

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	<p>INITIAL COMMENTS</p> <p>A complaint and follow up survey was completed on 11/26/25. The complaints were substantiated (intakes #NC00233489, #NC00233519, #NC00233635, #NC00233710, #NC00233852, and #NC00234088). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.</p> <p>This facility is licensed for 3 and has a current census of 1. The survey sample consisted of audits of 1 current client and 3 former clients.</p> <p>The Licensee/Director/Chief Executive Officer was employed as staff and worked in the facility.</p> <p>This survey was originally closed on 10/29/25 and was reopened 11/25/25.</p>	V 000		
V 107	<p>27G .0202 (A-E) Personnel Requirements</p> <p>10A NCAC 27G .0202 PERSONNEL REQUIREMENTS</p> <p>(a) All facilities shall have a written job description for the director and each staff position which:</p> <ul style="list-style-type: none"> (1) specifies the minimum level of education, competency, work experience and other qualifications for the position; (2) specifies the duties and responsibilities of the position; (3) is signed by the staff member and the supervisor; and (4) is retained in the staff member's file. <p>(b) All facilities shall ensure that the director, each staff member or any other person who provides care or services to clients on behalf of</p>	V 107		

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

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 107	<p>Continued From page 1</p> <p>the facility:</p> <ul style="list-style-type: none"> (1) is at least 18 years of age; (2) is able to read, write, understand and follow directions; (3) meets the minimum level of education, competency, work experience, skills and other qualifications for the position; and (4) has no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry. <p>(c) All facilities or services shall require that all applicants for employment disclose any criminal conviction. The impact of this information on a decision regarding employment shall be based upon the offense in relationship to the job for which the applicant is applying.</p> <p>(d) Staff of a facility or a service shall be currently licensed, registered or certified in accordance with applicable state laws for the services provided.</p> <p>(e) A file shall be maintained for each individual employed indicating the training, experience and other qualifications for the position, including verification of licensure, registration or certification.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain a personnel record with required documentation affecting 3 of 13 staff (the Licensee/Director/Chief Executive Officer (CEO), the Qualified Professional (QP), and staff</p>	V 107		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 107	<p>Continued From page 2</p> <p>#6) and failed to maintain a file for 1 of 13 staff (#4) with trainings, experience and other qualifications. The findings are:</p> <p>Review on 10/8/25 of staff #4's personnel record revealed: -Hired 9/8/25. -No documentation of trainings, experience and other qualifications.</p> <p>Review on 10/8/25 of staff #6's personnel record revealed: -Hired 7/1/25. -No documentation of a written job description.</p> <p>Review on 10/8/25 of the QP's personnel record revealed: -Hired 7/16/25. -No documentation of a written job description.</p> <p>Review on 10/8/25 of the Licensee/Director/CEO's personnel record revealed: -Hired 7/7/24. -No documentation of a written job description.</p> <p>Interview on 10/14/25 with staff #4 revealed: -"I really didn't have any training because I knew everything." -"I told her (Licensee/Director/CEO) I knew how to do the medication because I was a medication assistant." -Had medical assistant diploma. -Provided her medical assistant diploma to the Licensee/Director/CEO when she was hired.</p> <p>Interviews on 10/14/25 and 10/16/25 with staff #6 revealed: -Signed her job offer letter "through email." -Stated she would check her "onboarding"</p>	V 107		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 107	<p>Continued From page 3</p> <p>records, "yes, I have a job description." -Was not sure why the information was not in her personnel folder, "I keep everything in my phone, when things happen I document in my phone and I don't delete anything.</p> <p>Staff #6 did not provide the missing job description.</p> <p>Interviews on 10/8/25 and 10/23/25 with the Licensee/Director/CEO revealed: -Was the person responsible for hiring staff and completing human resource duties. -"I have that (job description) and I can send that to you"and "I will get that information for you." -Had no explanation for why she did not have a job description in her personnel file. -Had no explanation for why the missing documents were not in the staff's personnel files.</p> <p>Requested missing job descriptions for staff #6, QP and Licensee/Director/CEO on 10/8/25, 10/15/25, 10/16/25 and no documentation was provided prior to survey exit date.</p>	V 107		
