STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED			
		MHL083-031	B. WING		08/15/2025	
NAME OF PR	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE		
MIRACLE	HAVEN OF WAGRAM		JNDY STREET M, NC 28396			
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLE	ETE
V 000	INITIAL COMMENTS		V 000			
	on August 15, 2025. substantiated (Intake #NC00232846). Defi This facility is licensed category: 10A NCAC Treatment Staff Secundolescents and .510	#NC00232947 and ciencies were cited. d for the following service 27G .1700 Residential				
	This facility is licensecensus of 1. The sur	d for 4 and has a current vey sample consisted of ent and 1 former client.				
V 111	27G .0205 (A-B) Assessment/Treatme	nt/Habilitation Plan	V 111			
	PLAN (a) An assessment s client, according to go the delivery of service be limited to: (1) the client's prese (2) the client's needs (3) a provisional or a established diagnosis of admission, except detoxification or other shall have an establis admission; (4) a pertinent social and (5) evaluations or as	thall be completed for a overning body policy, prior to es, and shall include, but not enting problem; and strengths; admitting diagnosis with an eletermined within 30 days that a client admitted to a er 24-hour medical program thed diagnosis upon				
	psychiatric, substance					

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

(X6) DATE TITLE

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL083-031	B. WING		08/15/2025	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
I MIRACLE HAVEN OF WAGRAM		INDY STREET I, NC 28396				
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 1111	(b) When services are establishment and important treatment/habilitation referred to as the "planchient's presenting production". This Rule is not met a Based on record reviet failed to ensure an asfor 1 of 1 current client. Review on 08/13/25 or revealed: -Admission date of 07-Diagnoses of Oppositions.	e provided prior to the plementation of the or service plan, hereafter in," strategies to address the oblem shall be documented. as evidenced by: ew and interview, the facility sessment was completed ats (#1). The findings are: of client #1's record 1/07/25. ditional Defiant Disorder. dmission assessment to the client #1 revealed: facility since July 8th. issue was smoking	V 111	DEPICIENCY)		
	Professional revealed -She had not complet assessment for client	ed an admission				

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STATE FORM 6899 YOLK11 If continuation sheet 2 of 19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL083-031	B. WING		08/15/2025
	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STANDY STREET NDY STREET NC 28396	TE, ZIP CODE	1 00.10.2020
(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 COMPLETE
V 114	Continued From page	2	V 114		
V 114	27G .0207 Emergend	y Plans and Supplies	V 114		
	AND SUPPLIES (a) Each facility shall and a disaster plan at these plans available to the county emerge request. The plans ship procedures and route (b) The plans shall be and evacuation procedures in the facility. (c) Fire and disaster of shall be held at least repeated for each ship and a disaster of shall be held at least repeated for each ship and a disaster of shall be held at least repeated for each ship and a disaster of shall be held at least repeated for each ship and a disaster of shall be held at least repeated for each ship and a disaster of shall be held at least repeated for each ship and a disaster of shall be held at least repeated for each ship and a disaster of shall be held at least repeated for each ship and a disaster of ship	ncy services agencies upon hall include evacuation has. e made available to all staff edures and routes shall be drills in a 24-hour facility quarterly and shall be ft. ted under conditions that response to fire			
	failed to have disaste	as evidenced by: ew and interview the facility r drills held at least quarterly n shift. The findings are:			
	2024-July 2025 revea	d been documented as			
	Interview on 08/13/25	client #1 stated she had			

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completed fire and disaster drills at the facility.

