STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080-233	A. BUILDING: _____ B. WING _____	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 000	INITIAL COMMENTS An annual survey was completed on August 29, 2025. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children and Adolescents. This facility is licensed for 4 and has a current census of 4. The survey sample consisted of audits of 2 current clients and 1 former client.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080-233	A. BUILDING: _____ B. WING _____	08/29/2025

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V 112	Continued From page 1	V 112		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to develop and implement strategies to address client's needs affecting Former Client (FC #3). The findings are:

Cross Reference: 10A NCAC 27G .1704 Minimum Staffing Requirements (V296). Each facility shall ensure supervision of adolescents when they are away from the facility.

Review on 8/20/25 and 8/21/25 of Former Client (FC #3's) record revealed:
-Client is on juvenile probation for assault on a government official and a participant of the Recovery Court program;
-A Juvenile Secure Custody Order dated 5/16/25, "When he (FC #3) is released to the facility electronic monitoring can come off. Still on house arrest can leave only with adult from facility, parent or school;"
-Person Centered Plan (PCP) dated 6/24/25, "identified community living: The court has ordered him (FC #3) to stay on house arrest while in placement at facility. [FC #3] is only allowed to attend community activities and programming under the direct supervision of staff. This is a safety measure for [FC #3] due to his continuous substance abuse;"
-PCP dated 6/24/25, did not address supervision goals and strategies to identify direct supervision

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080-233	A. BUILDING: _____ B. WING _____	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 112	Continued From page 2	V 112		

needs while in the community or while attending community activities and while in programming and while under the direct supervision of staff for FC #3's safety, and expected outcomes.

Review on 8/21/25 of FC #3's Comprehensive Clinical Assessment (CCA) dated 2/13/25 revealed:
-Initial treatment recommendation was a Psychiatric Residential Treatment Program (PRTF) or other monitored residential services to ensure his safety and recovery. "Given his history of substance use disorder, hospitalizations, a higher level of care is necessary. A PRTF would provide structured support, intensive therapy, and 24/7 supervision to help him (FC #3) develop emotional regulation and coping skills. This placement also reduces immediate triggers, ensuring a secure environment for long term stability and recovery;"
-4/28/25, amended recommendations, "after a recent Care Review Team meeting the client's treatment needs have changed. The recommendation has shifted from a PRTF to a level III group home placement in order to provide the structure and support necessary for continued progress. An appropriate level III group home has been identified and pursued placement;"
-Was of moderate risk to harm himself because of substance use;
-History of using over the counter (OTC) medications in excessive dosages to experience intoxication led to the following;
-"Hospitalization from 4/10/24 to 4/14/24 for suicidal ideations;
-Hospitalization from 12/24/24 to 1/6/25, after he mixed alcohol and Dextromethorphan (DXM) three times;"
-He had a history of involuntarily commitments. Dates not provided;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080-233	A. BUILDING: _____ B. WING _____	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELAH HOUSE	1317 FORESTDALE DRIVE SALISBURY, NC 28144

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V 112	Continued From page 3 -"He has previous Substance Use hospitalizations for poison control from substance use;" -He suffered "road rash bruising and a cut on his right eyelid, after being hit by a car on 1/20/25. FC #3's vision was impaired because he was under the influence of Delsym extended release;" -He had surgery on his elbow date unknown and was prescribed Oxycodone for two weeks. "I took 2 instead of 1 (pill);" -Other OTC medications used were Diphenhydramine (Benadryl), DXM (Robitussin, Delsym/other cough medicines), and Dimenhydranite (motion sickness pills); -He described the OTC medications that he used as "deliriants;" -He stated that his frequency of use occurred in "binges lasting more than 24 hours." Interviews on 8/20/25, 8/22/25, and 8/28/25 with the Executive Director/Qualified Professional revealed: -He did not address supervision as a goal in the PCP for FC #3 because, it would then be a "required ongoing need;" -The dates on the PCP reflected ongoing changes in behaviors with FC #3. Review on 8/29/25 of the facility's Plan of Protection dated 8/29/25 and completed by the Executive Director (ED)/Qualified Professional (QP) on 8/29/25 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Buffalo Concerned for Youth, Inc. (Licensee) affirms that the supervision of all youth in our care is the sole responsibility of licensee staff at all times, including during transportation, community outings, medical/behavioral health appointments, and while attending external programs or services.	V 112		

