STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NEW HOPE HOME 4 CHANGE	5116 SAWBILL LANE GASTONIA, NC 28054

(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 10/30/25. The complaint was unsubstantiated (intake #NC00233354). 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 has a current census of 1. The survey sample consisted of audits of 1 current client and 2 former clients.	V 000		
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	V 296		

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V 296	Continued From page 1 children or adolescents; (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan. This Rule is not met as evidenced by: Based on record review, observation, and interviews the facility failed to ensure the minimum staffing ratio of two staff for up to four adolescents. The findings are: Review on 10/21/25 of client #1's record revealed: -Age 15 years old. -Admission 8/8/24. -Assessment dated 6/17/24, history of suicidal ideation, homicidal ideation, sexual trauma,	V 296		

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V 296	Continued From page 2 self-harming by picking her skin, scabs and restricting food intake. Diagnoses: Post Traumatic Stress Disorder; Disruptive Mood Dysregulation Disorder; Autism Spectrum disorder-level 1; Type I Diabetes; Shunt in head since age 2. Interview on 10/15/25 with client #1 revealed: -"Just one staff" worked in the facility on shift. -Staff provided transportation alone. Observation on 10/15/25 from approximately 3:37pm to 4:23pm at the facility revealed: -3:37pm, arrived at the facility. -3:58pm, the Associate Professional (AP) arrived at the facility. -4:05pm client #1 walked down the street toward the facility, book bag on her shoulder. -Entered the facility with the AP and client #1. -The AP was in the facility alone with client #1 from 4:05pm until approximately 4:23pm. -4:23pm Staff #1 arrived at the facility. Interviews on 10/15/25 and 10/20/25 with staff #1 revealed: -Two staff were working each shift at the facility. -Had no explanation for AP being alone with client #1 until he arrived. -Covered shifts if staff was unable to work. -"[QP #1] and I take clients to appointments, I get them from school if they are sick or in trouble", and worked in the facility on days when clients were out of school." -"I took [client # 1] to get clothing for her concert and I will pick her (client #1) up at 8:30pm (school)." -The QP scheduled medical appointments and "I get (pick up) them from school if they are sick, or in trouble (at school), or out of school."	V 296		

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V 296	Continued From page 3 Interviews on 10/15/25 and 10/21/25 with the AP revealed: -One staff "since [client #1] was the only one (client) in the facility." -There are "usually two staff on each shift." -One staff transported clients. -"One staff transport clients to school, pick up from school, like early releases." -When clients attend church with "[Staff #2]...usually has her (staff #2) mother with her when they go to church..." Interview on 10/23/25 with the Qualified Professional (QP) revealed: -"Two staff or one (staff) are on each shift", but there had been occasions when one staff worked alone. -If there were two staff, "one is doing something while the other staff is there (facility)." -"If one staff, that person (staff) is doing everything (alone), it's not really a big difference (whether there was one staff or two staff)." Interview on 10/17/25 with the Director/Licensee revealed -Was responsible for scheduling shifts. -The staff worked "their same schedule weekly." -Facility shifts were 4pm to 10pm, "10pm until they (clients) get on the bus or staff takes them to school, then they (staff) can leave...[AP] and [QP] work that shift." -There are 12-hour shifts on the weekend. -Staff #1 was at the facility "during the day if someone (client) is home (facility)." -There were two staff on each shift and two staff transported clients This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 296		

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V 366	Continued From page 4	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 5 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 6 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 records review and interviews, the facility failed to implement written policies governing their response to Level I and II incidents. The findings are: Reviews on 10/15/25, 10/20/25 and 10/21/25 of the facility's incident reports from 6/1/25 - 10/15/25 revealed: -The facility had no incident reports. Review on 10/21/25 of client #1's record revealed: -Age 15 years old. -Admission 8/8/24. -History of self-harming behaviors ("picking skin	V 366		

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and scabs"); aggressive behaviors; sexually inappropriate behaviors, sexual acting out "being inappropriate on line"; physical aggression...attempted to choke staff member at previous group home.
Diagnoses: Post Traumatic Stress Disorder (PTSD); Disruptive Mood Dysregulation Disorder; Autism Spectrum Disorder-Level I; Type 1 Diabetes; Hydrocephalus, Shunt in Head.

Review on 10/21/25 of FC #2's record revealed:
-Age 13 years old.
-Admission 7/22/24.
-Discharged 7/9/25.
-History of aggressive behaviors..."very aggressive and defiant"; verbally and physically abusive...homicidal ideation with intent toward foster mother and biological brother, "kicking, punching, verbal aggressive."
-Diagnoses: PTSD; Attention Deficit Hyperactivity Disorder (ADHD), Hyperactivity/Impulsive Type; Oppositional Defiant Disorder (ODD).

