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
	MHL036-382	A. BUILDING: _____ B. WING _____	R 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAY'S HOUSE	214 AUTEN CIRCLE MOUNT HOLLY, NC 28120

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 8-15-25. Three complaints were substantiated (Intake # NC00232493, #NC00232497, and #NC00231531) and two complaints were unsubstantiated (Intake #NC00231650, and #NC00232524). 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 4 and has a current census of 3. The survey sample consisted of audits of 1 former client.	V 000	RECEIVED OCT 06 2025 DHSR-MH Licensure Sect	
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid	V 108		

10/2/2025

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V 108	Continued From page 1 including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure 2 of 3 audited staff were trained in Cardiopulmonary Resuscitation (CPR) and First Aid and Seizure Management. The findings are: Review on 8-6-25 of staff #1's record revealed: -Date of hire: 12-2-24. -No documentation of training in CPR/First Aid and Seizure Management. Review on 8-6-25 of the Associate Professionals/AP record revealed: -Date of hire: 9-18-24. -No documentation of training in CPR/First Aid and Seizure Management. Interview on 8-6-25 with staff #1 revealed: -She completed CPR/First Aid training (1/2025) but did not receive a card to document the training. -" going to reach out to him (CPR instructor) to	V 108		

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V 108	Continued From page 2 see if I can get a card or a certificate." Interview on 8-15-25 with the AP revealed: -She did not take a CPR first Aid class through the facility but has a current CPR/First Aid certification through her other job. -"I have CPR from my other job. I though I gave them a copy of my cards." Interview on 8-6-25 and 8-15-25 with the Owner revealed: -"They should have their training completed within 30 days of coming in (hire date)." -"[Qualified Professional], handles trainings. I'm not sure why the documentation is not in the record."	V 108		
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 disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall	V 293		

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V 293	Continued From page 3 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 record reviews and interviews, the facility failed to ensure coordination of care with other individuals and agencies within the child's system of care affecting 1 of 1 audited clients (client #1). The findings are:	V 293		

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V 293	Continued From page 4 Review on 8-5-25 of client #2's record revealed: -Age: 11 years -Diagnoses: ADHD; PTSD; Disruptive Mood Dysregulation Disorder. Interview on 8-15-25 with the Nurse Manager at the local hospital: -Client #2 was brought to the local hospital by the the facility staff due to behavior (physical aggression towards staff and property damage). At 6:52pm client #2 was cleared for discharge by the hospital physician. "[Owner] was contacted and informed that the patient (client #2) was cleared for discharge and to arrange pick up. [Owner] became irate and stated he will not pick up the patient and neither will any other staff member and if the patient were Caucasian she would be treated with more respect and receive adequate care. [Owner] stated he wanted patient (client #2) to be re-evaluated and that he would not pick her up for at least 7 days." -Due to the facility's refusal to pick client #2 up from the hosptial, client #2 was left in the hospital emergency room department from 7-6-25 until 7-11-25. -Hospital staff contacted the owner again 7-7-25 and advised that client #2 was cleared for discharged and that client #2's issues were behavioral and did not meet the criteria for inpatient psychiatric care. Again the Owner stated he would not pick client #2 form the hospital. -7-8-25 the Owner contacted the hospital staff and reported that the facility had issued an immediate discharge for client #2 to her Department of Social Services guardian to arrange placement. -7-10-25 the Owner was contacted again by hospital staff and again refused to pick the client	V 293		

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V 293	Continued From page 5 up from the hospital. -Client #2 was not picked up from the hospital until 3:50pm on 7-11-25. Client was left in the emergency room for 5 after being medically cleared by the hosptial physician due to the facility's refusal to pick the client up. Interview on 8-8-25 with the Owner revealed: -Client #2 was experiencing escalating behaviors including damaging property (breaking windows and putting holes in walls) and being physically aggressive with staff. "She needed her medications adjusted. We kept taking her to the ER (emergency room) and they were not treating her. That day (7-6-25) she was acting out, we took her to the ER and they wanted to send her right back home. I did not feel that she would be safe here so I refused to pick her up until she was evaluated for 7 days." -He did not immediately reach out to the DSS guardian. "Initially our intention was to bring her back after they (hosptial staff) adjusted her medications and got her stable but they kept saying it was behavioral and she didn't need to be in the hospital. I mean this child was throwing bricks through the window and fight staff daily how can not be mental? So I was going to discharge her for safety reason. That's when I reached out to the social worker to let her know about the discharge." -Client #2 was not receiving therapy since being discharged from her day program in May 20, 2025. We were looking for a therapist for her but had not found one."	V 293		
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing 10A NCAC 27G .1704 MINIMUM STAFFING	V 296		

