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NEW BEGINNINGS RESIDENTIAL SERVICES	506 EAST LAFAYETTE STREET SALISBURY, NC 28144

(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 A complaint and follow up survey was completed on December 4, 2025. The complaint was substantiated (intake #NC00234827). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600B Supervised Living for Minors with Developmental Disability. This facility is licensed for 5 and has a current census of 3. The survey sample consisted of audits of 3 current clients.	V 000		
V 110	27G .0204 Training/Supervision Paraprofessionals 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 professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and	V 110		

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V 110	Continued From page 1 (7) clinical skills. (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. This Rule is not met as evidenced by: Based on observation, record review and interview, 1 of 2 audited paraprofessional staff (Staff #2) failed to demonstrate the knowledge, skills and abilities required of the population served. The findings are: Observation on 12/2/25 at approximately 2:05 pm revealed: -Staff #2 was present at the facility with Clients #1, #2 and #3. -No additional staff was present with Staff #2 upon surveyor's arrival. Review on 12/3/25 of Staff #2's personnel file revealed: -Hire date of 3/24/25. -Position as Paraprofessional. -Training certificate dated 7/3/25 of formal restraint and de-escalation training. Review on 12/3/25 of Client #1's record revealed: -Admission date of 1/27/25. -Diagnoses of Control Disorder, Attention-Deficit Hyperactivity Disorder (ADHD)-Combined Presentation, Other Specified Trauma and Stressor Related Disorder, Moderate Intellectual Developmental Disability (IDD), Seasonal	V 110		

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V 110	Continued From page 2 Allergies, and Klinefelter's Syndrome. -Age of 14 years. Review on 12/2/25 of an internal incident report completed and dated by Staff #2 on 11/19/25 revealed: -Staff #2 "confiscated" Client #1's electronic tablet after repeated requests to Client #1 to clean his room. -"[Client #1] became upset, began to cry and expressed frustration. In response, gaming privileges were going to be restricted for a period of time if the room was not cleaned." -Client #1 completed cleaning his room and went to school. -"Later it was brought to attention that [Client #1] claimed to have been physically harmed. It is important to note that no physical contact was made beyond the necessary confiscation of the [electronic tablet]." -No additional documentation of the internal investigation was made available for review. Review on 12/3/25 of an internal "Incident Report Summary" dated 11/19/25 revealed: -The report was completed by the Qualified Professional (QP). -Staff #2's statements were included from his incident report dated 11/19/25. -"The [electronic tablet] was removed without physical force other than retrieving the device from [Client #1]'s hands." -"Staff (Staff #2) report that no physical contact occurred beyond the necessary retrieval of the [electronic tablet]." -" ...[Client #1] attempted to physically confront him (Staff #2). In response, [Staff #2] put his hands up to create space and move [Client #1] back from advancing toward him. At no time did [Staff #2] restrain [Client #1] or use physical force	V 110		

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V 110	Continued From page 3	V 110		

beyond the defensive action."
-"After DSS (department of social services) visited the residential home (facility) in response to [Client #1]'s initial allegation, [Client #1] later approached staff and reported that he made up an untrue statement regarding [Staff #2]."

Interview on 12/2/25 with Client #1 revealed:
-Before he went on a holiday visit in November 2025 and during the morning hours before school, he was on the living room couch on his electronic tablet when Staff #2 told him to go clean his room. When he told Staff #2 it would take him a while to get up, Staff #2 took his electronic tablet from him.
-"I tried to grab my tablet away from him (Staff #2) and I pushed him. He (Staff #2) pushed me back. I was standing up. He shoved me. He put 1 hand on my shoulder."
-Client #1 pointed to his left shoulder and stated, "He pushed me right here. It didn't hurt. He didn't put bruises on me."
-"I feel safe there (at facility). It was a little shove ...It's never happened before."
-Staff #2 was the only staff present at the time of the incident.
-Client #2 was present in the living room and witnessed the incident between him and Staff #2.

Interview on 12/2/25 with Client #2 revealed:
-He was in the living room on the couch when Client #1 "pushed" Staff #2.
-Staff #2 had Client #1's electronic tablet.
-Client #1 "hit" Staff #2; "he punched [Staff #2]."
-"[Staff #2] pushed him (Client #1) back with his hand."
-Client #1 was not hurt.
-Staff #2 was the only staff at the facility when the incident occurred.
-He, Client #3 and Client #2 were present at the

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V 110	Continued From page 4	V 110		

facility when the incident occurred.
-He felt safe at the facility.

