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 000	INITIAL COMMENTS An annual and complaint survey was completed on 9/11/25. One complaint was substantiated (intake #NC00233458) and one complaint was unsubstantiated (intake #NC00233235). Deficiencies were cited. The facility is licensed for the following service category: 10A NCAC 27G .5000 Facility Based Crisis Service for Individuals of all Disability Groups. This facility is licensed for 16 and has a current census of 8. The survey sample consisted of audits of 2 current clients and 1 former client. This survey originally closed on 9/9/25 but was reopened on 9/10/25 and 9/11/25 due to additional complaints.	V 000		
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	V 132		

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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 record review and interview, the facility failed to ensure an allegation of abuse was reported to the Health Care Personnel Registry (HCPR) within 5 days of being notified of the allegation. The findings are:

Review on 9/4/25 of Staff #2's record revealed:
- Hired: 12/9/24

Interview on 9/3/25 the Clinical Director reported:
- The facility was made aware "around" 8/20/25 of the allegation against Staff #2
- Former Client (FC) #9 reported that Staff #2 has physically abused her
- The Crisis Program Director was on medical leave when the allegation occurred
- Staff #2 was placed on leave until an investigation was completed
- She did not notify the HCPR of the allegation because she did not know she had to notify the HCPR
- She would ensure the HCPR was notified of any future abuse allegations against facility staff

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V 132	Continued From page 2 Interview on 9/3/25 and 9/4/25 the Crisis Program Director reported: - She did not notify the HCPR, because "I thought it was done (reported to HCPR)" - She would follow up to ensure the HCPR was notified of any future abuse allegations	V 132		
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. (b) Category A and B providers shall explain any missing or incomplete information. The provider	V 367		

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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;
(2) restrictive interventions that do not meet the definition of a level II or level III incident;

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V 367	Continued From page 4 (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: Based on record review and interview, the facility failed to report to the Local Management Company (LME)/Managed Care Organization (MCO) all Level II incident reports within 72 hours and Level III incident reports within 24 hours. The findings are: Review on 8/29/25 of the Incident Response Improvement System (IRIS) from January 2025 to September 3, 2025 revealed: - No Level II or Level III IRIS reports were completed for the facility Review on 9/3/25 and 9/4/25 of the facility's Critical Incident Reports (CIR) from 8/3/25 to 9/3/25 revealed: - Client #3 was put in a restraint 6 times between 8/21/25 and 9/1/25 - Client #6 was put in a restraint on 8/27/25 and 8/29/25	V 367		

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V 367	Continued From page 5 Interview on 9/3/25 the Clinical Director reported: - She was was made aware of allegations against Staff #2 on 8/20/25 - She did not complete a Level III IRIS report for the allegation of abuse against Staff #2 because she did not know she had to Interview on 9/3/25 the Crisis Program Director reported: - She was responsible for completing IRIS reports - She was on medical leave when the allegation against Staff #2 was reported - There were no Level II or Level III incidents completed at the facility - She did not know that an IRIS report needed to be completed for each restraint - She did not know why an Level III IRIS report was not completed for the allegations against Staff #2, "she thought it was done (completed)" when she was on medical leave - She would follow up to ensure that IRIS reports were completed for allegations of abuse in the future	V 367		
V 518	27E .0104(e1-2) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (1) the requirement that positive and less restrictive alternatives are considered and attempted whenever possible prior to the use of more restrictive interventions;	V 518		

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V 518	Continued From page 6 (2) consideration is given to the client's physical and psychological well-being before, during and after utilization of a restrictive intervention, including: (A) review of the client's health history or the client's comprehensive health assessment conducted upon admission to a facility. The health history or comprehensive health assessment shall include the identification of pre-existing medical conditions or any disabilities and limitations that would place the client at greater risk during the use of restrictive interventions; (B) 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 by staff who are physically present and trained in the use of emergency safety interventions; (C) continuous monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being during the use of manual restraint; and (D) continued monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being for a minimum of 30 minutes subsequent to the termination of a restrictive intervention; This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure consideration was given to the client's physical and psychological well-being during and after the utilization of a restrictive intervention affecting 1 of 1 former clients (FC) #9. The findings are:	V 518		