STATE FORM 6899 YOLK11 If continuation sheet 3 of 19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SU COMPLE		
			A. BOILDING			
		MHL083-031	B. WING		08/1	5/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MIRACLE	HAVEN OF WAGRAM	21701 BUN	DY STREET			
		WAGRAM,	NC 28396			
(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 114	Continued From page	: 3	V 114			
	disaster drills had bee	staff #1 revealed fire and en completed at the facility. staff #2 revealed fire and				
	The staff were docum worksheet.	-				
	Interview on 08/13/25 staff #3 revealed fire and disaster drills had been completed at the facility.					
	-Interview on 08/13/25 the Qualified Professional revealed: - The staff had documented the drills on the					
	wrong worksheet.					
V 293	27G .1701 Residentia	ıl Tx. Child/Adol - Scope	V 293			
	children or adolescen free-standing resident intensive, active thera interventions within a shall not be the prima	ment staff secure facility for ts is one that is a tial facility that provides apeutic treatment and system of care approach. It ry residence of an individual				
	awake during client sl shall be continuous as this Section.	ns staff are required to be eep hours and supervision s set forth in Rule .1704 of				
	adolescents who have mental illness, emotio substance-related dis	orders; and may also have				
	disabilities. These ch not meet criteria for in	s including developmental ildren or adolescents shall patient psychiatric services. dolescents served shall				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		MHL083-031	B. WING		08	8/15/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
MIRACLE	HAVEN OF WAGRAM		UNDY STREET			
			M, NC 28396			
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 293	community-based res facilitate treatment; a (2) treatment in (e) Services shall be (1) include indistructure of daily livin (2) minimize the related to functional (3) ensure safe control behaviors include management with or (4) assist the cacquisition of adaptive communication, social (5) support the gaining the skills nee intensive treatment set (f) The residential treshall coordinate with	m home to a sidential setting in order to and a staff secure setting. designed to: vidualized supervision and g; e occurrence of behaviors deficits; by and deescalate out of uding frequent crisis without physical restraint; hild or adolescent in the e functioning in self-control, al and recreational skills; and child or adolescent in ded to step-down to a less etting.	V 293			
	coordinate with other					

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STATEMEN [*]	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE S	
	MHL083-031		B. WING		08/1	5/2025
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	ATE ZIP CODE	1 00/1	5/2025
			INDY STREET	(i, 2, 2), GGSL		
MIRACLE HAVEN OF WAGRAM WAGRAI		WAGRAM	I, NC 28396			
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
V 293	Continued From page	÷ 5	V 293			
	-13 year oldAdmission date of 06 -Discharge date of 07 -Diagnoses of Major I Reaction to Severe S Disorder, Attention Do and Pre-diabetic. Review on 08/15/25 of FC #2's guardian to the severe se	Depressive Disorder, tress, Oppositional Defiant eficit Hyperactivity Disorder of 2 text messages sent by the Qualified Professional or [FC #2] endocrinology (Facility] Tuesday July 15 w/ ward to seeing you at your day July 15 w/ [Provider]" 8/15/25 FC #2's guardian d that FC #2 was a ges to the QP reminding of the appointment because no book her to the appointment. It is office and they could not be 2025. 8/13/25 the QP revealed: etic. that FC #2 was seeing an of any appointments for FC				

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STATE FORM 6899 YOLK11 If continuation sheet 6 of 19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY PLETED	
		MHL083-031	B. WING		08	15/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
MIRACLE	HAVEN OF WAGRAM		UNDY STREET M, NC 28396			
(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 CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 296	Continued From page	÷ 6	V 296			
V 296	27G .1704 Residentia Staffing	al Tx. Child/Adol - Min.	V 296			
	telephone or page. A able to reach the facil times. (b) The minimum nur required when childre present and awake is (1) two direct cone, two, three or fou (2) three direct for five, six, seven or adolescents; and (3) four direct conine, ten, eleven or two adolescents. (c) The minimum nur during child or adolescents. (c) The minimum nur during child or adolescents follows: (1) two direct conditions and one shall be awa children or adolescent (2) two direct conditions and both shall be awa children or adolescent (3) three direct conditions to the asleep for nine, ten, endolescents. (d) In addition to the care staff set forth in length of facility based on the care staff set forth in length of the facility based on the care staff set forth in length of the facility based on the care staff set forth in length of the facility based on the care staff set forth in length of the facility based on the care staff set forth in length of the facility based on the care staff set forth in length of the facility based on the care staff set forth in length of the facility based on the care staff set forth in length of the facility based on the care staff set forth in length of the facility based on the care staff set forth in length of the facility based on the care staff set forth in length of the facility based on the care staff set forth in length of the facility based on the facility based on the care staff set forth in length of the facility based on the care staff set forth in length of the facility based on the care staff set forth in length of the facility based on the care staff set forth in length of the facility based on the care staff set forth in length of the facility based on the	sional shall be available by a direct care staff shall be ity within 30 minutes at all imber of direct care staff in or adolescents are as follows: are staff shall be present for richildren or adolescents; care staff shall be present eight children or are staff shall be present for welve children or imber of direct care staff cent sleep hours is as are staff shall be present ke for one through four ts; are staff shall be present ake for five through eight				

