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
	MHL014-006	A. BUILDING: _____ B. WING _____	R 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKWELL	3476 MORGANTON BOULEVARD LENOIR, NC 28645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and follow up survey was completed on August 14, 2025. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. The facility is licensed for 8 and currently has a census of 8. The survey sample consisted of audits of 3 current clients.	V 000		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility was not maintained in a safe manner. The findings are: Observation on 8/12/25 at 12:50pm of the facility's interior revealed: -Client #3's bedroom did not have a bedroom door. Interview on 8/13/25 with Client #3 revealed: -Did not have a bedroom door. -Didn't notice every other bedroom had a door "...doors can't be closed anyways." Interview on 8/13/25 with Staff #1 revealed: -"Never been a door on that room (Client #3's bedroom), I don't know why."	V 736	Doors have been added to all bedrooms that were missing doors. Agency currently gathering quotes to replace all bedroom doors to ensure safety.	8/15/2025

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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V 736	Continued From page 1 -Never asked why there wasn't a door. Interview on 8/12/25 with the House Manager revealed: -Client #3's bedroom hadn't had a door since "y'all (Division of Health and Service Regulation) came out last time (9/10/24)." -"...trying to find a door to fit the frame, can't find one." -The Director was responsible for finding a door for Client #3's bedroom. Interviews on 8/12/25 and 8/13/25 with the Qualified Professional #1 revealed: -"Never noticed (Client #3 did not have a bedroom door) because clients have to be in eyesight of staff at all times." -"[Client #3] didn't say anything about not having a door." -"Never thought anything about the door. Didn't ask anybody about it." Interview on 8/13/25 with the Licensed Professional revealed: -"Not sure why he (Client #3) doesn't have a door (bedroom door)." Interview on 8/13/25 with the Director revealed: -"I dropped the ball on that (putting a door on Client #3's bedroom)." -"I didn't call back (to the contractor) to have the door put on." -"Clients don't close their doors ever, but I understand a door still needs to be put on for safety, in case of a fire." This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		

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Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL014-006 Y1	A. Building B. Wing Y2	8/14/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKWELL	3476 MORGANTON BOULEVARD LENOIR, NC 28645

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0118 Reg. # 27G .0209 (C) LSC	Correction Completed 08/14/2025	ID Prefix V0119 Reg. # 27G .0209 (D) LSC	Correction Completed 08/14/2025	ID Prefix V0123 Reg. # 27G .0209 (H) LSC	Correction Completed 08/14/2025
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR Amy McFalls	DATE 8/14/25
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/10/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO