

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/03/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ADDICTION RECOVERY CARE ASSOCIATION, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5755 SHATTALON DRIVE WINSTON SALEM, NC 27105</b>
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V 000	<p><b>INITIAL COMMENTS</b></p> <p>An annual and complaint survey was completed on 11/3/25. The complaint was substantiated (intake #NC00233691). Deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G .3100 Nonhospital Medical Detoxification for Individuals Who are Substance Abusers, 10A NCAC 27G .3400 Residential Treatment/Rehabilitation for Individuals with Substance Abuse Disorders, 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program, 10A NCAC 27G .4500 Substance Abuse Comprehensive Outpatient Treatment Program, 10A NCAC 27G .5000 Facility Basis Crisis Service for Individuals of All Disability Groups, 10A NCAC 27G .5600E Supervised Living for Adults with Substance Abuse Dependency.</p> <p>This facility has a total capacity of 99 and currently has a census of 61. The 3100 Non-hospital Medical Detoxification-Individuals who are Substance Abusers has a current census of 4 and the .3400 Residential Treatment-Individuals with Substance Abuse Disorders has a current census of 57. The survey sample consisted of audits of 4 current Residential Treatment clients and 2 former Residential Treatment clients.</p>	V 000		
V 110	<p>27G .0204 Training/Supervision Paraprofessionals</p> <p>10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified</p>	V 110		

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Division of Health Service Regulation

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V 110	<p>Continued From page 1</p> <p>professional as specified in Rule .0104 of this Subchapter.</p> <p>(c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served.</p> <p>(d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence.</p> <p>(e) Competence shall be demonstrated by exhibiting core skills including:</p> <ol style="list-style-type: none"> <li>(1) technical knowledge;</li> <li>(2) cultural awareness;</li> <li>(3) analytical skills;</li> <li>(4) decision-making;</li> <li>(5) interpersonal skills;</li> <li>(6) communication skills; and</li> <li>(7) clinical skills.</li> </ol> <p>(f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, 1 of 4 paraprofessional staff (Staff #1) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are:</p> <p>Review on 10/29/25 of Staff #1's personnel record revealed: -Date of hire: 2/5/25; -Title: Registered Medical Assistant (RMA);</p>	V 110		

Division of Health Service Regulation

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V 110	<p>Continued From page 2</p> <p>-Job Description: "The scope of a RMA is to provide assistance to medical providers, nurses and additional medical staff to provide quality competent care to clients."</p> <p>-Ninety-Day Employee Evaluation completed by the Director of Nursing (DON) and dated 5/1/25 included, "has had a few concerns that were addressed with the employee: 1. Grievance - HIPAA (Health Insurance Portability and Accountability Act) violation - discussing another client's information with another client...was supervised and inform that this was a HIPAA violation and could result in termination if done again. 2. Medication error - 3/19/2025 - Ordered Suboxone instead of Subutex per order of provider. Medication review completed prior to administering medications. 3. [Staff #1] is not consistently in the quad (quadrant) and has been called to the quad several times. Incident - Employee called to quad and was offsite with other co-worker; without the knowledge or approval from Management. Employee did clock out, but did not follow proper protocol and was not at his station as scheduled. Incident was discussed with employee."</p> <p>-Supervision Form completed by the DON and dated 5/29/25 included, "Probation/Suspension - 3 days with no pay...Employee (Staff #1) operated outside of scope of practice as an RMA, an unlicensed Assistive Personnel employee. Employee operated with no orders from a provider and or direction from a nurse on duty. Employee retrieved and administered medications to a staff member with no orders from a provider or direction from a nurse on duty."</p> <p>-Mid Year Employee Evaluation completed by the DON and dated 8/12/25 included, "...does have 4 medication errors at the present time...completed medication review refresher in 3/2025...has been challenged to stay focused and focus on his</p>	V 110		
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Division of Health Service Regulation