Review on 10/21/25 of FC #3's record revealed:
-Age 13 years old.
-Admission 6/13/24.
-Discharged 8/21/25.
-Person Center plan dated 6/16/25: 5/16/25, "...last 90 days had 2 inpatient stays and 1 ER (Emergency Room) visit...has very short fuse...continues to become explosive...threats of violence toward staff and her peers...disrespectful with staff with threats of swing on them...; 6/18/25, "...regressed...punched a hole in the wall and eloped following an episode where staff asked her not to put [petroleum jelly brand] in her mouth...temper escalates rapidly...heightened sensitivity to minor inconveniences, resulting in frequent irritability; 8/19/25: "Immediate health and safety discharge...[FC #3]

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cycles..outbursts...and is aggressive toward authority...is doing extreme property damage...$3000 in property damage...has a congenital heart defect...when she (FC #3) becomes upset her behaviors escalate, she becomes very physical, she becomes very violent...hesitant (facility staff) to try to employ any type of therapeutic hold..."
-Diagnoses: Adjustment Disorder with Mixed Anxiety and Depressed Mood; ODD; ADHD Combined Presentation; Congenital Heart Defect.

Reviews on 10/21/2025 of the facility's records revealed:
-There was no documentation of incidents.
-No documentation to support that the facility attended to the health and safety needs of clients involved, determined the cause of the incidents, developed and implemented corrective measures, developed and implemented measures to prevent similar incidents and assigned persons to be responsible for implementation of the corrections and preventive measures.

Interview on 10/15/25 with client #1 revealed:
-She and FC #3 had eloped "the end of June, 6/27/25" to go to South Carolina."
-The Director/Licensee "saw us (client #1 and FC #3 walking) and drove us back to the facility and lectured us."
-"[FC #3] said it (elopement) was my idea, but it was her idea."
-Had never been restrained, but "FC #2 "was restrained when she was acting up (aggressive behavior) and her door got removed (date unknown)."

Interview on 10/20/25 with staff #1 revealed:
-FC #3 had done damage in her bedroom "that

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was in June or July (2025), something like that."
-FC #3 had a "very bad mood swing...[FC #2] said something she (FC #3) didn't like and she got mad.
-FC #3 "put the holes in the wall when she got mad again...about 3 weeks ago."
-FC #3 was dealing with not talking to her brother and death of a grandparent.
-Staff on shift were responsible for completing incident reports and there were no reports that he was aware of.
-FC #3 "went to the school (8/19/25), was trying to hurt herself and was running out of the school in the street."
-Was not aware of restraints done at the facility.

Interview on 10/21/25 with the Associate Professional revealed:
-Was not sure if incident reports were completed for FC #2's damage to the facility.
-Incident reports were completed "at the time whoever is on the shift documents the incidents; if more that level I, they go to [Director/Licensee]."
-There was an incident of FC #3 "head banging and kicking the door in August (2025)."
-"She (FC #3) just had an attitude that day...not sure if she had a bad day at school...she had lost a family member, I think her grandmother, or her dog died...she wasn't able to talk to her brother."
-"She (FC #3) cussed out the therapist (Licensed Professional)...kicking the door...started banging on walls...it was more like she wanted attention."
-Had never done a restraint in the facility.

Interview on 10/23/25 with the Qualified Professional revealed:
-FC #3 and client #1 eloped, "I don't have that exact date; they weren't gone for long...they were gone maybe forty-five minutes to an hour."
-"Yes, I'm pretty sure an incident report was done

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for that (client #1 and FC #3 elopement)...no incidents with [FC #2], not that I can remember"
-FC #2 "punched the door" and damaged it in "January or February 2025)."
-The "last incident was with FC #3", on 8/21/25 FC #3 became upset about the death of her grandmother, couldn't talk with her brother who was in the hospital.
-While at school on 8/21/25, FC #3 "was trying to hurt herself, ran into the street" and was taken to the hospital for evaluation.
-There were about "two incidents of property destruction" by FC #3. I don't know the exact dates...between July and August (2025)."
-"...any of [FC #3]'s behaviors in the facility were containable, we (staff) were able to handle it (behaviors), there was no need for the police to be called or anything like that."
-No restraints had been done in the facility.
-"Yes, there were incident reports written, me and [Director/Licensee] wrote those (reports)...my stuff is done on the computer and we also have files.
-The Director/Licensee should have the incident reports and "you would have to ask [Director/Licensee]...I don't want to answer that question (location of the reports)."
-Referred questions about incident response to Director/Licensee.