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SELAH HOUSE	1317 FORESTDALE DRIVE SALISBURY, NC 28144

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V 112	Continued From page 4 -This plan outlines the immediate protective actions taken to ensure the safety of all current and future members. All actions will be fully implemented within 7 calendar days and documented in each staff personnel file. QP will update each members Person Centered Plan (PCP) to reflect goals, interventions/strategies, timeframes, and outcomes based off the members Clinical Comprehensive Assessment (CCA). Furthermore, if a goal is updated by the therapist, the PCP must be updated to reflect within 72 hours to maintain consistency and compliance with North Carolina Division of Health and Human Services (NC DHHS) guidelines. Describe your plans to make sure the above happens. I. Youth will never be left unsupervised under any circumstances. Staff will maintain line-of-sight supervision at all times. -Ratios will be monitored daily by the Facility Director or Designee to ensure compliance with NC DHHS (North Carolina) (Department Health Human Services) .1700. II. Transportation and External Services -During all transportation and while attending external services (including Substance Abuse Intensive Outpatient Program (SAIOP) or other outpatient programs), a licensee staff member will remain present to maintain supervision. Handoff procedures will be documented, but licensee acknowledges that ultimate responsibility for supervision remains with our staff. III. Elopement Prevention and Safety -Staff will immediately intervene if a youth attempts to elope. -The QP and guardian will be notified without delay. -If clinically indicated, youth will be transported to	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080-233	A. BUILDING: _____ B. WING _____	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELAH HOUSE	1317 FORESTDALE DRIVE SALISBURY, NC 28144

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V 112	Continued From page 5	V 112		

the Emergency Department for evaluation and drug screening.
-Any youth who attempts elopement will be placed on 1:1 supervision for a minimum of 24 hours following the incident.
Iv. Training and documentation
-All staff will complete retraining on supervision, ratios, transportation, and elopement protocols within 7 days of this plan's approval.
-Completion will be documented through sign-in sheets verified by the Facility Director, and filed in personnel records.
- Ongoing quarterly refresher training will reinforce expectations.
Describe your plans to make sure the above happens.
I. CCA Review First
a. Before any PCP is developed or updated, each member's most recent CCA must be reviewed in full.
b. This ensures that all presenting diagnoses, psychosocial history, trauma exposure, strengths, and needs are accounted for.
II. Goal Development
a. PCP goals should flow directly from the clinical needs identified in the CCA.
b. Example: If the CCA documents frequent elopement and poor impulse control, a PCP goal may by "Member will demonstrate improved impulse control by reducing elopement attempts by 50% within 6 months."
III. Interventions
a. Interventions should match the needs and be clinically indicated (not generic). For instance, evidence-based intervention, motivational interviewing, active listening, Trauma-Focused Cognitive Behavioral Therapy (TF-CB), anger management, Problematic Sexual Behavior (PSB) group therapy, etc.
b. Example: Staff will provide weekly coping skills

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	MHL080-233	A. BUILDING: _____ B. WING _____	08/29/2025

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V 112	Continued From page 6 sessions, model self-regulation, and implement a token system tied to safety and compliance. IV. Timeframes a. Each goal/intervention must include a measurable timeframe (30, 60. 90 days, or 6 months). b. Timeframes should match the expected pace of progress and be revisited during quarterly reviews or more frequently if needed. c. If therapist(s) adds a goal, PCP must be updated to reflect new goal(s). V. Outcomes a. Outcomes should be written as observable and measurable behaviors that demonstrate progress. b. Example: "Within 90 days, member will attend 90% of scheduled appointments with staff support and no elopement incidents." Why CCA Review Before PCP is Important 1. Accuracy and Individualization-Ensures PCP goals match the youth's true diagnoses, needs, and strengths. 2. Compliance-Required by NC DHHS, Medicaid, and Managed Care Organization (MCO) standards; prevents audit issues and funding risks. 3. 3. Measurable Goals-Links CCA findings to time-bound, clinically justified PCP goals. 4. 4. Team Consistency-Keeps staff, QP's, therapists, and guardians aligned the same treatment priorities. 5. 5. Better Outcomes-Youth get interventions that fit their needs, leading to safer, more stable progress. In short: The CCA is the roadmap. PCPs must follow it to be valid, compliant, and effective." The facility served male adolescent clients diagnosed with Persistent Depressive Disorder	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080-233	A. BUILDING: _____ B. WING _____	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELAH HOUSE	1317 FORESTDALE DRIVE SALISBURY, NC 28144