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V 110	<p>Continued From page 3</p> <p>responsibilities."</p> <p>Review on 10/27/25 of Former Client (FC) #5's record revealed:</p> <ul style="list-style-type: none"> <li>-An admission date of 8/11/25;</li> <li>-A discharged date of 9/8/25;</li> <li>-Diagnoses included Cannabis Use Disorder, Opioid Use Disorder, Severe, Stimulant Use Disorder, Severe, Post Traumatic Stress Disorder, Depression, Attention Deficit Hyperactive Disorder (ADHD), Bipolar Disorder and Constipation.</li> <li>-Discharged medications dated 9/3/25 included Colace (Constipation) 100 milligrams (mg), take 1 capsule by mouth (po) daily, Divalproex (Bipolar) 500 mg delayed release, take 1 tablet po twice daily, Senna Laxative (Constipation) 8.6 mg, take 1 tablet po daily, Strattera (ADHD) 100mg, take 1 capsule po daily, Tamsulosin (Enlarged Prostrate) .4 mg, take 1 capsule po daily, Trileptal (Mood Stabilizer) 300 mg, take 1 tablet po twice daily.</li> </ul> <p>Review on 10/28/25 of text messages on FC #5's telephone between FC #5 and Staff #1 dated 9/9/25 and 9/11/25 revealed:</p> <ul style="list-style-type: none"> <li>-Messages dated 9/9/25 included:</li> <li>-FC #5: "If I was to ever use (illicit substances) today would have been it and I e wanted to but I'm better than that I'm sorry today isn't a good day for me;"</li> <li>-FC #5: "I've been crying my eyes out and I'm going to be ok but dam (d**n) it sucks to have to go over there (Social Security Administration) and tell them my child hood s**t again I'll show you what I wrote tomorrow I called them and told them I want a copy of that paper work that I had to fill out please don't judge me by it it hurts to have to relive this day after day I just talked to the man at the church next door and it made me cry today;"</li> </ul>	V 110		

Division of Health Service Regulation

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V 110	<p>Continued From page 4</p> <p>-FC #5: "I've been taking this meds and I told the doctor at Arca that s**t doesn't work I've been on all them meds for this and still I have theses feelings a told of 7 hours sleep in 2 days this s**t sucks;"</p> <p>-FC #5: "If I had some money I'd go get my meds from drug store did they give me sleep meds to pick up from drug store;"</p> <p>-FC #5: "That melatonin and trazodone;"</p> <p>-Staff #1: "I'll check babe;"</p> <p>-Staff #1: "Give me a few I gotta (got to) do a meeting;"</p> <p>-Messages dated 9/11/25 included:</p> <p>-FC #5: "Good morning didn't sleep last night went to drug store and only had flow max med (medication) for me;"</p> <p>-Staff #1: "What pharmacy do you use;"</p> <p>-Staff #1: "And in what city I will call ur (your) trazodone in at 8ooam;"</p> <p>-FC #5: "It's [Pharmacy A] (approximately 60 miles from the facility) they said that there was a prescription sent to [Pharmacy B] (local sister pharmacy) and was picked up at 3:06 in the morning and I was at down there to pick up;"</p> <p>-Staff #1: "You don't love me anymore?"</p> <p>-FC #5: "Yes I do you know this I'm running on fumes I my have to go to ER (emergency room) to get a zanx (Xanax) and all for my nerves because it's been bad"</p> <p>-Staff #1: "Cuz (Because) I love and care about ya (you) so d**n much and I'm very proud of you I'm on the phone with the pharmacist now;"</p> <p>-Staff #1: "You just need sleep you will get some good sleep tonight;"</p> <p>-Staff #1: "You're trazodone has been called in and you can pick it up after your group handsome;"</p> <p>-Staff #1: "Did you get your trazodone;"</p> <p>-FC #5: "Not yet my Doctor has sent me here to the hospital."</p>	V 110		

Division of Health Service Regulation

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V 110	<p>Continued From page 5</p> <p>Interview on 10/30/25 with FC #5 revealed: -Pharmacy A had not informed him that Trazodone had been called in to Pharmacy B as he had informed Staff #1; -He had lied to Staff #1 so that he would be more likely to call in Trazodone for him; -Pharmacy A and Pharmacy C prevented him from picking up Trazodone and both said they needed additional information from his insurance.</p> <p>Interview on 10/29/25 with the Licensed Practical Nurse revealed: -Medications authorized by the facility medical doctor to be called in for clients at discharge were only for medications the clients were ordered prior to when they arrived at the facility; -The medical doctor wouldn't have authorized Trazodone to be called in for FC #5 with the discharge orders or after discharge because he wasn't on the medication when he was admitted.</p> <p>Interview on 10/31/25 with the DON revealed: -It was not unusual for discharged medications to be called in a couple of days prior to the date of discharge; -FC #5 had requested all medications be called in to Pharmacy C (approximately 60 miles from the facility) prior to his discharge; -She contacted Pharmacy C on 10/31/25 and verified Trazodone 50 mg was called in for FC #5 on 9/11/25 by Staff #1.</p> <p>Interview on 11/3/25 with a pharmacist at Pharmacy A revealed: -Trazodone 50 mg was called in for FC #5 on 9/11/25; -She was unable to verify who called the Trazodone in, only the medical doctor that was supposed to have authorized the medication;</p>	V 110		