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V 296	Continued From page 6 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. (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	V 296		

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V 296	Continued From page 7 needs as specified in the treatment plan. This Rule is not met as evidenced by: Based on record reviews and interviews, and observation the facility failed to ensure the minimum staff ratio of 2 staff for up to 4 children or adolescents. The findings are Review on 8-5-25 of client #1's record revealed: -Date of admission: 5-16-24. -Age: 9 years. -Diagnoses: Attention Deficit Hyperactivity Disorder (ADHD), combined type; Oppositional Defiant Disorder, Post-Traumatic Stress Disorder (PTSD); Sleep Terror history. Review on 8-5-25 of client #2's record revealed>: -Date of admission: 12-4-24. -Age: 11 years. -Diagnoses: ADHD; PTSD; Disruptive Mood Dysregulation Disorder. Observation on 8-5-25 from approximately 2:45pm to 6pm revealed two clients present in the home (client #1 and #2) and only one staff working (staff #1). Interview on 8-5-25 with client #1 revealed: -"Usually we do two (two staff on shift), but the staff that know how to handle behavior, they can work by themselves. [Staff #1], she could take us out without us having any problems.	V 296		

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V 296	Continued From page 8 -Sometimes it's only one staff working. Interview on 8-5-25 with client #2 revealed: -"Usually two, (staff per shift). Sometimes only one." Interview on 8-5-25 with staff #1 revealed: -She normally works second shift but has been working with client #2 since client #2 was kicked out of the day program. Interview on 8-14-25 with staff #2 revealed: -Always two staff working per shift. "No, I've never worked by myself. Interview on 8-15-25 with the Associate Professional reveled: -Staff ratio is two staff per shift. There is always two staff per shift." Interview on 8-8-25 with the Owner revealed: -He was unaware that two staff were required to work with one client. -"Usually [Qualified Professional] is here during the day but she is on maternity leave. Not usre when she will be returning full time.	V 296		
V 297	27G .1705 Residential Tx. Child/Adol - Req. for L P 10A NCAC 27G .1705 REQUIREMENTS OF LICENSED PROFESSIONALS (a) Face to face clinical consultation shall be provided in each facility at least four hours a week by a licensed professional. For purposes of this Rule, licensed professional means an individual who holds a license or provisional license issued by the governing board regulating a human service profession in the State of North	V 297		

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V 297	Continued From page 9 Carolina. For substance-related disorders this shall include a licensed Clinical Addiction Specialist or a certified Clinical Supervisor. (b) The consultation specified in Paragraph (a) of this Rule shall include: (1) clinical supervision of the qualified professional specified in Rule .1702 of this Section; (2) individual, group or family therapy services; or (3) involvement in child or adolescent specific treatment plans or overall program issues. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure face to face clinical consultation was provided in the facility at least four hours a week by a Licensed Professional (LP). The findings are: Review on 8-5-25 of client #1's record revealed: -Date of admission: 5-16-24 -Age: 9 years. -Diagnoses: Attention Deficit Hyperactivity Disorder (ADHD), combined type; Oppositional Defiant Disorder, Post-Traumatic Stress Disorder (PTSD); Sleep Terror history Review on 8-5-25 of client #2's record revealed>: -Date of admission: 12-4-24 -Age: 11 years. -Diagnoses: ADHD; PTSD; Disruptive Mood Dysregulation Disorder. Interview on 8-5-25 with client #1 revealed: -She is reviving therapy at the day program.	V 297		

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V 297	Continued From page 10 -She is not receiving any individual or group therapy in the facility. Interview on 8-5-25 with client #2 revealed: -She has not received any therapy in the facility since she was admitted to the facility. Interview on 8-15-25 with the Owner revealed: -Client #1 received therapy weekly through her day treatment program. -Client #2 was receiving therapy through day treatment before she was discharged from day treatment. -"Right now we don't have an LP. My LP quit about 6 months ago (unsure of the exact date) and I've been trying to find a new LP." -"I am in the process of hiring a new LP. I've interviewed her and she accepted the position then we found out that she can't bill through [Local Management Entity] so we are working on billing then she will start (therapy with clients)." Interview on 8-15-25 with the LP revealed: -She has been speaking with the Owner for a couple of weeks regarding the LP position and providing services for client #1 and #2 however she has not actually seen either client or provided any actual services. - "As it turns out I am not credentialed through [LME], I'm credentialed thought medicaid but not through [LME]." -She is working with her billing agency to work through the credentialing process with the Owner and the LME. -"We (Owner and LP) are scheduled to meet on Tuesday (8-19-25) for a Comprehensive Clinical Assessment for client #1."	V 297		