V 108	<p>27G .0202 (F-I) Personnel Requirements</p> <p>10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation</p>	V 108		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 108	<p>Continued From page 4</p> <p>plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to document continuing education and ensure 1 of 13 staff (#4) received clients rights training to meet the MH/DD/SA needs of the clients, and failed to ensure that 3 of 13 staff (Licensee/Director/Chief Executive Officer (CEO), staff #5, and staff #6) received training in infectious disease and bloodborne pathogens. The findings are:</p> <p>Review on 10/8/25 of staff #4's personnel record revealed: -Hired 9/8/25. -No documentation of continuing education and</p>	V 108		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 108	<p>Continued From page 5</p> <p>client rights trainings .</p> <p>Review on 10/8/25 of staff #5's personnel record revealed: -Hired 9/8/25. -4/2/25, First Aid/Cardiopulmonary Resuscitation (CPR) certificated signed by Licensee/Director/CEO. -No documentation of training in infectious disease and bloodborne pathogens.</p> <p>Review on 10/8/25 of staff #6's personnel record revealed: -Hired 7/1/25. -Training on 6/26/25 for infectious disease and bloodborne pathogens was provided by the Licensee/Director/CEO.</p> <p>Review on 10/8/25 of the Licensee/Director/CEO's personnel record revealed: -Hired 7/7/24. -Training on 7/17/24 for infectious disease and bloodborne pathogens was provided by staff #1.</p> <p>Interview on 10/15/25 with staff #1 revealed: -Did not have a healthcare background and was not trained in infectious disease and bloodborne pathogens. -No staff training had been falsified. -Staff #5 did not remember she had training.</p> <p>Interview on 10/14/25 with staff #4 revealed: -"I really didn't have any training because I knew everything." -"I told her (Licensee/Director/CEO) I knew how to do the medication because I was a medication assistant." -Had medical assistant diploma. -Provided her medical assistant diploma to the</p>	V 108		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 108	<p>Continued From page 6</p> <p>Licensee/Director/CEO when she was hired. -I got training first aid/CPR training (10/6/25), now I am certified."</p> <p>Interview on 10/15/25 with staff #5 revealed: -"I was working with them back in Jan 2025 and most recently she asked me to come back when she opened the [sister facility]...been working with [sister facility location] for 4 weeks...no longer working with her (Licensee/Director/CEO)...unorganized, things I don't agree with...and how it's (facility) ran." -"Didn't have any training" at the facility..."ever...all my trainings came from the hospital and trainings "for first aid and CPR, will show that (previous employer) was who trained me." -Had provided a copy of her first aid and CPR training from her previous employer to the facility when she was hired. -Had "never sat in a training with [Licensee/Director/CEO], ever...the training dates provided (on certificates) are completely falsified" and "wasn't even working with them (facility) in April (2025)."</p> <p>Interviews on 10/8/25 and 10/16/25 with the Licensee/Director/CEO revealed: -She was responsible for ensuring staff was trained. -Staff #4 had trainings in first aid (10/6/25) and medication administration (9/12/25). -No documentation of training for client rights, client specific training in MH/DD/SA or infectious disease and bloodborne pathogens for staff #4 at hire 9/8/25. -Had no explanation for why there was no documentation of continuing education trainings in staff #4's personnel file prior to 10/8/25. -Staff #5 "had training (first aid, medication</p>	V 108		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 108	Continued From page 7 administration, and de-escalation) before she was hired." -Her husband (staff #1) had provided the infectious disease and bloodborne pathogens training on 7/17/24. -In the past, she had provided first aid training for staff (#5), prior to getting her certification on 7/1/25, "I just recently got certified...I was not certified at that time." -She did not have a healthcare background and was not trained in infectious disease and bloodborne pathogens.	V 108		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) 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 (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 109	<p>Continued From page 8</p> <p>employment system in the State Plan for MH/DD/SAS.</p> <p>(f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional.</p> <p>(g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to develop and implement policies and procedures for the initiation of an individualized supervision plan for the Associate Professional House Manager (AP/HM) and the Qualified Professional (QP) failed to supervise the AP (AP/HM). The findings are:</p> <p>Review on 10/1/25 of the facility's records revealed: -No policies and procedures for the initiation of an individualized supervision plan for the AP/HM. -No documentation of supervision for the AP/HM by the QP.</p> <p>Review on 10/8/25 of the AP/HM's personnel record revealed: -Hired 10/1/25. -Offer letter and job description for AP/HM signed and dated 10/2/25. -Scheduled hours Monday-Friday 4:00pm-10:00pm and Saturday 8:00am-8:00pm.</p>	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 109	<p>Continued From page 9</p> <p>-Responsibilities included "...supervision of paraprofessionals regarding responsibilities related to the implementation of each child or adolescent's treatment plan...assisting QP with administrative tasks. Attending weekly leadership meetings with owners and QP...Supervision shall be provided by a Qualified Professional with experience serving the population until you reach four (4) years of experience. An individualized plan will be developed upon hiring and reviewed annually by both parties..."</p> <p>Review on 10/8/25 of the QP's personnel record revealed: -Hired 7/16/25. -No documentation of a job description. -Offer letter signed and undated for "Part-Time Qualified Professional (QP)...working 15 hours per week, with one on-site day at the home per week. This initial schedule will be in effect for the next four (4) weeks, after which we will evaluate the needs of the program and consider increasing your hours to 20 hours per week based on demand and performance...contingent upon the following: completion of all training, submission of your Bachelor's Degree, current First Aid certification..."