STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 and complaint survey was completed on 8/12/25. The complaints were substantiated (intakes # NC00231809, NC00232695, and NC00232880). 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 3 and has a current census of 2. The survey sample consisted of audits of 2 current clients and 1 former client.	V 000		
V 107	27G .0202 (A-E) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (a) All facilities shall have a written job description for the director and each staff position which: (1) specifies the minimum level of education, competency, work experience and other qualifications for the position; (2) specifies the duties and responsibilities of the position; (3) is signed by the staff member and the supervisor; and (4) is retained in the staff member's file. (b) All facilities shall ensure that the director, each staff member or any other person who provides care or services to clients on behalf of the facility: (1) is at least 18 years of age; (2) is able to read, write, understand and follow directions; (3) meets the minimum level of education, competency, work experience, skills and other qualifications for the position; and	V 107		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 107	Continued From page 1 (4) has no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry. (c) All facilities or services shall require that all applicants for employment disclose any criminal conviction. The impact of this information on a decision regarding employment shall be based upon the offense in relationship to the job for which the applicant is applying. (d) Staff of a facility or a service shall be currently licensed, registered or certified in accordance with applicable state laws for the services provided. (e) A file shall be maintained for each individual employed indicating the training, experience and other qualifications for the position, including verification of licensure, registration or certification. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to have complete personnel records affecting 1 of 4 audited staff, the House Manager (HM). The findings are: Review on 8/1//25 of the HM's personnel record revealed: -Hired on 4/30/24. -No documentation of a written job description for the HM. Interview on 8/1/25 the HM stated:	V 107		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 107	Continued From page 2 -Was recently promoted to the HM on 7/12/25. -Worked overnight 10pm to 7am or 8am and fill in on weekends when needed. -On weekends she filled in where needed. -Had not signed a job description. Interview on 8/5/25 the Licensee/Qualified Professional revealed: -The HM was promoted in July 2024. -The HM had not signed a job description for the HM. -Would ensure the a written job description is placed in the personnel record for the HM.	V 107		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 109	Continued From page 3 met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to develop and implement policies and procedures (P & P) for the initiation of an individualized supervision plan for the Associate Professional (Licensee/Executive Director (ED)/AP) and the Qualified Professional (Licensee/QP) failed to supervise the AP. The findings are: Review on 8/1/25 and 8/11/25 of the facility's records revealed: -No policies and procedures for the initiation of an individualized supervision plan for the AP. -No documentation of supervision for the Licensee/ED/AP. Review on 8/1/25 of the Licensee/ED/AP's record revealed: -Hired 4/30/25. -Written and signed job description dated 4/30/25.	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 109	Continued From page 4 -Responsibilities included "...requires that the Associate Professional (Licensee/ED/AP) to assist the Qualified Professional (Licensee/QP) with the supervision of all staff ..." Review on 8/1/25 of the Licensee/QP's record revealed: -Hired 4/30/25. -Written and signed job description dated 4/30/25. -Responsibilities included "Supervise all staff...Supervise paraprofessionals regarding responsibilities related to the implementation of each child or adolescent's treatment plan..." Attempted review on 8/11/25 of the facility's P & P for individualized supervision plan and no documentation was provided was provided prior to survey exit. Interview on 8/1/25, 8/4/25 and 8/11/25 with the Licensee/ED/AP revealed: -Facility did not have supervision policies and procedures for supervision. -Did not have a supervision plan or documentation of supervision. -She and Licensee/QP supervised each other. Interview 8/1/25, 8/5/25 and 8/11/25 on with the Licensee/QP revealed: -She and the Licensee/ED/AP supervised each other. -She was the supervisor for the Licensee/ED/AP and all paraprofessional staff. -Had not received supervision from the facility's Licensed Professional. -Had no documentation of supervision for the Licensee/ED/AP. -Had no documentation of policies and procedures for the initiation of an individualized	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 109	Continued From page 5 supervision plan for the AP.	V 109		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional.	V 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 110	Continued From page 6 This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional, affecting 7 out of 7 paraprofessional staff (#1, #2, #3, #4, #5, #6, and the House Manager (HM)). The findings are: Review on 8/1/25 and 8/11/25 of the facility's records revealed: -No policies and procedures for the initiation of an individualized supervision plan for paraprofessionals. -No documentation of supervision for paraprofessional staff. Review on 8/1/25 of the Licensee/ED/AP record revealed: -Hired 4/30/25. -Written and signed job description dated 4/30/25 and responsibilities that included "...requires that the Associate Professional to assist the Qualified Professional (QP) with the supervision of all staff ..." Review on 8/1/25 of the Licensee/QP's record revealed: -Hired 4/30/25. -Written and signed job description dated 4/30/25 and responsibilities that included "Supervise all staff...Supervise paraprofessionals regarding responsibilities related to the implementation of each child or adolescent's treatment plan..." Attempted review on 8/11/25 of the facility's P & P for individualized supervision plan and no documentation was provided prior to survey exit.	V 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 110	Continued From page 7 Interview on 8/11/25 with the Licensee/ED/AP revealed: -Had no documentation of supervision for paraprofessional staff. -Had no documentation of policies and procedures for the initiation of an individualized supervision plan for paraprofessionals. Interview on 8/1/25, 8/5/25, 8/11/25 with Licensee/QP revealed: -She and the Licensee/ED/AP supervised each other. -She was the supervisor for the AP (Licensee/ED/AP) and all paraprofessional staff. -Had no documentation of supervision plan for paraprofessionals. -Had no documentation of policies and procedures for the initiation of an individualized supervision plan for paraprofessionals.	V 110		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history;	V 111		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 111	Continued From page 8 and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure an admission assessment was completed prior to the delivery of services affecting 1 of 2 clients (#2). The findings are: Review on 7/31/25 of client #2's record revealed: -Age 16 years. -Admission on 11/13/24. -Discharge on 4/7/25. -Readmission on 6/3/25. -Day Treatment Program Person Centered Plan dated 12/9/24. -Diagnoses: Oppositional Defiant Disorder; Mood Dysregulation Disorder; Generalized Anxiety Disorder; Unspecified Cannabis-Related Disorder; Post-Traumatic Stress Disorder. -Discharge Summary dated 4/7/25, "...decision to discharge based upon repeated violations of	V 111		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 111	Continued From page 9 program rules, unsafe behaviors, and AWOL (Absent Without Leave) behaviors that resulted in her being absent from the facility more than 10 days..." Interview on 8/1/25 with the Licensee/Qualified Professional (QP) revealed: -Participated in CFT (Child Family Team) meeting (3/26/25), client #2 did not want to participate, and was verbally aggressive. -Placed client #2 on a 30 day notice (3/26/25) to improve behaviors or be discharged from the facility (April 2025). -In March 2025 client #2 went AWOL from the facility, did not return and did not make contact with the facility. -Client #2 was discharged on 4/7/25 after she did not return and did not make contact with the facility. -Client #2 was readmitted on 6/3/25. -Client #2 was not assessed for admission on 6/3/25. -She was not aware client #2 needed a new assessment since she had recently been a former client.	V 111		
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	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 112	Continued From page 10 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; (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 record reviews and interviews, the facility failed to ensure treatment plans were developed based on assessments within 30 days of admission affecting 2 of 2 (#1, #2) clients and 1 of 1 former client (FC#3) and in partnership with legally responsible person affecting 1 former client (FC#3). The findings are: Review on 7/31/25 of client #1's record revealed: -Age 17 years. -Admission on 3/14/25. -Day Treatment Program (DTP) Person Centered Plan (PCP-treatment plan) dated 4/28/25. -Diagnoses: Posttraumatic Stress Disorder, With Dissociative Symptoms; Depressive Disorder, Unspecified; Borderline Personality Disorder	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 112	Continued From page 11 (Adolescent) (Per History); Generalized Anxiety Disorder; Unspecified Feeding or Eating Disorder; Child Sexual Abuse, Confirmed, Subsequent Encounter; History Of Suicidal Behavior; History Of Non Suicidal Self Injury. -Assessment dated 2/27/25, "...has history of significant trauma-related behaviors which put her at risk for self-harm, elopement and trafficking...history of abuse and neglect...family history of drug and alcohol use...family history of domestic violence and youth witnessed much of it..." -Has had "multiple suicidal attempts while in Psychiatric Residential Treatment Facility tried hang herself with her jeans and scrubs on several instances (4) and one time she tried to jump from a parking garage deck..." -Inpatient hospitalization 4/1/25-4/9/25 for suicidal ideation with attempts, "...voluntary admission...asked randomly by her friend at the group home if she wanted to run away...started to get a 'manic-panic' attack and continued to make impulsive decisions...was with her friend up until just before coming into the hospital, after her friend had gotten into a car with a stranger." Review on 8/5/25 of the Enhanced Services Form for client #1 revealed: -Facility submitted request form on 3/11/25. -Partial approved on 3/27/25 for 1:1 support with start date of 3/14/25 and end date of 7/9/25. Review on 7/31/25 of client #2's record revealed: -Age 16 years. -Admission on 11/13/24. -Discharged on 4/7/25. -Readmitted on 6/3/25. -DTP PCP (treatment plan) dated 12/9/24. -Diagnoses: Oppositional Defiant Disorder; Mood Dysregulation Disorder; Generalized Anxiety	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 112	Continued From page 12 Disorder; Unspecified Cannabis-Related Disorder. -Assessment dated 11/13/24, elopement, verbal and physical aggression. -Comprehensive Clinical Assessment dated 3/20/25, ...patterns of angry/irritable mood, argumentative/defiant behavior, or vindictiveness...recent marijuana use which align with the stressors identified -Discharge Summary dated 4/7/25, "...decision to discharge [client #2] based upon repeated violations of program rules, unsafe behaviors, and AWOL (Absent Without Leave) behaviors that resulted in her being absent from the facility more than 10 days..." Review on 7/31/24 of FC#3's record revealed: -Age 16 years. -Admission on 12/6/24. -DTP PCP dated 2/21/24. -Discharged on 6/23/25. -Diagnoses: Major Depressive Disorder, Single Episode, With Psychotic Features; Generalized Anxiety Disorder; Attention-Deficit Hyperactivity Disorder, Predominantly Inattentive Type; Child Physical Abuse, Suspected, Subsequent Encounter; Child Sexual Abuse, Suspected, Subsequent Encounter. -Assessment dated 11/1/24, "...problems getting along with peers, difficulty understanding jokes, poor eye contact, self conscious, fear of embarrassment,...uncomfortable socially, ...stubborn, lying, sneaking, frequent arguing, property destruction, self-esteem problems, immaturity, suicidal behaviors; has hurt or cut self, ...crying spells, not enjoying usual activities, difficulty making decisions, ...feeling guilty, ...moods change quickly, hallucinations, delusions, anxiety, gets frustrated easily, worried, trouble concentrating, memory problems,	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 112	Continued From page 13	V 112		