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V 518	Continued From page 7 Review on 9/3/25 of FC #9's record revealed: - Admitted: 8/8/25 - Discharged: 8/19/25 - Age: 8 years old - Diagnoses: Disruptive Mood Dysregulation Disorder, Autism Spectrum Disorder, Fetal Alcohol Syndrome, Attention Deficit Hyperactive Disorder - No documentation to 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 - continuous monitoring of the client's physical and psychological well-being during the use of manual restraint - continued monitoring of the client's physical and psychological well-being for a minimum of 30 minutes subsequent to the termination of a restrictive intervention Review on 9/4/25 of the facility's video surveillance on 8/17/25 from 5:35 pm to 5:50 pm revealed: - The Registered Nurse (RN) #2 put FC #9 in a restraint from 5:41 pm to 5:42 pm - RN #2 held FC #9 at the lower part of her arms, above the wrist and assisted her to the floor, and then released FC #9 from the restraint Interview on 9/3/25 RN #2 reported: - She placed FC #9 in a restraint on 8/17/25 - She "thought" if the restraint was less than two minutes, she did not need to complete a report but could not remember who told her that - She was informed "within the last month" that any restraint needed to be documented and would document any restraint moving forward - "There would not be documentation about the	V 518		

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V 518	Continued From page 8 restraint on FC #9" because the restraint was not documented on the facility's Critical Incident Report (CIR), which would require FC #9 to be monitored Interview on 9/4/25 and 9/10/25 the Program and Staff Development Supervisor reported: - He was responsible for training staff on restrictive interventions (Safety Crisis Management) - FC #9 should have been monitored during the restraint and after the restraint for at least 30 minutes Interview on 9/10/25 the Program Crisis Director reported: - There would be no documentation of any information regarding FC #9's restraint if a CIR report was not completed for the restraint - She would ensure all documentation following a restraint procedure were documented in the future	V 518		
V 521	27E .0104(e9) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (9) Whenever a restrictive intervention is utilized, documentation shall be made in the client record to include, at a minimum: (A) notation of the client's physical and psychological well-being; (B) notation of the frequency, intensity and duration of the behavior which led to the	V 521		

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V 521	Continued From page 9 intervention, and any precipitating circumstance contributing to the onset of the behavior; (C) the rationale for the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used; (D) a description of the intervention and the date, time and duration of its use; (E) a description of accompanying positive methods of intervention; (F) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate or reduce the probability of the future use of restrictive interventions; (G) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if determined to be clinically necessary; and (H) signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention. This Rule is not met as evidenced by: Based record review and interview, the facility failed to document a description of the debriefing with the client for the use of physical restraint for 1 of 2 audited current clients (#3) and failed to document a restraint in a client's record affecting 1 of 1 former clients (FC) #9. The findings are: Finding A: Review on 9/3/25 of Client #3's record revealed: - Admitted: 8/21/25 - Age: 10 years old	V 521		

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V 521	Continued From page 10 - Diagnoses: Post Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder - No documentation of the following restraints on 8/21/25 and 8/29/25: - a description of the debriefing and planning with the client and the legally responsible person for the emergency use of physical restraint to eliminate or reduce the probability of the future use of restrictive interventions - a description of the debriefing and planning with the client and the legally responsible person for the planned use of physical restraint Review on 9/3/25 of the facility's Incident Restraint records from 8/3/25 to 9/3/25 revealed: - Client #3 had been physically restrained on 8/21/25 and 8/29/25 with no documentation that debriefings were completed Interview on 9/3/25 Client #3 reported: - Had been in a restraint when "I first got here (was admitted)" - She was "sometimes" debriefed about the restraint, but sometimes she refused the debriefing Finding B: Review on 9/3/25 of FC #9's record revealed: - Admitted: 8/8/25 - Discharged: 8/19/25 - Age: 8 years old - Diagnoses: Disruptive Mood Dysregulation Disorder, Autism Spectrum Disorder, Fetal Alcohol Syndrome, Attention Deficit Hyperactive Disorder - No documentation of the following: - notation of the client's physical and	V 521		

