

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 10/28/2025
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NAME OF PROVIDER OR SUPPLIER NEWPORT ACADEMY-LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 10450 BRIEF ROAD CHARLOTTE, NC 28227
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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 000	<p>INITIAL COMMENTS</p> <p>A complaint and follow up survey was completed on 10/28/25. The complaints were unsubstantiated (intake #NC00233842 and #NC00233981). A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents.</p> <p>This facility is licensed for 6 and has a current census of 6. The survey sample consisted of audits of 2 former clients.</p>	V 000		
V 367	<p>27G .0604 Incident Reporting Requirements</p> <p>10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS</p> <p>(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:</p> <p>(1) reporting provider contact and identification information;</p> <p>(2) client identification information;</p> <p>(3) type of incident;</p> <p>(4) description of incident;</p> <p>(5) status of the effort to determine the</p>	V 367		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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V 367	<p>Continued From page 1</p> <p>cause of the incident; and</p> <p>(6) other individuals or authorities notified or responding.</p> <p>(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:</p> <p>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or</p> <p>(2) the provider obtains information required on the incident form that was previously unavailable.</p> <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <p>(1) hospital records including confidential information;</p> <p>(2) reports by other authorities; and</p> <p>(3) the provider's response to the incident.</p> <p>(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).</p> <p>(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</p>	V 367		

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V 367	<p>Continued From page 2</p> <p>include summary information as follows:</p> <ol style="list-style-type: none"> (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 (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure an incident report for a level II incident was completed and submitted within 72 hours of becoming aware of the incident. The findings are:</p> <p>Review on 10/20/25 of the North Carolina Incident Response Improvement System (IRIS) revealed: -No level II incident report was completed for Former Client (FC) #8's suicidal attempt that resulted in transportation to a local hospital by emergency services on 9/25/25.</p> <p>Review on 10/20/25 of the facility's incident report dated 9/25/25 revealed:</p>	V 367		

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V 367	<p>Continued From page 3</p> <p>-FC #8 "tried to go into a corner out of staff's vision to first use a belt to choke herself then once that was taken, tried to choke herself with her bare hands."</p> <p>-FC #8 "was not able to contract for safety and refused to do a risk assessment so I was instructed to call medic and police."</p> <p>-FC #8 was transported to the local hospital by the medic for psychiatric evaluation.</p> <p>Attempted interview on 10/24/25 with FC #8 was unsuccessful due to her refusal to talk to the surveyor.</p> <p>Interview on 10/28/25 with the Executive Director revealed:</p> <p>-Did not complete an IRIS report for FC #8's 9/25/25 incident that resulted in FC #8 being hospitalized.</p> <p>-Thought that it was a breach of confidentiality to report the incident through IRIS since the facility did not contract with Managed Care Organizations in North Carolina.</p> <p>-Planned to report future incidents via fax to IRIS.</p> <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 367		