STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL013-226	A. BUILDING: _____ B. WING _____	R 10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNION POINT	519 UNION STREET SOUTH CONCORD, NC 28025

(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	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 10/21/25. The complaint was unsubstantiated (Intake #NC00233789). 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 6 and has a current census of 3. The survey sample consisted of audits of 3 current clients.	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	V 112		

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V 112	Continued From page 1 obtained. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to develop and implement goals and strategies in the treatment/habilitation plan to address the client's needs for 1 of 3 clients (#2). The findings are: Review on 10/9/25 of Client #2's record revealed: - Admission date 8/20/25; - Age 17 years old; - Diagnoses Oppositional Defiant Disorder, Intermittent Explosive Disorder, Post Traumatic Stress Disorder, Cannabis Use Disorder; - Comprehensive Clinical Assessment (CCA) addendum dated 6/20/25- " ... This level of care will provide a safe and stable environment to address the client's behavioral, emotional, and substance use needs while promoting skill development and accountability;" - Person Centered Plan (PCP/treatment plan dated on 10/16/24 and updated on 8/20/25 with no goals or strategies related to substance use. Interview on 10/10/25 with the Qualified Professional revealed: - Reviewed Client #2's CCA addendum dated 6/20/25 prior to admission on 8/20/25; - Was responsible for completing and updating treatment plans;	V 112		

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V 112	Continued From page 2 - The goals in the treatment plan were decided by Client #2 and his legal guardian - "I have tried talking to him (Client #2) concerning the PCP but he knows it all."	V 112		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118		

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V 118	Continued From page 3	V 118		

This Rule is not met as evidenced by:
Based on record reviews, interviews and observation, the facility failed to ensure medications were administered on the written order of a physician and ensure that the MARs was kept current affecting 3 of 3 of clients (client #1, #2 and #3). The findings are:

Cross Reference: 10A NCAC 27G .0209 Medication Requirements (V123). Based on record reviews and interviews the facility failed to ensure all medications errors were reported immediately to a pharmacy or physician affecting 3 of 3 clients (client #1, #2 and #3).

Review on 10/6/25 of Client #1's MARs from 7/1/25 to 10/6/25 revealed the following medications were administered without a physicians' order on site:
- Erythromycin ointment 3500grams (pink eye), initialed as administered at 8am and 8pm from 7/24/25 to 7/28/25, 8am on 7/29/25 and 7/30/25;
- Cyproheptadine 4mg (milligram) (appetite), initialed as administered at 8am from 8/27/25 through 9/10/25, 9/12/25 through 9/23/25 and 10/4/25 and 10/5/25;
- Melatonin (sleep aid), initialed as administered on 8/3/25, 8/7/25, 9/14/25 through 9/18/25, 9/20/25 and 9/21/25 with no reason why the medication was administered or effectiveness documented;
- Dexmethylphenidate ER (extended release) 25mg (Attention Deficit Hyperactivity Disorder) (ADHD), Take one capsule by mouth every morning, No initials for documentation of

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V 118	Continued From page 4	V 118		

administration on 9/30/25;
- Risperidone 0.25mg (anxiety), Take 1 tablet by mouth every night, No initials for documentation of administration on 9/30/25.

Review on 10/6/25 of Client #2's record revealed:
- No physicians' order in Client #2's medical record for Erythromycin ophthalmic ointment.

Review on 10/6/25 of Client #2's MARs for 8/20/25 to 10/6/25 revealed the following medications were administered without a physicians' order on site:
- Emtricitabine 200-300mg (Human Immunodeficiency Virus/HIV prevention), first administration documented on 9/13/25;
- Levocetirizine 5mg (allergies), administration time initialed as 8am and 8pm on the 8/25, 9/25 and 10/25 MARs. Initialed as administered twice at 8am and 8pm on 9/2/25 to 9/4/25, 9/9/25, 9/15/25 to 9/17/25;
- Hydroxyzine 50mg (anxiety), initialed as administered on 8/24/25;
- Cromolyn 10ml (milliliter) (dry eye), initialed as administered on 8/27/25.