</p> <p>-Responsibilities included "Supervise all staff...Supervise paraprofessionals regarding responsibilities related to the implementation of each child or adolescent's treatment plan..."</p> <p>Interview on 10/10/25 with the Former Residential Director revealed: -"I worked 10 days, from 8/25 (2025) until 9/5 (2025)." -"When I was there was no AP only a QP." -"I told her QP had to be on site." -Had seen the QP in the facility "one time...I specifically asked the staff and they said they had</p>	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 109	<p>Continued From page 10</p> <p>not seen her (QP) in a month; she came on a Wednesday, August 27 (2025) and was pissed that I had her come there (facility); that was the only day she was there during the time I worked there."</p> <p>Interview on 10/13/25 with the AP/HM revealed: -"I am the House Manager. I started on 10/2/25, so I am really new." -"I have not been to Lakemore (facility staff) since my date of hire." -The facility was "in the process of hiring another House Manager so there can be one in each home (facility)." -"[Licensee/Director/Chief Executive Officer (CEO)] does my supervision." -"I believe the AP (AP/HM) is [QP]. I'm not sure, my apology, she [QP] is the QP; I'm not sure of the AP (who the AP was)." -Had not had supervision with the QP. -Did not know who the AP/HM was, was not aware that she was the AP/HM, was not aware the QP was to provide her supervision. -A plan for supervision with the QP had not been discussed with her.</p> <p>Interview on 10/13/25 with the QP revealed: -Her work hours "varies; not really set, according to how many residents" are in the facility. -"My time is split between 2 locations (facility and sister facility)." -"I'm on site for interventions...they (facility) have 24/7 access to me...they know to call me for de-escalation." -"Oversee" the direct support staff. -Did not do unannounced visits at the facility, "they (staff) are always aware that I am coming." -"Don't really do supervision, but if I need to provide training or show them (staff) how to do something, in that respect I provide supervision."</p>	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 109	<p>Continued From page 11</p> <p>-"I'm not sure who the AP (AP/HM) is; we (facility) did have an AP, but I am not sure the status of how long it will be for her (Licensee/Director/CEO) to refill that position (AP/HM)."</p> <p>Interviews on 10/8/25 and 10/14/25 with the Licensee/Director/CEO revealed: -"[AP/HM] works full-time." -The QP provided supervision to the AP/HM. -The QP worked "25 hours" weekly. -"...she (AP/HM) was hired as the AP slash House Manager (AP/HM). Most people don't know what the official title is." -"I went over that (AP/HM title and job description) with her when she was initially hired...she is the AP (AP/HM) and I will go over that with her again."</p> <p>Interview on 10/15/25 with the Licensee/Director/CEO revealed: -The AP/HM was "just hired...October 1st (2025)."</p> <p>Interview on 10/23/25 with the Licensee/Director/CEO revealed: -The Human Resources duties were "between me, the Director, and the AP, [AP/HM]." -Before [AP/HM] was hired she was responsible for hiring, staff training and scheduling staff. -"Our (facility) QP does supervise the AP (AP/HM), I can get the policy procedure for you."</p> <p>Interview on 10/29/25 with the Licensee/Director/CEO revealed: -The QP "is at this facility" and "she (QP) is contracted for 15 hrs a week, that's just here (facility); she's here 70 percent of that time." -"I will look at the contract we have."</p> <p>Attempted review on 10/1/25 and 10/15/25 of the</p>	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 109	Continued From page 12 facility's policy, individualized supervision plans for the AP and QP's supervision of the AP/HM. No documentation was provided prior to survey exit. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type B rule violation and must be corrected within 45 days.	V 109		
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		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 112	<p>Continued From page 13</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to develop and implement treatment plan, goals and strategies based on client needs after 30 days admission for 1 of 3 former client (FC #4). The findings are:</p> <p>Review on 10/7/25 of FC #4's record revealed: -Age 16 years old. -Admitted on 7/27/25 (with additional dates of admission in file 7/20/25, 7/25/25). -Discharged on 9/22/25. -Diagnoses: Post Traumatic Stress Disorder; Attention Deficit Hyperactivity Disorder; Major Depressive Disorder; Moderate Intellectual Disability Disorder; Seizures. -Facility assessment dated 7/27/25, ..struggles with following directives; verbal and physical aggression; depression; elopement; need assistance with everyday task; violent towards adults and peers; controlling anger; disruptive in school settings; Aggressive behavior; depression/anxiety, trauma/abuse history; family conflict. -No documentation of a treatment plan.</p> <p>Interview on 10/10/25 with the Former Residential Director revealed: -"I worked 10 days, from 8/25 until 9/5 (2025)." -Treatment plans were "a point of contention (disagreement) on 8/27 (2025)...I asked [Qualified Professional] when she was going to do the CFT (Child Family Team) meetings. I think she (QP) did one (CFT meeting) that month</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 112	<p>Continued From page 14</p> <p>(August 2025)."</p> <p>-Between 8/25/25 and 9/5/25 had "told [the Licensed Professional (LP)] she needed to update the CCA (comprehensive clinical assessment) and PCPs (Person Centered Plan-treatment plan) together (with the QP)" to ensure authorization of services for all clients.