STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	140239	A. BUILDING: _____ B. WING _____	08/26/2025

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VERITAS COLLABORATIVE, LLC	4024 STIRRUP DRIVE DURHAM, NC 27703

(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 survey was completed on August 26. 2025. Deficiencies were cited. This facility is licensed for the following service categories: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents (PRTF). 10A NCAC 27G .6000 Inpatient Hospital Treatment for Individuals who have Mental Illness or Substance Abuse Disorders (Acute Psychiatric). This facility is licensed for 52 and has a current census of 16. The PRTF has a current census 14 and the Acute Psychiatric has a current census of 4. The survey sample consisted of audits of 3 current clients in the PRTF and 1 current client in the Acute Psychiatric.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;	V 112		

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V 112	Continued From page 1 (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on records reviews and interviews, the facility failed to ensure treatment plans had written consent or agreement by the client's legal guardian of responsible party affecting 2 of 4 audited clients (#2 and #3). The findings are: Review on 8/26/25 of Client #2's record revealed: -Age 15 years. -Admitted on 6/11/25. -Diagnoses of Anorexia Nervosa, Restricting Type, Moderate, with Purging; Moderate Protein-Calorie Malnutrition; Slow Transit Constipation; Encounter for Screening of Nutritional Disorder; Major Depressive Disorder, Recurrent Episode, Unspecified; Generalized Anxiety Disorder. -Client #2's Treatment Plan had no written consent or agreement by the responsible party or a written statement by the provider stating why such consent could not be obtained. Review on 8/26/25 of Client #3's record revealed: -Age 12 years.	V 112		

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V 112	Continued From page 2 -Admitted on 7/24/25. -Diagnoses of Anorexia Nervosa, Restricting Type, Moderate; Excoriation Disorder; Gender Identity Disorder of Childhood; Abnormal Weight Loss; Protein Calorie Malnutrition of Moderate and Mild Degree; Personal History of Suicidal Behavior. -Client #3's Treatment Plan had no written consent or agreement by the responsible party or a written statement by the provider stating why such consent could not be obtained. Interview on 8/26/25 with the Clinical Director revealed: -Therapists were responsible for completing the treatment plans to include the parent's signature. -Therapists, together with the patients and their parents/guardians, identified goals for the treatment plans. -Therapists for Clients #2 and #3 had completed the goals, but had not gotten the parents to sign the plans. -She acknowledged that the treatment plans for clients #2 and #3 had not been signed by their legal guardians. Interview on 8/26/25 with the Executive Director revealed: -The Therapists completed the treatment plans. -The Clinical Director supervised the Therapists and ultimately made sure that treatment plans would get signed.	V 112		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to:	V 113		

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V 113	Continued From page 3 (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143.	V 113		

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V 113	Continued From page 4 This Rule is not met as evidenced by: Based on records reviews and interviews, the facility failed to have a signed consent to seek emergency treatment from a hospital or physician for 3 of 4 audited clients (#1, #2 and #3). The findings are: Review on 8/26/25 of Client #1's record revealed: -Age 17 years old. -Admission date of 7/16/25. -Diagnoses of Other Specified Feeding or Eating Disorder, Atypical Anorexia Nervosa with Purging; Generalized Anxiety Disorder; Major Depressive Disorder, Recurrent Episode, In Partial Remission; Obsessive-Compulsive Disorder by History; Attention Deficit Hyperactive Disorder, Predominantly Hyperactive Type by History; Borderline Personality Disorder; Moderate Protein-Calorie Malnutrition. -There was no signed consent from Client #1's legal guardian that granted permission to seek emergency care. Review on 8/26/25 of Client #2's record revealed: -Age 15 years old. -Admission date of 6/11/25.. -Diagnoses of Anorexia Nervosa, Restricting Type, Moderate, with Purging; Moderate Protein-Calorie Malnutrition; Slow Transit Constipation; Encounter for Screening of Nutritional Disorder; Major Depressive Disorder, Recurrent Episode, Unspecified; Generalized Anxiety Disorder. -There was no signed consent from Client #2's legal guardian that granted permission to seek emergency care.	V 113		