Observation on 10/6/25 at approximately 5:45pm of Client #2's medication storage container revealed:
- One opened tube of Erythromycin ophthalmic ointment 0.5% (5mg/g) and one unopened tube of Erythromycin ophthalmic ointment 0.5% (5mg/g).

Further review on 10/6/25 of Client #2's MARs for 8/20/25 through 10/7/25 revealed:
- No documentation of Erythromycin ophthalmic ointment being administered for the review period.

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V 118	Continued From page 5 Review on 10/6/25 of Client #3's MARs for 7/9/25 through 10/6/25 revealed the following medications were administered without a physicians' order on site: - Methylphenidate 54mg (ADHD), initialed as "O" (other see note) for administration from 8/10/25 through 8/13/25 however, there was no explanation noted on MAR; - Methylphenidate 36mg, order dated 9/5/25 there were no initials for administration until 9/18/25; - Flonase 200mg (allergies), listed on the 9/25 MAR to be administered at 8am, however, there were no initials for administration from 9/1/25 to 9/30/25. September MAR documented with 0's on 9/1/25 through 9/6/25. Notes in the comment section for 9/1/25 - 9/5/25 "out of nasal spray" 9/16/25 waiting on refill. 9/717/25 refill will be ready after 2pm. 9/29/25 refused all meds went to BH (behavioral health);" - Flonase 200mg no initials for administration on the 10/2025 MAR. - Initialed as administered on the back of the July 2025 MAR as "non-prescription medication given:" - 7/24/25 5:30pm Aspirin 81mg (pain relief); - 7/26/25 through 7/28/25 (8pm) Melatonin 10mg; - There were no administration instructions documented on the MARs, no documentation as to why the medication was administered or effectiveness of the medication. - Initialed as administered on the back of the August 2025 MAR as "non-prescription medication given:" - 8/3/25 8:55pm melatonin; - 8/6/25 8pm melatonin; - 8/7/25 8pm melatonin; - 8/12/25 "8" melatonin; - There were no administration instructions	V 118		

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V 118	Continued From page 6 documented on the MARs, no documentation as to why the medication was administered or effectiveness of the medication. - Initialed as administered on the back of the September 2025 MAR as "non-prescription medication given:" - 8/7/25 8pm melatonin; - 9/14/25 through 9/21/25 8pm melatonin; - 9/23/25 8pm melatonin; - 9/25/25 through 9/27/25 8pm melatonin; - 9/30/25 8pm melatonin; - There were no administration instructions documented on the MARs, no documentation as to why the medications were administered or effectiveness of the medication. - Initialed as administered on the back of the October 2025 MAR as "non-prescription medication given:" - 10/1/25 8pm melatonin; - 10/3/25 8pm melatonin; - There were no administration instructions documented on the MARs, no documentation as to why the medications were administered or effectiveness of the medication. Interview on 10/6/25 with Client #1 revealed: - Received medications daily; - "Was out of medication one time when came back from therapeutic leave but received the medication." Interview on 10/6/25 with Client #2 revealed: - "Most medications are PRN (as needed), so I take as needed." Interview on 10/6/25 with Client #3 revealed: - Received medications.	V 118		