disorganization, ...distractible, ...impulsiveness, bouts of excessive energy, always in motion; excessively fidgety; ...nail biting, thumb sucking, ...and frequent urinary accidents..."
-Inpatient hospitalization 6/17/25 for suicidal ideation.
-Discharge Summary dated 6/23/25, "...decision to discharge [FC #3] is due to multiple behavioral health hospital visits, reported suicidal and homicidal ideation in the home (facility), risk of self-harm, AWOL tendencies, and destruction of property within the past week (prior to discharge). Client is at high risk of safety to herself and potentially others..."

Interview on 8/4/25 and 8/5/25 with the the Department of Social Services Permanency Planning Program Manager for client #1 revealed:
-"Day Treatment is responsible for [client #1]'s treatment plan and is considered the clinical home."
-"We (team) talked about her (client #1) behaviors in the CFT (Child Family Team) meetings. I don't know if the goals were updated..."
-Client #1 was approved Enhanced Services for 1:1 support.

Inteviews on 8/4/25 and 8/5/25 with the Licensee/Executive Director/Associate Professional revealed:
-The DTP was the clinical home for facility clients and the DTP are responsible for completing the treatment plans.
-Had participated in the CFT meetings.
-The DTP Director does the treatment plan, "we just go off the ones (treatment plan) that [DTP Director] does; she (DTP Director) does the CFT and we (facility) work with her to develop the plans for treatment and at home (facility)...

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 112	Continued From page 14 (treatment plan) doesn't specify if it's day treatment or home (facility)...we update how they (clients) are behaving at home (facility)...we've (facility) always let [DTP Director] do the goals; that's how we learned to do it (treatment plans)." -Was not aware that the facility should complete develop a treatment plan based on assessment within 30 days of admission. Interview on 8/5/25 with the Licensee/Qualified Professional revealed: -Participated in CFT meetings. -Assisted DTP with treatment plan. -Had participated in the development of the DTP's treatment plan in FC #3's file and was not aware the plan had not been signed by the legal guardian. -Did not realize the facility should complete develop a treatment plan based on assessment within 30 days of admission.	V 112		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 118	Continued From page 15 all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to keep the MARs current affecting 2 of 2 clients (#1, #2) and failed to administer medication on the written order of a physician for 2 of 2 clients (#1, #2). The findings are: Review on 7/31/25 of client #1's record revealed: -Age 17 years. -Admission on 3/14/25. -Day Treatment Program (DTP) Person Centered Plan (PCP-treatment plan) dated 4/28/25. -Diagnoses: Posttraumatic Stress Disorder (PTSD), With Dissociative Symptoms; Depressive Disorder, Unspecified; Borderline Personality Disorder (Adolescent) (Per History); Generalized Anxiety Disorder (GAD); Unspecified Feeding or Eating Disorder; Child Sexual Abuse, Confirmed, Subsequent Encounter; History Of	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 118	Continued From page 16 Suicidal Behavior; History Of Non Suicidal Self Injury. Review on 8/5/25 of physician orders for client #1 revealed: -5/23/25 naltrexone 50 milligrams (mg) (anxiety, depression), take 1 tablet by mouth as directed. -7/9/25 clonidine 0.1 mg (anxiety) , take 1 tablet by mouth daily at bedtime. -7/18/25 prazosin 1 mg (PTSD), take 3 capsules by mouth at bedtime as directed. -No physician orders for the following: -Sumatriptan 100 mg (headache), may take 2nd dose of 1/2 tablet in two hours if no improvement. Do not take more than 2 doses in 24 hours; -Sumatriptan 50 mg (headache), take an additional 50 mg as needed if headache not resolved in 2 hours after taking 100mg; -Over-the-Counter (OTC) magnesium glycinate gummies (stress, sleep), take 2 gummies every evening. Review on 8/4/25 of client #1's MARs from May 2025 to August 2025 revealed: -No initials for administration on 7/1/25 for clonidine 0.1 mg (anxiety). -No initials for administration on 7/1/25 for OTC magnesium glycinate gummies (supplement-stress, sleep). -No initials for administration on 7/1/25 for prazosin 1 mg (PTSD). -No initials for administration on 7/1/25 for naltrexone 50 mg (anxiety, depression). Review on 7/31/25 of client #2's record revealed: -Age 16 years. -Admission on 11/13/24. -Discharged on 4/7/25. -Readmitted on 6/3/25. -DTP PCP (treatment plan) dated 12/9/24.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 118	Continued From page 17 -Diagnoses: Oppositional Defiant Disorder; Mood Dysregulation Disorder; GAD; Unspecified Cannabis-Related Disorder. Review on 8/5/25 of physician orders for client #2 revealed: -3/24/25 for the following: -Aripiprazole 5 mg (mood), take 1 tablet by mouth at bedtime for mood -Sertraline 100 mg (depression), take 1 tablet by mouth daily for depression. -Trazodone 100 mg (depression), take 2 tablets by mouth at bedtime for depressive disorder recurrent without psychotic features. -6/5/25 for OTC magnesium gummies 150 mg (anxiety, sleep), take 2 daily. -7/8/25 for clonidine 0.1 mg (anxiety), take 1 tablet 2 x (times) daily, 8am, 3pm. Review on 8/4/25 of client #2's MARs from May 2025 to August 2025 revealed: -No initials for administration of 3pm dose on 7/1/25 for clonidine 0.1 mg (anxiety). -No initials for administration of 7pm dose on 7/1/25 for aripiprazole 5 mg (mood). -No initials for administration on 7/1/25 for trazodone 100 mg (depression). -No initials for administration of 7am dose on 7/2/25 for clonidine 0.1 mg (anxiety) and sertraline 100 mg (depression). Interview on 7/31/25 with client #1 revealed: -Knew some of her medications and why they were prescribed. -Had never missed taking medications and never refused medications. -Recalled that she has had to "remind them (staff) to give me my 12 o'clocks (noon medications)." Interview on 8/1/25 with client #2 revealed:	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 118	Continued From page 18 -Knew most of her medications and why the medications were prescribed. -Had never missed taking medications and never refused medication. -Recalled that once, when she first arrived at the facilty, staff (Licensee/Executive Director (ED)/Associate Professional (AP)) forgot to give one pill (medication unknown) and she had to remind staff (Licensee/ED/AP). Interview on 8/1/25 with Staff #1 revealed: -Administered medications and was not aware of errors, client refusals and missing medications. Interview on 8/1/25 with the House Manager revealed: -Was trained to administer medications. -Was not aware of missed medications, client refusals, problems and medication errors. Interview on 8/4/25 with the Licensee/ED/AP revealed: -Reviewed MARs monthly. -Was not aware of missing physician orders for client #1. -"I think we (facility) did not have the MAR printed and I initialed on the 31st of June (2025) and did not go back and enter (initial) for the 1st of July (2025)." -"I think someone (staff) forgot to sign (7/2/25), confident that the medication was given." Interview on 8/5/25 with the Licensee/Qualified Professional revealed: -The Psychiatrist (prescriber) checked MARs and kept up with medication changes monthly. -Was not aware of missing initials on MARs (June, July 2025). -Was not aware there were missing physician orders for client #1's medications.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 139	27G .0404 (F-L) Operations During Licensed Period 10A NCAC 27G .0404 OPERATIONS DURING LICENSED PERIOD (f) DHSR shall conduct inspections of facilities without advance notice. (g) Licenses for facilities that have not served any clients during the previous 12 months shall not be renewed. (h) DHSR shall conduct inspections of all 24-hour facilities an average of once every 12 months, to occur no later than 15 months as of July 1, 2007. (i) Written requests shall be submitted to DHSR a minimum of 30 days prior to any of the following changes: (1) Construction of a new facility or any renovation of an existing facility; (2) Increase or decrease in capacity by program service type; (3) Change in program service; or (4) Change in location of facility. (j) Written notification must be submitted to DHSR a minimum of 30 days prior to any of the following changes: (1) Change in ownership including any change in partnership; or (2) Change in name of facility. (k) When a licensee plans to close a facility or discontinue a service, written notice at least 30 days in advance shall be provided to DHSR, to all affected clients, and when applicable, to the legally responsible persons of all affected clients. This notice shall address continuity of services to clients in the facility. (l) Licenses shall expire unless renewed by DHSR for an additional period. Prior to the expiration of a license, the licensee shall submit to DHSR the following information:	V 139		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 139	Continued From page 20 (1) Annual Fee; (2) Description of any changes in the facility since the last written notification was submitted; (3) Local current fire inspection report; (4) Annual sanitation inspection report, with the exception of a day/night or periodic service that does not handle food for which a sanitation inspection report is not required; and (5) The names of individuals who are owner, partners or shareholders holding an ownership or controlling interest of 5% or more of the applicant entity. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide the required written documentation of emergency relocation of clients to the Division of Health Service Regulation (DHSR). The findings are: Interviews on 7/31/25 and 8/8/25 with client #1 revealed: -Had "spent 2 nights over there" at Licensee/Qualified Professional's (QP) home in June 2025 (exact date unknown) when there was a plumbing problem in the facility. -Had slept on "the couch bed...big couch upstairs in the loft" with client #2. -Medications were taken from the facility and administered at Licensee/QP's home. -Did not recall if there was other staff that worked at Licensee/QP's home in June 2025 (plumbing problem). Interviews on 8/1/25 and 8/8/25 with client #2	V 139		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 139	Continued From page 21	V 139		

