

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/29/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012
--	--

(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>A complaint and follow up survey was completed on 8/29/25. The complaints were substantiated (intake #NC00232966 and NC00233278). A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children and Adolescents.</p> <p>This facility is licensed for 4 and has a current census of 3. The survey sample consisted of audits of 3 current clients, 1 former clients.</p> <p>This survey was originally closed on 8/22/25 but was approved to be reopened on 8/28/25 due to an additional complaint.</p>	V 000		
V 367	<p>27G .0604 Incident Reporting Requirements</p> <p>10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS</p> <p>(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 information:</p> <p>(1) reporting provider contact and</p>	V 367		

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: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/29/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012
--	--

(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 1</p> <p>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 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>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/29/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012
--	--

(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 2</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> <ol style="list-style-type: none"> (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. <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to submit, upon the request of the Local Management Entity/Managed Care Organization (LME/MCO), other information obtained regarding the incident and failed to submit an updated report for all required report recipients by the end of the next business day or when the required information was available for 3 of 4 clients (#1, #2, #3). The findings are:</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/29/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012
--	--

(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 3</p> <p>Review on 8/18/25 of client #1's record revealed: -Age 11 years. -Admitted on 6/17/25. -Diagnoses: Adjustment Disorders, With Mixed Disturbance of Emotions and Conduct; Adjustment Disorders, With Disturbance of Conduct; Upbringing Away From Parents.</p> <p>Review on 8/18/25 of client #2's record revealed: -Age 15 years. -Admitted on 7/1/25. -Diagnoses: Unspecified Mood Disorder; Oppositional Defiant Disorder; High Expressed Emotion Level Within Family.</p> <p>Review on 8/18/25 of client #3's record revealed: -Age 13 years. -Admitted on 10/24/24. -Diagnosis: Generalized Anxiety Disorder; Attention Deficit Hyperactivity Disorder (ADHD); Adjustment Disorder, Reaction to Severe Stress, Unspecified, Primary Insomnia.</p> <p>Review on 8/19/25 and 8/21/25 of former client #4's (FC #4) record revealed: -Age 13 years. -Admitted on 6/13/25. -Discharged on 8/1/25. -Diagnoses: Post-Traumatic Stress Disorder; Oppositional Defiant Disorder; ADHD, Combined Presentation; Specific Learning Disorder With Impairment in Reading Fluency and Calculation.</p> <p>Review on 8/19/25 of the facility incident reports from 5/1/25 to 8/19/25 revealed: -An "Incident Report" investigation "prepared by" the Assistant Director (AD) dated 8/1/25: -"Summary of Incident-During a planned group discussion (7/31/25) on bullying and the "snitching" stigma, consumer [client #2] disclosed</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/29/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012
--	--

(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 4</p> <p>that consumer [FC #4] routinely forces other residents (clients) to do things against their will, including physical assaults and sexual acts.</p> <p>-Immediate Actions Taken-Obtained written statements from all consumers (#1, #3, FC #4) involved; Contacted QP (Qualified Professional) and facility therapist, both of who responded to the crisis and conducted screenings (clients #1, #2, #3, FC #4); Contacted [County Law Enforcement]; Contacted Child Protective Services(CPS)...; Contacted DJJ (Department of Juvenile Justice) Court Counselor; Notified [County] DSS (Department of Social Services)/ [Client #1] legal guardian and all other guardians of involved consumers (#2, #3, FC #4); Notified [LME] Youth Advocate; Conducted an emergency Child and Family Team (CFT) meeting (FC #4) on 08/01/25; [FC #4] was successfully discharged from the program (facility) as an emergency measure (8/1/25); Created a safety plan (FC #4); Required staff to alternate sitting in the hallway during sleep hours; Scheduled Sexualized Risk training for all staff (8/29/25); *(handwritten on document) "Rooms (FC #4 in room alone) were changed immediately.</p> <p>-Outcome-Police report filed; CPS investigation initiated; Guardians notified (clients #1, #2, #3, FC #4); [FC #4] discharged from the facility for the safety and protection of other residents (clients #1, #2, #3).</p> <p>-Conclusion-We (facility) have come to the conclusion that some form of sexual misconduct has taken place between consumers (#1, #2, #3, FC #4). We were not able to determine if this misconduct was forced or willingly. We are waiting for the follow up from assigned detectives, CPS, and Forensic Interviews."</p> <p>Review on 8/18/25 of an IRIS Report dated 8/7/25 for FC #4 revealed:</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/29/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012
--	--