Division of Health Service Regulation

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V 110	<p>Continued From page 6</p> <p>-There was no record that Trazodone had been called in to Pharmacy B.</p> <p>Interview on 11/3/25 with the facility Medical Doctor revealed: -He had not authorized anyone to call in an order for Trazodone for FC #5 after he was discharged; -"This is a lot for someone so young (Staff #1) to make a number of bad decisions (call in unauthorized medications, give a gift to a client and have an inappropriate relationship with a client while they were admitted and after they were discharged) and throw their whole career away."</p> <p>Review on 10/31/25 of the Plan of Protection dated 10/31/25 and signed by the Chief Executive Officer (CEO) and the Chief Operating Officer (COO) revealed: "What immediate action will the facility take to ensure the safety of the consumers in you care? 1. Upon notification of this incident, the employee (Staff #1) was suspended and subsequently resigned from ARCA. 2. ARCA has conducted a review of agency policies and procedures regarding ordering of prescription medications. 3. Foundational safeguards are already in place. ARCA has a robust framework for preventing rogue behavior by staff in our Employee Handbook, Policy &amp; Procedure manual, and ARCA Nursing Medication Policy. 4. We will be implementing additional training to improve our organizational culture that empowers staff to report improprieties or violations. ARCA will create and implement a new prescription call in log for accountability and awareness. (Attached to the Plan of Protection was a copy of the Prescription Call In Log) Describe you plans to make sure the above</p>	V 110		

Division of Health Service Regulation

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V 110	<p>Continued From page 7</p> <p>happens.</p> <ol style="list-style-type: none"> <li>1. All medical staff will be required to sign a statement that acknowledges their understanding of ARCA's medication administration policies and procedures.</li> <li>2. The DON will conduct a review of these policies at quarterly meetings</li> <li>3. The CEO will follow up with the DON to ensure"</li> </ol> <p>Review on 11/3/25 of the amended Plan of Protection dated 11/3/25 and signed by the CEO and the COO revealed: "What immediate action will the facility take to ensure the safety of the consumers in you care?</p> <ol style="list-style-type: none"> <li>1. Upon notification of this incident, the employee (Staff #1) was suspended and subsequently resigned from ARCA.</li> <li>2. ARCA has conducted a review of agency policies and procedures regarding ordering of prescription medications.</li> <li>3. Foundational safeguards are already in place. ARCA has a robust framework for preventing rogue behavior by staff in our Employee Handbook, Policy &amp; Procedure manual, and ARCA Nursing Medication Policy.</li> <li>4. We will be implementing additional training to improve our organizational culture that empowers staff to report improprieties or violations.</li> <li>5. ARCA will create and implement a new prescription call in log for accountability and awareness. (Attached) This will be implemented in the week of 11/3/2025.</li> </ol> <p>Describe you plans to make sure the above happens.</p> <ol style="list-style-type: none"> <li>1. All medical staff will be required to sign a statement that acknowledges their understanding of ARCA's medication administration policies and procedures. This will be completed by November 30, 2025</li> </ol>	V 110		

Division of Health Service Regulation

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V 110	<p>Continued From page 8</p> <p>2. The DON will conduct a review of these policies at subsequent quarterly meetings</p> <p>3. The CEO will follow up with the DON to ensure completion of these tasks."</p> <p>This facility primarily served clients with diagnoses of substance abuse disorders. FC #5 was admitted to the facility on 8/11/25 and discharged from the 28-day treatment program on 9/8/25. FC #5 contacted Staff #1 by text on 9/11/25 and informed him he was having trouble sleeping. Despite knowing that FC #5 had a diagnoses of substance abuse disorders and had expressed an urge to use illicit substances, he called in Trazodone 50 mg to 2 different pharmacies for the client without provider authorization. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients and must be corrected within 45 days.</p>	V 110		
V 512	<p>27D .0304 Client Rights - Harm, Abuse, Neglect</p> <p>10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION</p> <p>(a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66.</p> <p>(b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter.</p> <p>(c) Goods or services shall not be sold to or purchased from a client except through established governing body policy.</p> <p>(d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual</p>	V 512		

Division of Health Service Regulation

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V 512	<p>Continued From page 9</p> <p>characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter.</p> <p>(e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, 1 of 4 paraprofessional staff (Staff #1) abused 1 of 2 former clients (Former Client (FC) #5) and 1 of 1 audited Licensed Practical Nurse (LPN) failed to protect 1 of 2 former clients (FC #5) from abuse. The findings are:</p> <p>Review on 10/27/25 of the facility's Therapeutic Boundaries training that all staff are required to review at hire:</p> <ul style="list-style-type: none"> <li>- "Do not exchange numbers or personal information with clients."</li> <li>- "Do not allow clients to call you by your nickname."</li> <li>- "Do not engage in romantic or sexual relationships with clients. This is a clear violation of the therapeutic relationship and is harmful to clients."</li> <li>- "Staff members who engage in romantic or sexual relationships with clients are abusing their power and can be seen as taking advantage of their clients."</li> <li>- "Employees will not have any sexual intimacies with clients or former clients for two years after discharge from ARCA."</li> <li>- "Hugs between staff clients and staff members should be avoided."</li> </ul>	V 512		