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STATE FORM 6899 YOLK11 If continuation sheet 7 of 19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		MHL083-031	B. WING		08	8/15/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE	-	
MIRACLE	HAVEN OF WAGRAM		JNDY STREET M, NC 28396			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
V 296	(e) Each facility shall supervision of childre are away from the fac	be responsible for ensuring n or adolescents when they illity in accordance with the ndividual strengths and	V 296			
	staff were present for The findings are: Review on 08/13/25 or revealed: -Admission date of 07-Diagnosis of Opposit Observation on 08/13 11:45am upon arrival -Staff #1 was present -No other staff were p -Staff #2 arrived to the During interview on 06 -When she was first a always two staff becathe homeSometimes the facilit times it will have two shappening that day.	n, record review and hailed to ensure 2 direct care 1 of 1 current clients (#1) of client #1's record 1/07/25. It ional Defiant Disorder 1/25 at approximately to the facility revealed: in the facility with client #1. resent.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		MHL083-031	B. WING		08	3/15/2025
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	E, ZIP CODE		
MIRACLE	HAVEN OF WAGRAM		M, NC 28396			
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 296	Continued From page	8	V 296			
	-She worked all shifts -Two staff work each -The other staff that w morning had gone to During interview on 0 -She worked all shifts -Two staff are always -She had stepped out surveyor had arrived errand. During interview on 0 -She had worked at tt -She worked all shifts -Two staff work each During interview on 0 Professional revealed -Two staff work each -She would ensure th	shift. /as working with her that the store to get a mop. 8/13/25 staff #2 revealed: on shift in the home. for a few minutes before to the facility to run an 8/13/25 staff #3 revealed: he facility for 3 years. shift at the facility. 8/15/25 the Qualified I:				
V 536	27E .0107 Client Right Int.	nts - Training on Alt to Rest.	V 536			
	to restrictive intervent (b) Prior to providing disabilities, staff inclu employees, students demonstrate compete	Delement policies and size the use of alternatives ions. services to people with ding service providers, or volunteers, shall				

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STATE FORM 909 YOLK11 If continuation sheet 9 of 19