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V 113	Continued From page 5 Review on 8/26/25 of Client #3's record revealed: -Age 12 years old. -Admission date of 7/24/25 -Diagnoses of Anorexia Nervosa, Restricting Type, Moderate; Excoriation Disorder; Gender Identity Disorder of Childhood; Abnormal Weight Loss; Protein Calorie Malnutrition of Moderate and Mild Degree; Personal History of Suicidal Behavior. -There was no signed consent from Client #3's legal guardian that granted permission to seek emergency care. Interview on 8/26/25 with the Director of Adolescent Psychiatric Services revealed: -Case managers were responsible for completing all the consent forms with the patient's parents. -Some forms may had been completed electronically prior to meeting in person with the patient's parents. -Case managers may had used an older version of the consent forms. -Older version of the consent for treatment form did not include the consent for emergency care. -Consent for treatment form was revised in 2024. -Some of the case manager had been using the consent for treatment form that was dated 2022 instead. Interview on 8/26/25 with the Executive Director revealed: -She had been in the current position for only a few months. -Consent for emergency care was part of the admissions package. -The admission package was completed by Case Managers. -Admission was done in person. It was unknown of why the Case Managers used online forms to	V 113		

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V 113	Continued From page 6 complete them. -Online forms used for clients #1, #2 and #3 were from 2022. They did not include most recent version and hence the consent for emergency care was not signed. -The Case Manager's Supervisor and the Patient Navigator would have audited the forms to make sure they were completed correctly. -She would make sure that moving forward, all case managers complete and use the most update consent for treatment forms to include the consent for emergency care.	V 113		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes. (b) The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate the facility's response to fire emergencies. (d) Each facility shall have a first aid kit accessible for use. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure fire and disaster drills were	V 114		

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V 114	Continued From page 7 conducted quarterly and on each shift. The findings are: Review on 8/26/25 of the facility's fire and disaster drills from August 2024 through August 2025 revealed: -3rd quarter (July, August, September) 2024. No fire or disaster drills conducted on 1st shift, 2nd shift or 3rd shift. -4th quarter (October, November, December) 2024. No fire or disaster drills conducted on 1st or 2nd shift. -1st quarter (January, February, March) 2025. No fire or disaster drills conducted on 1st shift, 2nd shift or 3rd shift. -2nd quarter (April, May, June) 2025. No fire or disaster drills conducted on 1st or 2nd shift. Interview on 8/26/25 with the Executive Director revealed: -She had just started working in the position a few months ago. -She was not aware that the emergency drills had not been conducted. -Faciity had an Interim Director that was covering three sites prior to her arrival. She may not had been able to attend to the drills at this facility. -Moving forward, she would be in charge to make sure the fire and disaster drills would be completed according to the rules.	V 114		
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	V 367		

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V 367	Continued From page 8	V 367		

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;
(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.

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V 367	Continued From page 9 (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter 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.	V 367		

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V 367	Continued From page 10 This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure a Level II incident report was completed within 72 hours and submitted to the Local Management Entity/Managed Care Organization. The findings are: Review on 8/26/25 of Client #1's record revealed: -Age 17 years old. -Admission date of 7/16/25. -Diagnoses of Other Specified Feeding or Eating Disorder, Atypical Anorexia Nervosa with Purging; Generalized Anxiety Disorder; Major Depressive Disorder, Recurrent Episode, In Partial Remission; Obsessive-Compulsive Disorder by History; Attention Deficit Hyperactive Disorder, Predominantly Hyperactive Type by History; Borderline Personality Disorder; Moderate Protein-Calorie Malnutrition. Review on 8/26/25 of the facility's internal incident reports revealed: -On 7/17/25, Client #1 had to be restrained as she was trying to hurt self with a pen. -Client #1 had to be restrained twice on 7/17/25 due to self harm behavior. Review on 8/26/25 of the North Carolina Incident Response Improvement System (IRIS) revealed: -There were no IRIS reports for Client #1 for the month of July 2025. Interview on 8/26/25 with the Director of Education revealed: -Facility conducted restraints when needed. -All staff at the facility had been trained on restraints.	V 367		

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V 367	Continued From page 11 -Facility used the Crisis Prevention Institute training as their curriculum for training on restraints. -Any of the trained staff at the facility where able to conduct a restraint if needed. -There was no staff in charge to make the call if a restraint was warranted. Interview on 8/26/25 with the Executive Director revealed: -She had consulted with the Senior Compliance Specialist and she was told that they were under the impression that they did not need to submit incidents on IRIS because facility did not use Medicaid funds. -Facility had never completed any incident on IRIS. -All incident reports were placed on their internal system electronically. -Incident reports were submitted into their system by the person that dealt or witnessed the incident. -They would review the incident reporting procedures with staff. -Moving forward, she and the Senior Compliance Specialist would make sure that all level 2 and/or level 3 incidents were submitted to IRIS.	V 367		