Division of Health Service Regulation

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V 512	<p>Continued From page 10</p> <p>-"Employees are prohibited from engaging in a personal relationship, including any type of sexual contact, with clients." -"Staff should avoid giving clients gifts."</p> <p>Review on 10/27/25 of the facility's Policy and Procedures Manual revealed: -"Hugging is not acceptable between staff and any persons served." -"Employees will not have any type of sexual intimacies with clients or former clients for a period of two years after discharge from ARCA." -"ARCA strictly prohibits client or staff use of any identifying devices such as cameras, cell phone cameras, or video cameras or audio devices, unless special permission is received from the Administration." -"No photographs or recordings will be released and all will be subject to the same regulations as any other confidential records at ARCA."</p> <p>Review on 10/27/25 of FC #5's record revealed: -An admission date of 8/11/25; -A discharge date of 9/8/25; -Diagnoses included Cannabis Use Disorder, Opioid Use Disorder, Severe, Stimulant Use Disorder, Severe, Post Traumatic Stress Disorder (PTSD), Depression, Attention Deficit Hyperactive Disorder (ADHD), Bipolar Disorder and Constipation.</p> <p>Review on 10/29/25 of Staff #1's personnel record revealed: -A hire date of 2/5/25: -Title: Registered Medical Assistant (RMA); -Job Description: "The scope of a RMA is to provide assistance to medical providers, nurses and additional medical staff to provide quality competent care to clients." -Ninety-Day Employee Evaluation completed by</p>	V 512		