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V 118	Continued From page 7 Interview on 10/6/25 with Staff #1 revealed: - Only lead staff administered medications. Interview on 10/6/25 with Staff #2 revealed: - She administered medications; - Denied clients "run out" of medications. Interview on 10/9/25 and 10/15/25 with the Associate Professional (AP) revealed: - Qualified Professional (QP) monitors the MARs and ensures physicians' orders and medications are in the facility. - "[QP] is responsible for the MARs, medications and physician orders"; - He was unaware that the medication information leaflets were not physicians' orders; - "When we get a med (medication) from the pharmacy, we take the order that comes with the prescription (information leaflet), and we put it with the MAR. That's what we use as the doctor's order, we thought that was the order;" - "The MARs are being monitored weekly by me and [QP]. I know I look over them to make sure there are no holes on the MARs and make sure all the staff have signed off on the MARs and things like that. I usually do my checks (MAR) on Mondays after the weekend. I'm not sure when she (QP) does hers (monitors the MARs). Not sure exactly what she checks;" - He was unaware that the administration instructions for Client #2's Levocetirizine were incorrect on the MARs for August, September and October 2025 MARs and that Client #2 had received double doses of his Levocetirizine on 9/2/25 to 9/4/25, 9/9/25, 9/15/25 to 9/17/25; - Did not know why staff had not documented PRNs correctly or why there was no documentation of why medications were not being administered to Client #1 (Dexmethylphenidate ER 9/30/25 and	V 118		

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V 118	Continued From page 8 Risperidone .25mg 9/30/25) and Client #3 (Methylphenidate 54mg from 8/10/25 through 8/13/25) was missing; - "Yeah, yeah, all of that should have been caught. I don't know how we would have missed all of that." Interview on 10/10/25 and 10/15/25 with the QP revealed: - "I review MARs twice a month;" - Ensured the MARs were documented and that staff initialed MARs correctly; - Ensured that each medication had a physicians' order; - "We (staff) just found out that we needed signed orders (physicians orders). We are working to make sure that all the clients have the signed orders in the facility;" - "We had physicians' orders for meds, last month when we had management meeting;" - Was unaware that the administration instructions for Client #2's Levocetirizine were incorrect on the MARs for August, September and October 2025 MARs and that Client #2 had received double doses of his Levocetirizine on 9/2/25 to 9/4/25, 9/9/25, 9/15/25 to 9/17/25; - Did not know why staff had not documented PRNs correctly or why there was no documentation of why medications were not being administered to Client #1 (Dexmethylphenidate ER 9/30/25 and Risperidone .25mg 9/30/25) and Client #3 (Methylphenidate 54 mg from 8/10/25 through 8/13/25) was missing; - Not sure what clients are taking their medications for. "I'm not a medical provider. There's no reason I should know what their meds (medications) are for;" - "I am not working right now, I'm not in my office and I don't have my laptop. I can pull up all that	V 118		

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information (physicians' orders/documentation of medical visits/guardian information) on my laptop once I get to my office and look at what you are asking. I can give you a call back when I get to my laptop and call you back."

- The QP had not returned call prior to survey exit.

Due to the failure to accurately document medications administration, it could not be determined if clients received their medications as ordered by the physician.

Review on 10-17-25 of the facility's Plan of Protection dated 10-17-25 and signed by the Quality Management (QM) Director revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care?

- On 10/10/2025 the Quality Management Director met with the house QP, AP and shift team lead to retrain and review all medication policies and procedures.
o This training included:
" How to accurately document medications on the MAR
" How to document medication errors, and who needs to be notified in the event of a med (medication) error.
" requirements of obtaining E-scripts Med (medication) orders from the pharmacy
" review of how to communicate medication changes to the team
" processes on how to document those medication changes on the MAR.
" what qualifies an incident report as it pertains to the MAR
" the requirement of needing a script for any medication including over the counter meds