revealed:
-"[Licensee/QP]'s house is considered an emergency placement and we (clients) go there on holidays if we don't go home."
-Clients had gone to the Licensee/QP's home in June 2025 when there was a plumbing problem in the facility.
-Clients slept in the "upstairs in the loft" of the Licensee/QP's home, on "a really long couch and we (clients #1, #2) slept on either (opposite) half of it (couch)."
-Medications were taken from the facility by "the staff that took us, [Licensee/Executive Director/Associate Professional] or Licensee/QP, not sure which", and administered at Licensee/QP's home.
-"...we stayed there 2-3 days..." and "there was no other staff, just [Licensee/QP]..."
-"[Staff #1] was there (Licensee/QP's home) for some part but left about 10 (pm) at night and the second day, she (staff #1) didn't come at all."

Interview on 8/7/25 with staff #1 revealed:
-Clients #1 and #2 recently stayed at Licensee/QP's home July 2024 (date unknown) due to a plumbing issue at the facility.
-"This last time (July 2024), I don't remember how we took care of meds, don't know if I gave (administered) or [Licensee/QP] gave, don't remember if meds were taken to [Licensee/QP]'s house."
-"They (clients #1, #2) slept in [Licensee/QP]'s loft, she (Licensee/QP) has two pull out couches in the loft."
-"[Licensee/QP] and I both monitored, we would take turns...me, [Licensee/QP] and just the kids (clients) were in the house."

Interview on 8/1/25 with staff #3 revealed:
-Was told by the Licensees that the facility had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 139	Continued From page 22 issues with plumbing and clients (#1, #2) "had to be removed (from facility) to use the restrooms at [Licensee/QP]'s..." -Clients #1 and #2 were at the Licensee/QP's home " a few hours because the plumber couldn't get there (facility); I don't know exactly how long." Interview on 8/4/25 with Licensee/Executive Director/Associate Professional revealed: -"[Licensee/QP]'s is the emergency place, that's in our policies and procedures..." -Had a plumbing issue in July 2025 (date unknown) when toilets couldn't be flushed and clients (#1, #2) were unable to take showers. -Clients #1 and #2 were "at [Licensee/QP]'s house less than 24 hours, over night; they (clients #1, #2) came at 7 (pm) and left early the next morning around 8 (am)." -Thought that staff #1 was at the Licensee/QP's home but did not know all the details. -Landlord would have plumbing invoice with date of repair and she would follow up with the landlord to request a copy. -Was not aware that written documentation was required to be submitted to DHSR. Interviews on 8/5/25 and 8/7/25 with the Licensee/QP revealed: -The facility policy is that her home is the emergency location. -Had a pull out sectional couch in the upstairs loft of her home that clients slept on. -Had an emergency plumbing problem in the facility on 6/19/25 and clients (#1, #2) went to the Licensee/QP's home. -"...toilets backed up, water was coming out when flushed and was coming out in the shower when flushed (toilet)." -Clients (#1, #2) were unable to take showers, "so they (clients) came to my house."	V 139		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 139	Continued From page 23 -Clients stayed over night, from about 10pm until 8am the next morning. -Clients were not gone from the facility for more than 24 hours and no clients had sexualized behaviors. -She and staff #1 took turns monitoring clients (#1, #2) during the night. -Administered medications at the facility before going to her home and when clients returned to the facility the next morning. -Notified legal guardians (LGs) after the evacuation event, but was unsure when LGs were notified and how long after the evacuation event, "...we (facility) did tell them (LGs) but it was after, don't remember how long after, it was probably that Monday, 7/23, 2025." -Landlord had addressed the plumbing problem. -Was not able to get an invoice from the landlord for the plumbing repair. -She was not aware that required written documentation needed to be submitted to DHSR if there was a change in program service.	V 139		
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	V 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 293	Continued From page 24 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 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.	V 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 293	Continued From page 25 This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to provide residential treatment to individuals within the scope of their program affecting 2 of 2 current clients (#1 and #2) and 1 of 1 former client (FC #3). The findings are: Cross Reference: 10A NCAC 27G .1704 Minimum Staffing Requirements (V296). Based on observations, record reviews, and interviews, the facility failed to ensure the minimum staffing ratio of two staff for up to four adolescents. Cross Reference: 10A NCAC 27G .1705 Requirements of Licensed Professionals (V297). Based on record reviews and interviews, the facility failed to ensure face to face clinical consultation was provided in the facility at least four hours a week by a Licensed Professional (LP). Review on 7/31/25 of client #1's record revealed: -Age 17 years. -Admitted on 3/14/25. Review on 7/31/25 of client #2's record revealed: -Age 16 years. -Admitted on 11/13/24. Review on 7/31/24 of FC #3's record revealed: -Age 16 years. -Admitted on 12/6/24. -Discharged on 6/23/25. Interviews on 7/31/25 and 8/8/25 with client #1 revealed: -Had spent 2 nights at Licensee/Qualified Professional's (QP) home in June 2025 (exact	V 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 293	Continued From page 26	V 293		

date unknown) when there was a plumbing problem in the facility.
-Had slept on "the couch bed...big couch upstairs in the loft" with client #2.
-"...me and [client #2] stole alcohol."
-Alcohol was in an unlocked cabinet in Licensee/QP's kitchen.
-Alcohol was taken "in the middle of the night and everyone was sleep (in Licensee/QP's home)."
-"...that night [client #2] had a [liquor A] shot, 2 shots of [liquor B]; I just had some shots of [liquor B] and we also took (from Licensee/QP's home) some (alcohol) with us (to the facility)..."
-While at the Licensee/QP's home, client #1 filled up a "little water bottle" with alcohol and "we drank it (alcohol) over a period of a month (at the facility)."
-"...we (clients #1, #2) were sharing...mainly kept everything in my room.."
-Did not recall if there was other staff that worked at Licensee/QP's home in June 2025 (plumbing problem).

Interviews on 8/1/25 and 8/8/25 with client #2 revealed:
-"[Licensee/QP]'s house is considered an emergency placement and we (clients) go there on holidays if we don't go home."
-Clients had gone to the Licensee/QP's home in June 2025 when there was a plumbing problem in the facility.
-Clients slept in the "upstairs in the loft" of the Licensee/QP's home, on "a really long couch and we (clients #1, #2) slept on either (opposite) half of it (couch)."
-"...we stayed there 2-3 days..." and "there was no other staff, just [Licensee/QP]..."
-"[Staff #1] was there (Licensee/QP's home) for some part but left about 10 (pm) at night (June 2025) and the second day, she (staff #1) didn't

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 293	Continued From page 27	V 293		

come at all."
-"Someone (client #1) took alcohol from her (Licensee/QP) pantry or fridge, not sure which, it was [client #1]; not sure how she (client #1) got it (alcohol) without any one seeing, she (Licensee/QP) has cameras over every inch of her house, this was in June (2025)."
-Client #2 was not forthcoming about drinking alcohol and her involvement in getting the alcohol while at Licensee/QP's home in June 2025.

Interview on 8/1/25 and 8/4/25 with the Department of Social Services Permanency Planning Program Manager for client #1 revealed:
-Was concerned about "lack of supervision (facility) and taking clients to staff's home."
-Was not aware there was a plumbing emergency (June 2025) as the reason clients went to the Licensee/QP home.
-Received information that client #1 had taken a vape from a staff 's car (Licensee/ED/AP), took alcohol (June 2025) from staff's home (Licensee/QP), had eloped from the facility twice in March 2025, in May 2025, eloped for several hours in June 2025 and eloped on 7/17/25.
-Was concerned about increase in client #1's behaviors and need for enhanced services with 1:1 support which was approved for client #1.

