

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL036-417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEYOND BELIEF FAMILY SERVICES LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>309 1ST STREET</b> <b>MOUNT HOLLY, NC 28120</b>		
(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	<p>INITIAL COMMENTS</p> <p>An annual, follow up and complaint survey was completed on 8-28-25. One complaint was substantiated (#NC00323703) and one was unsubstantiated (#NC00232843). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.</p> <p>This facility is licensed for 4 and currently has a census of 2. The survey sample consisted of audits of 2 current clients and 1 former client.</p>	V 000		
V 114	<p>27G .0207 Emergency Plans and Supplies</p> <p>10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES</p> <p>(a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes.</p> <p>(b) The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.</p> <p>(c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate the facility's response to fire emergencies.</p> <p>(d) Each facility shall have a first aid kit accessible for use.</p> <p>This Rule is not met as evidenced by:</p>	V 114		

Division of Health Service Regulation

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

TITLE

(X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL036-417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEYOND BELIEF FAMILY SERVICES LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>309 1ST STREET</b> <b>MOUNT HOLLY, NC 28120</b>		
(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 114	Continued From page 1  Based on interviews and record reviews the facility failed to ensure that disaster drills were completed at least quarterly on each shift. The findings are:  Review on 8-18-25 of the facility fire drills revealed: -No third shift fire drills for 2025. -No disaster drills for 2025.  Interview on 8-7-25 with client #1 revealed: -The facility has fire and disaster drills.  Interview on 8-7-25 with Client #2 revealed: -The facility has 3 shifts.  Interview on 8-7-25 with the facility manager revealed: -She is responsible for the fire drills and they are done monthly.  Interview on 8-19-25 with the Associate Professional revealed: -The facility had fire drills but, "not at night".  Interview on 8-28-25 with the Licensee revealed: -She had never heard anything about disaster drills being required.	V 114		
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	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL036-417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEYOND BELIEF FAMILY SERVICES LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>309 1ST STREET</b> <b>MOUNT HOLLY, NC 28120</b>		
(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	<p>Continued From page 2</p> <p>clients only when authorized in writing by the client's physician.</p> <p>(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.</p> <p>(4) A Medication Administration Record (MAR) of 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:</p> <p>(A) client's name;</p> <p>(B) name, strength, and quantity of the drug;</p> <p>(C) instructions for administering the drug;</p> <p>(D) date and time the drug is administered; and</p> <p>(E) name or initials of person administering the drug.</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure that an MAR was kept and prescriptions were administered per the physicians orders, and all staff administering medications had been trained by a legally qualified person. The findings are:</p> <p>Finding A</p> <p>Review on 8-18-25 of Client #1's record revealed:</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL036-417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEYOND BELIEF FAMILY SERVICES LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>309 1ST STREET</b> <b>MOUNT HOLLY, NC 28120</b>		
(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	<p>Continued From page 3</p> <p>-Admitted 4-14-25 -17 years old -Diagnoses include: Attention Deficit/Hyperactivity Disorder (ADHD), Borderline Personality Disorder, Post traumatic Stress Disorder, and a history of abuse, and Oppositional Defiant Disorder.</p> <p>Review on 8-12-25 of Client #1's MAR's for June 2025-August 2025 revealed: -Oxcarbazepine 600 mg (mood stabilizer) take one tab by mouth twice daily for 1 week and then take 1 1/2 tab by mouth twice daily, Clonidine .1mg (ADHD) once daily, Trazadone (sleep) 150mg take one tablet at bedtime. -Review of June MAR revealed: Oxcarbazepine 600mg am dose not documented as being given on 1-4, 10-11, 20-23, 27. PM dose not documented as being given on 1-4, 19-23. Clonidine not documented as being given 1-4, 16-23, Trazadone 150 not documented as being given 1-4, 11-23. -July MAR: Oxcarbazepine 600 mg not documented as being given 7, 19-28 for the AM dose, for the pm dose; 1, 19-29. Clonidine .1mg not documented as being given ; 1, 14, 19-28. Trazadone 150 mg not documented as being given ; 1, 13, 14, 19-28. -August MAR; Oxcarbazepine 600 mg am dose not documented as being given on 1-3, 9, 10. pm dose not documented as being given; 1-3, 9, 10. Clonidine .1mg not documented as being given 1-3, and 10. Trazadone 150mg not documented as being given 1-3. and the 10th.</p> <p>Interview on 8-12-25 with the Facility Manager revealed: -They also have a med count sheet and some of the documentation is there.</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL036-417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEYOND BELIEF FAMILY SERVICES LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>309 1ST STREET</b> <b>MOUNT HOLLY, NC 28120</b>		
