STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601585	A. BUILDING: _____ B. WING _____	R 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MHVII	710 BRAXFIELD DRIVE CHARLOTTE, NC 28217

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V 000	INITIAL COMMENTS A complaint and follow-up survey was completed on 09/19/2025. The complaint was substantiated (Intake #NC00232746). 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 currently has a census of 3. The survey sample consisted of audits of 2 current clients.	V 000		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (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. (b) The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (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. (d) Each facility shall have a first aid kit accessible for use. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure fire and disaster drills were	V 114		

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V 114	Continued From page 1 conducted quarterly and repeated on each shift. The findings are: Review on 08/18/2025 of the facility's fire and disaster drills log from 04/01/2025 - 06/30/2025 revealed: -There was no first shift (7 am-3 pm), second shift (3 pm-11 pm), or third shift (11 pm- 7 am) disaster drills for the first quarter. Interviews on 08/18/2025 and 08/21/2025 with the Qualified Professional revealed: -Facility shifts were first shift (7 am-3 pm), second shift (3 pm-11 pm), and third shift (11 pm-7 pm). -"We document everything together (fire and disaster drills)." -"The drills (disaster) were done, they just were not indicated there (on Fire & Disaster Drill form)." -" ...Moving forward, we will add all natural disasters on the form." Interview on 09/04/2025 with the Administrator #1 revealed: -Facility shifts were first shift (7 am-3 pm), second shift (3 pm-11 pm), and third shift (11 pm-7 pm). -"We have them (fire and disaster drills) each shift. Its, quarterly but we do it monthly." -" ...They had completed them (disaster drills) and did not document it." -"In our leadership meeting, we added it to our agenda to make sure they (fire and disaster drills) are completed correctly." Interview on 09/04/2025 with the Administrator #2 revealed: -"Because mostly, we were concentrating on the fire drills, and they (clients) just did not like the tornado drills." -Would ensure the completion of disaster drills	V 114		

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V 114	Continued From page 2 moving forward. This deficiency constitutes a recited deficiency and must be corrected within 30 days.	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 clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118		

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V 118	Continued From page 3	V 118		

This Rule is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure medications were administered on the written order of a physician for 1 of 2 audited clients (Clients #1). The findings are:

Reviews on 08/18/2025 and 08/19/2025 of Client #1's record revealed:
-Admission date 06/24/2025.
-Diagnosed with Autism Spectrum Disorder and Attention Deficit Hyperactivity Disorder (ADHD).
-There were no Physician Orders for:
-Prazosin 1 milligrams (mg) (Mood Disorder)- Take 1 capsule (cap) by mouth every night at bedtime.
-Escitalopram 5 mg (ADHD)- Take 1 take by mouth at bedtime with Lexapro 10 mg tab for a total dose
15 mg.
-Vitamin D 1000 Unit (IU) (Vitamin D Deficiency)- Give 1 cap by mouth daily.

Observation on 08/18/2025 at 6:21 p.m. of Client #1's medication container revealed:
-Prazosin 1 mg.
-Escitalopram 5 mg.
-Vitamin D 1000 IU.

Review on 08/18/2025 of Client #1's MARs from 06/01/2025-08/17/2025 revealed:
-Prazosin 1 mg, Escitalopram 5 mg, and Vitamin D 1000 IU were administered daily from 06/01/2025-08/17/2025.

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V 118	Continued From page 4 Interview on 08/18/2025 with Client #1 was unsuccessful due to his refusal to continue the interview. Interview on 09/04/2025 with the Qualified Professional revealed: -"[Administrator #1 and Administrator #2] are in charge of ensuring medication orders are at the facility." Interviews on 08/18/2025 and 09/04/2025 with Administrator #1 revealed: -"Medication orders are in the hard file at the main office." -Administrator #2 was responsible for ensuring medication orders were at the facility. -Would ensure medication orders were present prior to administering medications to clients moving forward. Interview on 09/04/2025 with Administrator #2 revealed: -"I look at it (medication orders) when DSS (Department of Social Services) brings them in. Before the children come there is a requirement that the orders come to us. If we have missing orders, they (clients) can't come, and we have to send them (clients) back." -Would ensure medication orders were present prior to administering medications to clients moving forward. This deficiency constitutes a recited deficiency and must be corrected within 30 days.	V 118		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL	V 132		

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V 132	Continued From page 5 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 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 records review and interviews, the facility failed to ensure that the Health Care Personnel Registry (HCPR) was notified of all allegations against health care personnel and failed to report, within 5 working days, the results of the investigation to the Department. The findings are:	V 132		

