a member of the POI team.  -POI team was responsible for reporting level II incidents in IRIS.  -Vas an ember of the POI team.  -POI team was responsible for reporting level II incidents in IRIS.  -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 reported to the local DSS on 7/8/25.		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	8 0	LE CONSTRUCTION		DATE SURVEY COMPLETED	
MHL011-443  R. WING  ELIADA TREATMENT CENTER  882 ELIADA HOME ROAD  882 ELIADA HOME ROAD  882 ELIADA HOME ROAD  882 ELIADA HOME ROAD  884 ELIADA HOME ROAD  884 ELIADA HOME ROAD  884 ELIADA HOME ROAD  885 ELIADA HOME ROAD  884 ELIADA HOME ROAD  885 ELIADA HOME ROAD  885 ELIADA HOME ROAD  885 ELIADA HOME ROAD  886 ELIADA HOME ROAD  887 ELIADA HOME ROAD  888 ELIADA HOME SANDERS  898					· <del></del>		R	
ELIADA TREATMENT CENTER    SUMMARY STATEMENT OF DEPICIENCIES   Discussion of the content of the			MHL011-443	B. WING		07		
ASHEVILLE, NC 28806   SUMMARY STATEMENT OF DEPOCINCIES   ID   PROVIDERS PLAN OF CORRECTION   (PA)	NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
PREFIX TAG  (EACH DEPICIENCY JUST BE PRECEDED BY FULL TAG  REQULATORY OR LSC IDENTIFYING INFORMATION)  V 367  Continued From page 9  Review on 7/14/25 of Client #2's record revealed: -Age: 16Date of admission: 2/25/25Diagnoses: Disruptive Mood Dysregulation Disorder, and Attention Deficit Hyperactivity Disorder, and Attention Deficit Hyperactivity Disorder, combined type.  Review on 7/14/25 of [RIS 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: 6/16/25-6/17/25There were no listed allegations 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: -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 teamPQI team was responsible for reporting level II incidents in IRISWas not aware of an allegation of abuse prior to 7/8/25Level II incident was not completed in IRIS for the allegation of abuse against Staff #1 involving Client #1 and Client #2 due to ** as review of the PQI team was responsible for reporting level II incidents in IRISLevel II incident was not completed in IRIS for the allegation of abuse against Staff #1 involving Client #1 and Client #2 due to ** as review of the PQI team was responsible for the ore of the PQI team.	I ELIADA IREAINENI CENTER							
Review on 7/14/25 of Client #2's record revealed: -Age: 16Date of admission: 2/25/25Diagnoses: Disruptive Mood Dysregulation Disorder, and Attention Deficit Hyperactivity Disorder, and Attention 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: 6/16/25-6/17/25There 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 teamPQI team was responsible for reporting level II incidents in IRISWas not aware of an allegation of abuse prior to 7/8/25Level II incident was not completed in IRIS for the allegation of abuse against Staff #1 reported to the local DSS on 7/8/25Level II incident was not completed in IRIS for the allegation of abuse against Staff #1 involving Client #1 and Client #2 use to 's series of	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	ILD BE	COMPLETE	
		Review on 7/14/25 of -Age: 16Date of admission: 2/-Diagnoses: Disruptive Disorder, and Attention Disorder, combined ty Review on 7/14/25 of -No documentation of allegation of abuse rep Department of Social Sinvolving Client #1 and Review on 7/14/25 of the Investigation complete Quality Improvement (revealed: -Date of incident: 6/16/2-There were no listed at Interview on 7/15/25 were vealed: -Confirmed allegation of involving Client #1 and Interview on 7/15/25 were was a member of the -PQI team was responsincidents in IRISWas not aware of an at 7/8/25Level II incident was not the allegation of abuse to the local DSS on 7/8-Level II incident was not allegation of abuse Client #1 and Client #2	Client #2's record revealed:  25/25.  Mood Dysregulation Deficit Hyperactivity pe.  IRIS revealed: level II IRIS report for borted to the local Services (DSS) on 7/8/25 If #2.  Ithe Licensee Internal Ind by the Performance and PQI) team dated 6/23/25  If #2.  In the local DSS Worker In the local DSS Worker In the local DSS Worker In the Quality Assurance In the Quality Assurance PQI team. In the Quality Assurance PQI team. In the Quality Assurance In the Quality Assu	V 367	DEFICIENCE			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
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		MHL011-443	B. WING		1 0	R	
						7/15/2025	
NAME OF F	PROVIDER OR SUPPLIER	STREETAD	DRESS, CITY, S	TATE, ZIP CODE			
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		ASHEVILI	LE, NC 28806	E .			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 367	Continued From page	10	V 367				
	-Aware of the requiren IRIS, "we dropped the incident was not compallegation of abuse ag Client #1 and Client #2 Interview on 7/15/25 w Officer revealed: -Was a member of the -PQI team was responsincidents in IRISWas not aware of an at 7/8/25Level II incident was rethe allegation of abuse Client #1 and Client #2 on 7/8/25"was rushing (complesince the incident had at Will make sure to use processing incidents merequired departments at allegation of abuse upon Will update the incident include to refer back to checklist to ensure all sufficient was not the allegation of abuse upon PQI team responsible incidents in IRIS for allegation of abuse Client #1 and Client was not the allegation of abuse Client #1 and Client #2	nent for incident reporting in the ball honestly (Level II bleted in IRIS for the ainst Staff #1 involving 2)."  with the Chief Compliance  PQI team.  sible for reporting level II ballegation of abuse prior to the completed in IRIS for against Staff #1 involving are reported to the local DSS bleting internal investigation) already been delayed."  ther checklist for avoing forward to ensure are notified of any on being made aware. In investigation form to incident processing steps are taken.  the the Chief Operating	V 367				
	following up and the ste	matic overview of who is ep by step process and processes involved.					