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V 118	Continued From page 10 (medications). - On 10/10/2025 the team lead communicated e-script needs with the pharmacy. The pharmacy agreed to release the script they receive from the medical provider in addition to the medication packet on the front of the med (medication) pack. - Turning Point Homes (Licensee) has scheduled a all-staff meeting on 10/17/2025 to address medication compliance. o QM director will create a MAR/Medication admin (administration) check list as a resource for staff administering medication starting 10/17/2025. This check list will be utilized by all staff administering medication. o Review when Incident reports are required as it pertains to the MAR. o Program director will review Medication policies and procedures with all staff. - Turning Point Homes will require all clients to go to [Local pharmacy] in order to acquire the Med order that the prescribing physician sends directly to the pharmacy. o The QP and AP will check MAR daily to ensure adherence to Medication Administration Rules. Describe your plans to make sure the above happens. - The AP and QP will review MARS daily. - The AP and QP will submit a checklist to the Quality Management Director Weekly to report Medication changes. - The Quality Management Director will meet with the QP, AP and Team leader each month until MAR compliance is brought back into standard." Review on 10-20-25 of the facility's amended plan of protection dated 10-20-25 and signed by the Quality Management Director revealed:	V 118		

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V 118	Continued From page 11 o "Our Medical provider [Local Provider], PA-C (Physician Assistant-Certified) will train our QP, AP, house team leaders, program Director on Medication Administration on 10/21/2025 at 11:30 am. Describe your plans to make sure the above happens. - QM director will maintain oversight of the AP and QP to ensure compliance with medication and MARS. - The AP and QP will review MARS daily - The AP and QP will submit a checklist to the Quality Management Director Weekly to report Medication changes. This checklist will highlight the following areas: o Staff will sign and initial off on the MAR o Staff will document Medication errors on the MAR as applicable o Staff will observe, monitor and document medication side effects o Staff will attach the Med (medication) order to the MAR o ETC (et cetera). - The Quality Management Director will meet with the QP, AP and Team leader each month until MAR compliance is brought back into standard." The facility served clients ranging from 12-17 years diagnosed with Post Traumatic Stress Disorder, Impulse Control, Conduct Disorder and Attention Deficit Hyperactivity Disorder. Between July 2025- October 2025, facility staff administered Client #1, #2, #3 medications approximately 56 times in total without a written physician. Client #2 received double doses of an allergy medication on five separate occasions. Client #2's medication storage container contained an opened and unopened tube of an	V 118		

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V 118	Continued From page 12 eye cream but there was no physician order or documentation of the eye cream. The facility also failed to notify a pharmacist of physician about medication errors, missed does, and client refusals for Client #1, #2 and #3. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 118		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. . This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure all medication errors were immediately reported to a physician or pharmacist affecting 3 of 3 clients (client #1, #2 and #3). The findings are: Review on 10/9/25 of Client #1's record revealed: - Date of admission: 5/19/25; - Age: 16 years; - Diagnoses: Post Traumatic Stress Disorder	V 123		

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V 123	Continued From page 13 (PTSD); Other Specified Disruptive Disorder; Impulse Control and Conduct Disorder; - Physicians' orders for the following: - 5/20/25 Dexmethylphenidate ER (extended release) 25mg (milligram) (Attention Deficit Hyperactivity Disorder/ADHD), take one capsule by mouth every morning; - 5/20/25 Risperidone 0.25mg (anxiety), take 1 tablet by mouth every night; - There were no physicians' orders for the following: - Erythromycin ointment 3.500grams (pink eye), Apply 0.5 inches in the right eye twice daily for 7 days; - Cyproheptadine 4mg (appetite), Take one tablet by mouth every morning. Review on 10/6/25 of Client #1's MARs for July 2025 revealed: - Erythromycin ointment 3.500grams initialed as "R" (refused) on 7/29/25 and 7/30/25; - There was no documentation reported to Client #1's physician or pharmacist for Client #1's refusal of Erythromycin ointment on 7/29/25 and 7/30/25. Review on 10/6/25 of Client #1's MARs for August 2025 revealed: - Dexmethylphenidate Extended Release 25mg initialed as "R" (refused) from 8/13/25 to 8/26/25; - Risperidone 0.25mg initialed as "R" on 8/23/25; - Risperidone 0.25mg initialed as "R" on 8/24/25; - There was no documentation reported to Client #1's physician or pharmacist for Client #1's refusal of Dexmethylphenidate from 8/13/25 to 8/26/25 and Risperidone on 8/23/25 and 8/24/25. Review on 10/6/25 of Client #1's MARs for September 2025 revealed:	V 123		