Interview on 12/2/25 with Client #3 revealed:
-Confirmed Staff #2 removed Client #1's electronic tablet from him when Client #1 did not follow Staff #2's direction to clean his room before school.
-"When [Staff #2] took [Client #1's electronic tablet], [Client #1] ran at [Staff #2]."
-"[Staff #2] gave [Client #1] a little push to separate from him."

Interview on 12/2/25 with Staff #2 revealed:
-The Chief Executive Officer (CEO) was at the sister facility.
-On 11/18/25 around 7:00 am, he told Client #1 to clean his bedroom before school.
Client #1 "ignored" his instruction and continued using his electronic tablet."
-He removed Client #1's electronic tablet from his possession and Client #1 "tried to snatch it back."
-He returned the tablet back to Client #1 after he had cleaned his room and before he went to school that same morning.
-On 11/19/25, a social worker from a DSS came to the facility and told him Client #1 said he (Staff #2) "attacked him and grabbed his arm."
-He was suspended from his job from 11/20/25 to 11/29/25 because there was an investigation he had physically harmed Client #1.
-He denied he had any physical contact with Client #1 during the incident on 11/18/25.
-"I just put my hands out to keep the [electronic tablet] away from him (Client #1)."

Interview on 12/3/25 with the QP revealed:
-She learned of Client #1's allegation of "assault" against Staff #2 when Client #1 went to school on 11/18/25.

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V 110	Continued From page 5 -The incident report summary resulted from her internal investigation. -"[Client #1] admitted he lied because he wanted extra food that morning." -Client #1 had a red mark around his wrists that resulted from his jacket being tight around his wrist. -"No marks or bruises were found on [Client #1]." -Clients #2 and #3 wrote statements as part of the internal investigation and "they all said [Staff #2] didn't put his hands on [Client #1] ...Only one who said that was [Client #1]. He finally admitted he was not honest." -The outcome of the internal investigation for the alleged assault on Client #1 was unsubstantiated. Interview on 12/2/25 with the CEO revealed: -She received a call from the school on 11/18/25 about Client #1's allegation of Staff #2 having put his hands on him. -Client #1 said he made up the allegation because Staff #2 did not have time to make his breakfast before school and he refused Staff # 2's instruction to clean his room. -The red mark around Client #1's arm came from the arm of his jacket having been too tight. -When she asked Client #1 if Staff #2 put his hands on him, Client #1 said no, it was a lie. -"Once he (Client #2) said he lied, we ended our investigation." -"I don't know why the other [Clients #2 and #3] said [Staff #2] pushed him. They wrote statements and didn't say this." -Staff #2 denied he put his hands on Client #1. -Staff #2 was suspended from work from 11/20/25 until 11/29/25 pending the outcome of the internal investigation. -Staff #2 had no work performance issues. -Her preventive measure since Staff #2 returned to work to prevent a reoccurrence of an incident	V 110		

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V 110	Continued From page 6 between Client #1 and Staff #2 was to have 2 staff present at the facility when clients were awake. She, Staff #1 or Staff #3 were working with Staff #2 on his shift until Clients #1, #2 and #3 went to bed. -She was at the sister facility for "a few minutes" when surveyor arrived at the facility.	V 110		
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 obtained.	V 112		

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V 112	Continued From page 7	V 112		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to develop and implement treatment goals and strategies based on client needs within 30 days of admission for 1 of 1 current clients (Client #3). The findings are:

Review on 12/3/25 of Client #3's record revealed:
-Admission date of 9/1/25.
-Diagnoses of Major Depressive Disorder, Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder, Homicidal ideation, Suicidal ideation, Autistic, Attention-Deficit Hyperactivity Disorder, Type 1 Mellitus, and Hypoglycemia.
-Age of 15 years.
-No documentation of a treatment plan having been developed within 30 days of Client #3's admission.

Interview on 12/2/25 with Client #3 revealed:
-He stepped down from a Level 4 facility, and his admission was his 1st group home placement.
-His goals included learning to control his anger and passing all of his school classes.
-His coping strategies for his anger was using his bedroom closet as his "calm down place" and he "fidgeted with stuff."