Interview on 8/4/25, 8/5/25 and 8/12/25 with the Licensee/ED/AP revealed:
-There were times when one staff is on shift alone "if someone calls out; but as soon as I get that call, I'm on my way (to fill in)."
-Had a plumbing emergency in June 2025 and clients #1 and #2 were taken to Licensee/QP's home overnight, alcohol was taken and was found in the facility in July 2025 during a room search.
-The alcohol was "...taken from a stand alone

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 293	Continued From page 28 cabinet, they (clients #1, #2) somehow got into the cabinet; it's not locked, in the kitchen and sits (cabinet) to the other side of the refrigerator. I don't know where [Licensee/QP] was when this (alcohol removal) happened..." -"...we found alcohol in their (clients #1, #2) rooms (bedrooms) a week later (July 2025)." -Alcohol was found "in client #1's bedroom, found a little bottle that was still full of alcohol, bigger that airplane bottle, (alcohol) was in 8 ounce water bottle." Interview on 8/4/25 and 8/5/25 with the Licensee/QP revealed: -On 7/17/25, while searching clients #1 and #2's bedrooms, she was made aware that alcohol was stolen from her home in June 2025. -"...on 7/15 (2025), we (Licensee/QP and Licensee/ED/AP) found a vape, alcohol, and [over-the-counter medication]; it (alcohol) was (in) like a small water bottle and with an amount that was under (up to) the wrapper of the bottle; she (client #1) only drank out of the bottle once. I was unable to tell how much was missing, but it didn't look like a lot." -"I don't keep alcohol laying around, it (alcohol) was in the kitchen cabinet. They (clients #1, #2) don't cook or go in my refrigerator. The cabinet was by the refrigerator, if you open the cabinet it (alcohol) was right where you could see it. I would have never opened it (cabinet) in front of them (clients), but if they were looking in cabinets they would see it (alcohol)." --"[Client #1] told me where they (clients #1, #2) sleep, the loft is beside my bedroom, so I'm assuming it was in the middle of the night that they stole the alcohol." -She and staff #1 had taken turns monitoring clients during the night when client were at the Licensee/QP's home in June.	V 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 293	Continued From page 29 -Was responsible for staff schedules. -Was not aware of staff ratios when providing transportation for clients. -Her home was location used for emergencies. -Clients #1, #2 and FC #3 had been in her home during holidays and had stayed overnight. -Had not provided notification to legal guardians prior to taking clients to her home. -Had not seen clients intoxicated and did not notice if they had been drinking alcohol at her home or in the facility. -Was not aware alcohol had been taken from her home in June 2025 until it was found in client #1's room during a room search in on 7/17/25. Review on 8/11/25 of the Plan of Protection completed by the Licensee/QP dated 8/11/25 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Effective immediately (8/11/2025), The owners of Helping Hands Sanctuary will ensure that there is always 2 direct care staff present for all shifts, and that during sleep hours at least one staff is up at all times. Effective immediately (8/11/2025), The owners of Helping Hands Sanctuary will ensure that the Licensed Professional (LP) provides at least four hours weekly of face-to-face clinical consultation at the facility. Describe your plans to make sure the above happens. Helping Hands Sanctuary will recruit direct staff to serve as on call employees. As a contingency plan, the QP (Licensee/QP) and AP (Licensee/ED/AP) will act as emergency coverage in the event that we are unable to secure staffing during call outs or emergency departures.	V 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 293	Continued From page 30 Helping Hands Sanctuary will come to a verbal agreement with LP that all services rendered will take place at 6800 Sun Ray Ct. for a minimum of 4 hours a week." Review on 8/12/25 of the Amended Plan of Protection completed by the Licensee/QP dated 8/12/25 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Effective immediately (8/12/2025)... Describe your plans to make sure the above happens. [Licensee/QP] and [Licensee/ED/AP] of Helping Hands Sanctuary...This job posting will take place on 8/13/25... [Licensee/QP] and [Licensee/ED/AP] of Helping Hands Sanctuary will come to a verbal agreement with LP on 8/14/2025..." The facility served adolescents aged 16 and 17 years old with diagnoses which included the following: PTSD, With Dissociative Symptoms; Depressive Disorder, Unspecified; Borderline Personality Disorder; GAD; Feeding or Eating Disorder; Child Sexual/Physical Abuse; History Of Suicidal Behavior and Non Suicidal Self Injury; ODD; MDD; Cannabis-Related Disorder; Major Depressive Disorder, With Psychotic Features; ADHD, Predominantly Inattentive Type. The LP did not provide at least 4 hours of face to face clinical consultation weekly in the facility, did not supervise the Qualified Professional, nor participated in treatment planning. In June 2025, the Licensee/QP took clients #1 and #2 to her home and they took alcohol from the Licensee/QP's kitchen cabinet. The Licensee/QP was not aware that alcohol had been from her home until 7/17/25, when it was found in the	V 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 293	Continued From page 31 facility in client #1's bedroom during a room search. This deficiency constitutes a Type B violation which is detrimental to the health, safety and welfare of the clients and must be corrected within 45 days.	V 293		
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present of which two shall be awake and the third may be	V 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 296	Continued From page 32 asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the minimum staffing ratio of two staff for up to four adolescents. The findings are: Observation on 7/31/25 of the facility at approximately 2:50pm-3:15pm revealed: -Staff #2 came into the facility alone with client #2. -The Licensee/Qualified Professional (QP) and staff #1 were present in the facility when staff #2 arrived. Observation on 8/8/25 of the facility from approximately 3:48pm until approximately 4:05pm revealed: -Staff #6 worked alone in the facility with clients	V 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 296	Continued From page 33 #1 and #2. Review on 7/31/25 of client #1's record revealed: -Age 17 years. -Admission on 3/14/25. -Day Treatment Program (DTP) Person Centered Plan (PCP-treatment plan) dated 4/28/25. -Diagnoses: Posttraumatic Stress Disorder, With Dissociative Symptoms; Depressive Disorder, Unspecified; Borderline Personality Disorder (Adolescent) (Per History); Generalized Anxiety Disorder; Unspecified Feeding or Eating Disorder; Child Sexual Abuse, Confirmed, Subsequent Encounter; History Of Suicidal Behavior; History Of Non Suicidal Self Injury. -Assessment dated 2/27/25, "...has history of significant trauma-related behaviors which put her at risk for self-harm, elopement and trafficking...history of abuse and neglect...family history of drug and alcohol use...family history of domestic violence and youth witnessed much of it..." -Has had "multiple suicidal attempts while in Psychiatric Residential Treatment Facility tried hang herself with her jeans and scrubs on several instances (4) and one time she tried to jump from a parking garage deck..." -Inpatient hospitalization 4/1/25-4/9/25 for suicidal ideation with attempts, "...voluntary admission...asked randomly by her friend at the group home if she wanted to run away...started to get a 'manic-panic' attack and continued to make impulsive decisions...was with her friend up until just before coming into the hospital, after her friend had gotten into a car with a stranger." Review on 7/31/25 of client #2's record revealed: -Age 16 years. -Admission on 11/13/24. -Discharged on 4/7/25.	V 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 296	Continued From page 34 -Readmitted on 6/3/25. -DTP PCP (treatment plan) dated 12/9/24. -Diagnoses: Oppositional Defiant Disorder; Mood Dysregulation Disorder; Generalized Anxiety Disorder; Unspecified Cannabis-Related Disorder. -Assessment dated 11/13/24, elopement, verbal and physical aggression. -Comprehensive Clinical Assessment dated 3/20/25, ...patterns of angry/irritable mood, argumentative/defiant behavior, or vindictiveness...recent marijuana use which align with the stressors identified -Discharge Summary dated 4/7/25, "...decision to discharge [client #2] based upon repeated violations of program rules, unsafe behaviors, and AWOL (Absent Without Leave) behaviors that resulted in her being absent from the facility more than 10 days..." Review on 7/31/24 of former client (FC) #3's record revealed: -Age 16 years. -Admission on 12/6/24. -DTP PCP dated 2/21/24. -Discharged on 6/23/25. -Diagnoses: Major Depressive Disorder, Single Episode, With Psychotic Features; Generalized Anxiety Disorder; Attention-Deficit Hyperactivity Disorder, Predominantly Inattentive Type; Child Physical Abuse, Suspected, Subsequent Encounter; Child Sexual Abuse, Suspected, Subsequent Encounter. -Assessment dated 11/1/24, "...problems getting along with peers, difficulty understanding jokes, poor eye contact, self conscious, fear of embarrassment,...uncomfortable socially, ...stubborn, lying, sneaking, frequent arguing, property destruction, self-esteem problems, immaturity, suicidal behaviors; has hurt or cut	V 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 296	Continued From page 35 self, ...crying spells, not enjoying usual activities, difficulty making decisions, ...feeling guilty, ...moods change quickly, hallucinations, delusions, anxiety, gets frustrated easily, worried, trouble concentrating, memory problems, disorganization, ...distractible, ...impulsiveness, bouts of excessive energy, always in motion; excessively fidgety; ...nail biting, thumb sucking, ...and frequent urinary accidents..." -Inpatient hospitalization 6/17/25 for suicidal ideation. -Discharge Summary dated 6/23/25, "...decision to discharge [FC #3] is due to multiple behavioral health hospital visits, reported suicidal and homicidal ideation in the home (facility), risk of self-harm, AWOL tendencies, and destruction of property within the past week (prior to discharge). Client is at high risk of safety to herself and potentially others..." Interview on 7/31/25 and 8/8/25 with client #1 revealed: -"One staff here when we're awake, normally one; one or two when asleep..." -Had never been left at the facility alone. -"One staff transports clients; either our staff (facility) here or teachers at school (day treatment); anyone (transported) and normally just one (staff)." -Staff #6 was alone 8/8/25 on shift (2pm-10pm) and was unsure how long staff #6 had been in the facility alone. Interview on 8/1/25 and 8/8/25 with client #2 revealed: -There were "anywhere from 1 to 2 staff on shift; there is one overnight, 1 to 2 on the morning or day shift; 1 to 2 after school and one at night." -"One staff transports clients to and from school (day treatment)."	V 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 296	Continued From page 36	V 296		

-On 8/8/25 staff #6 was alone on the shift (2pm-10pm) and had been in the facility since 2pm.