(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	<p>Continued From page 4</p> <p>-The facility was having trouble with staff not giving medications, so they started counting them every shift.</p> <p>Finding B</p> <p>Review on 8-18-25 of Client #2's record revealed:</p> <ul style="list-style-type: none"> <li>-Admitted 5-14-25</li> <li>-12 years old</li> <li>-Diagnoses include: Oppositional Defiant Disorder, Post Traumatic Stress Disorder, Sexually aggressive behaviors, Adjustment Disorder, Intermittent Explosive Disorder.</li> </ul> <p>Review on 8-12-25 of Client #2's medications revealed:</p> <ul style="list-style-type: none"> <li>-Cetirizine 10 mg Allergies), 1 tablet (tab) by mouth daily, Fluticasone Propionate (Allergies) 1 spray each nostril 2x day, and Inhaler (Albuterol) 2 puffs daily PRN (as needed).</li> <li>-Review on 8-12-25 of Client #2's MAR for August 2025: Cetirizine was documents and being given on the 6th, 8th, 11, and 12th, all the rest of August was blank, Fluticasone Propionate 1 spray each nostril 2x day was not documented as being given for the month of July, not documented as being given.</li> <li>-Review on 8-12-25 of July 2025's MAR; Cetirizine was not documented as being given on 21 through the 29th, Fluticasone Propionate 1 spray each nostril 2x day the am dose was not documented as being given 21-30, the PM dose was only documented as being given on the 5th, 6th, and the 10th through the 16th.</li> <li>-Review on 8-12-25 of June 2025 MAR revealed: Cetirizine documented as being given on th 21, 22, 23, 24, 27, 28, 28, and the 30. Fluticasone Propionate 1 spray each nostril 2x day pm dose was documented as being given</li> </ul>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL036-417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEYOND BELIEF FAMILY SERVICES LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>309 1ST STREET</b> <b>MOUNT HOLLY, NC 28120</b>		
(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	<p>Continued From page 5</p> <p>only on the 21, 22, 23, 26, 28. The pm dose was only documented as being given on the 20, 23, and the 24.</p> <p>Review on 8-12-25 of June, July and August medication count sheet for Client #2 revealed:</p> <ul style="list-style-type: none"> <li>-August and July medication count sheet differed as to what the dose of Cetirizine was.</li> <li>-Med count and MAR's still did not account for documentation of all medications.</li> </ul> <p>Interview on 8-12-25 with the Facility Manager revealed:</p> <ul style="list-style-type: none"> <li>-Client #2 did not need her Cetirizine daily for her allergies.</li> <li>-The facility had a medication count sheet that they also documented as the medication being given.</li> </ul> <p>Finding C</p> <p>Review on 8-27-25 of the Associate Professionals record revealed:</p> <ul style="list-style-type: none"> <li>-Hire date 4-7-25.</li> <li>-No training in medication administration.</li> </ul> <p>Interview on 8-19-25 with the Associate Professional revealed:</p> <ul style="list-style-type: none"> <li>-Part of her job was medication administration.</li> <li>-She had been trained by the Owner/Director. saying "She was very thorough."</li> </ul> <p>Interview on 8-28-25 with the Facility Manager revealed:</p> <ul style="list-style-type: none"> <li>-The Associate Professional had not been trained to give medications and she should not be giving them</li> <li>-The Associate Professional missed the last class, but would be trained soon.</li> </ul>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL036-417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEYOND BELIEF FAMILY SERVICES LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>309 1ST STREET</b> <b>MOUNT HOLLY, NC 28120</b>		
(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 131	<p>G.S. 131E-256 (D2) HCPR - Prior Employment Verification</p> <p>G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interview the facility failed to ensure that Health Care Personnel Registry (HCPR) was accessed before employee hire. The findings are:</p> <p>Review on 8-26-25 of the Facility Manager's personnel file revealed: -Hire date of 5-27-24 -HCPR was accessed 7-1-24.</p> <p>Review on 8-26-25 of Former Staff #1's personnel file revealed: -Hire date of 4-7-25 -HCPR was accessed 8-21-25.</p> <p>Review on 8-26-25 of Staff #2's personnel file revealed: -3-1-25 -HCPR was accessed on 8-21-25.</p> <p>Interview on 8-28-25 with the Licensee revealed: -She had completed the HCPR checks</p>	V 131			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL036-417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEYOND BELIEF FAMILY SERVICES LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>309 1ST STREET</b> <b>MOUNT HOLLY, NC 28120</b>		
(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 131	Continued From page 7  before hire, but she could not find them.	V 131		
V 133	G.S. 122C-80 Criminal History Record Check  G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT. (a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter. (b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record	V 133		