Interview on 12/4/25 with the Chief Executive Officer (CEO) revealed:
-The Qualified Professional (QP) was responsible for development of Client #3's treatment plan along with the Care Coordinator from the Local Management Entity/Managed Care Organization

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V 112	Continued From page 8 (LME/MCO). -She believed there was a current treatment plan for Client #3 but she could not reach the QP to request a copy of the plan for review. -The QP was currently sick. -She did not have a current treatment plan for Client #3 to provide for review.	V 112		
V 117	27G .0209 (B) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner.	V 117		

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V 117	Continued From page 9 This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure prescription medications had the required dispensing information and 1 prescribed medication was not stored in a package with required dispensing information for 2 of 2 clients (Client #1 and Client #3). The findings are: Observation on 12/3/25 at 12:48 pm of Client #1's medications revealed: -Hydroxyzine Hydrochloride (HCL) (anxiety) 25 milligrams (mg), 1 tablet (tab) twice daily. -The dispense information on the pharmacy label for the Hydroxyzine HCL was faded and the filled date and expiration date were not legible. Observation on 12/3/25 at 1:18 pm of Client #3's medications revealed: -A pharmacy label with handwritten name of "Seraquil" with no correct name, dispense date, strength, quantity, expiration date and no directions for administration. -1 Novolog Flex Pen (diabetes) 3 milliliters (ml) was not stored in a package with dispensing information. Interview on 12/2/25 with Client #1 revealed: -He took medication daily and at night. -He did not know what his medications were for. -Staff gave him his medications. Interview on 12/2/25 with Client #3 revealed: -He took medication for his Attention-Deficit Hyperactivity Disorder, hypersexuality, depression, sleeping, Oppositional Defiant	V 117		

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V 117	Continued From page 10 Disorder, Attention-Deficit Disorder and diabetes. -Staff gave him his medications with exception of his insulin injections. Interview on 12/3/25 with the Chief Operating Officer revealed -The dispensing labels from Client #1's Hydroxyzine and Client #3's Seroquel was "worn" off. -She would have the pharmacy place new labels on the medication bottles. -She did not have the box Client #3's Novolog Flex Pen came in. -Client #3 self -administered his insulin medications and knew how and when to take his insulin.	V 117		
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:	V 118		

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V 118	Continued From page 11 (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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure all medications were administered on the written order of a person authorized to prescribe drugs for 2 of 2 clients (Clients #1 and #3), and failed to have a self-administration order from a physician of a client's medication affecting 1 of 3 clients (Client #3). The findings are: Review on 12/3/25 of Client #1's record revealed: -Admission date of 1/27/25. -Diagnosis of Seasonal Allergies. -Age 14 years. -No physician orders for the following medications: -Fluticasone 50 Micrograms (mcg) Nasal Spray (allergies). -Ventolin Inhaler 200 puffs(wheezing or shortness of breath). Review on 12/3/25 of Client #3's record revealed: -Admission date of 9/1/25.	V 118		

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V 118	Continued From page 12 -Diagnosis of Type 1 Diabetes Mellitus. -Age 15 years. -No self-administer physician's order for Lantus Solostar Insulin Pen 3 milliliters (ML) and Novolog Flex Pen 3 ML. Interview on 12/2/25 with Client #1 revealed: -He took medication; however, he did not know what his medications were or what his medications were for. Interview on 12/2/25 with Client #3 revealed: -He took insulin daily which he administered himself. Interview on 12/4/25 with the Chief Executive Officer revealed: -Client #1 no longer used the Ventolin Inhaler. -Client #1 used his Fluticasone Propionate Nasal Spray only as needed. -Before Client #3 was discharged from the hospital prior to his placement, she received diabetes training from the hospital to learn about Client #3's insulin and diabetic care. -She did not ask for a self-administration doctor's order at Client #3's hospital discharge. -Client #3 self-administered his insulin at the facility. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118		
V 119	27G .0209 (D) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that	V 119		

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V 119	Continued From page 13 guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction. (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure all prescription medications were disposed of in a manner that guards against diversion or accidental ingestion. The findings are: Observation on 12/3/25 at 1:00 pm of Client #1's medications revealed: -Medications were stored in a clear plastic container.	V 119		

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	MHL080-240	A. BUILDING: _____ B. WING _____	C 12/04/2025

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V 119	Continued From page 14 -In Client #1's medication container, there were at least 6 pills loose inside the container: -4 tan-colored pills with the number 215 imprinted on each pill; -1 white oval pill approximately ½ inch in linear size; -1 white oval pill approximately ¼ inch in linear size. Interview on 12/3/25 with the Chief Executive Officer revealed: -The tan-colored pills were Client #1's Concerta, the larger white pill was his Metformin and the smaller white pill looked like Client #1's night medication. -Client #1's Metformin was discontinued in 10/2025. -"They (medications) must have fallen out in the bin." -When a medication is no longer taken by a client and when pills fall out of their packaging, the medications are returned to the pharmacy.	V 119		
V 120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use;	V 120		