Interview on 8/6/25 with FC #3 revealed:
-"When there was 3 of us (clients) there would have been 2 staff, but when there were 2 of us there was 1 staff."

Interview on 8/1/25 and 8/4/25 with the Department of Social Services Permanency Planning Program Manager for client #1 revealed:
-Had concerns about "lack of supervision of clients at the facility."
-Was concerned that client #1 had stole alcohol from Licensee/QP's home, stole vape from a facility staff's car and was eloping.

Interview on 8/1/25 with staff #1 revealed:
-Two staff on each shift.
-"Usually work overnight, 10pm-8am, on Sunday and Monday, 20 hours a week."
-Had never worked shift alone.
-"Usually [Licensee/Executive Director (ED)/Associate Professional (AP)] will come in on my shift..."
-Recalled she had worked alone on night shift, "not often just sometime, [Licensee/ED/AP] has stayed with me 2 or 3 times."

Interview on 8/5/25 with staff #2 revealed:
-Worked middle shift, 2pm-10pm and weekends 8am until about 4pm.
-Two staff on each shift.

Interview on 8/1/25 with staff #3 revealed:
-Worked part-time at the facility on the weekends, 7pm-7am.
-Recalled an occasion (date unknown) when she had to leave and there was only one staff left in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 296	Continued From page 37	V 296		

the facility.
-"When I leave there is another person coming and 1 still there...had to be gone by certain time...doesn't happen that often because the thing with them (Licensee/QP and Licensee/ED/AP) is they want 2 people there at all times."

Interview on 8/6/25 with staff #4 revealed:
-"I work this job whenever I have availability."
-Two staff on shifts.

Interview on 8/1/25 with the House Manager revealed:
-Two staff on each shift.
-"The only time there is one (staff) is if someone doesn't show or calls out."
-There are 2 staff overnight.

Interview on 8/4/25 and 8/5/25 with the Licensee/ED/AP revealed:
-Was employed full-time at the facility.
-There were times when one staff is on shift alone "if someone calls out; but as soon as I get that call, I'm on my way (to fill in)."
-"We (Licensee/QP and Licensee/ED/AP) are a stickler for having 2 staff on shift, but sometimes it does happen."
-Client #1's enhanced services ended on 7/9/25 due to the facility's inability to provide 1:1 staff support.

Interview on 8/4/25 and 8/5/25 with the Licensee/Qualified Professional revealed:
-Was responsible for staff schedules.
-Worked shifts at the facility 2pm-10pm and 10pm-8am on weekdays; 7am-7pm and 7pm-7am on weekends.
-Two staff worked on each shift.
-"One staff transports clients."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 296	Continued From page 38 -"I was not aware that 2 staff needed to be present when transporting clients." Attempted review on 8/4/25 of staff schedules 4/1/25-8/1/25 but documentation was not received prior to survey exit. This deficiency is cross referenced into 10A NCAC 27G .1701 Residential Treatment Staff Secure for Children or Adolescents-Scope (V293) for a Type B rule violation and must be corrected within 45 days.	V 296		
V 297	27G .1705 Residential Tx. Child/Adol - Req. for L P 10A NCAC 27G .1705 REQUIREMENTS OF LICENSED PROFESSIONALS (a) Face to face clinical consultation shall be provided in each facility at least four hours a week by a licensed professional. For purposes of this Rule, licensed professional means an individual who holds a license or provisional license issued by the governing board regulating a human service profession in the State of North Carolina. For substance-related disorders this shall include a licensed Clinical Addiction Specialist or a certified Clinical Supervisor. (b) The consultation specified in Paragraph (a) of this Rule shall include: (1) clinical supervision of the qualified professional specified in Rule .1702 of this Section; (2) individual, group or family therapy services; or (3) involvement in child or adolescent specific treatment plans or overall program issues.	V 297		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 297	Continued From page 39	V 297		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure face to face clinical consultation was provided in the facility at least four hours a week by a Licensed Professional (LP). The findings are:

Review on 8/5/25 of the LP's file revealed:
-Hired 7/3/25..
-Job Description signed and dated 7/1/25 had the following Role and Responsibilities: "...Face to face clinical consultation shall be provided in each facility at least four hours a week by a licensed professional.
Responsibilities include but not limited to:
-clinical supervision of the qualified professional (QP) specified in Rule.
-individual, group or family therapy services; or
-involvement in child or adolescent specific treatment plans or overall program issues."

Attempted interview with the LP on 8/6/25 was unsuccessful due to no returned call.

Attempted review of the facility records on 8/11/25 revealed:
-No documentation of face to face clinical supervision by the LP in the facility weekly for four hours.