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V 132	Continued From page 6 Review on 08/18/2025 of the facility's records revealed: -There was no evidence of HCPR notification for the allegation that the Qualified Professional (QP) physically abused Client #1 on 07/22/2025. -There was no evidence that the results of the investigation for the above 07/22/2025 incident were reported to the Department within 5 days. Review on 08/18/2025 of the North Carolina Incident Response Improvement System (IRIS) from 05/15/2025 - 08/17/2025 revealed: -There was no HCPR notification for the QP's alleged physical abuse of Client #1 incident dated 07/22/2025. -There was no evidence that the results of the investigation were reported within 5-day to the Department for the above 07/22/2025 incident. Interview on 08/18/2025 with the HCPR representative revealed: -"She (Administrator #1) is supposed to submit it (HCPR notifications) in IRIS initially and it is not in IRIS." -"She (Administrator #1) did not do it, because if she did it would be in IRIS." -Did not have record of the HCPR notification and results of the investigation within 5-days report for allegation that the QP physical abuse Client #1 incident dated 07/22/2025. -"It is required that they (Providers) do it (report) in IRIS." -"They (Providers) can do a confidential email and call, but it is still required that they do it in IRIS." -"That lady (Administrator #1) did not report it, and I don't know who would tell her to mail it when it has to go in IRIS."	V 132		

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V 132	Continued From page 7 Interview on 09/04/2025 with Administrator #1 revealed: -"I mailed that (HCPR notification and results of the investigation within 5-days report) in." -"After she (HCPR representative) told me, I completed it (HCPR notification and results of the investigation within 5-days report) and put it in the mail." -Did not contact the Department to verify receipt of the HCPR notification and results of the investigation within 5-days report for the allegation that the QP physical abuse of Client #1 incident dated 07/22/2025. -Was not aware that the HCPR notification and results of the investigation within 5-days report was not received by the Department. -Would ensure proper submission of the HCPR notification and results of the investigation within 5-days report moving forward.	V 132		
V 293	27G .1701 Residential Tx. Child/Adol - Scope 10A NCAC 27G .1701 SCOPE (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility. (b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental	V 293		

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V 293	Continued From page 8 disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to a community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting. (e) Services shall be designed to: (1) include individualized supervision and structure of daily living; (2) minimize the occurrence of behaviors related to functional deficits; (3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting. (f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to operate within the scope of their	V 293		

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V 293	Continued From page 9 license and failed to provide services to address the functioning level of the children or adolescents services affecting 2 of 2 Current Clients (#1 and #2). The findings are: Reviews on 08/18/2025 and 09/04/2025 of Client #1's record revealed: -Admission date 06/24/2025. -Discharge date 08/28/2025. -Diagnosed with Autism Spectrum Disorder and Attention Deficit Hyperactivity Disorder (ADHD). Review on 08/18/2025 of Client #2's record revealed: -Admission date 06/16/2025. -Discharge date 08/18/2025. -Diagnosed with Post Traumatic Stress Disorder-Primary, Disruptive Mood Dysregulation Disorder, and ADHD. -A Treatment Plan dated 06/13/2025 revealed: " ...The FCT Supervisor spoke with the DSS (Department of Social Services) Targeted Case Manager endorsing the recommendation from the Sparc Services and Programs for level two therapeutic foster care and the continuation of FCT ...The DSS Legal Guardian and LME-MCO (Local Management Entity-Managed Care Organization) decided to discharge the client today in order to transition him into the crisis level 3 residential program." Review on 08/18/2025 and 08/26/2025 of the Division of Health Service Regulation (DHSR) facility's folder revealed: -Facility was licensed for Program Code 10A NCAC 27G .1700 Residential Treatment Staff Secure For Children Or Adolescents. -No evidence of a waiver to provide Emergency Transitional Residential Intervention (ETRI) services.	V 293		