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V 366	Continued From page 11	V 366		
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 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	V 366		

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V 366	Continued From page 12 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 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	V 366		

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V 366	Continued From page 13 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, interviews and observation the facility failed to implement written policies governing their response to level I incidents. The findings are: Observation of client #2's bedroom on 8-5-25 between 3:30pm and 4pm revealed: -A hole, approximately 12 inches long and 10 inches wide in the drywall on the left side of the bedroom wall above client #2's bed which exposed the brick foundation of the home. -A hole approximately 8 to 9 inches long and 3 to 4 inches wide in the drywall on the left side of the bedroom wall above client #2's bed (approximately 3 feet from the first hole.	V 366		

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V 366	Continued From page 14 -A hole approximately 5 inches long and 2 inches wide in the drywall on the left side of headroom wall. -The glass from client #2's bedroom window was missing and the window was covered with plastic. Review on 8-5-25 ow the facility's incident reports from 5-1-25 to 8-5-25 revealed: -No documentation for the holes in client #2's bedroom walls or for the missing glass from the bedroom window. Review on 8-5-25 of the facility's records revealed: No documentation to support the above incidents had been evaluated to: -Attend to the health and safety needs of individuals involved in the incident. -Determine the cause of the incident. -Developed and implemented corrective measures according to provider specified timeframes not to exceed 45 days. -Developed and implemented measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days. -Assign person(s) to be responsible for implementation of the corrections and preventive measures. Interview on 8-5-25 with client #2 revealed: -She put the holes in the walls because she was angry. Interview on 8-8-25 with the Owner revealed: -There were no incident reports for the period requested. -Incidents had been documented in shift notes. -"I talked to my Associate Professional (AP), she will be responsible for doing the incident reports going forward.	V 366		

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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 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.	V 367		

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V 367	Continued From page 16 (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; (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	V 367		

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V 367	Continued From page 17 (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 reviews and interviews, the facility failed to report all level II incidents in the Incident Response Improvement /system (IRIS) and notify the Local Management Entity (LME)/Managed Care Organization (MCO) responsible for the catchment area where services as required. The findings are: Review on 8-5-25 of the facility records for period of 12-4-25 to 8-5-25 revealed: -No level II incident documenting client #2 being hospitalized from 7-6-25 to 7-11-25 due to aggressive behaviors towards staff and damaging her room by punching a hole in her bedroom wall and throwing a brick through her bedroom window and bursting out the window. -No documentation of an unknown number of incidents from 12-4-24 to 8-5-25 of client #2' becoming aggressive with staff by hitting, kicking, biting and expressing suicidal ideation. Interview on 8-5-25 with staff #1 revealed: -From 12-4-25 to the most recent hospitalization client #2 was having aggressive behaviors including, hitting, the staff, almost daily. -Incident reports were not completed. "I really don't know why. We just always documented her behaviors in the daily notes." -Not sure who would be responsible for the IRIS,	V 367		

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V 367	Continued From page 18 " I guess either [Owner] or [Qualified Professional]." Interview on 8-15-25 with staff #2 revealed: -"[Client #2] will hit, kick, spit, destroy furniture,bust out windows, yeah all of that. She's jumped on multiple staff. It's a lot for her." -No, never completed a incident report. "I'm not sure who would do the IRIS. I guess all things would go through the Owner." Interview on 8-8-25 with the Owner revealed: -There were no IRIS reports for the period requested. - Going forward the Associate Professional will be completing IRIS reports.	V 367		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered.	V 536		

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V 536	Continued From page 19 (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).	V 536		

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V 536	Continued From page 20 (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing,	V 536		

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V 536	Continued From page 21 reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interviews, the	V 536		

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V 536	Continued From page 22 facility failed to ensure staff had completed current and refresher training in seclusion, physical restraint, and isolation/time out affecting 3 of 3 audited staff. (staff #1, Associate Professional (AP), and Executive Director/Qualified Professional (ED/QP) The findings are: Review on 8-8-25 of staff #1's record revealed: -Date of hire: 12-2-24 -No documentation of training in alternatives to restrictive interventions. Review on 8-8-25 of the AP's record revealed: -Date of hire: 9-18-24. -No documentation of training in alternatives to restrictive interventions. Review on 8-8-25 of the QP's record revealed: -Date of hire 7-8-22. -No documentation of training in alternatives to restrictive interventions. Interview on 8-5-25 with staff #1 revealed: -"She never received training in alternative to restrictive interventions. -"I was suppose to get the training. I know he (Owner) is working on getting the training set up but so far I haven't had it." Interview on 8-15-25 with the AP revealed: -"I have not had that training (alternatives to restrictive interventions) since I have been employed with the company." Interview on 8-8-25 with the QP revealed: -She is responsible for ensuring staff complete trainings. -"[Owner] is in the process of securing a trainer for the alternatives to restrictive intervention	V 536		