MHL083-031 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 21701 BUNDY STREET WAGRAM, NC 28396 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (CACH DEFICIENCY MUST BE PRESEDED BY SITH A COUNTY ACTION SHOULD BE	STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 21701 BUNDY STREET WAGRAM, NC 28396 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)				5 14/11/0			
MIRACLE HAVEN OF WAGRAM 21701 BUNDY STREET WAGRAM, NC 28396 (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)			MHL083-031	B. WING		08/15/2025	
MIRACLE HAVEN OF WAGRAM WAGRAM, NC 28396 (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)	NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WAGRAM, NC 28396 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	MIDACLE HAVEN OF WACDAM 21701 BUN		NDY STREET				
(X.) IS	WAGRAM, WAGRAM		I, NC 28396				
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMP	LETE
V 536 Continued From page 9 V 536	V 536	Continued From page	9	V 536			
other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or falling the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) Knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life;	v 536	other strategies for criving which the likelihood or injury to a person or property damage is provided include measurable lember include measurable testing (which is person is provided in the	reating an environment in if imminent danger of abuse with disabilities or others or revented. It is shall establish training retencies, monitor for internal constrate they acted on data to be competency-based, earning objectives, written and by observation of objectives and measurable is passing or failing the training must be completed der periodically (minimum ming that the service apploy must be approved by D/SAS pursuant to Rule. Instrate competence in the and understanding of the and interpreting human the effect of internal and at may affect people with the importance of and interpretance of an interpret	V 550			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL083-031	B. WING		08/15/2025	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
MIDACLE	MIRACLE HAVEN OF WAGRAM 21701 BUN		INDY STREET			
WIRACLE	HAVEN OF WAGRAW	WAGRAN	1, NC 28396			
(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 APPROPE DEFICIENCY)	BE COMPLETE	
V 536	Continued From page	e 10	V 536			
	escalating behavior;					
	_	tion strategies for defusing				
		tentially dangerous behavior;				
		navioral supports (providing				
		n disabilities to choose				
	activities which direct	ly oppose or replace				
	behaviors which are u					
	(h) Service providers					
		al and refresher training for				
	at least three years.	tion abolt include:				
	` '	tion shall include:				
	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	ations and Training				
	Requirements:					
		all demonstrate competence				
	,	esting in a training program				
		reducing and eliminating the				
	need for restrictive int (2) Trainers sha	all demonstrate competence				
		grade on testing in an				
	instructor training pro	•				
	(3) The training	_				
		nclude measurable learning				
	objectives, measurab	le testing (written and by				
		or) on those objectives and				
		to determine passing or				
	failing the course.					
		t of the instructor training the				
	service provider plans					
	to Subparagraph (i)(5	sion of MH/DD/SAS pursuant				
		instructor training programs				
		not limited to presentation of:				

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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
		MUU 002 024	B. WING		00/45/0005
		MHL083-031	B: Will (08/15/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	
		21701 RI	JNDY STREET		
MIRACLE	HAVEN OF WAGRAM		M, NC 28396		
			W, NC 20390		
(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 APPROPE	
iAO		,	170	DEFICIENCY)	
V 536	Continued From page	e 11	V 536		
	(A) understandi	ng the adult learner;			
	. ,				
	, ,	r teaching content of the			
	course;				
	• •	r evaluating trainee			
	performance; and				
	` '	ion procedures.			
	` '	all have coached experience			
		ogram aimed at preventing,			
		ting the need for restrictive			
		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	east every two years.			
	(j) Service providers	shall maintain			
	documentation of initi	al and refresher instructor			
	training for at least the	ree years.			
	(1) Docume	entation shall include:			
	(A) who particip	ated in the training and the			
	outcomes (pass/fail);				
	(B) when and w	vhere attended; and			
	(C) instructor's	name.			
		n of MH/DD/SAS may			
	request and review th	nis documentation any time.			
	(k) Qualifications of 0	Coaches:			
	(1) Coaches sh	nall meet all preparation			
	requirements as a tra	iner.			
	(2) Coaches sh	nall teach at least three times			
	the course which is be	eing coached.			
		nall demonstrate			
	competence by comp				
	train-the-trainer instru	<u> </u>			
		iall be the same preparation			
	as for trainers.	proparation			

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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		
		MHL083-031	B. WING		08/15/2025	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MIRACLE	HAVEN OF WAGRAM		NDY STREET , NC 28396			
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTE	
			1	DEFICIENCY)		
V 536	Continued From page	÷ 12	V 536			
	facility failed to ensure and #3) received ann restrictive intervention	ews and interviews, the e three of three staff (#1, #2 ual training in alternatives to ns. The findings are:				
	-Date of hire: 03/28/2	of staff #1's record revealed: 5. Intervention (NCI) training				
	Review on 08/13/25 c -Date of hire: 06/30/2 -No NCI training in the					
	Review on 08/13/25 c -Date of hire: 07/11/1 -No NCI training in the					
	During interview on 0 -She had received the	8/13/25 staff #1 revealed: e NCI training.				
	During interview on 0 -She had received the	8/13/25 staff #2 revealed: e NCI training.				
	During interview on 0 -She had received the	8/13/25 staff #3 revealed: e NCI training.				
	During interview on 0 Professional revealed -All the staff had beer -The instructor was of unable to get the cert	l: n trained with NCI. ut of town and she was				