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V 293	Continued From page 10 Interview on 08/22/2025 with Client #1's DSS Legal Guardian revealed: -"He was placed (at the facility) on a crisis basis, but they (Administrators) are holding him until we can get another bed." -"He is supposed to go to foster home, so we are trying to find placement." Attempted interview on 09/04/2025 with Client #2's DSS Legal Guardian was unsuccessful due to no response to phone call. Attempted interviews on 09/04/2025 and 09/08/2025 with Clients #1 and #2's LME/MCO Care Coordinator was unsuccessful due to no response to phone call. Interview on 09/04/2025 with the Qualified Professional revealed: -"This is an ETRI facility." -"I would not know the answer (how long the facility has operated as an ETRI program), you would have to ask [Administrator #1]." Interviews on 08/18/2025 and 09/04/2025 with Administrator #1 revealed: -"We are (a Crisis/ETRI program) ..." -"The clients end up staying until they find them another placement." -"We are not a crisis home; we are a level III facility." -"We stay away from ETRI until we have instructions for DHSR." Interview on 09/08/2025 with Administrator #1 revealed: -" ...they (clients) were discharged based what their social workers need. We stay away from short term. We look for level of care."	V 293		

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V 293	Continued From page 11 Interview on 09/04/2025 with Administrator #2 revealed: -"We go by the 1700 rules."	V 293		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall	V 366		

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V 366	Continued From page 12	V 366		

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 final written report shall address the issues

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V 366	Continued From page 13 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 (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement written policies governing their response to Level III incidents. The findings are: Review on 08/18/2025 of the facility's incident reports from 05/15/2025 - 08/17/2025 revealed: -There was no incident report the Qualified Professional's (QP) alleged physical abuse of Client #1 incident dated 07/22/2025.	V 366		

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	MHL0601585	A. BUILDING: _____ B. WING _____	R 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MHVII	710 BRAXFIELD DRIVE CHARLOTTE, NC 28217

(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 14 Review on 08/18/2025 of Incident Response Improvement System (IRIS) from 05/15/2025 - 08/17/2025 revealed: -There was no IRIS report submitted for the incident identified above. Review on 08/18/2025 of the facility's records revealed: The above incident was not evaluated for the following Risk Cause Analysis (RCA) components: -Attended to the health and safety needs of individuals involved in the incident. -Determined the cause of the incident. -Developed/implemented corrective measures. -Developed/implemented measures to prevent similar incidents. -Assigned a person to be responsible for implementation of the corrections and preventive measures. -Adhered to confidentiality requirements. -Maintained documentation regarding the above subparagraphs. Interview on 09/04/2025 with the QP revealed: -Was not responsible for completing the RCA for Client #1's incident dated 07/22/2025. Interview on 09/04/2025 with Administrator #1 revealed: -"I am responsible for that (completing the RCA for incidents)." -"I keep it (RCA for Client #1's incident dated 07/22/2025) in our main file." -Did not provide documentation of the RCA for the QP's alleged physical abuse of Client #1 incident dated 07/22/2025. Interview on 09/04/2025 with Administrator #2	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 366	Continued From page 15 revealed: -"The both of us, but [Administrator #1] is ultimately (responsible for completing the RCA). -Did not complete the RCA for the QP's alleged physical abuse of Client #1 incident dated 07/22/2025. This deficiency constitutes a recited 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 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: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding.	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 367	Continued From page 16 (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident;	V 367		

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V 367	Continued From page 17 (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: (V367) Based on record reviews and interviews, the facility failed to report all level III incidents in the Incident Response Improvement System (IRIS) and failed to notify the Local Management Entity (LME)/Managed Care Organization (MCO) responsible for the catchment area where services were provided as required after becoming aware of the incident. The findings are: Review on 08/18/2025 of the facility's incident reports from 05/15/2025 - 08/17/2025 revealed: -There was no incident report the Qualified Professional's (QP) alleged physical abuse of Client #1 incident dated 07/22/2025. Review on 08/18/2025 of Incident Response Improvement System (IRIS) from 05/15/2025 -	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 367	Continued From page 18 08/17/2025 revealed: -There was no IRIS report or LME/MCO notifications submitted for the incident identified above. Interview on 08/18/2025 with the Health Care Personnel Registry (HCPR) representative revealed: -There was no report in IRIS for the QP's alleged physical abuse of Client #1 incident dated 07/22/2025. Interview on 09/04/2025 with Administrator #1 revealed: -"[Administrator #2] was responsible for doing it (IRIS report)." -Was not aware that Client #1's incident dated 07/22/2025 was not submitted in IRIS. -Would ensure submission of IRIS reports moving forward. Interview on 09/04/2025 with Administrator #2 revealed: -"I did it (IRIS report for the QP's alleged physical abuse of Client #1 incident dated 07/22/2025). -Was not aware that Client #1's incident dated 07/22/2025 was not submitted in IRIS. -Would ensure submission of IRIS reports moving forward. This deficiency constitutes a recited deficiency and must be corrected within 30 days.	V 367		