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V 536	Continued From page 23 training. We had been using an online program until earlier in the year (unsure of the exact date) but [Owner] did not like that program because it was all online. So he (owner) didn't renew the program and he is looking for someone to train the staff. Interview on 8-8-25 with the Owner revealed: -"I am currently in the process of looking for a trainer. I'm trying to find someone local that will come to us (faciity) and train all the staff. I was using a program (unnamed) that was approved by the state but I didn't like it because it was all online and I didn't feel like the staff was getting what they needed from the program." This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 536		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out	V 537		

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V 537	Continued From page 24 and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which 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;	V 537		

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V 537	Continued From page 25 (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation	V 537		

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V 537	Continued From page 26 of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or	V 537		

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V 537	Continued From page 27 train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure staff had completed current and refresher training in seclusion, physical restraint, and isolation/time out affecting 3 of 3 audited staff. (staff #1, Associate Professional (AP), and Executive Director/Qualified Professional (ED/QP) The findings are: Review on 8-8-25 of staff #1's record revealed: -Date of hire: 12-2-24 -No documentation of training in seclusion, physical restraint, and isolation/time out. Review on 8-8-25 of the AP's record revealed: -Date of hire: 9-18-24. -No documentation of training in seclusion, physical restraint, and isolation/time out. Review on 8-8-25 of the QP's record revealed: -Date of hire 7-8-22. -No documentation of training in seclusion, physical restraint, and isolation/time out. Interview on 8-5-25 with staff #1 revealed: -"She never received training in seclusion, physical restraint, and isolation/time out. -"I was suppose to get the training. I know he (Owner) is working on getting the training set up but so far I haven't had it."	V 537		

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V 537	Continued From page 28 Interview on 8-15-25 with the AP revealed: -"I have not had that training seclusion, physical restraint, and isolation/time out since I have been employed with the company." Interview on 8-8-25 with the QP revealed: -She is responsible for ensuring staff complete trainings. -"[Owner] is in the process of securing a trainer for the alternatives to restrictive intervention training. We had been using an online program until earlier in the year (unsure of the exact date) but [Owner] did not like that program because it was all online. So he (owner) didn't renew the program and he is looking for someone to train the staff. Interview on 8-8-25 with the Owner revealed: -"I am currently in the process of looking for a trainer. I'm trying to find someone local that will come to us (faciity) and train all the staff. I was using a program (unnamed) that was approved by the state but I didn't like it because it was all online and I didn't feel like the staff was getting what they needed from the program." This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 537		
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.	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-382	A. BUILDING: _____ B. WING _____	R 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAY'S HOUSE	214 AUTEN CIRCLE 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 736	Continued From page 29 This Rule is not met as evidenced by: Based on interviews and observation the facility was not maintained in a clean, safe, attractive and orderly manner. The findings are: Observation of client #2's bedroom on 8-5-25 between 3:30pm and 4pm revealed: -A hole, approximately 12 inches long and 10 inches wide in the drywall on the left side of the bedroom wall above client #2's bed which exposed the brick foundation of the home. -A hole approximately 8 to 9 inches long and 3 to 4 inches wide in the drywall on the left side of the bedroom wall above client #2's bed (approximately 3 feet from the first hole. -A hole approximately 5 inches long and 2 inches wide in the drywall on the left side of headroom wall. -The light switch cover was cracked and broken and approximately 1//3rd of the cover was missing. -The ceiling title was buckling and pulling away from the ceiling. Interview on 8-5-25 with client #2 revealed -She put the holes in the walls because she was angry. -Client #2 was unsure of specific dates when the damages occurred. "They (holes) have been there a long time." -"This one (Observed client #2 point to the largest hole) really wasn't that big at first. That got there from me banging my head on the wall. Then after it was there I just kept putting my hand in it and picking the dry wall until it got bigger and bigger. -"I broke the glass two weeks ago because I was having a behavior. -"[Owner] said he was going to fix it but he never did "Yeah, they have been there a long time."	V 736		

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 736	Continued From page 30 Interview on 8-8-25 with the Owner revealed: -He was aware of the damages client #2 caused in her room. -"I'm waiting on DSS (Department of Social Services) to pay me for the damages. I've submitted two invoices to DSS. They have not paid either one (of the invoices)."	V 736		

DHSR Plan of Correction

V108

To make corrections, the Qualified Professional will review records to see who does not have CPR and seizure management trainings. Trainings will be scheduled for those who do not have them. Trainings will be scheduled and then documented in personnel records. Prevention of inadequacy of this finding will be enforced by making sure that trainings are scheduled, taken, and documented within 30 days of hire as well as before CPR certificates expire. [redacted](QP) will monitor records quarterly.