Interview on 8/5/25 with the Licensee/Executive Director/Associate Professional revealed:
-The LP saw clients for therapy at her office location once weekly, "the LP never comes to the facility, me or [Licensee/QP] takes them (clients) to her office once a week."
-Was not aware of requirements for LP to be in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 297	Continued From page 40 the facility for 4 hours of face to face consultation. Interview on 8/4/25, 8/5/25, 8/12/25 with the Licensee/Qualified Professional revealed: -Therapy was not provided at the facility by the LP. "...so she (LP) will need to come here (facility) to do the therapy." -The LP had to cancel appointments and would reschedule virtual appointments with clients #1 and #2. -LP had been out of town and unavailable. -Clinical supervision was not provided to the QP by the LP. -Was not aware LP should be providing supervision to the QP. (rhetorical question)..."she (LP) is supposed to be training (supervising) me and I pay her?" -Was not aware the LP had to be in the facility for face-to-face clinical consultation at least 4 hours a week. This deficiency is cross referenced into 10A NCAC 27G .1701 Residential Treatment Staff Secure for Children or Adolescents-Scope (V293) for a Type B rule violation and must be corrected within 45 days.	V 297		
V 364	G.S. 122C- 62 Additional Rights in 24 Hour Facilities § 122C-62. Additional Rights in 24-Hour Facilities. (a) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-61, each adult client who is receiving treatment or habilitation in a 24-hour facility keeps the right to: (1) Send and receive sealed mail and have access to writing material, postage, and staff assistance when necessary;	V 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 364	Continued From page 41 (2) Contact and consult with, at his own expense and at no cost to the facility, legal counsel, private physicians, and private mental health, developmental disabilities, or substance abuse professionals of his choice; and (3) Contact and consult with a client advocate if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each adult client may exercise these rights at all reasonable times. (b) Except as provided in subsections (e) and (h) of this section, each adult client who is receiving treatment or habilitation in a 24-hour facility at all times keeps the right to: (1) Make and receive confidential telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over therapies; (3) Communicate and meet under appropriate supervision with individuals of his own choice upon the consent of the individuals; (4) Make visits outside the custody of the facility unless: a. Commitment proceedings were initiated as the result of the client's being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found not guilty by reason of insanity or incapable of proceeding; b. The client was voluntarily admitted or committed to the facility while under order of commitment to a correctional facility of the Division of Adult Correction of the Department of Public Safety; or	V 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 364	Continued From page 42 c. The client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; A court order may expressly authorize visits otherwise prohibited by the existence of the conditions prescribed by this subdivision; (5) Be out of doors daily and have access to facilities and equipment for physical exercise several times a week; (6) Except as prohibited by law, keep and use personal clothing and possessions, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Keep and spend a reasonable sum of his own money; (9) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes; and (10) Have access to individual storage space for his private use. (c) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-57 and G.S. 122C-59 through G.S. 122C-61, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to have access to proper adult supervision and guidance. In recognition of the minor's status as a developing individual, the minor shall be provided opportunities to enable him to mature physically, emotionally, intellectually, socially, and vocationally. In view of the physical, emotional, and intellectual immaturity of the minor, the 24-hour facility shall provide appropriate structure, supervision and control consistent with the rights given to the minor pursuant to this Part. The facility shall also, where practical, make reasonable efforts to ensure that each minor client receives treatment apart and separate from adult clients unless the treatment needs of the	V 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 364	Continued From page 43 minor client dictate otherwise. Each minor client who is receiving treatment or habilitation from a 24-hour facility has the right to: (1) Communicate and consult with his parents or guardian or the agency or individual having legal custody of him; (2) Contact and consult with, at his own expense or that of his legally responsible person and at no cost to the facility, legal counsel, private physicians, private mental health, developmental disabilities, or substance abuse professionals, of his or his legally responsible person's choice; and (3) Contact and consult with a client advocate, if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each minor client may exercise these rights at all reasonable times. (d) Except as provided in subsections (e) and (h) of this section, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to: (1) Make and receive telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Send and receive mail and have access to writing materials, postage, and staff assistance when necessary; (3) Under appropriate supervision, receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over school or therapies; (4) Receive special education and vocational training in accordance with federal and State law; (5) Be out of doors daily and participate in play, recreation, and physical exercise on a regular basis in accordance with his needs;	V 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 364	Continued From page 44 (6) Except as prohibited by law, keep and use personal clothing and possessions under appropriate supervision, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Have access to individual storage space for the safekeeping of personal belongings; (9) Have access to and spend a reasonable sum of his own money; and (10) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes. (e) No right enumerated in subsections (b) or (d) of this section may be limited or restricted except by the qualified professional responsible for the formulation of the client's treatment or habilitation plan. A written statement shall be placed in the client's record that indicates the detailed reason for the restriction. The restriction shall be reasonable and related to the client's treatment or habilitation needs. A restriction is effective for a period not to exceed 30 days. An evaluation of each restriction shall be conducted by the qualified professional at least every seven days, at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's record. Restrictions on rights may be renewed only by a written statement entered by the qualified professional in the client's record that states the reason for the renewal of the restriction. In the case of an adult client who has not been adjudicated incompetent, in each instance of an initial restriction or renewal of a restriction of rights, an individual designated by the client shall, upon the consent of the client, be notified of the restriction and of the reason for it. In the case of a minor client or an incompetent adult client, the legally responsible person shall be notified of each instance of an initial restriction	V 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 364	Continued From page 45 or renewal of a restriction of rights and of the reason for it. Notification of the designated individual or legally responsible person shall be documented in writing in the client's record. This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to ensure client rights to privacy in a 24 hour facility affecting 2 of 2 clients (#1 and #2) and 1 of 1 former client (FC #3). The findings are: Observation on 8/5/25 of the facility at approximately 4:30pm revealed: -Staff #1 informed Licensee/Executive Director (ED)/Associate Professional (AP) that client #2 "is requesting to call her mom." -The Licensee/ED/AP granted permission for staff #1 to assist client #2 with calling client #2's mother. -Staff #1 monitored the call process by dialing the number and placing the call on speaker. -Client #2 was heard from the kitchen, on speaker phone, while in the living room talking with her mother. -Staff #1, Licensee/ED/AP, Licensee/QP and client #2 watched television in the living room. Review on 7/31/25 of client #1's record revealed: -Age 17 years. -Admitted on 3/14/25. -Day Treatment Program (DTP) Person Centered Plan (PCP-treatment plan) dated 4/28/25. -Diagnoses: Posttraumatic Stress Disorder, With Dissociative Symptoms; Depressive Disorder,	V 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 364	Continued From page 46 Unspecified; Borderline Personality Disorder (Adolescent) (Per History); Generalized Anxiety Disorder; Unspecified Feeding or Eating Disorder; Child Sexual Abuse, Confirmed, Subsequent Encounter; History Of Suicidal Behavior; History Of Non Suicidal Self Injury. Review on 7/31/25 of client #2's record revealed: -Age 16 years. -Admitted on 11/13/24. -Discharged on 4/7/25. -Readmitted on 6/3/25. -DTP PCP (treatment plan) dated 12/9/24. -Diagnoses: Oppositional Defiant Disorder; Mood Dysregulation Disorder; Generalized Anxiety Disorder; Unspecified Cannabis-Related Disorder. Review on 7/31/24 of FC#3's record revealed: -Age 16 years. -Admitted on 12/6/24. -Discharged on 6/23/25. -DTP PCP dated 2/21/24. -Diagnoses: Major Depressive Disorder, Single Episode, With Psychotic Features; Generalized Anxiety Disorder; Attention-Deficit Hyperactivity Disorder, Predominantly Inattentive Type; Child Physical Abuse, Suspected, Subsequent Encounter; Child Sexual Abuse, Suspected, Subsequent Encounter. Interview on 7/31/25 with client #1 revealed: -"Staff is present during phone calls; the only time staff isn't present is if talking with [Licensee/Qualified Professional] and [Licensee/Executive Director (ED)/Associate Professional (AP)], or social worker (Department of Social Services SW). If it's not any of them (Licensee, DSS SW), then the phone has to be on speaker, so they (staff) can hear it (call) and	V 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 364	Continued From page 47 we have to be in ear shot of them." Interview on 8/1/25 with client #2 revealed: -Phone calls are "placed on speaker". Interview on 8/6/25 with FC #3 revealed: -Staff "listened" to clients' phone calls. Interview on 8/1/25 with staff #3 revealed: -Clients have phone privilege with certain days and list of people they can call. -Get 8-9 minutes call on the designated day. -"...phone calls are monitored, placed in a mutual area and staff is always there in the room where the phone is...has to be someone on their list that has been approved...on speaker, we ask them to stay in the area with us and not in their bedroom, we don't want them to talk about anything that is inappropriate; will take it off speaker if another client is present, but if it's just me and the client, I make her put it on speaker." Interview on 8/1/25 with staff #4 revealed: -"Telephone calls are monitored, we (staff) make sure things are not getting out of hand. I'm listening but giving them (clients) their privacy to talk and say whatever they need to say; the calls are sometimes on speaker." Interview on 8/5/25 and 8/12/25 with the Licensee/QP revealed: -Facility monitors calls for client safety, "phone calls are always monitored by staff." -"We (facility) do notify them (clients) and it (monitor) is in our consent forms that all calls will be monitored". -No documentation phone call restriction in in clients' treatment plans. -Was not aware that the facility could not monitor phone calls without justification documented in	V 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 364	Continued From page 48 the client treatment plan.	V 364		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 366	Continued From page 49	V 366		

or while the client is on the provider's premises. The policies shall require the provider to respond by:
(1) immediately securing the client record by:
(A) obtaining the client record;
(B) making a photocopy;
(C) certifying the copy's completeness; and
(D) transferring the copy to an internal review team;
(2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:
(A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;
(B) gather other information needed;
(C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and
(D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 366	Continued From page 50	V 366		

minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and
(3) immediately notifying the following:
(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;
(B) the LME where the client resides, if different;
(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;
(D) the Department;
(E) the client's legal guardian, as applicable; and
(F) any other authorities required by law.

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to implement policies governing their reporting and response to level I, II and II incidents as required. The findings are:

Review on 8/1/25 of the facility's internal incident reports revealed 3/1/25 to 8/1/25:
-On 3/27/25 client #1 and client #2 eloped from the facility and law enforcement was contacted
-On 6/17/25 former client #3 (FC#3) eloped from the facility, had stolen scissors from day treatment program and threatened staff, peers, threatened to stab herself, had to be restrained,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 366	Continued From page 51 got a hammer from staff's car and hit herself in the head; law enforcement was contacted and client #3 was taken to the hospital on involuntary commitment (IVC). -No documentation of an investigation for the 6/17/25 incident that resulted in FC #3 being restrained, law enforcement contact and IVC. -On 7/15/25 a random room search was conducted and client #1 confessed to contraband (small bottle of alcohol, vape, and [over-the-counter medication]) found. -No documentation of daily searches of clients and their belongings when arriving to the facility from the day treatment program. -On 7/17/25 client #1 eloped from the facility. -No documentation for the theft of alcohol from Licensee/Qualified Professional's (QP) home in June 2025. -No documentation for client #1 stealing vape from Licensee/Executive Director (ED)/Associate Professional's (AP) car (June/July 2025). -No documentation for FC #3's elopement in April 2025. -No documentation for FC #3's abdominal pain (March) and subsequent hospitalization for gallstone removal (3/18/25-3/21/25). -No documentation for law enforcement calls to the facility on 4/13/25 (FC #3 suicidal ideation(SI)); 4/16/25 (FC #3 disturbance); 6/18/25 (FC #3 SI). There was no documentation to support that the above incidents had been evaluated to attend to the health and safety needs of the individuals involved in the incident, determine the cause of the incident, develop and implement corrective measures, develop and implement measures to prevent similar incidents, and assign person (s) to be responsible for implementation of the corrections and preventive measures.	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 366	Continued From page 52 Interview on 8/4/25 with the Licensee/QP revealed: -Was responsible for submitting incident reports. -Did not document an investigation of the 6/17/25 incident that resulted in FC #3 being restrained, law enforcement contact and IVC. -Thought incident reports had been completed for client elopements (April 2025, 7/17/25). -Was not aware of need to document daily searches of clients and planned to come up with a daily search log for staff to sign off. -Had not documented finding vapes in the facility, police calls to the facility related to FC #3's behaviors and FC #3 medical condition resulting in hospitalization for surgery. -Had failed to document incidents and was aware of the need to improve the process of responding timely to incidents.	V 366		
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	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 367	Continued From page 53	V 367		

