ET

PRINTED: 05/30/2025
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-420	A. BUILDING: _____ B. WING _____	C 05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVING OTHERS UNTIL LIFE STOPS LLC	117 ABERNATHY STREET MOUNT HOLLY, NC 28120

(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 A complaint survey was completed on 5/28/25. The complaint was unsubstantiated (intake #NC00230208. 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 3. The survey sample consisted of audits of 3 current clients.	V 000	1. Corrective Action (Describe what you did or will do to correct the deficiency) We will immediately revise our internal training and supervision policy to comply with 10A NCAC 27G .0204. All paraprofessional staff will complete CPI (Crisis Prevention Intervention) training within 30 days. Weekly supervision sessions will be conducted by a Qualified Professional (QP) to ensure staff meet competency requirements. Updated training logs and supervision records will be maintained.	
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	V 110	2. Measures to Prevent Recurrence (Describe how you will prevent the deficiency from happening again) We will implement an annual training schedule that includes CPI recertification and competency refreshers. A pre-service competency checklist will be completed and signed off by a supervisor before paraprofessionals provide independent services. Quarterly workshops will reinforce CPI principles and regulatory competencies. Orientation materials will be updated to include these requirements.	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: executive officer — (X6) DATE: 8/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-420	A. BUILDING: _____ B. WING _____	C 05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVING OTHERS UNTIL LIFE STOPS LLC	117 ABERNATHY STREET MOUNT HOLLY, NC 28120

(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 2 the moment." -"Shortly afterward, [client #1] retracted her statements and admitted that she was upset and made the allegations because she was angry. She stated, 'I was just mad-that didn't really happen.' Staff documented the statement and continued to provide support to help her regulate her emotions. Review on 5/12/25 of the North Carolina Incident Response Improvement System (IRIS) revealed: -Abuse allegation by client #1 was submitted on 5/10/25. -"On 5/7/2025 (client #1) made a verbal allegation to her assigned Social Worker stating that a staff member (Licensee/Direct Care Staff) 'pulled her fingers off the car door and pulled her hair.' This statement was made during a moment of emotional upset. Shortly after making the statement, the client (#1) recanted and admitted to the same Social Worker that the allegation was not true. She clarified that she only said it because she was upset at the time and did not intend for it to be taken seriously. Despite the client's retraction, the Social Worker explained that the allegation must still be reported per protocol. At no point did staff (Licensee/Direct Care Staff) use physical force or engage in any behavior consistent with the allegation. There were witnesses and no observable injuries, and the staff involved (Licensee/Direct Care Staff) denied the accusation. The client's (#1) behavior before and after the incident did not indicate distress or injury." Interview on 5/12/25 with client #1 revealed: -Was angry at her school teacher when picked up by the facility on 5/7/25. -Walked to the trees. -"[Licensee/Direct Care Staff] came to get me. I	V 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-420	A. BUILDING: _____ B. WING _____	C 05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVING OTHERS UNTIL LIFE STOPS LLC	117 ABERNATHY STREET MOUNT HOLLY, NC 28120

(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 3 was being defiant. She tried to get me in the car." .-"I grabbed the seatbelt, and she tried to get my fingers off." -"I fell on the ground because I was being defiant. She accidentally pulled my hair." -"Afterwards we talked and I know that some parts I was wrong." -Was not hurt or bruised. Interview on 5/12/25 with client #2 revealed: -Was not present on 5/7/25 when the incident occurred with client #1. Interview on 5/12/25 with client #3 revealed: -On 5/7/25 the Licensee/Direct Care Staff tried to get client #1 to get into the car. -Client #1 was being aggressive. -"[Licensee/Direct Care Staff's] hands were on client #1's shoulders and she (client #1) dropped to the floor on purpose." -"[Licensee/Direct Care Staff] said 'please get in the car.'" -"[Licensee/Direct Care Staff] tried to help her (client #1) up and she kept fighting back." -"[Client #1] grabbed hold of something. She (Licensee/Direct Care Staff) tried to get her hands off it. I don't know what she was grabbing." -"[Licensee/Direct Care Staff] tried to lift her (client #1) up a little and pulled a piece of hair and said sorry and stopped." -"She (client #1) went into the car." -"[Licensee/Direct Care Staff] was trying to help her (client #1) that day ... She protects us." Interview on 5/27/25 with staff #1 revealed: -On 5/7/25 "Me and [Licensee/Direct Care Staff] was trying to get her (client #1) into the vehicle to figure out what was going on." -"We did how we did in the training (CPI) and	V 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-420	A. BUILDING: _____ B. WING _____	C 05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVING OTHERS UNTIL LIFE STOPS LLC	117 ABERNATHY STREET MOUNT HOLLY, NC 28120