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER  <b>ADDICTION RECOVERY CARE ASSOCIATION, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5755 SHATTALON DRIVE WINSTON SALEM, NC 27105</b>
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V 512	<p>Continued From page 11</p> <p>the Director of Nursing (DON) and dated 5/1/25 included, "has had a few concerns that were addressed with the employee: 1. Grievance - HIPAA (Health Insurance Portability and Accountability Act) violation - discussing another client's information with another client...was supervised and inform that this was a HIPAA violation and could result in termination if done again. 2. Medication error - 3/19/2025 - Ordered Suboxone instead of Subutex per order of provider. Medication review completed prior to administering medications. 3. [Staff #1] is not consistently in the quad and has been called to the quad several times. Incident - Employee called to quad and was offsite with other co-worker; without the knowledge or approval from Management. Employee did clock out, but did not follow proper protocol and was not at his station as scheduled. Incident was discussed with employee."</p> <p>-Supervision Form completed by the DON and dated 5/29/25 included, "Probation/Suspension - 3 days with no pay...Employee (Staff #1) operated outside of scope of practice as an RMA, an unlicensed Assistive Personnel employee. Employee operated with no orders from a provider and or direction from a nurse on duty. Employee retrieved and administered medications to a staff member with no orders from a provider or direction from a nurse on duty. -Mid Year Employee Evaluation completed by the DON and dated 8/12/25 included, "...does have 4 medication errors at the present time...completed medication review refresher in 3/2025...has been challenged to stay focused and focus on his responsibilities."</p> <p>-"Client Rights and Confidentiality Regulations Attestation signed and dated 2/5/25 included, "Protect all client and family members from abuse, exploitation, and neglect and to report any</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/03/2025</b>
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V 512	<p>Continued From page 12</p> <p>violations of the North Carolina statutes on abuse."</p> <p>-"Ethical and Professional Staff/Client Interaction signed and dated 2/10/25 included, "Risks of Inappropriate Relations with Clients - Jeopardize ARCA's Licensure, Civil Litigation, Loss of Dignity and Credibility and Psychological damage to client."</p> <p>Review on 10/29/25 of the LPN's personnel record revealed: -A hire date of 5/6/25; -A title of LPN.</p> <p>Interview on 10/3/25 with FC #5 revealed: -He felt that Staff #1, "seen an opportunity to take advantage of what I was going through (recently released from prison, detox then the substance abuse treatment program);" -For approximately the first 14 days of his treatment at the facility, the interactions with Staff #1 were verbal flirtations such as names of endearment, "big daddy and little girl" used; -From approximately the 15th - 28th days of his treatment at the facility, interactions with Staff #1 progressed to physical touch with examples of shoulder rubs and hugs..."He really progressed trying to get with me." -His roommate (FC #6) while he was at the facility witnessed the interactions with Staff #1..."He (FC #6) walked into the room (bedroom) as that guy (Staff #1) was in the room rubbing my shoulder. He (Staff #1) jerked and pulled back when he came into the room that day. Another day he was kind of hugging on me. I was sitting on the bed. He was in there trying to comfort me. I was stressing out. He (FC #6) walked in and the same thing happened (Staff #1 jerked and pulled back)." -He liked the attention from at first until Staff #1</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/03/2025</b>
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V 512	<p>Continued From page 13</p> <p>informed him he couldn't tell anyone about their relationship and if anyone found out, they'd both have to leave the facility;</p> <p>-"He (Staff #1) kept saying this has to be our little secret. He said that while I was there (facility). You can't let other people know. They'll get jealous;"</p> <p>-On 9/8/25, prior to discharge, he and Staff #1 were at the nurse's desk and Staff #1 informed him that he wasn't allowed to provide him with his personal cell phone number but if the client found it on the desk, he wasn't responsible for that;</p> <p>-After Staff #1 walked away from the desk, Staff #1's cell phone number and name were written on a piece of paper, so he took the paper and texted Staff #1 after he was discharged while he waited outside for someone to arrive to pick him up;</p> <p>-When he was discharged on 9/8/25, Staff #1 gave him a gold chain with a J charm on it that matched the one that the staff always wore;</p> <p>-He didn't want anything to do with Staff #1 or any reminders of him, so he gave the necklace to his parole officer.</p> <p>-After he was discharged but still on the facility premises, Staff #1 used his personal cell phone to take a picture of the security camera screen which displayed him standing outside and sent him the picture with the text, "Look at that sexy man who's that haha;"</p> <p>-"He (Staff #1) was sending me pictures of him in bed. He sent me a picture of him in his boxers on 9/9/25;"</p> <p>-"He (Staff #1) made promises like he was going to send me money" the whole time they talked after he was discharged but he never received money;</p> <p>-"He (Staff #1) offered money for sex and s**t. He offered me \$60."</p> <p>-He informed Staff #1 to not contact him anymore</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/03/2025</b>