</p> <p>-The QP "was not updating those treatment plans as needed...told [Licensee/Director/Chief Executive Officer (CEO)] to talk to her people because you can't provide service if the treatment plan is out dated."</p> <p>Interview on 10/24/25 with FC #4's Department of Social Services (DSS) Social Worker (SW) revealed:</p> <p>-The IIHS (Intensive In-Home Services) treatment plan was completed by the IIHS therapist, when client #4 was previously receiving IIHS services.</p> <p>-IIHS services plan was developed prior to client #4's admission to the facility; "they (facility) made it like the information (FC #4's needs) was not given to them."</p> <p>-There were CFT meetings held on 9/17/25 and 9/18/25 to address FC #4's behaviors.</p> <p>-"That (CFT) was the first time (9/17/25) talking about her (FC #4) behaviors...we were waiting on an updated CCA (Comprehensive Clinical Assessment) from [Qualified Professional]."</p> <p>-The QP "told about the 'fake' seizures and aggressive behaviors...they (facility) felt they weren't meeting her (FC #4) needs."</p> <p>-"She (Licensee/Director/CEO) was aware of all these things...information like her (FC #4) medical information, IQ (intelligence quotient), seizures...and would say she didn't know she (FC #4) had these behaviors and, yes she did, because that was always discussed."</p> <p>Interview on 10/13/25 with the QP revealed:</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 112	<p>Continued From page 15</p> <p>-She was responsible for CFT meetings, client treatment plans and treatment plan updates. -"I'm actively updating (treatment plan) as we are conducting the CFT meeting." -Treatment plans were "updated approximately 21-28 days at every CFT meeting; everything we talk about it's updated in the CFT. " -Had updated the treatment plans "in the clients' (all, including FC #4) charts and I have an electronic folder of all their (clients) documents."</p> <p>Provided no documentation prior to survey exit of an updated treatment plan after 30 days of FC #4's admission.</p> <p>Interview on 10/15/25 with the LP revealed: -Did not attend CFT meetings. -Qualified Professional (QP) updated client's treatment plans, "I don't touch them (treatment plans)."</p> <p>Interview on 10/7/25 with the Licensee/Director/CEO revealed: -Confirmed FC #4's admission date, "she (FC #4) was admitted on 7/27 (2025)." -Provided no explanation for why there were three admission dates in FC #4's file. -The treatment plan for FC# 4 was updated, "...that is it (treatment plan)...we use their (IHHS) formatting...we had a CFT (Child Family Team) meeting (no date) and the plan was updated, would you like for me to send that one to you? I will send that one."</p> <p>Interviews on 10/23/25 and 10/24/25 with the Licensee/Director/CEO revealed: -The treatment plan for FC #4 was updated "and the QP (Qualified Professional) wanted to keep the goals from the previous (treatment plan)." -The QP scheduled the CFT meetings and does</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 112	<p>Continued From page 16</p> <p>the documentation.</p> <p>-The QP was responsible for the treatment plans and updates.</p> <p>-Was not sure if there were strategies and interventions to address FC #4's seizures included in FC #4's treatment goals, "let me look and see. I would have to see as it relates to that; I would have to double check."</p> <p>Requested on 10/1/25, 10/7/25, and 10/23/25 to review the facility's documentation of treatment plan, goals and strategies for FC #4. -No documentation was provided prior to survey exit.</p> <p>-Provided no documentation prior to survey exit of an updated treatment plan after 30 days of admission for FC #4.</p> <p>Requested review of FC #4's CFT meetings and notes on 10/13/25, 10/23/25 and 10/24/25. No documentation was provided prior to survey exit.</p> <p>This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type B rule violation and must be corrected within 45 days.</p>	V 112		
V 118	<p>27G .0209 (C) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</p> <p>(c) Medication administration:</p> <p>(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.</p> <p>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.</p> <p>(3) Medications, including injections, shall be</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 118	<p>Continued From page 17</p> <p>administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure medications were administered on the written order of a person authorized by law to prescribe drugs and failed to ensure the MAR of all drugs administered to each client was kept current affecting 1 of 1 current client (#1) and 1 of 3 former clients (former client (FC) #4). The findings are:</p> <p>Cross Reference: 10A NCAC 27G .0209 Medication Requirements (V121). Based on record reviews and interviews, the facility failed to</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 118	<p>Continued From page 18</p> <p>obtain drug regimen reviews every six months for 1 of 1 current clients (client #1) who received psychotropic drugs.</p> <p>Observation on 10/1/25 at approximately 1:40pm of client #1's medications revealed: -The following medications were available in the facility for client #1: -Norethindrone (contraceptive) 0.35 milligram (mg), take 1 tablet by mouth daily, expiration 8/26/26; -Methylphenidate (Attention Deficit Hyperactivity Disorder (ADHD) 50mg, every day 1 time(s) a day; -Hydroxyzine (anxiety) 10mg, take 1 by mouth once a day as needed for anxiety.