Interview on 10/30/25 with the Licensed Professional revealed:
-"She (FC #3) would get real upset, my last interaction with her (8/20/25) she was getting upset, destroying property (at the facility), and that precipitated because she was unable to connect with her brother on the phone and she went into tantrum."
-FC #3 was "having episodes (aggressive behaviors) at least once every other week with

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V 366	Continued From page 11 severity becoming more concerning." Interview on 10/30/25 with the Director/Licensee revealed: -Was the person responsible for responding to incidents at the facility. -She did not have documentation of any facility incidents. -She was not aware that a restraint had been performed. -"I didn't do any incident documentation, I dropped the ball on that." -She had not developed and implemented corrective measures. -Had not developed and implemented measures to prevent similar incidents and had not assigned persons to be responsible for implementation of the corrections and preventive measures.	V 366		
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:	V 367		

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V 367	Continued From page 12 (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. (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	V 367		

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V 367	Continued From page 13 .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 (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to report all level II incidents in the North Carolina Incident Response Improvement System (IRIS) within 72 hours of becoming aware of the incident. The findings are: Reviews on 10/15/25, 10/20/25 and 10/21/25 of the facility's incident reports from 6/1/25 - 10/15/25 revealed:	V 367		

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	MHL036-303	A. BUILDING: _____ B. WING _____	R 10/30/2025

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V 367	Continued From page 14 -The facility had no incident reports. Review on 10/15/25 of IRIS from 6/1/25 - 10/15/25 revealed: -No submission of incidents in IRIS. Review on 10/21/25 of client #1's record revealed: -Age 15 years old. -Admission 8/8/24. -History of self-harming behaviors ("picking skin and scabs"); aggressive behaviors; sexually inappropriate behaviors, sexual acting out "being inappropriate on line"; physical aggression...attempted to choke staff member at previous group home. Diagnoses: Post Traumatic Stress Disorder (PTSD); Disruptive Mood Dysregulation Disorder; Autism Spectrum Disorder-Level I; Type 1 Diabetes; Hydrocephalus, Shunt in Head. Review on 10/21/25 of FC #2's record revealed: -Age 13 years old. -Admission 7/22/24. -Discharged 7/9/25. -History of aggressive behaviors..."very aggressive and defiant"; verbally and physically abusive...homicidal ideation with intent toward foster mother and biological brother, "kicking, punching, verbal aggressive." -Diagnoses: PTSD; Attention Deficit Hyperactivity Disorder (ADHD), Hyperactivity/Impulsive Type; Oppositional Defiant Disorder (ODD). Review on 10/21/25 of FC #3's record revealed: -Age 13 years old. -Admission 6/13/24. -Discharged 8/21/25. -Person Center plan dated 6/16/25: 5/16/25, "...last 90 days had 2 inpatient stays and 1 ER	V 367		

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V 367	Continued From page 15 (Emergency Room) visit...has very short fuse...continues to become explosive...threats of violence toward staff and her peers...disrespectful with staff with threats of swing on them...; 6/18/25, "...regressed...punched a hole in the wall and eloped following an episode where staff asked her not to put [petroleum jelly brand] in her mouth...temper escalates rapidly...heightened sensitivity to minor inconveniences, resulting in frequent irritability; 8/19/25: "Immediate health and safety discharge...[FC #3] cycles..outbursts...and is aggressive toward authority...is doing extreme property damage...$3000 in property damage...has a congenital heart defect...when she (FC #3) becomes upset her behaviors escalate, she becomes very physical, she becomes very violent...hesitant (facility staff) to try to employ any type of therapeutic hold..." -Diagnoses: Adjustment Disorder with Mixed Anxiety and Depressed Mood; ODD; ADHD Combined Presentation; Congenital Heart Defect. Review on 10/21/2025 of the facility's records revealed: -No documentation of incidents. -There was no documentation of client #1 and FC # 3's elopement in 6/27/25. -No documentation of FC # 2's incidents of property destruction and aggressive behaviors. -No documentation of FC #3's incidents of "extreme" property destruction, "outbursts", "swinging on staff"and aggressiveness. -No documentation of incidents with restraints of FC #2 and FC #3. Interview on 10/15/25 with client #1 revealed: -She and FC #3 had eloped on 6/27/25, "to go to South Carolina...I wasn't trustworthy back then." -The Director/Licensee "saw us (client #1 and FC	V 367		