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL036-417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEYOND BELIEF FAMILY SERVICES LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>309 1ST STREET</b> <b>MOUNT HOLLY, NC 28120</b>		
(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 133	Continued From page 8  check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency. (c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all	V 133			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL036-417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEYOND BELIEF FAMILY SERVICES LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>309 1ST STREET</b> <b>MOUNT HOLLY, NC 28120</b>		
(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 133	<p>Continued From page 9</p> <p>of the following factors in determining whether to hire the applicant:</p> <p>(1) The level and seriousness of the crime.</p> <p>(2) The date of the crime.</p> <p>(3) The age of the person at the time of the conviction.</p> <p>(4) The circumstances surrounding the commission of the crime, if known.</p> <p>(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.</p> <p>(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed.</p> <p>(7) The subsequent commission by the person of a relevant offense.</p> <p>The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.</p> <p>(d) Limited Immunity. - A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for:</p> <p>(1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual.</p> <p>(2) Failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section.</p> <p>(e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or</p>	V 133			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL036-417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEYOND BELIEF FAMILY SERVICES LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>309 1ST STREET</b> <b>MOUNT HOLLY, NC 28120</b>		
(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 133	Continued From page 10  federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL036-417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEYOND BELIEF FAMILY SERVICES LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>309 1ST STREET</b> <b>MOUNT HOLLY, NC 28120</b>		
(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 133	<p>Continued From page 11</p> <p>impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.</p> <p>(f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor.</p> <p>(g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met:</p> <p>(1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10.</p> <p>(2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.)</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure that all Criminal Background Checks were completed within 5 business days of hire. The findings are:</p> <p>Review on 8-26-25 of the Facility Manager's personnel file revealed: -Hire date of 5-27-24 -Criminal background check was 7-16-24.</p>	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL036-417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEYOND BELIEF FAMILY SERVICES LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>309 1ST STREET</b> <b>MOUNT HOLLY, NC 28120</b>		
(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 133	Continued From page 12  Interview on 8-28-25 with the Licensee revealed: -She would make sure all criminal background checks were completed in a timely manner.	V 133		
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	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL036-417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEYOND BELIEF FAMILY SERVICES LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>309 1ST STREET</b> <b>MOUNT HOLLY, NC 28120</b>		
(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 13  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 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	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL036-417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEYOND BELIEF FAMILY SERVICES LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>309 1ST STREET</b> <b>MOUNT HOLLY, NC 28120</b>		
(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	<p>Continued From page 14</p> <p>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 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</p> <p>(3) immediately notifying the following:</p> <p>(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;</p> <p>(B) the LME where the client resides, if different;</p> <p>(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;</p> <p>(D) the Department;</p> <p>(E) the client's legal guardian, as applicable; and</p> <p>(F) any other authorities required by law.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to implement policies to respond to incidents. The findings are:</p> <p>Review on 8-18-25 of email dated 8-18-25 from the Owner/Director revealed: -"I do not have copies of any IRIS (Incident response Improvement System) reports, should I be printing them? I can put in a request to see if</p>	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL036-417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEYOND BELIEF FAMILY SERVICES LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>309 1ST STREET</b> <b>MOUNT HOLLY, NC 28120</b>		
(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 15  they can be sent over. CCA, PCP are attached as well as any internal incidents for the 3 girls listed."  Review on 8-18-25 of Level I incidents dated May 2025 through August 18, 2025 revealed: -5 Level I incidents for Client #2.  Review on 8-13-25 of 911 calls to the local police dated 5-17-25 through 8-8-25 revealed: -Police were called to the facility 17 times.  Interview on 8-7-25 with the Facility Manager revealed: -The Owner/Director is responsible for the incident reports  Interview on 8-28-25-25 with the Director/Owner revealed: -She would talk with the IRIS administrator to get a better understanding of the incident reports.  This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	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	V 367			