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V 112	Continued From page 7 (Dysthymia); Cannabis Use Disorder, moderate, and other (or unknown) Substance Use Disorder, moderate; and Nicotine Use Disorder. The facility admitted FC #3 with moderate risk of harm to self because of his substance use. FC #3 had a recent hospitalization from 12/24/24 to 1/6/25 for mixing alcohol and DXM and 4/10/24 to 4/14/24 for suicidal ideations. FC #3 was on juvenile probation, a participant of Recovery Court, and was placed on house arrest while admitted to residential placement. The facility did not supervise FC #3's movements when FC #3 was dropped off by the facility staff at a local outpatient substance abuse center and he was left unsupervised. FC #3 walked away from the local outpatient substance abuse center unsupervised to nearby stores and stole over-the-counter medications which contained Dextromethorphan and other substances Oxycodone, and Fentanyl while in the community. The facility did not develop strategies to identify and provide for the supervision needs of FC #3's when he was in community activities and community programming and provide for his safety and treatment needs. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 112		
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times.	V 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SELAH HOUSE	1317 FORESTDALE DRIVE SALISBURY, NC 28144

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V 296	Continued From page 8 (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan.	V 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080-233	A. BUILDING: _____ B. WING _____	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELAH HOUSE	1317 FORESTDALE DRIVE SALISBURY, NC 28144

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V 296	Continued From page 9	V 296		

This Rule is not met as evidenced by:
Based on record reviews and interviews, facility staff failed to ensure direct supervision of client away from the facility in accordance with Former Client (FC #3's) needs affecting 2 of 2 paraprofessionals (#1 and #2). The findings are

Review on 8/20/25 and 8/21/25 of FC #3's record revealed:
-Date of Admission: 5/19/25;
-Date of Discharge: 8/18/25;
-Age: 17 years;
-Diagnoses: Persistent Depressive Disorder (Dysthymia); Cannabis Use Disorder, moderate, and Other (or unknown) substance use disorder, moderate; and Nicotine use disorder, other tobacco product, uncomplicated;
-Juvenile Secure Custody Order dated 5/16/25, FC #3 "can only leave with adult from facility, parent or school;"
-Internal incident report dated 7/28/25, completed by the Executive Director (ED)/Qualified Professional (QP). FC #3 was unsupervised on 7/25/25 and 7/28/25 while attending Substance Abuse Intensive Outpatient Program (SAIOP). FC #3 went to a local store and stole Mucinex (Over the Counter cough and cold medicine). He ingested approximately 300 milligrams (mgs) of Mucinex on 7/25/25 and approximately 480 mgs on 7/28/25. On 7/28/25, FC #3 tested positive for Oxycodone;
-Internal Incident report dated 7/29/25, completed by the ED/QP. FC #3 was involuntarily committed to the local hospital.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080-233	A. BUILDING: _____ B. WING _____	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELAH HOUSE	1317 FORESTDALE DRIVE SALISBURY, NC 28144

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V 296	Continued From page 10 Review on 8/26/25 of FC #3's medical records from 7/28/25 to 8/21/25 revealed: -Diagnoses: Disruptive Mood Dysregulation Disorder and Dextromethorphan use disorder, mild, abuse; -7/31/25, FC #3 was transferred to the Psychiatric Inpatient Unit for suicidal ideations; -On 7/29/25, FC #3 was involuntarily committed to the local hospital for suicidal ideations; -On 7/28/25, FC #3 tested positive for Fentanyl. Interview on 8/27/25 with FC #3 revealed: -"No, staff did not stay with me at [SAIOP] during his outpatient treatment. No, staff did not watch me walk to [therapist] office;" -"Staff signed me in on the tablet and left. It was probably [staff #1], it was usually her, who signed me in. I sat in the lobby and waited;" -7/28/25, was the only day that staff #2 stayed with FC #3, until he went into the SAIOP therapist's office; -He arrived at SAIOP at approximately 8:27am and was picked up by the group home staff at approximately 11:30am consistently. -7/25/25, he arrived at SAIOP. Staff #1 signed him in on the tablet and left; -"I left 20 minutes after the group home staff;" -He went to the local store and stole DXM and "made sure that I did not take too much, acting funny;" -"I was gone 30 minutes and came back to [SAIOP];" -"I took DXM at the group home in my room around 4:30pm during quiet time;" -On 7/28/25, he arrived at SAIOP, and was unsure of the time he left; -He was gone between 20 or 25 minutes because, "I knew the directions to the [local store];" -He stole a total of two packs of Mucinex with	V 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080-233	A. BUILDING: _____ B. WING _____	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELAH HOUSE	1317 FORESTDALE DRIVE SALISBURY, NC 28144

(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 296	Continued From page 11	V 296		

eight pills each in a pack;
-He ingested a total of 9 pills, totaling approximately 480mgs of Mucinex;
-On the unknown date, he arrived at SAIOP. He waited until 9:30am to leave, and went to a nearby gas station, "no clue where;"
-"I was gone for 1 hour and 15 minutes ..." He returned to the SAIOP.
-"I left a total of three times from [SAIOP]. I left on 7/25/25 and 7/28/25."