(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 5</p> <p>-Provider Comments dated 7/31/25: "During group (7/31/25), the discussion focused on making positive choices and advocating for oneself in situations involving bullying. [Client #2] disclosed to the group (facility) that [FC #4] had been bullying them (#1, #2, #3)and coercing them into engaging in inappropriate sexual behaviors during bedtime. Staff (AD) immediately initiated individual processing with all involved consumers (clients #1, #2, #3, FC #4). During the follow-up (7/31/25), [Client #3] also disclosed that they (#1, #2, #3) had experienced sexual violation by [FC #4]. Appropriate reporting procedures were followed, and staff provided support and ensured the safety of all consumers (clients #1, #2, #3, FC #4).</p> <p>Review on 8/18/25 and 8/22/25 of IRIS revealed</p> <p>-The Incident Comments had the following information:</p> <p>-"Date of incident: 7/31/25."</p> <p>-Date Provider Learned of Incident: 8/7/25 (7/31/25)."</p> <p>-Incident Information: "No" specified for associated incident reports. Specified "2" other consumers required, or will require, incident reports for this same incident (clients #2, #3).</p> <p>-Consumer Behavior: Specified "yes" this act was potentially a serious threat to the health or safety of the consumer or others. "Inappropriate Sexual Behavior."</p> <p>-The Incident Comments had the following requests:</p> <p>-8/7/25 This incident report was completed on 7/31/25. report number [IRIS report number] was generated on 7/31/25. However, [LME/MCO] shared that they were unable to locate the report. We (facility) were asked to go back in (IRIS) and resave all the information and wait for the thumbs-up symbol. When doing that, all</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/29/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012
--	--

(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 6</p> <p>information is saved with today's date only.</p> <p>-8/8/25 LME/MCO Review...Please follow-up to address the requested information within 5 business days. 1. Have there been any similar instances in the past with this member? 2. Were there any other [LME/MCO] members involved? Were IRIS reports completed for those involved? 3. What are the prevention strategies? 4. Was the staff in ratio and performing checks...? Please complete the HCPR tab completely...5. Please provide the HCPR report..., LE (law enforcement) report, and the DSS Notification to Reporter Letter...6. Please report to DSS and add this and the Law Enforcement contact to the Authorities Contacted tab. 7. Please attach the Internal Review. 8. Were there any injuries reported? 9. Please add the LME (LME/MCO) consumer identification number, the Medicaid, and the CNDS (common name data services) number...10. Were additional services offered/planned for those involved? 11. Please correct the date of incident and date provided notified...12. Please complete the Member Behavior tab and indicate that this event will have a long-term effect on those involved to upgrade this report to a Level III. Please resubmit in the Supervisor Actions tab...</p> <p>-8/22/25 LME/MCO...Review Awaiting response. Provider contacted again per DHHS (Division of Health and Human Services)' recent request."</p> <p>Interview on 8/19/25 and 8/21/25 with the facility AD revealed:</p> <p>-The facility was informed on 7/31/25 of the incident of bullying and inappropriate sexual behaviors involving FC #4 and other clients (#1, #2, #3).</p> <p>-The IRIS report was submitted by the facility on 7/31/25 but was entered incorrectly and had to be resubmitted on 8/7/25.</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/29/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER NEXX PHASE, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 101 APRICOT STREET BELMONT, NC 28012
--	--

(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 7</p> <ul style="list-style-type: none"> -The IRIS submission was late due to facility error so the date informed of the incident and date of submission were the same(8/7/25). -The incident was reported to the proper authorities (DSS, LME, LE, LG) on 7/31/25. -She did a written investigation of the incident of bullying and inappropriate sexual behaviors by FC #4 was completed on 8/1/25. -She held an emergency CFT meeting for FC #4 on 8/1/25 with recommendation to discharge FC #4. -She had been contact by IRIS staff and had sent the information requested to complete the submission. "We are working with someone from IRIS." -Was not aware that an incident report submission was required for each client involved in the incident. -Had not submitted IRIS report for other clients (#1, #2, #3) involved in the 7/31/25 incident of bullying and inappropriate sexual behaviors with FC #4. 	V 367		