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL036-417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEYOND BELIEF FAMILY SERVICES LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>309 1ST STREET</b> <b>MOUNT HOLLY, NC 28120</b>		
(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	<p>Continued From page 16</p> <p>services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:</p> <p>(1) reporting provider contact and identification information;</p> <p>(2) client identification information;</p> <p>(3) type of incident;</p> <p>(4) description of incident;</p> <p>(5) status of the effort to determine the cause of the incident; and</p> <p>(6) other individuals or authorities notified or responding.</p> <p>(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:</p> <p>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or</p> <p>(2) the provider obtains information required on the incident form that was previously unavailable.</p> <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <p>(1) hospital records including confidential information;</p> <p>(2) reports by other authorities; and</p> <p>(3) the provider's response to the incident.</p> <p>(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</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL036-417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEYOND BELIEF FAMILY SERVICES LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>309 1ST STREET</b> <b>MOUNT HOLLY, NC 28120</b>		
(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	<p>Continued From page 17</p> <p>providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).</p> <p>(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:</p> <p>(1) medication errors that do not meet the definition of a level II or level III incident;</p> <p>(2) restrictive interventions that do not meet the definition of a level II or level III incident;</p> <p>(3) searches of a client or his living area;</p> <p>(4) seizures of client property or property in the possession of a client;</p> <p>(5) the total number of level II and level III incidents that occurred; and</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to report all Level II incidents to the</p>	V 367			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL036-417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEYOND BELIEF FAMILY SERVICES LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>309 1ST STREET</b> <b>MOUNT HOLLY, NC 28120</b>		
(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	<p>Continued From page 18</p> <p>Local management Entity in the catchment area within 72 hours of becoming aware of the incident. The findings are:</p> <p>Review on 8-13-25-25 of Police 911 calls for facility address revealed: -Police responded to 911 calls from the facility 17 times from 5-17-25 to 8-8-25.</p> <p>Review on 8-13-25-25 of the North Carolina Incident Response Improvement System (IRIS) revealed: -No Level II incidents had been submitted by the facility during the months of 5-2025 though 8-13-2025.</p> <p>Interview on 8-18-25 with the IRIS Administrator revealed: - "They have several created but not submitted." - 6-4-25 for Former Client #4, - 6-4-25 for Client #2 - 6-6-25 for Client #2 - 6-7-25 for Client #2 - 6-2-25 for Client #2 - 7-28-25 for Former Client #3 - 8-8-25 for Client #2 - 6-23-25, 6-24-25, 6-26-25, and 8-1-25 were all for Client #1</p> <p>Interview on 8-7-25 with the Facility Manager revealed: -The Owner/Director is responsible for putting incidents into the IRIS system if necessary.</p> <p>Interview on 8-8-25-25 with the Owner/Director revealed: -She had submitted the reports into IRIS. -She had gotten a confirmation number and</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL036-417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEYOND BELIEF FAMILY SERVICES LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>309 1ST STREET</b> <b>MOUNT HOLLY, NC 28120</b>		
(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 19  there didn't seem to be anything else to do. -If the IRIS administrator can see them then they must be submitted. -She had never heard of any need for a "thumbs up" signal that meant the report had been submitted.  This deficiency constitutes a re-cited deficiency and must be corrected within 30 days	V 367		
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.	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL036-417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEYOND BELIEF FAMILY SERVICES LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>309 1ST STREET</b> <b>MOUNT HOLLY, NC 28120</b>		
(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 20  (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (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);	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL036-417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEYOND BELIEF FAMILY SERVICES LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>309 1ST STREET</b> <b>MOUNT HOLLY, NC 28120</b>		
(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 21  (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 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	V 536		

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**BEYOND BELIEF FAMILY SERVICES LLC**

309 1ST STREET  
MOUNT HOLLY, NC 28120

Division of Health Service Regulation  
STATE FORM

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL036-417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEYOND BELIEF FAMILY SERVICES LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>309 1ST STREET</b> <b>MOUNT HOLLY, NC 28120</b>		
(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 23  Review on 8-26-25 of the Facility Manager's personnel record revealed: -Date of hire 7-1-24. -Last training for Evidence Based Protective Interventions (EBPI) was 6-4-24.  Review on 8-26-25 of the Licensee's personnel record revealed: -Date of hire 2-20-22 -Last training for EBPI was 6-4-24.  Interview on 8-28-25 with the Licensee revealed: -There was a training scheduled next week that staff would be completing.	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 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	V 537		



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL036-417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEYOND BELIEF FAMILY SERVICES LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>309 1ST STREET</b> <b>MOUNT HOLLY, NC 28120</b>		
(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 24  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 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.	V 537		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL036-417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEYOND BELIEF FAMILY SERVICES LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>309 1ST STREET</b> <b>MOUNT HOLLY, NC 28120</b>		
(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 25  (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 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;	V 537		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL036-417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEYOND BELIEF FAMILY SERVICES LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>309 1ST STREET</b> <b>MOUNT HOLLY, NC 28120</b>		
(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 26  (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 times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers.	V 537		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL036-417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEYOND BELIEF FAMILY SERVICES LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>309 1ST STREET</b> <b>MOUNT HOLLY, NC 28120</b>		
(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	<p>Continued From page 27</p> <p>This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure that all staff received Training in Seclusion, Physical Restraint, and Isolation Time Out and have it updated at least annually. The findings are:</p> <p>Review on 8-26-25 of the Facility Manager's personnel record revealed: -Date of hire 7-1-24 -Last training for Evidence Based Protective Interventions (EBPI) was 6-4-24.</p> <p>Review on 8-26-25 of the Licensee's personnel record revealed: -Date of hire 2-20-22 -Last training for EBPI was 6-4-24.</p> <p>Interview on 8-28-25 with the Licensee revealed: -There was a training scheduled next week that staff would be completing.</p>	V 537		