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V 512	<p>Continued From page 14</p> <p>on 9/12/25 because he felt like Staff #1 hadn't loved him and only wanted a sexual relationship; -When he realized he had gotten involved in an inappropriate relationship, his anxiety worsened and he spent 2 days in a local hospital on 9/11/25 - 9/12/25; -"This is hard for me to go back and see the text it makes me sad and mad because he knew what he was doing."</p> <p>Interview on 10/9/25 with FC #6 revealed: -He was admitted (8/11/25) and discharged (9/8/25) the same days as FC #5; -He shared a bedroom with FC #5 while at the facility; -He was aware there were interactions, "...that were against the rules" between FC #5 and Staff #1; -He heard FC #5 and Staff #1 call each other terms of endearments, "daddy and girl" rather than their names; -He walked into his shared bedroom with FC #5 several times and observed Staff #1 rub FC #5's shoulders or hug him and Staff #1 jumped away from FC #5.</p> <p>Interview on 10/27/25 with Staff #1 revealed: -He had been employed at the facility since February 2025; -He remembered FC #5..."I was his caretaker among many;" -Gave FC #5 a gold chain with a J charm that matched the one he wore when the client was discharged from the facility on 9/8/25. -Acknowledged that he had verbal contact with FC #5 after he was discharged despite knowing it was against policy; -Had asked FC #5 after he was discharged to spend time with him at his home but their relationship ended before it progressed to that</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/03/2025</b>
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V 512	<p>Continued From page 15</p> <p>point;</p> <ul style="list-style-type: none"> <li>-His relationship with FC #5 started when FC #5 was admitted to the facility and began with consensual flirting and then progressed..."With any clients, it was always a side hug. I don't remember ever hugging him. I may have though."</li> <li>-He wasn't aware that it was against facility policy for staff to hug clients.</li> <li>-Wasn't able to remember if he ever rubbed FC #5's shoulders or touched him anywhere else;</li> <li>-He didn't give FC #5 his personal cell phone number intentionally..."I had wrote down my contact and left it on the desk and he took it;"</li> <li>-Both he and FC #5 exchanged pictures;</li> <li>-He had sent a picture of him in white shorts and FC #5 thought he was in his underwear and FC #5 had sent him a picture of his head one day when he woke up;</li> <li>-Messages and pictures he exchanged with FC #5 were no longer on his personal telephone..."I never had his number saved. I must have deleted them."</li> <li>-"I was just trying to help him (FC #5). He always called me his girl. Have you seen him? I didn't understand the dual diagnosis between substance abuse and mental health until he called me from the hospital after we had been texting for about a week and a half. I stopped all contact after that."</li> <li>-He used his personal cell phone and took a picture of FC #5 that was displayed on the security camera screen;</li> <li>-Was aware that it was against facility policy to take pictures of clients without their permission;</li> <li>-He had not obtained FC #5's permission to take his picture.</li> <li>-Had never been informed by any of his supervisors at the facility that he had been too friendly with clients, or he needed to stop calling them by nicknames.</li> </ul>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/03/2025</b>
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V 512	<p>Continued From page 16</p> <p>Review on 10/28/25 of the text messages from FC #5's telephone dated 9/8/25 - 9/12/25 between Staff #1 and FC #5 revealed:</p> <ul style="list-style-type: none"> <li>-Approximately 123 text messages exchanged on 9/8/25 between 11:16am - midnight included:</li> <li>-FC #5: "First off who's your daddy;"</li> <li>-FC #5: "You still my girl and I'm daddy you hear me;"</li> <li>-Staff #1 "oh yes you definitely are daddy;"</li> <li>-FC #5: "little momma just got to get you working out;"</li> <li>-Staff #1: "I'm nothing near as sexy as you;"</li> <li>-FC #5: "You are too;"</li> <li>-Staff #1: Picture of FC #1 standing outside the facility;</li> <li>-Staff #1: "Look at that sexy man who's that haha;"</li> <li>-Staff #1: "Remember only we can know that we talk bubba;"</li> <li>-Staff #1: "U (you) can't say nothing;"</li> <li>-Staff #1: "Miss u;"</li> <li>-FC #5: "I miss you, too;"</li> <li>-FC #5: " I told ya (you) baby Daddy makes that hurt hehehe (laughing) [Staff #1] babie (baby);"</li> <li>-Staff #1: "I know you told me ur (you are) black from the waste down hahaha;"</li> <li>-Staff #1: "Anaconda daddy heheh;"</li> <li>-Staff #1: " Might be scared tho (though) lol (laughing out loud);"</li> <li>-Staff #1: "And what do you make hurt;"</li> <li>-FC #5: "That boddy;"</li> <li>-Staff #1: "Oh is that right haha;"</li> <li>-Approximately 24 text messages exchanged on 9/9/25 included:</li> <li>-Staff #1: "How did ya sleep;"</li> <li>-FC #5: "Not good my room mates son went off;"</li> <li>-FC #5: "On him;"</li> <li>-FC #5: "So how you doing this morning baby girl;"</li> </ul>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/03/2025</b>
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V 512	<p>Continued From page 17</p> <p>-Staff #1: "I'm sorry daddy that sucks I wish I could help and I'm ok sleep aight (alright) besides missin (missing) you I'm great!"</p> <p>-Staff #1: 2 heart emojis</p> <p>-Approximately 35 text messages exchanged on 9/10/25 included:</p> <p>-Staff #1: Picture of him lying down with no shirt with only the chest up visible;</p> <p>-Staff #1: "Here's a handsome pic (picture) to wake up to;"</p> <p>-Staff #1: "As long as us talking stays between us I'm not going anywhere baby daddy;"</p> <p>-FC #5: "Ok little momma and I'm not in there now so how would you lose your job I don't understand why you doubt me;"</p> <p>-Staff #1: "I'm not doubting u we just aren't supposed to talk to anyone after they leave for a year;"</p> <p>-Staff #1: "I'm sorry babe I trust you and I'll show you and make it up to you love;"</p> <p>-Approximately 22 text messages exchanged on 9/11/25 included:</p> <p>-Staff #1: "As long as us talking stays between us I'm not goin (going) anywhere baby daddy;"</p> <p>-Staff #1: " Is that ok;"</p> <p>-FC #5: "Ok it's hard to talk to my drunk mom and text you but why would I say anything to anyone you know I just got out of the prison and don't know anyone you talking about why you keep saying that girl;"</p> <p>-FC #5: Who would I tell;"</p> <p>-Staff #1: "Just don't wanna (want to) lost my job handsome;"</p> <p>-Staff #1: "I trust you;"</p> <p>-Staff #1: "Pls (Please) forgive me;"</p> <p>-Staff #1: "I love u;"</p> <p>-Approximately 3 text messages sent from Staff #1 to FC #5 on 9/12/25 and included:</p> <p>-"Hope you're ok bro (brother);"</p> <p>-"Hey buddy;"</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/03/2025</b>