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V 120	Continued From page 15 (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to store refrigerated medications in a separate, locked compartment or container. The findings are: Observation on 12/4/25 at 10:34 am, Client #3's box of Lantus Solostar Insulin Pen 3 milliliters (ML) and 1 of the Lantus Solostar insulin pens outside the boxed package were in an unlocked refrigerated door compartment and beside a package of sliced cheese. Interview on 12/4/25 with the Chief Executive Officer revealed: -She had combination lock box which she would use to store Client #3's insulin in inside the refrigerator. -She was aware that refrigerated medications were to be in a locked container when stored in the refrigerator.	V 120		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY	V 132		

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V 132	Continued From page 16 (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to notify all allegations of abuse and neglect against health care personnel to the North Carolina Health Care Personnel Registry (HCPR) within 5 days of being notified. The findings are: Review on 12/3/25 of Staff #2's personnel file revealed:	V 132		

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V 132	Continued From page 17 -Hire date of 3/24/25. -Position as Paraprofessional. -No documentation of information submitted to HCPR about the allegation by Client #1 on 11/18/25 against Staff #2. Interview on 12/3/25 with the Qualified Professional (QP) revealed: -Did not submit an IRIS report of Client #1's allegation of assault against Staff #2 with HCPR notification because the allegation was unsubstantiated. Interview on 12/2/25 with the Chief Executive Officer (CEO) revealed: -The QP was responsible for completing the HCPR report.	V 132		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the	V 291		

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V 291	Continued From page 18 legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to coordinate client care and services with others responsible for a client's treatment for 1 of 3 clients (Client #3). The findings are: Review on 12/3/25 of Client #3's record revealed: -Admission date of 9/1/25. -Diagnoses of Major Depressive Disorder, Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder, Homicidal ideation, Suicidal ideation, Autistic, Attention-Deficit Hyperactivity Disorder, Type 1 Mellitus, and Hypoglycemia. -Age of 15 years. -No documentation of a diabetic plan of care for Client #3. -No documentation of efforts to communicate with Client #3's public guardian about equipment needed for Client #3's continuous glucose monitoring system. -No documentation provided of efforts to follow up with medical treatment providers to address Client #3's glucose levels of 500 and high blood	V 291		

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V 291	Continued From page 19 pressure. Observation on 12/3/25 at 1:18 pm of Client #3's diabetic supplies revealed: -A continuous glucose monitoring system which was filled by the pharmacy on 8/25/25 with directions to change the sensor every 10 days. -Manual glucose testing supplies which included test strips, lancets, pin needles and a glucometer. Interview on 12/4/25 with Client #3 revealed: -His normal blood glucose level ranged from 90 to 260. -He administered his own insulin dosages and did his own blood glucose checks at the facility and at school. -On 12/2/25 and 12/3/25, the school sent him home because his blood glucose was 500. -On 12/4/25, he did not go to school because he did not have his insulin to take with him. Interview on 12/4/25 with Staff #1 revealed: -Client #3's insulin pens were in the refrigerator for him to take to school each day. -Client #3's blood glucose ran between 158-250 at the facility while at school his blood glucose had risen to 500. -"We don't know why its (blood glucose level) is so high at school because it's not like that here (at facility)." - "It's in normal range here but we are constantly asking [Client #3] 'have you checked your sugar?'" -Client #3 did not choose to use his continuous blood glucose monitoring system; instead he was checking his glucose level by finger pricks. Interview on 12/4/25 with Client #3's school nurse revealed: -Client #3 was sent home from school on 12/2/25	V 291		

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V 291	Continued From page 20 and 12/3/25 because his blood glucose level reached 500. -Client #3's glucometer did not work; he used the school's glucometer which does not read over 500. -Client #3 had a continuous glucose monitoring system which she had seen him use "only 2 times." -Client #3 said he did not have all the equipment for his continuous glucose monitoring system and this system was locked up with his emergency nasal spray. -Client #3 was supposed to bring to school his prescribed Baqsimi, an emergency nasal spray, to treat low glucose symptoms such as seizures, nausea and fainting. -She did not know what was causing Client #3's blood glucose levels to rise to 500. -She had recommended to facility staff (unnamed) that Client #3 be seen by an endocrinologist for specific instructions to help Client #3 maintain his blood glucose to an acceptable level. Interview on 12/4/25 with the Chief Executive Officer revealed: -Client #3 was seen by an endocrinologist on 10/31/25. -At his 10/31/25 appointment, Client #3's blood pressure was "an issue" and he needed to be seen by a pediatric cardiologist. -Client #3 had not yet been seen by a cardiologist because the facility was waiting to receive a referral to find out what cardiologist he was to be seen by. -She and her consultant would follow up on the referral for the pediatric cardiologist and her consultant would pick up a diabetic plan of care for Client #3 from the nurse of his endocrinologist.	V 291		