(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 5 because of "the way she (client #1) was gripping the van. It did not take much force the way she was gripping the door." -"She (client #1) was still holding on to the seat belt. She let go on her own (of the seatbelt) and said ok I'll get in the car. She was laughing about it." -Denied bending client #1's fingers. -Denied pulling client #1's hair. -Did not observe any injuries to client #1. -Client #1 did not complain of any injuries.	V 110		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is	V 132		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-420	A. BUILDING: _____ B. WING _____	C 05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVING OTHERS UNTIL LIFE STOPS LLC	117 ABERNATHY STREET MOUNT HOLLY, NC 28120

(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 132	Continued From page 6 providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the North Carolina Health Care Personnel Registry (HCPR) was notified of all allegations against health care personnel within 24 hours, failed to make every effort to protect clients from harm while an investigation was in progress, and failed to report the results of the investigation within five working days of the initial notification. The findings are: Review on 5/12/25 of the North Carolina Incident Response Improvement System (IRIS) revealed: -Abuse allegation by client #1 was submitted on 5/10/25. -"On 5/7/2025 (client #1) made a verbal allegation to her assigned Social Worker stating that a staff member (Licensee/Direct Care Staff) 'pulled her fingers off the car door and pulled her hair.' This statement was made during a moment of emotional upset. Shortly after making the statement, the client (#1) recanted and admitted to the same Social Worker that the allegation was not true. She clarified that she only said it because she was upset at the time and did not intend for it to be taken seriously. Despite the client's retraction, the Social Worker explained that the allegation must still be reported per protocol. At no point did staff (Licensee/Direct Care Staff) use physical force or engage in any behavior consistent with the allegation. There	V 132	1. Corrective Measures Policy Revision: Update the facility's Abuse/Neglect Reporting and HCPR Notification policy to explicitly require timely reporting of all allegations (abuse, neglect, exploitation, diversion of drugs) involving healthcare personnel to the Health Care Personnel Registry as mandated by law. Staff Training: Within 14 days, provide mandatory training for all supervisors, administrators, and direct care staff on identifying reportable incidents, the steps for notification, and legal protections for residents and staff. Reporting Structure: Assign a Compliance Officer as the designated point of contact responsible for filing HCPR notifications and maintaining documentation of submissions. Immediate Implementation: Any current pending allegations will be reviewed and reported promptly to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-420	A. BUILDING: _____ B. WING _____	C 05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVING OTHERS UNTIL LIFE STOPS LLC	117 ABERNATHY STREET MOUNT HOLLY, NC 28120

(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 132	Continued From page 7 were witnesses and no observable injuries, and the staff involved (Licensee/Direct Care Staff) denied the accusation. The client's (#1) behavior before and after the incident did not indicate distress or injury." -The HCPR Facility Allegation section was not completed. -Staff was not identified. -Documentation of the internal investigation was not uploaded. Interview on 5/28/25 with the Qualified Professional revealed: -Conducted the investigation beginning on 5/8/25 and finishing in "a couple of days." -The Licensee/Direct Care Staff was not suspended during the investigation. -Was not responsible for completing IRIS reports, but did review them. -Knew that allegations of abuse were required to be reported to the HCPR within 24 hours. -"It was an oversight on my part that the HPCR section (of the IRIS report) was not filled out." -Did not upload the investigation report to IRIS. Interview on 5/28/25 with the Licensee/Direct Care Staff revealed: -Was made aware of the allegation on 5/7/25 after client #1 reported it to her social worker. -Continued to work the remainder of the shift, including processing with client #1, after becoming aware of the allegation. -Was not suspended during the investigation. -Completed the IRIS report on 5/10/25 for the allegation on 5/7/25, but failed to complete the HCPR portion of the IRIS report. -Did not upload the investigation report to IRIS.	V 132	2. Measures to Prevent Recurrence Standardized Incident Reporting Process: Implement a uniform incident reporting form that includes a required HCPR notification step and management approval checklist. Annual Refresher Training: Incorporate HCPR reporting requirements into annual mandatory training for all employees. Automated Alerts: Set up internal electronic reminders to notify the Compliance Officer and Administrator of any unresolved incidents requiring HCPR reporting. Oversight Committee: Monthly meetings by the Quality Assurance (QA) Committee to review all incidents and verify that proper notifications were made. 3. Monitoring and Oversight Responsible Person: Compliance Officer – Ensures timely HCPR notifications and maintains logs. Program Director – Reviews incident reports and monitors compliance. Frequency of Monitoring: Weekly: Compliance Officer reviews new incident reports for required notifications. Monthly: Program Director and HR conduct an audit of incident documentation and HCPR reporting logs. Quarterly: QA Committee conducts a full audit of past incidents and verifies that all required notifications were submitted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-420	A. BUILDING: _____ B. WING _____	C 05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVING OTHERS UNTIL LIFE STOPS LLC	117 ABERNATHY STREET MOUNT HOLLY, NC 28120