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V 512	<p>Continued From page 18</p> <p>"R (Are) you still at the hospital I would like an update if possible."</p> <p>Interview on 10/27/25 with the Director of Nursing revealed:                      -FC #5 was discharged on 9/8/25 at 9:50am;                      -All staff are trained in therapeutic boundaries when they start and based on that training, "We don't give hugs. You ask them can I touch you."                      -Staff #1 was a part of the Nursing staff;                      -She was responsible for ensuring training was completed by all Nursing staff when hired;                      -Because of the importance of the training, she also sent it to all Nursing staff annually for it to be reviewed;                      -All Nursing staff reviewed the training in May 2025;                      -Based on company policy which staff were required to review when hired, staff were not allowed to have a relationship with clients until 2 years after they were discharged from the facility.</p> <p>Interview on 10/7/25 with FC #5's Parole Officer revealed:                      -Based on what FC #5 had informed him in September 2025 (exact date unknown) Staff #1 and FC #5 had an inappropriate relationship that began while the client was at the facility and continued after the client was discharged;                      -FC #5 informed him he believed Staff #1 was trying to solicit him for sex;                      -FC #5 informed him that there had been hugs with Staff #1 while at the facility and telephone contact that was sexual in nature since discharge from the facility;                      -He had observed messages on FC #5's telephone sent from Staff #1 that consisted of a picture of Staff #1 lying in bed, a picture of Staff #1 in his boxers, a picture of Staff #1 that appeared to be taken in the facility restroom and</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/03/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ADDICTION RECOVERY CARE ASSOCIATION, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5755 SHATTALON DRIVE WINSTON SALEM, NC 27105</b>
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V 512	<p>Continued From page 19</p> <p>messages of, "Remember, only we can know that we talked...Make it \$60 and I'll give you a massage too. Yours comes with a happy ending." -He was in possession of a gold necklace with a J charm; -He was given the necklace by FC #5 and informed that Staff #1 gave him the necklace when he was discharged from the facility on 9/8/25.</p> <p>Interview on 10/29/25 with Staff #2 revealed: -She worked with Staff #1 regularly..."Me and him butt heads a lot." -"My first 3 months (March 2025 - June 2025) here with him (Staff #1) were good;" -After the first 3 months, Staff #1 was lying, manipulated staff by telling them they were in trouble with the DON and was always worried about whether he was in trouble; -She had concerns at that time that Staff #1 was too friendly with clients; -Staff #1 routinely called the men nicknames such as, "baby mama, baby daddy, aunt and uncle and disappeared into the vitals room numerous times daily (with clients) where there were no cameras;" -She had informed her direct supervisor, the LPN about her concerns approximately a month ago (exact date unknown).</p> <p>Interview on 10/29/25 with the LPN revealed: -She worked regularly with Staff #1 as his immediate Supervisor..."Sometimes it's a little tense. Our bump heads are on more of responsibilities. I'm your boss on the floor. We bump head about stuff like that." -Staff #1 was too friendly (calling clients by nicknames and allowing clients to call him nicknames and spending too much time with clients trying to be their friend rather than develop</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/03/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ADDICTION RECOVERY CARE ASSOCIATION, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5755 SHATTALON DRIVE WINSTON SALEM, NC 27105</b>
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V 512	<p>Continued From page 20</p> <p>a therapeutic relationship) with the clients and didn't separate his personal and professional life..."I have pulled him to the side to remind him of that (exact date unknown but approximately a month to a month and a half prior)."</p> <p>-She also informed Staff #1 if he continued then she'd have to report him to the DON;</p> <p>-She was unable to provide written documentation or dates that she informed Staff #1 he had been too friendly with clients;</p> <p>-Other staff that she'd rather not name had informed her that they were concerned that Staff #1 was too friendly with clients and she had assured them she had talked with him about it.</p> <p>-She was never concerned that Staff #1 called clients by nicknames. "It's a joking kind of thing. I call people sweetie sometimes. It doesn't mean anything. He was smart enough to know who would be receptive."</p> <p>-She had heard Staff #1 address FC #5, "Hey big daddy," numerous times while FC #5 was at the facility;</p> <p>-She hadn't informed the DON of the concern about Staff #1 because she "didn't want to make a big deal of it and get him (Staff #1) in trouble and it had gotten better the last 3 weeks;"</p> <p>-She understood now that she should have informed the DON immediately after her own observations and the complaint from Staff #2 and asked for guidance on how to handle the situation.</p> <p>Interview on 10/31/25 with the DON revealed:</p> <p>-She was not aware that Staff #2 had voiced her concerns about Staff #1 to the LPN;</p> <p>-She was not aware that the LPN had informed Staff #1 that he was too friendly with the clients and needed to separate his personal and professional lives.</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/03/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ADDICTION RECOVERY CARE ASSOCIATION, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5755 SHATTALON DRIVE WINSTON SALEM, NC 27105</b>