Interview on 8/22/25 and 8/25/25 with the Juvenile Court Counselor revealed:
-"My understanding or expectation is [FC #3] is to be supervised by the group home. He (FC#3) is not to be left alone, and the SAIOP therapist should be an extension of the group home. The group home (Licensee) and the SAIOP therapist should be on the same page about supervision;"
-"My expectation is make sure to take care of FC #3 and supervise him. You (Licensee) are the guardian, and you are responsible for whatever happens to him (FC #3)."
-The facility Director requested more structure for FC #3. "The judge made the court order to fit [FC #3's] level of need for supervision;"
-"The judge made the court order specific to the program (level III) and kept the house arrest in there (court order) so FC #3 would not run off (elope)."

Interview on 8/28/25 with FC #3's Legal Guardian revealed:
-"[FC #3's] case is if he wants to do it (drugs), he's going to do it. Nothing is going to stop him. He will find a way;
-[FC #3] has a strong addiction ..."

Interview on 8/20/25 with staff #1 revealed:
-She did not remain on site with FC #3 during his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SELAH HOUSE	1317 FORESTDALE DRIVE SALISBURY, NC 28144

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V 296	Continued From page 12 SAIOP appointments; -"[FC #3's] first day at [SAIOP] was on 6/23/25. I and [FC #3] arrived, I signed him in at the front desk and asked if I needed to stay with him. I was told no and as I was leaving the office assistant took [FC #3] to the counselor's office door;" -When she transported FC #3 to SAIOP, "every time the same procedure happened;" -The office assistant walked FC #3 to the door of the office that staff #1 went to when she picked FC #3 up from group; -FC #3 was usually in the office with the SAIOP therapist when she picked him up after group. Interview on 8/22/25 with staff #2 revealed: -"I am aware that [FC #3] has substance abuse issues and needs to be supervised at all times; -Either I or another staff member would take [FC#3] inside the SAIOP and get him checked-in;" -"I probably dropped him off at [SAIOP], supposed to sign them (FC#3) in on the tablet;" - There were at least two days that the tablet was not functioning. Unsure of the dates; -Once they have (staff checked-in), [FC #3] would sit down (lobby) or walk back to the counselor's office;" -He believed on 7/25/25, the group home staff arrived early at the SAIOP; He was unsure of the time, but he arrived 10 to 15 minutes earlier than the usual time; -No one was there to open the SAIOP. The group home staff sat in the parking lot. Then the therapist arrived; -" ... the tablet was not set-up yet (dark screen). [FC #3] could come inside and have a seat. They [SAIOP] would help him get checked-in later;" -On either "7/25/25 or 7/28/25", when he arrived at the SAIOP to pick-up FC #3. "[FC #3] was sitting in the f*****g lobby at least one of those	V 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080-233	A. BUILDING: _____ B. WING _____	08/29/2025

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(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 296	Continued From page 13	V 296		

days. The SAIOP staff said that group ended early."

Interviews on 8/20/25, 8/22/25, and 8/28/25 with the ED/QP revealed:
-"I understood the assignment and what [FC #3's] needs were;"
-FC #3 arrived at the facility by juvenile justice transport, "in handcuffs and shackles." The transportation team took the electronic monitor off FC #3's ankle and the group home became the supervision (line-of-sight);
-Staff would get FC #3 to treatment on time, "sign him (FC #3) in, and do a hand off to the treatment program;"
-He assigned a staff member to be one-on-one with FC #3 while out in the community for the first 7 days;
-Staff are trained in direct line of sight and close proximity supervision while in the community;
-"I was told by [SAIOP], their adolescent clients are not allowed to leave;"
-On 7/28/25, he believed that he and another staff member picked FC #3 up from group. They went to lunch and FC #3 did not eat lunch.
-"I immediately knew something was wrong ..." FC #3 previously disclosed when he's under the influence of DXM, he does not eat;
-"We're not going to be the fall guy for this situation;"
-He repeatedly stated, "we (Licensee) did nothing wrong."
-A enhanced rate was partially approved by the Local Management Entity/Managed Care Organization (LME/MCO) from 5/19/25 to 7/17/25;
-FC #3 was on house arrest inside the facility, and staff signed off on direct line of sight supervision while in the community;
-"I did not think that the order (secure custody)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080-233	A. BUILDING: _____ B. WING _____	08/29/2025

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V 296	Continued From page 14 specified for [FC #3] to be with staff during his substance abuse treatment." This deficiency is cross referenced into 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112) for a Type A1 rule violation and must be corrected within 23 days.	V 296		