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V 123	Continued From page 14 - Cyproheptadine 4mg initialed as "R" on 9/11/25; - There was no documentation of administration for Dexmethylphenidate ER and Risperidone on 9/30/25; - There was no documentation reported to Client #1's physician or pharmacist for Client #1's refusal of Cyproheptadine on 9/11/25 or for no initials for documentation of Dexmethylphenidate or Risperidone on 9/30/ 25. Review on 10/9/25 of Client #2's record revealed: - Date of admission: 8/20/25; - Age: 17 years; - Diagnoses: PTSD; Intermittent Explosive Disorder; Oppositional Defiant Disorder (ODD); Cannabis Use Disorder; - Physicians' order for the following: - 9/11/25 Emtricitabine 200-300mg (Human Immunodeficiency Virus/HIV prevention), take one tablet by mouth daily. Review on 10/6/25 of Client #2's September 2025 MARs revealed: - Emtricitabine 200-300mg initialed as "R" on 9/19/25, 9/20/25, 9/21/25, 9/28/25, 9/29/25 and 9/30/25; - There was no documentation reported to Client #2's physician or pharmacist for Client #2's refusal of Emtricitabine on 9/19/25, 9/20/25, 9/21/25, 9/28/25, 9/29/25 and 9/30/25. Review on 10/6/25 of Client #2's October 2025 MARs revealed: - Emtricitabine 200-300mg initialed as "R" on 10/1/25, 10/4/25; - There was no documentation reported to Client	V 123		

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V 123	Continued From page 15	V 123		

#2's physician or pharmacist for Client #2's refusal of
Emtricitabine on 10/1/25 or 10/4/25.

Review on 10/6/25 of Client #3's record revealed:
- Date of admission: 7/9/25;
- Age: 12 years;
- Diagnoses: ODD; ADHD, combined presentation; Unspecified Trauma and Stressor related Disorder;
- Physicians' order for the following:
  - 9/25/25-Methylphenidate 36mg (ADHD), take one tablet by mouth every morning;
  - 10/9/25-Risperidone 0.5mg (anxiety), take 1 tablet by mouth two times a day;
  - 8/7/25-Guanfacine 4mg (ADHD), take 1 tablet by mouth at bedtime;
  - 6/30/25-Hydroxyzine 50mg (anxiety), Take one tablet by mouth two times a day as needed;
- No physicians' orders for the following:
- Methylphenidate 54mg;
- Melatonin 10mg (sleep);
- Aspirin 81mg (pain relief);
- Flonase 200mg (allergies) administer 2 sprays into each nostril every morning.

Review on 10/6/25 of Client #3's August 2025 MARs revealed:
- Guanfacine 4mg initialed as "R" on 8/19/25;
- Methylphenidate 54mg initialed as "O" (other see note) from 8/10/25 through 8/13/25 however there was no explanation noted on MAR;
- There was no documentation reported to Client #3's physician or pharmacist for Client #3's refusal of
Guanfacine on 8/19/25 or for no administration of Methylphenidate from 8/10/25 through 8/13/25.