V293

Correction: Staff will ensure coordination of care with other individuals and agencies within the child's system of care by contacting the legal guardian/social worker immediately concerning any disruption of placement or hospitalizations. To prevent insufficient contact, staff will be trained to contact both chain of command (Associate Professional/Qualified Professional/Owner) as well as the legal guardian of client. The Qualified Professional will update Population Served training to include contacting all stakeholders involved in child's system of care. Trainings will be monitored or reviewed yearly to ensure all updates are prolific.

V296

Correction: The Owner will ensure that 2 staff are present for all shifts. More staff will be hired or placed on-call to cover shifts in the time that a staff member quits or calls out. To prevent further inadequacies, the Owner will schedule 2 staff per shift accordingly as well as enforce an on-call list; which will be added to the schedule. The Owner will hold staff responsible for making the proper contacts when quitting or calling out. The Owner will monitor the schedule weekly and monitor staff daily to ensure that all shifts are covered by 2 staff members.

V297

Correction: The Owner will hire a LP to provide therapy to clients within the group home. To prevent further inadequacies, the owner will consistently advertise for the LP position if it occurs that we lose another LP. The owner will monitor having a LP that consistently provides therapy to the group home clients by immediately advertising in the event that we don't have one and will consistently advertise until the position is filled.

V366

All incidents will be properly documented and reported to the proper agencies and authorities according to Level I, Level II, or Level III status. Level I incidents (including property damage) will be internally reported and documented within 24 hours. The Associate Professional will be held responsible for ensuring that all Level I incidents are documented and reported. All Level I incidents will be reported to the host LME quarterly.

Staff will completely attend to the health and safety needs of individuals involved in the incident before proceeding to document. Once a stable environment is achieved after an incident, staff must document the facts of the incident to determine the cause of the incident.

Reviews will be conducted to determine whether incidents were properly responded to, to determine the cause of the incident, to take appropriate corrective measures and actions, and to develop and implement measures to prevent similar incidents in the future. Once corrective measures have been established, the Associate Professional will be held responsible for implementing the corrective and preventive measures. Establishing and implementing corrective and preventive measures shall not exceed 45 days from the initial date of the incident.

Staff will do a review of IRIS manual trainings to refresh on how to properly respond to all incidents. The Associate Professional will ensure that all incident reports are properly documented (within 24 hrs) and reported in a timely manner, in accordance to Level I, II, or III status to prevent further inadequacies. The Owner and/or QP will monitor the Associate Professional to ensure that he/she remains in compliance with this rule after each incident.

V367

Correction: All Level II incidents will be reported through IRIS and will also be reported to the proper LME. All incidents will be properly documented and reported to the proper agencies and authorities according to Level I, Level II, or Level III status. Level II incidents will be documented and reported through the IRIS system and reported to the LME within 72 hours. The Associate Professional will be held responsible for overseeing paraprofessionals to ensure that all incidents are properly documented and then reported to all participants of client's system of care, IRIS, and LME. To prevent further inadequacies, the owner will ensure that all staff is refreshed in IRIS training and that all staff understand

expected procedures. The owner will monitor to ensure that both staff and the Associate Professional are complying with reporting procedures after each incident.

V536

Correction: Training on Alternatives to Restrictive Interventions will be scheduled and completed for all employees that need it. To prevent future deficiencies, newly hired employees will complete this training within 30 days of hire. The Executive Director will monitor these trainings to ensure that all employees take refresher courses in a timely manner (once a year). The Executive Director will monitor and review staff records quarterly to ensure that all trainings including Alternatives to Restrictive Interventions are up to date.

V537

According to our Policy and Procedure Manual, Seclusion, Physical Restraint, and Isolation Time-Out are prohibited procedures. Physical Restraint will be considered once a suitable CPI training is completed by staff. Once training is completed, physical restraint will no longer be a prohibited procedure and our policies and procedure manual will be updated to reveal as such.

V736

The owner is responsible for all needed repairs. The owner will complete the necessary steps to repair all damaged dry wall. To prevent future deficiencies, the owner will complete repairs in a timely manner. Staff will review the facility daily to look for any other damages to the group home and will report all damages to the owner. Both staff and the owner will monitor to ensure that damages are reported and repaired as soon as possible.

All corrections will be made by October 14, 2025.