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V 521	Continued From page 11 psychological well-being - notation of the frequency, intensity and duration of the behavior which led to the intervention, and any precipitating circumstance contributing to the onset of the behavior - the rationale for the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used - a description of the intervention and the date, time and duration of its use - a description of accompanying positive methods of intervention - a description of the debriefing and planning with the client and the legally responsible person for the emergency use physical restraint to eliminate or reduce the probability of the future use of restrictive interventions; - a description of the debriefing and planning with the client and the legally responsible person for the planned use of physical restraint - signature and title of the facility employee who initiated, and of the employee who further authorized the use of the intervention Review on 9/4/25 of the facility's video surveillance on 8/17/25 from 5:35 pm to 5:50 pm revealed: - RN #2 put FC #9 in a restraint from 5:41 pm to 5:42 pm - RN #2 was holding FC #9 at the lower part of her arms, above the wrist and assisted her to the floor, and then released FC #9 from the restraint Interview on 9/3/25 RN #1 reported: - Any staff can complete a debriefing	V 521		

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Interview on 9/3/25 RN #2 reported:
- Any staff member can debrief with a client
- Sometimes a debriefing is "overlooked," because "the kid (client) may not want to do it (debrief)" and "staff may forget to complete the debriefing"
- She placed FC #9 in a restraint on 8/17/25, but did not complete an Restraint Incident report
- She "thought" if the restraint was less than two minutes, she did not need to complete a report but could not remember who told her that
- She was informed "within the last month" that any restraint needed to be documented and would document any restraint moving forward

Interview on 9/9/25 Staff #1 reported:
- She had heard by "word of mouth" that RN #2 had placed FC #9 in a restraint, but was not sure what day or time

Interview on 9/3/25 Staff #2 reported:
- "Usually" the shift coordinator would debrief the client and complete the documentation
- Staff involved in the restraint would not do the debrief, as it would "trigger" (upset) the client

Interview on 9/4/25 the Nurse Practitioner reported:
- She did the debriefing when she completed "face-to face" evaluations that occurred after a restraint

Interview on 9/4/25 the Program and Staff Development Supervisor reported:
- He was responsible for training staff on restrictive interventions and was "made aware of every restraint" that occurred in the facility
- He "usually" reviewed documentation of the restraint to ensure it was completed correctly
- He would debrief with a client or staff after a

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V 521	Continued From page 13 restraint occurred - It was possible that the debriefings "could have been missed", or the documentation was not competed due to oversight - A Critical Incident Report for the restraint on FC #9 should have been completed with the appropriate documentation - He would ensure that debriefing occurred moving forward Interview on 9/3/25 and 9/4/25 the Crisis Program Director reported: - The RN or the shift coordinator were "usually" responsible for the completion of the debriefing after a restraint - She was unsure why there were no debriefings completed for the above incidents - She would ensure that all restraints are documented and the proper paperwork is completed in the future	V 521		
V 524	27E .0104(e12-16) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (12) The use of a restrictive intervention shall be discontinued immediately at any indication of risk to the client's health or safety or immediately after the client gains behavioral control. If the client is unable to gain behavioral control within the time frame specified in the authorization of the intervention, a new authorization must be obtained.	V 524		

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V 524	Continued From page 14 (13) The written approval of the designee of the governing body shall be required when the original order for a restrictive intervention is renewed for up to a total of 24 hours in accordance with the limits specified in Item (E) of Subparagraph (e)(10) of this Rule. (14) Standing orders or PRN orders shall not be used to authorize the use of seclusion, physical restraint or isolation timeout. (15) The use of a restrictive intervention shall be considered a restriction of the client's rights as specified in G.S. 122C-62(b) or (d). The documentation requirements in this Rule shall satisfy the requirements specified in G.S. 122C-62(e) for rights restrictions. (16) When any restrictive intervention is utilized for a client, notification of others shall occur as follows: (A) those to be notified as soon as possible but within 24 hours of the next working day, to include: (i) the treatment or habilitation team, or its designee, after each use of the intervention; and (ii) a designee of the governing body; and (B) the legally responsible person of a minor client or an incompetent adult client shall be notified immediately unless she/he has requested not to be notified. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to notify the legally responsible person of a minor client immediately after a restraint affecting 1 of 2 audited current clients (#3) and 1 of 1 former clients (FC #9). The findings are: Review on 9/4/25 of the facility's Restrictive Intervention policy revealed: - "The Registered Nurse (RN) monitoring the	V 524		