</p> <p>Observation on 10/7/25 at approximately 12:08pm of client #1's medications revealed: -The following medications were available in the facility for client #1: -Aripiprazole (bipolar disorder, depression) 15mg, take 1 tablet by mouth once daily in the evening. -Clonidine (ADHD, insomnia) 0.1mg, take 1 tablet by mouth at bedtime for sleep. -Cyproheptadine (allergy) 4mg, take 1 tablet by mouth in the morning and evening. -Lamotrigine (bipolar disorder) 150mg, take 1 tablet by mouth in the AM (morning). -Sertraline (Post Traumatic Stress Disorder (PTSD)) 25mg, take 1 tablet by mouth once daily in the morning. -Norethindrone 0.35mg, take 1 tablet by mouth daily, expiration 8/26/26; -Methylphenidate 50mg, every day 1 time(s) a day; -Hydroxyzine 10mg, take 1 by mouth once a day as needed for anxiety.</p> <p>Finding #1</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 118	<p>Continued From page 19</p> <p>Review on 10/7/25 of client #1's record revealed: -Physician Orders (PO): -1/21/25 Norethindrone 0.35 mg, take 1 tablet by mouth daily. -5/2/25 Aptensio 40 mg, take 1 capsule by mouth once daily in the morning. -6/17/25 Aripiprazole 15mg, take 1 tablet every evening change in dosing time; Clonidine 0.1 mg, take 1 tablet by mouth at bedtime for sleep; Cyproheptadine 4mg, take 1 tablet by mouth in the morning and evening; Lamotrigine 150 mg, take 1 tablet by mouth in the morning; Sertraline 25mg, take 1 tablet by mouth once daily in the morning; Hydroxyzine 10mg, take 1 tablet by mouth once a day as needed for anxiety. -7/11/25 Aptensio 40 mg, take 1 capsule by mouth once daily in the morning. -No PO for Methylphenidate 50 mg, take 1 tablet by mouth daily. -No PO for Aripiprazole 15mg, take 1 tablet every morning.</p> <p>Reviews on 10/1/25 and 10/7/25 of client #1's MARs from March 2025-September 2025 revealed: March 2025: -No March 2025 MAR.</p> <p>April 2025: -Aptensio 40 mg, take 1 capsule by mouth once daily in the morning, documented as administered 29 days without a PO on cite at the facility, 4/1/25-4/16/25 and 4/18/25-4/30/25; no staff initial for administration on 4/17/25. -Aripiprazole 15 mg, take 1 tablet by mouth once daily in the morning, documented as administered 29 days without a PO on cite at the facility, 4/1/25-4/16/25 and 4/18/25-4/30/25; no staff initial for administration on 4/17/25. -Clonidine 0.1 mg tablet, take 1 tablet by mouth at</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 118	<p>Continued From page 20</p> <p>bedtime for sleep, documented as administered 30 days without a PO on cite at the facility, 4/1/25-4/30/25;</p> <p>-Cyproheptadine 4mg, take 1 tablet by mouth in the morning and evening, documented as administered 29 days in the morning, 4/1/25-4/16/25 and 4/18/25-4/30/25 without a PO on cite at the facility; documented as administered 30 days in the evening, 4/1/25-4/30/25, without a PO on cite at the facility; no initials for administration on 4/17/25.</p> <p>-Lamotrigine 150 mg, take 1 tablet by mouth in the morning, documented as administered 29 days without a PO on cite at the facility, 4/1/25-4/16/25 and 4/18/25-4/30/25; no initials for administration on 4/17/25.</p> <p>-Norethindrone 0.35 mg, take 1 tablet by mouth daily, no initials for administration on 4/17/25.</p> <p>-Sertraline 25mg, take 1 tablet by mouth once daily in the morning, documented as administered 29 days without a PO on cite at the facility, 4/1/25-4/16/25 and 4/18/25-4/30/25; no initials for administration on 4/17/25.</p> <p>May 2025:</p> <p>-Aripiprazole 15 mg, take 1 tablet by mouth once daily in the morning, documented as administered 31 days without a PO on cite at the facility, 5/1/25-5/31/25.</p> <p>-Clonidine 0.1 mg tablet, take 1 tablet by mouth at bedtime for sleep, documented as administered 31 days without a PO on cite at the facility, 5/1/25-5/31/25.</p> <p>-Cyproheptadine 4mg, take 1 tablet by mouth in the morning and evening, documented as administered 31 days morning and evening without a PO on cite at the facility, 5/1/25-5/31/25.</p> <p>-Lamotrigine 150 mg, take 1 tablet by mouth in the morning, documented as administered 31 days without a PO on cite at the facility,</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 118	<p>Continued From page 21</p> <p>5/1/25-5/31/25. -Sertraline 25mg, take 1 tablet by mouth once daily in the morning, documented as administered 31 days without a PO on cite at the facility, 5/1/25-5/31/25.</p> <p>June 2025: -Aripiprazole 15mg, take 1 tablet every evening change in dosing time, documented as administered mornings as, take 1 tablet by mouth (AM) from 6/17/26-6/30/25 (14 days). -Clonidine 0.1 mg, take 1 tablet by mouth at bedtime for sleep, documented as administered 16 days with no PO on cite at the facility, 6/1/25-6/16/25. -Cypheptadine 4mg, take 1 tablet by mouth in the morning and evening, documented as administered 16 days with no PO on cite at the facility, 6/1/25-6/16/25. -Lamotrigine 150 mg, take 1 tablet by mouth in the morning, documented as administered 16 days with no PO on cite at the facility, 6/1/25-6/16/25. -Sertraline 25mg, take 1 tablet by mouth once daily in the morning, documented as administered 16 days with no PO on cite at the facility, 6/1/25-6/16/25.</p> <p>July 2025: -Aripiprazole 15mg, take 1 tablet every evening change in dosing time, documented as administered mornings as, take 1 tablet by mouth once daily for 31 days, 7/1/25-7/31/25.</p> <p>August 2025: -Aripiprazole 15mg, take 1 tablet every evening change in dosing time, documented as administered mornings as, take 1 tablet by mouth once daily for 31 days, 8/1/25-8/31/25. -Methylphenidate 50 mg, take 1 tablet by mouth</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 118	<p>Continued From page 22</p> <p>daily, documented as administered 2 days without a PO on cite at the facility, 8/27/25 and 8/28/25. -Methylphenidate 50 mg, take 1 tablet by mouth daily, documented as administered 4 days without a PO on cite at the facility, 8/28/25-8/31/25.