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.
(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 367	Continued From page 54 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. This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to report all Level II and III incidents to the Local Management Entity/Managed Care Organization (LME/MCO) within 72 hours of becoming aware of the incidents. The findings are: Observation on 7/31/25 at the facility at	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 367	Continued From page 55 approximately 11:29am revealed: -Client #1 demonstrated restraint used with FC #3 on 6/17/25. -Client #1 showed how staff #4 had his hands closed over FC #3's wrist and demonstrated squat position used by Licensee/ED/AP as she held the area around FC #3's hip and upper thigh area. -Client #1 demonstrated that staff #4 had FC #3's arms raised slightly, not above FC #3's head, but as high as FC #3's ears. Review on 7/31/25 of the facility's police response calls revealed: -4/12/25, 16:06 (4:06pm), MP-RUNWY (missing person-runaway) -4/13/25, 18:05 (6:05pm), SU-THRET (suicide-threat) -4/16/25, 9:46am DIS-DISTURBANCE -6/17/25, 18:47 (6:47pm), SU-THRET -6/18/25, 10:43am, SU-THRET 7/17/25, 17:38 (5:38pm) MP-MISSNG Review on 8/1/25 of the facility's internal incident reports revealed: -3/27/25, 9pm "[client #1] along with another client (#2) decided they were going to go AWOL (absent without leave). They waited until one staff member was in the living room and ran out the front door while the other staff member was in the back of the house. Staff on duty (Licensee/Executive Director (ED)/Associate Professional (AP) and staff #2) contacted law enforcement and filed a report. Owners went out and looked for clients but they were unable to locate them." -3/27/25, "Client (#2) stated to staff on duty (Licensee/ED/AP and staff #2) that she was crashing out as her and another resident (client #1)opened the front door and proceeded to run.	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 367	Continued From page 56 One staff was at the back of the house so was unaware of what was happening while the other one tried to call for them to come back. Staff on duty called the police and the owners. Both owners (Licensee/ED/AP and Licensee/Qualified Professional (QP)) went in the area and tried to locate them. [Licensee/QP] was able to locate them walking, but when she approached the girls to took off running behind some houses and [Licensee/QP] was no longer able to locate them." -6/17/25, "[FC #3] had become frustrated about the adoption process and began to act out. She first walked off the property and ran away to a nearby shopping center where she made staff (staff #2) follow her as she was screaming and running from staff for about an hour before agreeing to go back to the facility. [FC #3] went into her room and began attempting to cut herself with scissors she had stolen from school (day treatment program). [FC #3] threatened to kill staff and clients (#1, #2) if they came near her while holding the scissors in a defensive stance. The additional staff member on duty (staff #4) calmed [FC #3] down enough to grab scissors from her. She then began to attempt to break into the staff closet in attempt to retrieve a knife "so that she can kill herself." I(Licensee/ED/AP) phoned law enforcement, tried using coping strategies to deal with [FC #3] in the meantime. The more we tried calming her down the more aggressive she became. She then started aggressively throwing her action figures out the window in attempt to break it so that she could use the glass "to cut herself". I placed [FC #3] in a restraint for a few seconds to stop her from trying to break the window and that's when she began kicking me. Another staff member (staff #4) came in and escorted [FC #3] outside where she could get some fresh air. [FC #3] walked	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 367	Continued From page 57 away from staff member (#4) and picked up a hammer she spotted inside of a vehicle (staff #4) where she began hitting herself with it before the staff member (#4) quickly took it out of her hand. herself with it. Staff (#4) grabbed hammer so [FC #3] came back inside and tried to cut herself with a tape dispenser she also obtained from day treatment. I restrained client until she dropped the tape and client began throwing things aggressively at the window again attempting to break it. By this time police and medic arrived where they did an evaluation and decided to take [FC #3] to the hospital." -7/17/25, 4pm "[Client #1] was asked to get off the phone due to having her privileges revoked after a recent room search. Client (#1) was upset that she was not able to speak to her boyfriend on the phone and decided she wanted to go Awol. I (staff #4) followed client in my car until she cut behind some houses where I lost sight of her. I contacted local law enforcement and filed a report of Awol incident. I continued driving up and down the neighborhood and nearby highways until I spotted client walking down the road. I called the officer who filed the report for assistance with getting the client back to the home. My Co-owner (Licensee/ED/AP) and I along with the reporting officers were able to stop client and speak with her and got her back to the home safely. The entire incident lasted for about an hour. Review on 7/31/25 and 8/12/25 of the North Carolina Incident Response Improvement System (IRIS) from 1/1/25-8/12/25 revealed: -No level II incident report was completed for law enforcement's response to the facility on 3/27/25, 4/12/25, 4/13/25, 4/16/25, 6/17/25, 6/18/25, and 7/17/25. -No level II or III incident report was completed for FC#3's aggressive, threatening behavior, restraint	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 367	Continued From page 58	V 367		

to remove weapon (scissors), injury (FC #3 hit herself in the head with a hammer), and destruction of property on 6/17/25.
-No level II incident reports submitted for client elopements and law enforcement response.

Interview on 7/31/25 with client #1 revealed:
-Police had been called "a couple of times" to the facility for FC #3.
-"...former resident [FC #3] had scissors and was cutting herself. There is a big hole in the wall because she took the drywall and started peeling. CPS (Child Protection Services) came out (to facility) because of that girl. Allegedly a staff [staff #4] hit her up side the head with a hammer. I wasn't outside, [client #2] was outside.
-FC #2 was restrained to remove scissors from her possession (June 2025).
-"...they were holding her wrists. [Staff #4] had her wrist and [Licensee/ED/AP] had her lower body, from like her hips down, she was pinned on the wall holding her wrist up and [Licensee/ED/AP] was on her knees crouched..."
-Did not recall date of the incident or when FC #3 left the facility.

Interview on 8/1/25 with client #2 revealed:
-Eloped on 3/3/25 and was in the hospital for over a month.
-Had never been restrained but had seen FC #2 restrained by Licensee/ED/AP (June 2025).
-Did not remember details of the restraint.
-She was outside when FC #2 went out to staff #4's car, got a hammer from the open trunk and started "hitting herself over the head" with the hammer.
-Recalled that she didn't hear the conversation between FC #2 and staff #4 while outside, "...I was on side of the house (facility) and he (staff #4) was parked in the driveway and I watched

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 367	Continued From page 59	V 367		

and saw her (FC #3) start beating herself (with hammer). The police got called, they (police) brought her to hospital and brought her back home (facility) the same day (6/17/25); she was the same (unstable), the next day (6/18/25) she ran away, had [staff #4] to chase her in the middle of the highway and he took us with him to go get her...and that's when she kicked the hole in the wall and started tearing at it down to the insulation."

Interview on with FC #3 revealed:
-She was living with her grandmother.
-Staff #4 gave her the hammer because she said she wanted to kill herself.
-Did not want to discuss details from the 6/17/25 incident.

Interview on 8/7/25 with FC #3's Department of Social Services Social Worker revealed:
-Got report from FC#3 that she had threatened staff with scissor, ran outside and to a hammer from a male staff's trunk and hit herself in the head once or twice.
-FC #3 did not report to him that a staff hit her with a hammer.