Review on 10/6/25 of Client #3's September 2025

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V 123	Continued From page 16 - October 2025 MARs revealed: - Guanfacine 4mg initialed as "R;" - Risperidone 0.5mg initialed as "R" on 9/2/25; - Methylphenidate 36 mg initialed as "R" on 9/2/25; - Flonase 200mg was not initialed for documentation on 9/1/25, 9/2/25, 9/3/25, 9/4/25, and 9/5/25; - Methylphenidate 36 mg: order dated 9/5/25 was not initialed for documentation of administration until 9/18/25; - Flonase 200mg, listed on the 9/25 MAR to be administered at 8am, however was not initialed for documentation of administration from 9/1/25 to 9/30/25. 9/25 MAR initialed as 0's on 9/1/25 through 9/6/25. Notes in the comment section for 9/1/25 through 9/5/25 "out of nasal spray" 9/16/25 waiting on refill. 9/17/25 refill will be ready after 2pm; 9/29/25 refused all meds went to BH (behavioral health);" - Flonase 200mg not documented on the 10/25 MAR; - There was no documentation reported to Client #3's physician or pharmacist for Client #3's refusal of Guanfacine on 9/29/25, Risperidone and Methylphenidate on 9/2/25. Interview on 10/9/25 with the Associate Professional (AP) revealed: -"Most of the time, they (clients) don't have any problem taking their meds (medications). But they are allowed to refuse meds (medications). Refusals are documented on MARs." -"Yes, someone should be calling the doctor (to inform of medication refusals), I believe that would be [Qualified Professional/QP]." Interview on 10/10/25 and 10/15/25 with the QP revealed:	V 123		

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V 123	Continued From page 17 -Was not sure who was reporting medication errors or refusals to the pharmacy. "I'm sure that that is being done, I'm just not sure who exactly is doing it. I believe it would be [AP's] responsibility." This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type A1 rule violation and must be corrected within 23 days.	V 123		
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. (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	V 296		

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V 296	Continued From page 18 (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. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure the minimum staffing ratio of two staff for up to four adolescents. The findings are: Observation on 10/6/25 of the facility at approximately 2:25pm-3:05pm revealed: - Division Health Service Regulation surveyors arrived at the facility at 2:25pm and rang the door bell, no answer; - Client #2 arrived at the facility walking alone at 2:40pm and preceded to walk to the back of the facility and entered the facility; - At 2:41pm surveyors walked to the back of the facility and no one was there, the back door was ajar;	V 296		

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V 296	Continued From page 19 - Staff #2 arrived at the facility at 3:00pm; - Staff #1 arrived at the facility at 3:05pm. Review on 10/9/25 of Client #2's record revealed: - Admission date 8/20/25; - Age 17 years old; - Diagnoses: Oppositional Defiant Disorder, Intermittent Explosive Disorder, Post Traumatic Stress Disorder, Cannabis Use Disorder. Interview on 10/6/25 with Client #2 revealed: - At 2:46pm came to the front door of the facility and asked the Division Health Service Regulation (DHSR) surveyors if they were at the facility for the Shift Supervisor; - At 2:49pm returned back to the front door and informed DHSR surveyors that staff would be at the facility in 5-10 minutes; - Was not aware staff was not at the facility when arrived to the facility from school; - Today (10/6/25) was the first time any staff was not at the facility when arrived from school; - Rode the bus home from school; - Walked to the facility from bus stop; - Arrived to the facility each day from school around 2:45-2:50pm. Interview on 10/6/25 with Client #1 revealed: - Two or three staff worked each shift; - Never left alone in the facility. Interview on 10/6/25 with Client #3 revealed: - Never left alone in the facility; - Refused to state how many staff worked each shift. Interview on 10/6/25 with Staff #1 revealed: - Worked 2nd shift (3pm-11pm); - Shift Supervisor worked until 7pm with 2nd shift staff;	V 296		

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V 296	Continued From page 20 - Four staff worked each shift when 6 clients were in the facility; - 2 staff work each shift due to only 3 clients in the facility; - Client #2 arrived daily at the facility from school before the start of his shift. Interview on 10/6/25 with Staff #2 revealed: - Two or three staff worked each shift; - Client #2 arrived at the facility from school before the start of her shift daily. Interview on 10/6/25 with the Shift Supervisor revealed: - Left the facility with Client #1 and Client #3 to purchase food on 10/6/25; - Received a telephone call from Client #2, that surveyors were at the facility; - Client #2 was not due to be at the facility from school until after 3pm; - Staff #1 and Staff #2 usually started shift between 2:45pm-2:50pm; - Two or three staff worked each shift. Interview on 10/9/25 with the Associate Professional revealed: - "We (administrative staff) try to have 2-3 staff work each shift depending on how many clients are in the home (facility) at the time;" - "I work all shifts, anytime someone (staff) calls out. The last few months I have been working the weekend shift." Interview on 10/10/25 with the Licensed Professional/Program Director revealed: - Two or three staff are on shift depending on the ratio of clients in the home; - "He (Client #2) will be turning 18 in a few days he wants to come and go as he pleases and we (staff) are dealing with those behaviors with him	V 296		