(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 513	Continued From page 8	V 513		
V 513	27E .0101 Client Rights - Least Restrictive Alternative 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (a) Each facility shall provide services/supports that promote a safe and respectful environment. These include: (1) using the least restrictive and most appropriate settings and methods; (2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the clients served/supported; and (4) sharing of control over decisions with the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include: (1) using the intervention as a last resort; and (2) employing the intervention by people trained in its use. This Rule is not met as evidenced by: Based on record review, observation, and interview, the facility failed to use the least restrictive environment for 2 of 3 clients (#2 and #3). The findings are: Observation on 5/12/25 at 4:00pm in the facility revealed: -Doorknobs had been removed from client #2's	V 513	Plan of Correction Deficiency: 27E .0101 – Client Rights: Least Restrictive Alternative 1. Corrective Measures Immediate Physical Correction: Upon identification of the deficiency, door knobs were immediately placed back on the doors to restore client access and ensure a less restrictive environment. Policy Revision: Update the facility's Client Rights and Service Delivery policy to ensure all interventions and environmental modifications prioritize the least restrictive alternatives consistent with client treatment needs and safety. Staff Training: Within 30 days, provide mandatory training for all staff on client rights, focusing on least restrictive intervention principles, de-escalation strategies, and alternative behavior management techniques. Individualized Care Review: Require supervisory review of all client service plans and behavioral interventions to verify that less restrictive options are explored and documented prior to implementing any restrictive measure. Documentation Updates: Modify client progress note templates to include a mandatory field confirming that less restrictive alternatives were considered and attempted before any restrictive intervention is used.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-420	A. BUILDING: _____ B. WING _____	C 05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVING OTHERS UNTIL LIFE STOPS LLC	117 ABERNATHY STREET MOUNT HOLLY, NC 28120

(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 513	Continued From page 9 and client #3's bedroom doors. Interview on 5/12/25 with client #2 revealed: -Staff took the doorknob off. -The doorknob had been taken off "a long time ago." -The doorknob was taken off due to self-harm. Interview on 5/12/25 with client #3 revealed: -Doorknob was taken off by staff because she "locked it too much." -"They (staff) were going to put it (doorknob) back the other day, but they can't find it. -Was worried about staff and clients listening at her door. Interview on 5/27/25 with staff #1 revealed: -"I took the doorknobs off." -"It was to ensure their (clients') safety." -"When they have episodes, they like to lock their self in the room. I don't know what they are doing." -"That (taking the doorknobs off) was a decision I made." -Was not worried about client privacy. -Was asked by the Licensee/Direct Care Staff to put the doorknobs back on the doors, but had not done it yet. Interview on 5/28/25 with the Qualified Professional revealed: -The doorknobs were missing due to client property destruction. -Was concerned about privacy and was working on finding someone to replace the doorknobs. Interview on 5/28/25 with the Licensee/Direct Care Staff revealed: -Client #2 "gets upset and locks her door and bangs her head."	V 513	Measures to Prevent Recurrence Ongoing Education: Incorporate least restrictive practices and client rights into annual continuing education for all paraprofessionals and supervisors. Behavior Support Plan Enhancements: Require each client's plan to explicitly list non-restrictive alternatives and staff responsibilities for implementing them. Internal Review: Implement an incident review process for any use of restrictive interventions or environmental changes (e.g., removal of door knobs) to ensure justification and immediate corrective actions. Supervisory Oversight: Supervisors will observe direct care interactions regularly to ensure compliance with least restrictive practices and environmental standards. Monitoring and Oversight Responsible Person: Qualified Professional (QP): Reviews individual service plans and monitors interventions. Program Director: Ensures policy adherence, training compliance, and environmental integrity. Frequency of Monitoring: Weekly: QP reviews client records and performs environmental checks to ensure no restrictive modifications are present. Monthly: Program Director audits a random sample of service plans, incident reports, and environmental compliance. Quarterly: QA Committee reviews overall trends and confirms corrective actions for any deviations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-420	A. BUILDING: _____ B. WING _____	C 05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVING OTHERS UNTIL LIFE STOPS LLC	117 ABERNATHY STREET MOUNT HOLLY, NC 28120

(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 513	Continued From page 10 -Client #3 had an incident where she locked the door and attempted to self-harm. -Staff #1 took the doorknobs off "towards the end of April." -Told staff #1 to put the doorknobs back on the doors.	V 513		