Interview on 8/1/25 with Staff #4 revealed:
-Was outside with clients (#1, #2) came out to get him to assist the Licensee/ED/AP.
-Was able to take the scissors from FC #2's, "... [FC #2] started making motion of stabbing in the direction of [Licensee/ED/AP]; that's when I grabbed the scissors...[Licensee/ED/AP] had [FC #3] around her waist from behind and was holding her real tight while talking in to her; it was like a bear hug. I went back to the room and [FC #3] was sitting on the bed was talking, and was calm.
-While waiting for the police to arrive he took FC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 367	Continued From page 60 #3 outside for some air and "get her to stop crying" when FC #3 grabbed the hammer from his open trunk and hit her self in the head with it. -Facility did an investigation, "...[Licensee/ED/AP] and [Licensee/QP] pulled me to the side to get my side of the story; don't know if it (investigation) was documented." -Management was responsible for submitting incident reports. Interview on 8/7/25 with Licensee/ED/AP revealed: -FC #3 was upset about her adoption, had taken scissors from day treatment program and was threatening to harm herself, staff and clients on 6/17/25. -"[FC #3] said if i stepped near her she would kill me...[client #1] and [client #2] were calming her down and she (FC #3) said she would kill them (clients #1, #2) if they came near her...that's when I called 911 because I wasn't going to wrestle he to get the scissors...[staff #4] was able to get the scissors from her..." -Described standing behind FC #3, holding her around the waist and FC #3's arms were to on her sides. "...I was around her waist to keep her from breaking the window...I did the restraint when she was trying to break the window...after [staff #4] took the scissors..." -Completed the internal incident report. -Had not submitted an report in IRIS. Interview on 8/4/25 with the Licensee/QP revealed: -Was responsible for submitting reports in IRIS. -Thought incident reports had been completed. -Had not submitted reports in IRIS. -"I thought an IRIS report was submitted for June (2025) for incident with [FC #3]. I looked in IRIS and could not find any for our facility."	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 367	Continued From page 61 -Had not submitted report in HCPR for allegation that staff #4 hit FC #3 with a hammer on 6/17/25 because CPS informed the facility that it was not necessary since the investigation was unsubstantiated and closed. -Had not submitted IRIS reports for all police calls and was not aware of the number of times police had been called. -Would work to improve documentation of incidents.	V 367		
V 503	27D .0103 Client Rights - Search And Seizure Policy 10A NCAC 27D .0103 SEARCH AND SEIZURE POLICY (a) Each client shall be free from unwarranted invasion of privacy. (b) The governing body shall develop and implement policy that specifies the conditions under which searches of the client or his living area may occur, and if permitted, the procedures for seizure of the client's belongings, or property in the possession of the client. (c) Every search or seizure shall be documented. Documentation shall include: (1) scope of search; (2) reason for search; (3) procedures followed in the search; (4) a description of any property seized; and (5) an account of the disposition of seized property. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure every search or seizure was documented as required. The findings are:	V 503		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 503	Continued From page 62 Review on 7/31/25 of client #1's record revealed: -Age 17 years. -Admitted on 3/14/25. -Day Treatment Program (DTP) Person Centered Plan (PCP-treatment plan) dated 4/28/25. -Diagnoses: Posttraumatic Stress Disorder, With Dissociative Symptoms; Depressive Disorder, Unspecified; Borderline Personality Disorder (Adolescent) (Per History); Generalized Anxiety Disorder; Unspecified Feeding or Eating Disorder; Child Sexual Abuse, Confirmed, Subsequent Encounter; History Of Suicidal Behavior; History Of Non Suicidal Self Injury. Review on 7/31/25 of client #2's record revealed: -Age 16 years. -Admitted on 11/13/24. -Discharged on 4/7/25. -Readmitted on 6/3/25. -DTP PCP (treatment plan) dated 12/9/24. -Diagnoses: Oppositional Defiant Disorder; Mood Dysregulation Disorder; Generalized Anxiety Disorder; Unspecified Cannabis-Related Disorder. Review on 7/31/24 of FC#3's record revealed: -Age 16 years. -Admitted on 12/6/24. -Discharged on 6/23/25. -DTP PCP dated 2/21/24. -Diagnoses: Major Depressive Disorder, Single Episode, With Psychotic Features; Generalized Anxiety Disorder; Attention-Deficit Hyperactivity Disorder, Predominantly Inattentive Type; Child Physical Abuse, Suspected, Subsequent Encounter; Child Sexual Abuse, Suspected, Subsequent Encounter. Review on 8/1/25 of the facility's incident report	V 503		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 503	Continued From page 63 dated 7/15/25 revealed: -Brief Summary of Incident "On this day (7/15/25), the ED (Licensee/Executive Director (ED)/Associate Professional (AP)) and QP (Licensee/Qualified Professional (QP)) decided to do a random room search. Upon searching clients (#1) room, a small water bottle with a little alcohol was found, a vape, and some Benadryl pills. Once client (#1) returned home from school, informed client that room searches was about to be completed and client confessed to all contraband found in her room." -Documentation did not include scope of search, reason for search, procedures followed in search, a full description of property seized, and an account of what happened to the seized property. Interview on 7/31/25 with client #1 revealed: -She and client #2 had drank alcohol while at Licensee/QP's home in June 2025 and had brought alcohol back to the facility. -Had hid "a little water bottle that we filled up and we drank it over a period of a month, staff didn't smell it..." -"...they (Licensees) did room searches" and found alcohol, over-the-counter medication], vape in client #1's bedroom and alcohol in client #2's bedroom, "we (clients #1, #2) were sharing everything and mainly kept everything in my room (bedroom)." -The vape found on 7/15/25 had nicotine. -Had used marijuana in a vape she got from another student while at day treatment and recalled a day about 2 weeks ago (date unknown) when she came to the facility high. -The search (7/15/25) of clients (#1, #2) bedrooms began while they were at school, "we (clients #1, #2) came in when they (Licensee) were in the middle of the search, they asked it there was contraband, we told them and they just	V 503		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 503	Continued From page 64 took it out of our room (bedroom)." Interview on 8/1/25 with client #2 revealed: -Client #1 took alcohol from Licensee/QP's home. -Staff thought she and client #1 had taken a vape and clients' (#1, #2) bedrooms were search, "...they (Licensees) didn't find anything, they checked everything in my room; drawers, under my bed" and nothing was found. -She did not recall the date of the room search. Interview on 8/1/25 with staff #1 revealed: -FC #3 took scissors from day treatment and "snuck the scissors in the facility." -Clients (#1, #2) stole alcohol from the Licensee/QP's home "that was found in their room (bedroom) during room check (search)." -Client #1 took a vape from Licensee/ED/AP's unlocked car. -"[Licensee/QP] and [Licensee/ED/AP] did a room search (date unknown) and found the vape. -All clients are searched when they come in the facility from the day treatment program. -Staff did not document daily searches. Interview on 8/5/25 with staff #2 revealed: -Client #1 stole vape from Licensee/ED/AP's car and stole alcohol from Licensee/QP's home in July 2025. -All clients get searched "when they walk through the door" when coming in from the day treatment program. -Staff did not document daily searches. Interview on 8/4/25 and 8/12/25 with the Licensee/ED/AP revealed: -Had done the room searches on 7/15/25 to look for a phone in client's (#1, #2) possession. -Day treatment Director reported a vape had been found with marijuana and nicotine.	V 503		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 503	Continued From page 65 -On 7/15/25, found "a little bottle that was still full of alcohol, bigger than an airplane (size) bottle, in an 8 ounce water bottle." -"Did room search (7/15/25) while they (clients #1, #2) were in school (day treatment) and confronted them when came home (facility)." -The alcohol and vape were found in client #1's bedroom. -An incident report was submitted for the 7/15/25 room search and tenants of documentation were not met. -Confirmed that clients were search daily coming in from day treatment. -Daily searches of clients were not documented. Interview on 8/5/25 with the Licensee/QP revealed: -Client #1 stole alcohol from her home in June 2025. -A room search was conducted on 7/15/25 to search for a cell phone based on report from the day treatment director that clients (#1, #2) were calling clients at another group home. -No cell phone was found, but alcohol, vape and [over-the-counter medication] was found in client #1's bedroom, "...it was like a small water bottle and with an amount that was under (up to) the wrapper of the bottle; she (client #1)only drank out of the bottle once. I was unable to tell how much was missing, but it didn't look like a lot." -Had found (dates unknown) vape on client #1 at least 2 times prior to the 7/15/25 search. -Client was getting vape from someone at the day treatment program. -"...when we (facility) search them (clients) there is more than one staff, and we make sure it is female staff and they (clients) will know that we are searching." -Clients (#1, #2) were informed of the search on 7/15/25.	V 503		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 503	Continued From page 66 -Was not sure if legal guardians and responsible parties were notified. -Did not have a policy for documenting daily client searches. -Would implement ways to improve reporting and documentation of search and seizures.	V 503		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and 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 failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	Continued From page 67 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; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (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.	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	Continued From page 68 (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) 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 failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	Continued From page 69 documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) 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. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure the Licensed Professional (LP) received initial training in alternatives to restrictive interventions. The findings are: Review on 8/7/25 of the Approval of request for waiver of 10A NCAC 27E for Licensed Professionals revealed: -Approval of the waiver will allow Licensed Professional not to have to complete the training in alternative intervention if they attest to	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	Continued From page 70 competence in the areas outlined in 10A NCAC 27E .0107 (g). Review on 8/6/25 of the LP's record revealed: -Hired 7/3/25. -Job description signed and dated 7/1/25. -Current license for Licensed Clinical Social Worker. -Had no documented Alternatives to Restrictive Intervention training. -Had no signed attestation on file. Attempted on 8/6/25 to interview LP was unsuccessful because there was no returned call. Interview on 8/4/25 and 8/11/25 with the Licensee/Executive Director/Associate Professional revealed: -Was unable to get attestation from LP. -LP had been out of town and unavailable due to family deaths.	V 536		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 537	Continued From page 71 service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (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 failing 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 plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 537	Continued From page 72 psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (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) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) 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 failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 537	Continued From page 73 to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (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. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 537	Continued From page 74 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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Licensed Professional received training in seclusion, physical restraint and isolation time-out. The findings are: Review on 8/6/25 of the LP's record revealed: -Hired 7/3/25. -Job description signed and dated 7/1/25. -Current license for Licensed Clinical Social Worker. -Had no documented training in seclusion, physical restraint and isolation time-out. Attempted on 8/6/25 to interview LP was unsuccessful because there was no returned call. Interview on 8/4/25 and 8/11/25 with the Licensee/Executive Director/Associate Professional revealed: -Was unable to get attestation from LP. -LP had been out of town and unavailable due to family deaths.	V 537		
V 539	27F .0102 Client Rights - Living Environment 10A NCAC 27F .0102 LIVING	V 539		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 539	Continued From page 75 ENVIRONMENT (a) Each client shall be provided: (1) an atmosphere conducive to uninterrupted sleep during scheduled sleeping hours, consistent with the types of services being provided and the type of clients being served; and (2) accessible areas for personal privacy, for at least limited periods of time, unless determined inappropriate by the treatment or habilitation team. (b) Each client shall be free to suitably decorate his room, or his portion of a multi-resident room, with respect to choice, normalization principles, and with respect for the physical structure. Any restrictions on this freedom shall be carried out in accordance with governing body policy. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure there was an atmosphere conductive to uninterrupted sleep during scheduled sleeping hours and accessible areas for personal privacy affecting 1 of 2 clients (#1). The findings are: Observation on 8/5/25 in the facility at approximately 3:55pm revealed: -Locked bathroom in client #1's bedroom. -Licensee/Executive Director (ED)/Associate Professional (AP) demonstrated the use of a key or keypad combination to unlock the door. Interview on 8/5/25 with client #1 revealed: -Staff access the staff bathroom (staff bathroom) during the day and night. -"I'm sleeping, so I don't hear them (staff); it (staff entry to her room) doesn't bother me and only	V 539		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601599	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS SANCTUARY LLC	6800 SUN RAY COURT CHARLOTTE, NC 28212

(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 539	Continued From page 76 female staff use it (staff bathroom)." -No male staff used the staff bathroom at night because she had never seen male staff working the night shift. Interview on 8/5/25 and 8/12/25 with the Licensee/ED/AP revealed: -The bathroom (accessible through client #1's bedroom) was a staff bathroom, stayed locked and only staff had a key. -Clients were not allowed to use that bathroom (staff bathroom). -Tried to be quiet at night while client #1 slept. Interview on 8/12/25 with the Licensee/Qualified Professional (QP) revealed: -When client #1 was awake, Licensee/QP had asked that client #1 to "step out of the room (client #1's bedroom) when staff has to use the bathroom during the day." -Client #1 had not complained about staff accessing her bedroom to enter the staff bathroom.	V 539		