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V 296	Continued From page 21 now."	V 296		
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	V 366		

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or while the client is on the provider's premises. The policies shall require the provider to respond by:
(1) immediately securing the client record by:
(A) obtaining the client record;
(B) making a photocopy;
(C) certifying the copy's completeness; and
(D) transferring the copy to an internal review team;
(2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:
(A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;
(B) gather other information needed;
(C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and
(D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for

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V 366	Continued From page 23 minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement written policies governing their responses to level II incidents affecting 3 of 3 clients (Client #1, #2, #3). The findings are: Review on 10/6/25 of the facility's incident reports for Client #1 from July 1, 2025-October 6, 2025 revealed: No incident reports or Risk/Cause/Analysis for: - Client #1's refusal of Erythromycin ointment 3.500 grams two times in July (7/29, 7/30/25); - Client #1's refusal of Risperidone 25 mg two	V 366		

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times in August (8/23-8/24/25);
- Client #1's refusal of Dexmethylphenidate Extended Release 25 mg (milligram) 14 times in August (8/14-8/26/25) 8/13/25;
- Client #1 refused Dexmethylphenidate Extended Release 25 mg on 9/11/25;
- Client #1 refused Cyproheptadine 4 mg on 9/11/25.

Review on 10/6/25 of the facility's incident reports for Client #2 from July 1, 2025-October 6, 2025 revealed:
No incident reports or Risk/Cause/Analysis for:
- Client #2's refusal of Emtricitabine 200-300mg four times in September (9/19, 9/28-9/30/25);
- Client #2's Emtricitabine 200-300mg was not administered two times in September (9/20, 9/21/25);
- Client #2's refusal of Emtricitabine 200-300mg two times in October (10/1-10/4/25).

Review on 10/6/25 of the facility's incident reports for Client #3 from July 1, 2025-October 6, 2025 revealed:
No incident reports or Risk/Cause/Analysis for:
- Client #3 refused Guanfacine 4mg on 8/19/25;
- Client #3 refused Guanfacine 4mg on 9/29/25;
- Client #3 refused Risperidone 0.5mg on 8/2/25
- Client #3 refused Risperidone 0.5mg on 9/2/25;
- Client #3 refused Methylphenidate 36mg on 9/2/25;
- Client #3's Flonase 200mg was not administered five times in September(9/1-9/5/25).

Interview on 10/6/25 with Staff #2 revealed:
- Completed incident reports when a client refused medication on her shift;
- Was not aware incident reports were not being completed when a client refused their medications.

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V 366	Continued From page 25 Interview on 10/9/25 with the Associate Professional revealed: - Was responsible for making sure incident reports were completed; - Documented on the MARs, and in the client's notes if the clients refused their medication but did not complete an incident report; - Planned to start documenting medication refusal on incident reports. Interview on 10/10/25 with the Qualified Professional revealed: - Learned in a meeting in September (2025), that incident reports should be completed when a client refused their medication.	V 366		
V 752	27G .0304(b)(4) Hot Water Temperatures 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (4) In areas of the facility where clients are exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit. This Rule is not met as evidenced by: Based on the interviews and observation the facility failed to ensure that hot water was maintained between 100 and 116 degrees Fahrenheit. The findings are: Observation on 10/6/25 at approximately 3:41-3:47pm of the facility's hot water	V 752		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNION POINT	519 UNION STREET SOUTH CONCORD, NC 28025