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V 512	<p>Continued From page 21</p> <p>Review on 10/31/25 of the Plan of Protection dated 10/31/25 and signed by the Chief Executive Officer (CEO) and the Chief Operating Officer (COO) revealed:</p> <p>"What immediate action will the facility take to ensure the safety of the consumers in your care? As a result of the findings,</p> <ol style="list-style-type: none"> <li>1. Suspension and resignation of the employee in question happened immediately.</li> <li>2. We have reviewed the organization's policies regarding harm, abuse, neglect or exploitation</li> <li>3. We have reviewed our training(s) pertaining to harm, abuse, neglect or exploitation</li> <li>4. We will be implementing the following immediately:               <ol style="list-style-type: none"> <li>a. Additional training to improve our organizational culture that empowers staff to report improprieties or violations.</li> <li>b. Additional training to address professional etiquette when communicating via email/phone/text.</li> <li>c. Create an awareness campaign highlighting our policies that protect client rights</li> <li>d. A review of ARCA's Therapeutic Boundaries presentation with staff."</li> </ol> </li> </ol> <p>"Describe your plans to make sure the above happens.</p> <ol style="list-style-type: none"> <li>1. All staff will be required to sign a statement that acknowledges they understand ARCA's policies on boundaries and ethics, and they are to report any perceived violations.</li> <li>2. Quarterly departmental meetings will now include a review or organizational policies pertaining to abuse, neglect and exploitation."</li> </ol> <p>Review on 11/3/25 of the amended Plan of Protection dated 11/3/25 and signed by the CEO and the COO revealed:</p> <p>"What immediate action will the facility take to</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/03/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ADDICTION RECOVERY CARE ASSOCIATION, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5755 SHATTALON DRIVE WINSTON SALEM, NC 27105</b>
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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 512	<p>Continued From page 22</p> <p>ensure the safety of the consumers in your care? As a result of the findings,</p> <ol style="list-style-type: none"> <li>1. Suspension and resignation of the employee in question happened immediately. (10/28/2025)</li> <li>2. We have reviewed the organization's policies regarding harm, abuse, neglect or exploitation. (10/31/2025)</li> <li>3. We have reviewed our training(s) pertaining to harm, abuse, neglect or exploitation. (10/31/2025)</li> <li>4. We will be implementing the following immediately:               <ol style="list-style-type: none"> <li>a. Additional training to improve our organizational culture that empowers staff to report improprieties or violations. (Completed by 12/31/2025. HR manager will ensure compliance.</li> <li>b. Additional training to address professional etiquette when communicating via email/phone/text. (completed by 12/31/2025) HR manager will ensure compliance.</li> <li>c. Create an awareness campaign highlighting our policies that protect client rights.</li> <li>d. A review of ARCA's Therapeutic Boundaries presentation with staff. (Medical staff completed 10/30/2025. remainder of staff to be completed by 11/28/2025)"</li> </ol> </li> </ol> <p>"Describe your plans to make sure the above happens.</p> <ol style="list-style-type: none"> <li>1. All staff will be required to sign a statement that acknowledges they understand ARCA's policies on boundaries and ethics, and they are to report any perceived violations. Completed by 11/28/2025)</li> <li>2. Future quarterly departmental meetings will now include a review or organizational policies pertaining to abuse, neglect and exploitation."</li> </ol> <p>FC #4 has diagnoses of Cannabis Use Disorder, Opioid Use Disorder, Severe, Stimulant Use</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/03/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ADDICTION RECOVERY CARE ASSOCIATION, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5755 SHATTALON DRIVE WINSTON SALEM, NC 27105</b>
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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 512	<p>Continued From page 23</p> <p>Disorder, Severe, PTSD, Depression, ADHD, and Bipolar Disorder. Staff #1 took advantage of FC #5's vulnerable situation and used his power of authority to abuse him when he started flirting with him then continued to build an inappropriate personal relationship with FC #5. Approximately 207 text messages were shared between Staff #1 and FC #5 the day FC #5 was discharged and the following 4 days until FC #5 was hospitalized. Staff #1 also gifted FC #5 a gold chain and charm that matched the one he wore and disregarded facility policy by when he took a picture of FC #5 and messaged it. Based on her own observations and information from other staff, the LPN was aware of the inappropriate behavior such as calling clients by nicknames and allowing clients to call him by nicknames of Staff #1 with clients but failed to take action to resolve the issue. Failure to resolve the issue earlier resulted in a lack of protection for FC #5. This deficiency constitutes a Type A1 rule violation for abuse and failure to protect from abuse and must be corrected within 23 days.</p>	V 512		