</p> <p>September 2025: -Aripiprazole 15mg, take 1 tablet every evening change in dosing time, documented as administered as take 1 tablet by mouth once daily in the morning for 30 days, 9/1/25-9/30/25. -Methylphenidate 50 mg, take 1 tablet by mouth daily, documented as administered 30 days without a PO on cite at the facility, 9/1/25-9/30/25.</p> <p>Finding #2 Reviews on 10/7/25 and 10/14/25 of FC #4's record revealed: -Age 16 years old. -Admission on 7/27/25, other admission dates in the record were 7/20/25 and 7/25/25. -Discharged on 9/22/25, "Reason for Discharge: ...due to ongoing, frequent, and severe seizures that presented significant safety concerns ...the severity and frequency of the seizures created medical and safety risks..." -Diagnoses: PTSD; ADHD; Major Depressive Disorder; Moderate IDD; Seizures. -Letter from FC #4's Neurologist dated 9/11/25: "Dear Care Providers: [FC #4] is my patient with refractory epilepsy. She can have subtle seizures while awake or asleep. Her seizures can go unnoticed at times. She is now requiring three antiseizure medications and still having seizures. I am concerned about her current living environment. She needs to be in an environment with caregivers/caretakers can monitor her regularly (While awake and asleep) to identify seizures and seizure safety. I am concerned that</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 118	<p>Continued From page 23</p> <p>her current level of care and supervision is not adequate. this is essential for her well being, safety and health. I am adjusting her daily medications along with her emergency plan but she needs to have close monitoring."</p> <p>-Physician Orders: -8/19/25 for Zonisamide (epilepsy) 50mg, 3 QAM (every morning); -No PO for Zonisamide 100mg, take one (100mg) in the morning and two (200mg) at bedtime; -No PO for -Aripiprazole (mood) 2 mg, take 1 tablet daily; -No PO for Clobazam (seizures) 10mg, take 3 tablets twice daily; -No PO for Folic Acid (generalized epilepsy) 1 mg, take 1 tablet by mouth every morning; -No PO for Fycompa (seizures) 12 mg, take 1 tablet by mouth every day; -No PO for Guanfacine (ADHD) 1 mg tablet, take 2 tablets by mouth daily; -No PO for Melatonin (sleep) 3 mg, take 1 tablet by mouth at bedtime; -No PO for PRN (as needed) medications: Nayzilam (seizure clusters) 5 mg spray, instill one spray as needed for clear epileptic activity; Olanzapine (depression) 2.5 mg, take 1 tablet by mouth every 6 hours as needed for agitation; and Clonazepam 0.5 mg, take 2 time(s) a day as needed.</p> <p>Reviews on 10/1/25 and 10/7/25 of FC #4's MARs from July 2025-September 22, 2025 revealed: July 2025: -Aripiprazole 2 mg, take 1 tablet daily, documented as administered 5 days without a PO on cite at the facility, 7/27/25-7/31/25; no staff initials for administration on 7/26/25. -Clobazam 10mg, take 3 tablets twice daily, documented as administered 5 days in the</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 118	<p>Continued From page 24</p> <p>morning, 7/27/25-7/31/25, without a PO on cite at the facility; documented as administered 5 days in the evening, 7/27/25-7/31/25, without a PO on cite at the facility; no staff initials for administration of the morning and evening dose 7/26/25.</p> <p>-Folic Acid 1 mg, take 1 tablet by mouth every morning, documented as administered 5 days without a PO on cite at the facility, 7/27/25-7/31/25; no staff initials for administration 7/26/25.</p> <p>-Fycompa 12 mg, take 1 tablet by mouth every day, documented as administered 5 days without a PO on cite at the facility, 7/27/25-7/31/25; no staff initials for administration 7/26/25.</p> <p>-Guanfacine 1 mg tablet, take 2 tablets by mouth daily, documented as administered 5 days without a PO on cite at the facility, 7/27/25-7/31/25; no staff initials for administration 7/26/25.</p> <p>-Melatonin 3 mg, take 1 tablet by mouth at bedtime, documented as administered 5 days without a PO on cite at the facility, 7/27/25-7/31/25; no staff initials for administration 7/26/25.</p> <p>-Zonisamide 100mg, take one (100mg) in the morning and two (200mg) at bedtime, documented as administered 5 days in the morning, 7/27/25-7/31/25 without a PO on cite at the facility; documented as administered 5 days in the evening, 7/27/25-7/31/25, without a PO on cite at the facility; no staff initials for administration of the morning and evening dose 7/26/25.</p> <p>No PO for PRN medications:</p> <p>-Nayzilam 5 mg spray, instill one spray as needed for clear epileptic activity, not documented as administered in July 2025; Olanzapine 2.5 mg, take 1 tablet by mouth every 6 hours as needed for agitation, not documented as administered in July 2025.</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 118	<p>Continued From page 25</p> <p>August 2025: -Zonisamide 50mg, 3 QAM (every morning); Not listed on August MAR and was not documented as administered 8/19/25-8/31/25. -Aripiprazole 2 mg, take 1 tablet daily, documented as administered 31 days without a PO on cite at the facility, 8/1/25-8/31/25. -Clobazam 10mg, take 3 tablets twice daily, documented as administered 31 days in the morning, 8/1/25-8/22/25 and 8/24/25-8/31/25, without a PO on cite at the facility; documented as administered 28 days in the evening, 8/23/25 without PO on cite at the facility; no staff initials for administration of the morning dose on 8/23/25; no staff initials for administration of the evening dose on 8/20/25, 8/22/25 and 8/23/25. -Folic Acid 1 mg, take 1 tablet by mouth every morning, documented as administered 31 days without a PO on cite at the facility, 