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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	
		MHL083-031	B. WING		08/15/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
MIRACI E	HAVEN OF WAGRAM	21701 BU	INDY STREET		
		WAGRAN	I, NC 28396		
(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 537	27E .0108 Client Righ	nts - Training in Sec Rest &	V 537		
	ISOLATION TIME-OU (a) Seclusion, physic time-out may be emp been trained and hav competence in the property to these procedures. Staff authorized to emprocedures are retrained to procedures are retrained to private the service providers, emproved to providers, emproved to providers, emproved to providers and shall not use the straining is completed demonstrated. (c) A pre-requisite for demonstrating competer training in preventing the need for restrictive (d) The training shall include measurable testing (when the procedure of the testing to provide the procedure of the trained to provide the provident of the trained to provide the provident of the provident of the trained to provide the provident of th	cal restraint and isolation loyed only by staff who have e demonstrated oper use of and alternatives Facilities shall ensure that aploy and terminate these ned and have demonstrated annually. direct care to people with atment/habilitation plan terventions, staff including aployees, students or olete training in the use of estraint and isolation time-out se interventions until the and competence is a taking this training is estence by completion of a reducing and eliminating e interventions. The competency-based, earning objectives, written and by observation of objectives and measurable e passing or failing the training must be completed der periodically (minimum ning that the service oloy must be approved by D/SAS pursuant to			

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MHL08	3-031			(X3) DATE SURVEY COMPLETED	
		B. WING		08/15/2025	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MIRACLE HAVEN OF WAGRAM	21701 BUN	DY STREET			
WAGRAM, I		NC 28396			
(X4) ID SUMMARY STATEMENT OF DEF PREFIX (EACH DEFICIENCY MUST BE PREC TAG REGULATORY OR LSC IDENTIFYING	EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 537 Continued From page 14		V 537			
(g) Acceptable training programs so but are not limited to, presentation (1) refresher information on the use of restrictive interventions; (2) guidelines on when to int (understanding imminent danger to others); (3) emphasis on safety and rights and dignity of all persons invocepts of least restrictive interverincemental steps in an intervention (4) strategies for the safe im of restrictive interventions; (5) the use of emergency sa interventions which include continuassessment and monitoring of the psychological well-being of the clie use of restraint throughout the dura restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, inclimportance and purpose; and (8) documentation methods/ (h) Service providers shall maintain documentation of initial and refresh at least three years. (1) Documentation shall include (A) who participated in the traoutcomes (pass/fail); (B) when and where they att (C) instructor's name. (2) The Division of MH/DD/S review/request this documentation (i) Instructor Qualification and Train Requirements: (1) Trainers shall demonstrated by scoring 100% on testing in a train aimed at preventing, reducing and	of: alternatives to ervene o self and respect for the olved (using ntions and n); plementation fety lous physical and nt and the safe ation of the uding their procedures. ner training for ude: aining and the ended; and AS may at any time. ning te competence ining program	V 537			

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STATE FORM 6899 YOLK11 If continuation sheet 15 of 19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A BOILDING.		
MHL083-031 B. WING			08/15/2025		
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
		21701 BU	NDY STREET		
MIRACLE HAVEN OF WAGRAM WAGRAM,			I, NC 28396		
(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 APPROPE DEFICIENCY)	BE COMPLETE
V 537	Continued From page	e 15	V 537		
	(2) Trainers sha	all demonstrate competence			
		esting in a training program			
		eclusion, physical restraint			
	and isolation time-out	i.			
	(3) Trainers sha	all demonstrate competence			
	by scoring a passing	grade on testing in an			
	instructor training pro	_			
	(4) The training				
		nclude measurable learning			
		le testing (written and by			
		or) on those objectives and			
		to determine passing or			
	failing the course.	t of the instructor training the			
	(5) The content service provider plans	t of the instructor training the			
	I	sion of MH/DD/SAS pursuant			
	to Subparagraph (j)(6				
		instructor training programs			
		be limited to, presentation			
	of:	, ,			
	(A) understandi	ng the adult learner;			
		r teaching content of the			
	course;				
	(C) evaluation	of trainee performance; and			
	` '	ion procedures.			
	\ <i>\</i>	all be retrained at least			
	_	trate competence in the use			
		restraint and isolation			
		in Paragraph (a) of this			
	Rule.				
	(8) Trainers sha	all be currently trained in			
		all have coached experience			
		restrictive interventions at			
	_	positive review by the			
	coach.	-			
	(10) Trainers sha	all teach a program on the			
	use of restrictive inter	ventions at least once			
	annually.				