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V 291	Continued From page 21 -Client #3 had his emergency nasal spray to take to school with his insulin pens. -When Client #3's glucose level was checked at the facility, Client #3 showed his reading to staff which was communicated between staff in a group chat format. -She did not have a chart or document which recorded Client #3's checked blood glucose levels to determine if there were any patterns or trends associated with his blood glucose readings. -Client #3 did not use his continuous glucose monitoring system because the "valves" used with the system were delivered to his father. -She had no contact information for Client #3's father but she had informed Client #3's public guardian of having no valves to use the glucose monitoring system.	V 291		
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	V 366		

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V 366	Continued From page 22	V 366		

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 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

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V 366	Continued From page 23 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 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.	V 366		

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V 366	Continued From page 24 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to immediately notify a client's legal guardian and the Local Management Entity/Managed Care Organization (LME/MCO) of all Level III incidents. The findings are: Review on 12/2/25 of the North Carolina Incident Response and Improvement System (IRIS) of incidents between 10/1/25 to 12/2/25 revealed: -No Level III incident report for Client #1. Review on 12/3/25 of an internal "Incident Report Summary" dated 11/19/25 revealed: -No documentation Client #1's legal guardian or the LME/MCO was immediately notified of the 11/18/25 allegation by Client #1 against Staff #2. Interview on 12/3/25 with Client #1's public legal guardian revealed: -He was unaware of Client #1's allegation against Staff #2 until he visited with Client #1 at the facility on 11/20/25. -He understood Client #1 reported at school on 11/18/25 that Staff #2 "grabbed" his arm and left a bruise. -He observed Client #1 during his 11/20/25 visit and did not see any visible bruises on Client #1. Interview on 12/3/25 with the Qualified Professional (QP) revealed: -"We found out [Client #1] made an accusation that [Staff #2] had assaulted him when he went to school on the 18th (November)." -She did not immediately notify Client #1's legal guardian or the LME/MCO of Client #1's	V 366		

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V 366	Continued From page 25 allegation. Interview on 12/2/25 with the Chief Executive Officer (CEO) revealed: -She did not know if Client #1's legal guardian was aware of Client #1's allegation on 11/18/25. -She did not notify the LME/MCO of the incident between Client #1 and Staff #2.	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: (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	V 367		

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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 .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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080-240	A. BUILDING: _____ B. WING _____	C 12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BEGINNINGS RESIDENTIAL SERVICES	506 EAST LAFAYETTE STREET SALISBURY, NC 28144

(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 367	Continued From page 27 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 interview, the facility failed to report all Level III incidents to the Local Management Entity/Managed Care Organization (LME/MCO) within 72 hours of becoming aware of the incident. The findings are: Review on 12/2/25 of the North Carolina Incident Response and Improvement System (IRIS) of incidents between 10/1/25 to 12/2/25 revealed: -No Level III incident report for Client #1. Interview on 12/3/25 with the Qualified Professional (QP) revealed: -Did not submit an IRIS report of Client #1's allegation of assault against Staff #2 because the allegation was unsubstantiated. -"We didn't have one (IRIS report) to do because it (allegation) didn't occur."	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 367	Continued From page 28 Interview on 12/2/25 with the Chief Executive Officer (CEO) revealed: -The QP was responsible for submission of all IRIS reports for the facility.	V 367		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure the facility and its grounds was maintained in a safe manner. The findings are: Observation on 12/3/25 at 4:30 pm of Client #3 having walked up the stone steps attached to the sidewalk next to the road and the sidewalk leading to the facility. Observation on 12/4/25 at 10:11 am of 1 stone step attached to the sidewalk next to the road and the sidewalk leading to the facility which was separated from the walkway and ground. Interview on 12/4/25 with the Chief Executive Officer revealed: -She did not know how long the stone step had been in a loose condition. -She would have a maintenance staff to repair the step as soon as possible. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		