8/1/25-8/31/25. -Fycompa 12mg, take 1 tablet by mouth every day, documented as administered 31 days without a PO on cite at the facility, 8/1/25-8/31/25. -Guanfacine 2 mg tablet, take 1 tablet by mouth daily, documented as administered 30 days without a PO on cite at the facility, 8/1/25-8/31/25. -Melatonin 3 mg, take 1 tablet by mouth at bedtime, documented as administered 30 without a PO on cite at the facility, 8/1/25-8/19/25 and 8/21/25-8/31/25; no staff initials for administration 8/20/25. -Zonisamide 100mg, take one (100mg) in the morning and two (200mg) at bedtime, documented as administered 27 days in the morning, 8/1/25-8/27/25, without a PO on cite at the facility; documented as administered 25 days in the evening, 8/1/25-8/19/25, 8/21/25-8/22/25, and 8/24/25-8/27/25 without a PO on cite at the facility; no staff initials for administration for the evening dose on 8/20/25 and 8/23/25; "on hold"</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 118	<p>Continued From page 26</p> <p>8/28/25. -Zonisamide 100mg, take 2 (200mg) tablets 2 times a day, documented as administered 4 days for the morning dose, 8/28/25-8/31/25 without PO on cite at the facility; documented as administered 4 days for the evening dose, 8/28/25-8/31/25 without PO . No PO for PRN medications: Nayzilam 5mg/spray, instill on spray as needed for clear epileptic seizure, not documented as administered in August 2025; Olanzapine 2.5 mg, take 1 tablet by mouth every 6 hours as needed for agitation, not documented as administered in August 2025.</p> <p>September 2025: -Aripiprazole 2 mg, take 1 tablet daily, documented as administered 18 days without a PO on cite at the facility, 9/1/25-9/8/25, 9/11/25-9/20/25; no staff initials for administration on 9/9/25, 9/10/25, 9/21/25 and 9/22/25. -Clobazam 10mg, take 3 tablets twice daily, documented as administered 18 days in the morning 9/1/25-9/8/25, 9/11/25-9/20/25 without a PO on cite at the facility; documented as administered 18 days in the evening 9/1/25-9/7/25, 9/10/25-9/20/25 without PO on cite at the facility; no staff initials for administration for the morning, 9/9/25, 9/10/25, 9/21/25 and 9/22/25; no staff initials for administration in the evening 9/8/25, 9/9/25, 9/21/25 and 9/22/25. -Folic Acid 1 mg, take 1 tablet by mouth every morning, documented as administered 18 days without a PO on cite at the facility, 9/1/25-9/9/25 and 9/11/25-9/20/25; no staff initials for administration 9/9/25, 9/10/25, 9/21/25 and 9/22/25. -Fycompa 12mg, take 1 tablet by mouth every day, documented as administered 12 days without a PO on cite at the facility, 9/1/25-9/8/25,</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 118	<p>Continued From page 27</p> <p>9/11/25-9/14/25; no staff initials for administration 9/9/25 and 9/10/25.</p> <p>-Fycompa 12mg, take 1 tablet by mouth every day, documented as administered 6 days without a PO on cite at the facility, 9/15/25-9/20/25; no staff initials for administration 9/21/25 and 9/22/25.</p> <p>-Guanfacine 2 mg tablet, take 1 tablet by mouth daily, documented as administered 18 days without a PO on cite at the facility, 9/1/25-9/8/25 and 9/11/25-9/20/25; no staff initials for administration 9/9/25, 9/10/25, 9/21/25 and 9/22/25.</p> <p>-Melatonin 3 mg, take 1 tablet by mouth at bedtime, documented as administered 18 days without a PO on cite at the facility, 9/1/25-9/7/25 and 9/10/25-9/20/25; no staff initials for administration 9/8/25, 9/9/25, 9/21/25 and 9/22/25.</p> <p>-Zonisamide 100mg, take 2 (200mg) tablets 2 times a day, documented as administered 18 days in the morning, 9/1/25-9/8/25 and 9/11/25-9/20/25 without PO on cite at the facility; documented as administered 18 days in the evening, 9/1/25-9/7/25 and 9/10/25-9/20/25, without PO on cite at the facility; no staff initials for administration in the morning 9/9/25, 9/10/25, 9/21/25, 9/22/25; no staff initials for administration in the evening 9/8/25, 9/9/25, 9/21/25, 9/22/25.</p> <p>No PO for PRN medications:</p> <p>-Nayzilam 5mg/spray (myoclonic epileptic seizures), instill on spray as needed for clear epileptic seizure, not documented as administered in September; Olanzapine 2.5 mg, take 1 tablet by mouth every 6 hours as needed for agitation, documented as administered once without PO on cite at the facility 9/18/25, 5pm; Clonazepam 0.5 mg, take 2 time(s) a day as needed, not documented as administered in September 2025.</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 118	<p>Continued From page 28</p> <p>Review on 10/2/25 of the facility's incident reports related to FC#4 revealed: The facility documented incidents of 4 seizures in August 2025 :</p> <ul style="list-style-type: none"> -8/18/25, FC #4 "had a recurrent seizure that required medical intervention at the hospital for stabilization." -8/20/25, 11:44am FC#4 was experiencing cramping in hands "a short time later, she experienced a seizure"; medical support was contacted -8/22/25, 3:38pm FC#4 "told staff she felt as though she was about to have a seizure ...she began to experience seizure activity. Additional seizures occurred later that evening" and staff contacted emergency medical services. FC#4 was transported to the hospital "three times during the night" and remained under medical care overnight. -8/23/25, 4:00am FC #4 "after returning from the hospital", FC#4 indicated she felt "unwell" and "moments later, she began to experience another seizure." <p>The facility documented incidents of 3 seizures in September 2025:</p> <ul style="list-style-type: none"> -9/4/25, 7:57pm "after returning from the hospital earlier in the day" FC#4 "experienced another seizure" and medical personnel were contacted. -9/8/25, 3:55pm FC#4 complained of headache and blurred vision, also vomited; "due to persistence of symptoms", facility arranged "evaluation by healthcare provider and remained under observation from September 8 through September 10." -9/17/25, FC #4 "call from the school at 9:45 AM requesting that the client (FC #4) be picked up due to complaints of blurry vision in her left eye"; evaluated by hospital provider. 	