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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	
MHL083-031		B. WING		08/15/2025		
NAME OF PROVIDER OR SUPPLIER STREET ADDI MIRACLE HAVEN OF WAGRAM 21701 BUN			DRESS, CITY, STANDY STREET , NC 28396	TE, ZIP CODE	,	
(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 537	(11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (I) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers.		V 537			
	facility failed to ensur	ews and interviews, the e three of three staff (#1, #2 ual training updates in estraint and isolation				
	-Date of hire: 03/28/2	of staff #1's record revealed: 5. Intervention (NCI) training				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

_ ` · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL083-031	B. WING		08/15/2025	
NAME OF PROVIDER OR SUPPLIER STREET ADDI MIRACLE HAVEN OF WAGRAM 21701 BUN			PRESS, CITY, STA	TE, ZIP CODE		
(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 537	-Date of hire: 06/30/2 -No NCI training in the Review on 08/13/25 of -Date of hire: 07/11/1 -No NCI training in the During interview on 00 -She had received the	of staff #2's record revealed: 3. e record. of staff #3's record revealed: 9. e record. 8/13/25 staff #1 revealed: e NCI training. 8/13/25 staff #2 revealed:	V 537			
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Baaed on observation and interview the facility failed to ensure the home was maintained in a safe, clean, attractive manner. The findings are: Observation on 08/13/25 at approximately 12:00 pm revealed: -A smoke detector was chirping approximately every 60 seconds (low battery)Vacant bedroom at the end of the hallway had an area behind the bed approximately 2 feet by 3 feet and an area next to the window that had been patched but had not been paintedTwo areas at the end of the hallway approximately 2 feet by 2 feet that had been patched but had not been painted.		V 736			

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Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 21701 BUNDY STREET WAGRAM, NC 28396 (ICA) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG TAG V 736 Continued From page 18 During interview on 08/15/25 the Qualified Professional revealed: -She would address the areas of concern.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE S COMPL	URVEY ETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 21701 BUNDY STREET WAGRAM, NC 28396 (X4) ID PREFIX TAG CONTINUED REGULATORY OR LSC IDENTIFYING INFORMATION) V 736 Continued From page 18 During interview on 08/15/25 the Qualified Professional revealed: STREET ADDRESS, CITY, STATE, ZIP CODE 21701 BUNDY STREET WAGRAM, NC 28396 Dip PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE V 736 During interview on 08/15/25 the Qualified Professional revealed:				A. BUILDING:				
MIRACLE HAVEN OF WAGRAM 21701 BUNDY STREET WAGRAM, NC 28396 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 736 Continued From page 18 During interview on 08/15/25 the Qualified Professional revealed: 10 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE V 736 During interview on 08/15/25 the Qualified Professional revealed:			MHL083-031	B. WING		08/1	5/2025	
WAGRAM, NC 28396 WAGRAM WAGRAM, NC 28396 WA	NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 736 Continued From page 18 During interview on 08/15/25 the Qualified Professional revealed: (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE V 736 V 736	MIRACLE	HAVEN OF WAGRAM						
During interview on 08/15/25 the Qualified Professional revealed:	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETE	
Professional revealed:	V 736	Continued From page	e 18	V 736				
	V 736	During interview on 0 Professional revealed	8/15/25 the Qualified d:	V 736				

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