(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 752	Continued From page 26 temperature revealed: - Water temperature in the kitchen sink was 135 degrees Fahrenheit - Water temperature in Client #2's bathroom sink was 135 degrees Fahrenheit - Water temperature in Client #3's bathroom sink was 135 degrees Fahrenheit - Water temperature in the bathroom in the hallway was 135 degrees Fahrenheit Interview on 10/6/25 with Client #1 revealed: - "I think it's too low, the water is cold; - Had not been burned by the water. Interview on 10/6/25 with Client #2 revealed: - The water was not too hot; - Had not been burned by the water. Interview on 10/6/25 with Client #3 revealed: - The water was not too hot; - Had not been burned by the water. Interview on 10/6/25 with Staff #1 revealed: - There were three water temperature levels (A, B, C) on the hot water heater; - Turned the hot water heater back down to level A from level B on 10/6/25 due to level B water temperature being too hot; - "Level A is usually not hot enough;" - Hot water temperature was turned up to level B on 10/6/25 so the facility could be clean due to a staff member being sick in the facility over the weekend. Interview on 10/6/25 with Staff #2 revealed: - Clients nor facility staff were burned by the water; - "The water is normally never that hot (135 degrees Fahrenheit); - "They (staff) must have just done that (turned	V 752		

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V 752	Continued From page 27 the water temperature up) it's usually too cool." Interview on 10/6/25 with the Shift Supervisor revealed: - Turned up the water temperature on 10/6/25 to clean the facility after learning a staff member had been sick in the facility over the weekend; - Planned to turn back down the water before leaving shift on 10/6/25. Interview on 10/9/25 with the Associate Professional (AP) revealed: - "The water was turned up due to us (staff) sterilizing in the home;" - "We have never had concerns with the water, it's always been 107;" - "We (AP and maintenance) check the water every month." Interview on 10/6/25 with the Quality Management Director revealed: - Had staff to turn the water temperature down on 10/6/25 due to the water being too hot; - Maintenance checked the water temperature monthly; - There was not a log of the water temperature that was checked monthly. Review on 10/6/25 of the Plan of Protection written by the Quality Management Director and dated 10/6/25 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Once TPH (Turning Point Homes) (Licensee) learned the water temperature was too high we immediately acted and lowered the temperature on site. Describe your plans to make sure the above happens. TPH will post a sign with compliance rules for	V 752		

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V 752	Continued From page 28	V 752		

temperature range on the water meter.
TPH will create a water temp log to be filled out weekly by the AP. "

Review on 10/6/25 of the amended Plan of Protection written by the Quality Management Director and dated 10/6/25 revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care?
Once Turning Point Homes learned the water temperature was too high in the kitchen and the three bathrooms, we immediately acted by lowering the water temperature on site.
Staff retested the water temperature in the kitchen and 3 bathrooms; the newly tested temperature was: 107' f (Fahrenheit).
Describe your plans to make sure the above happens.
Turning Point Homes will post a sign with compliance rules for temperature range on the water meter by 10/10/2025.
Turning Point Homes will create a water temp log to be filled out weekly by the AP. The temperature log will be created on 10/7/2025 and implemented in the week of 10/13/2025."

The facility served clients who were between 12 and 17 years old and diagnosed with Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Intermittent Explosive Disorder, Post Traumatic Stress Disorder, Cannabis Use Disorder. On 10/16/25, the hot water temperature in the facility was 135 degrees Fahrenheit in the kitchen, the hallway bathroom, Client #2's bathroom and Client #3's bathroom. The clients were being exposed to hot water of 135 degrees Fahrenheit which placed them at substantial risk of harm.
This deficiency constitutes a Type A2 rule violation for substantial risk of serious harm and

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V 752	Continued From page 29 must be corrected within 23 days.	V 752		