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V 524	Continued From page 15	V 524		

intervention and the Shift Coordinator are responsible for notifying senior leadership and the parent/guardian of the use of restricted interventions....Parent/Guardian- Immediately following intervention debriefing and health screening"

Finding A:

Review on 9/4/25 of the facility's Admission agreement revealed:
- "Medications can be given as part of a daily routine or "PRN" (as needed)....Medications are almost always given by mouth, but in emergency situations and in order to protect clients or others from harm, medication is offered by mouth, but may be given by injection (STAT). Typical emergency medications used (sometimes in combination) include Haldol, Ativan, Benadryl.... In these rare emergency cases, the parent/guardian will be notified as soon as possible after an emergency medication has been administered."

Review on 9/3/25 of Client #3's record revealed:
- Admitted: 8/21/25
- Age: 10 years old
- Diagnoses: Post Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder
- Had been put in a restraint 6 times since being admitted to the facility
- Diphenhydramine Hydrochlorothiazide Novaplus (Intramuscular Injection), Inject 50 milligrams immediately for agitation was administered on 8/21/25 and 9/1/25
- Documentation on 8/21/25: "This nurse contacted social worker (SW) [SW name] to let her know about the restraint that occurred the evening of 8/25/25. AA voice mail was left and info given so that if she had any questions she

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could call back"
- Documentation on 9/1/25: "Guardian DSS (Department of Social Services) called and Voicemail left regarding incident"
- No documentation of guardian being notified for the use of a restraint on 8/21/25, 8/23/25, 8/29/25, 9/1/25

Interview on 9/3/25 Client #3 reported:
- Had been in a restraint when "I first got here"

Interview on 9/5/25 Client #3's DSS guardian reported:
- She was aware that Client #3 had been put in restraints when at the facility
- She was not contacted immediately after a restraint occurred or after an injection was administered during the restraint
- She wanted to be made aware immediately of a restraint or that emergency medication that was administered after a restraint was completed
- She was made aware when she visited the facility on a "7 day visit" (facility visit), or during a treatment team meeting

Finding B:

Review on 9/3/25 of Former Client (FC) #9's record revealed:
- Admitted: 8/8/25
- Discharged: 8/19/25
- Age: 8 years old
- Diagnoses: Disruptive Mood Dysregulation Disorder, Autism Spectrum Disorder, Fetal Alcohol Syndrome, Attention Deficit Hyperactive Disorder
- No documentation that FC #9's guardian was notified of a restraint occuring on 8/17/25

Interview on 9/4/25 FC #9's family guardian

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V 524	Continued From page 17 reported: - FC #9 had reported to her that she was put in a "hold" when at the facility - She would "have wanted" to be notified if a restraint had been used on FC #9 - The facility reported to her that FC #9 had not been in any restraints when at the facility Interview on 9/3/25 the RN #1 reported: - Nurses are "usually" responsible for contacting the clients' guardians for the use of restraints Interview on 9/4/25 the RN #2 reported: - Any staff member could contact the guardian after a restraint or emergency medication, "it did not have to be a nurse" - FC #9's family was "probably" not notified of the restraint - "I am assuming that if it was not reported as a hold, the parents (guardian) would not have been contacted" Interview on 9/4/25 Staff #2 reported: - It was usually the shift coordinator that notified the guardian following a restraint or emergency medication Interview on 9/10/25 the Program and Staff Development Supervisor reported: - He was responsible for training staff on the restrictive intervention process, including the "post-restraint" duties - The nurse contacted the guardian, "especially if medication is involved (administered)" Interview on 9/4/25 the Director of Nursing reported: - Nursing "usually" contacted the guardian after a restraint was used or medication was	V 524		

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V 524	Continued From page 18 administred during the restraint Interview on 9/3/25 and 9/24/25 the Crisis Program Director reported: - The nurses notified the guardian of a restraint or medication being used during a restraint - The guardian should be notified "as soon as possible" (by the end of day) - She was not sure why the guardians were not notified of a restraint or medication being administered during a restraint - She will ensure guardians are contacted about any restraints or medication use during a restraint moving forward	V 524		