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V 367	Continued From page 16 #3) and drove us back to the facility and lectured us." -Had written about the 6/27/25 elopement in her journal. -Had never been restrained, but "FC #2 "was restrained when she was acting up (aggressive behavior) and her door got removed (date unknown)." Interview on 10/20/25 with staff #1 revealed: -FC #3 had done damage in her bedroom "that was in June or July (2025), something like that." -FC #3 had a "very bad mood swing...[FC #2] said something she (FC #3) didn't like and she got mad. -FC #3 "put the holes in the wall when she got mad again...about 3 weeks ago." -The school petitioned for involuntary commitment, FC #3 "went to the school (8/19/25), was trying to hurt herself and was running out of the school in the street." -Was not aware of restraints done at the facility. -The Director/Licensee was responsible for incident reports in IRIS. Interview on 10/21/25 with the Associate Professional revealed: -Was not sure if incident reports were completed for FC #2's damage to the facility. -FC #3 "could go from okay to not doing good" and was sent to her room "for calming." -There was an incident "in August (2025)" with FC #3, "she just had an attitude that day." -"She (FC #3) cussed out the therapist (Licensed Professional)...kicking the door...started banging on walls...it was more like she wanted attention." -Had never done a restraint in the facility. -Incidents were reported by staff on shift, "whoever is on shift documents incidents, if it's more than a level one, they (incidents) go to	V 367		

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V 367	Continued From page 17 [Director/Licensee]." Interview on 10/23/25 with the Qualified Professional revealed: -FC #3 and client #1 eloped, "I don't have that exact date; they weren't gone for long...they were gone maybe forty-five minutes to an hour." -FC #2 "punched the door" and damaged it in "January or February 2025)." -The "last incident was with FC #3", on 8/21/25 FC #3 became upset about the death of her grandmother, couldn't talk with her brother who was in the hospital, "it was hard on her (FC #3)." -When she went to school on 8/21/25, "I just went left." -While at school, FC #3 "was trying to hurt herself, ran into the street" and was taken to the hospital for evaluation. -There were about "two incidents of property destruction" by FC #3. I don't know the exact dates...between July and August (2025)." -"...any of [FC #3]'s behaviors in the facility were containable, we (staff) were able to handle it (behaviors), there was no need for the police to be called or anything like that." -No restraints had been done in the facility. -Had submitted incidents reports for client #1 and FC #3, no incidents with FC #2. -Had copies of of incident reports "on my laptop, but if you have questions about incident reports, [Director/Licensee] is who you would refer them to." -Director/Licensee was responsible for incident report submissions in IRIS. Interview on 10/30/25 with the Licensed Professional revealed: -"She (FC #3) would get real upset, my last interaction with her (8/20/25) she was getting upset, destroying property, and that precipitated	V 367		

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V 367	Continued From page 18 because she was unable to connect with her brother on the phone and she went into tantrum." -FC #3 was "having episodes at least once every other week with severity becoming more concerning." Interview on 10/30/25 with the Director/Licensee revealed: -Was the person responsible for reporting incidents in IRIS. -She was not aware that a restraint had been performed. -"I didn't do any incident documentation, I dropped the ball on that."	V 367		
V 742	27G .0304(a) Privacy 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (a) Privacy: Facilities shall be designed and constructed in a manner that will provide clients privacy while bathing, dressing or using toilet facilities. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to be maintained in a manner that allowed for client privacy while in their bedrooms. The findings are: Observation on 10/15/25 at approximately 4:09 pm of the facility revealed: -Doors were missing from all vacant bedrooms. -Door was missing from client #1's bedroom. Interview on 10/15/25 with client #1 revealed: -She had not had a door to her bedroom since she was admitted to the facility on 8/8/24.	V 742		

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V 742	Continued From page 19 -"I've never had a door, mine was removed prior to me being here." -FC #3 "was acting up and her door was removed...because of her (FC #3) behaviors." Interview on 10/15/25 with staff #1 revealed: -The facility had clients with "...anger issues, slamming and kicking (doors). So we (facility) took the hinges off (door)." Interview on 10/15/25 with the Associate Professional revealed: -"I don't know the reason the doors were removed, you'll have to ask [staff #1] or [Director/Licensee] about that ...the facility may be able to explain why there are no doors." Interview on 10/15/25 with the Director/Licensee revealed: -"The doors off in the facility was just [FC #2], she would repeatedly slam the door and it was keeping [client #1] from sleeping; when [FC #2]'s behaviors were over, the door was returned (put back on)." -Client #1 had door to her bedroom but, "when you see her (client #1) chart you will understand...the door has been down for a month and we didn't put it back up because [client #1] was scared of the dark." -"I understand that by statute we (facility) need to have the door and we have explained this to clients. We have explained that it is for aesthetics and if there is a fire a towel would need to go under the door for smoke." -Would have the door put back for all the clients bedrooms.	V 742		