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 118	<p>Continued From page 29</p> <p>Review on 10/20/25 of FC#4's hospital after visit summaries revealed:</p> <p>-Emergency Department visits on 8/18/25, 8/23/25, 9/1/25, 9/2/25, 9/4/25, 9/8/25, 9/17/25, 9/18/25 and 9/20/25.</p> <p>-8/23/35, "Reason for visit, seizures...Diagnosis, breakthrough seizure...Instructions...seen for a seizure...ensure medication dosing is as close to 12 hours apart A(AM and PM) as possible to ensure that the medication levels remain stable in the body...we recommend following up with your outpatient neurologist for further management."</p> <p>-Admission 9/8/25, discharged 9/10/25, "dehydration"; FC #4 experienced "blurry vision 3 days ago" that improved and was "associated with her headache"; had "tactile fever on 9/5 (2025) AM (morning) ...hot to touch on 9/7 (2025) ...sent home from school on 9/5 (2025) due to her illness ...vomited on 9/6 (2025) ...unable to eat or drink ...had 6 seizures last week, with most recent one occurring on 9/4 (2025)."</p> <p>-9/11/25, "...the following issues were addressed: Generalized epilepsy; Convulsions, unspecified convulsion type; and Myoclonic epileptic seizures..."</p> <p>-Emergency Department to Hospital Admission, Admission 9/20/25 "for seizure activities concerning for breakthrough seizures", discharged 9/22/25 ... "presenting with 4 witnessed (facility staff) seizures today, with one lasting 20 minutes...had 1 seizure this morning...lasted less than 3 minutes...next seizure happened in the car ...this seizure lasted for less than 3 minutes...last seizure happened shortly after getting out of the shower...this lasted for 20 minutes at which time they (facility) called EMS. Intranasal Versed (Nayzilam) was not administered because the group home states they ran out ..."</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 118	<p>Continued From page 30</p> <p>Interviews on 10/1/25 and 10/20/25 with client #1 revealed: -"I am getting my meds, I have never ran out and never missed days taking them" -"I don't take Aptensio anymore, I don't know why it was stopped." -"I don't know all the meds I am taking."</p> <p>Attempted interview on 10/13/25 with client #1's Legal Guardian/Mother (LG/Mother) was unsuccessful due to no return call prior to survey exit.</p> <p>Interview on 10/22/25 with the LG/Mother of FC #4 revealed: -"...as far as her (FC #4) getting her medications, it was undetermined...she (FC #4) was having about 2 seizures about every 6 months (before admission) and by the end of the process (discharge), she was having them (seizures) back to back."</p> <p>Interview on 10/22/25 with FC #4's Local Management Entity/Managed Care Organization's Care Manager revealed: -Had requested copies of FC #4's MARs, "after asking multiple times, it took a long time for them (facility) to give it (MAR) to me; when she (FC #4) was discharged they (facility) finally provided it (MAR) to me."</p> <p>Interview on 10/10/25 with the Former Residential Director revealed: -No longer employed at the facility. - "I worked there 10 days, from 8/25 (2025) until 9/5 (2025)...I was working as the residential director" -There were issues "with medications not being picked up on time" to be administered. -Between 8/25/25 and 9/5/25, she reviewed the</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 118	<p>Continued From page 31</p> <p>MAR for FC #4 and "after a week, it (FC #4's medication) was not on the MAR (medication unknown)"</p> <p>-Had asked the Licensee/Director/CEO about the medication that was not on the MAR and the missing PO.</p> <p>-When staff #8 didn't get a response from the Licensee/Director/Chief Executive Officer (CEO), she told staff "they can't administer a med (medication) that is not on the MAR. I instructed staff to wait until [Licensee/Director/CEO] got a doctor's order for the medication."</p> <p>-FC #4 "was on two medications...having seizures everyday..."</p> <p>-FC #4's "neurologist prescribed Levetiracetam and [Licensee/Director/CEO] held off getting the med (medication).</p> <p>-The medication for FC #4 "that was there (facility) was not accurate."</p> <p>-FC #4 was started on "Keppra and I don't recall the other seizure med (medication)...she (FC #4) was on two of the newer seizure meds (medications) that were out...she (FC #4) already had Zonisamide."</p> <p>-"...there was a delay on [Licensee/Director/CEO] getting the med (new medication) for whatever reason. I don't know if she (Licensee/Director/CEO) didn't want to pay for it or what..."</p> <p>-No one had training for managing seizures, "I told her (Licensee/Director/CEO) if she had a nurse, they (nurse) could also provide seizure management (training), that was one of my recommendations and I provided a contact (nurse) to her (Licensee/Director/CEO) of a nurse I knew who did training.</p> <p>-There was never a plan (seizure management) provided for the staff, "what to look for and what to do" if FC #4 had a seizure.</p> <p>-Told staff "all they (staff) could do is call 911 and</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 118	<p>Continued From page 32</p> <p>call [Licensee/Director/CEO]; I told them (staff) to call 911 so it is documented, until [Licensee/Director/CEO] puts something in place</p> <p>-The Licensee/Director/CEO "thought I was asking too many questions."</p> <p>Interview on 10/29/25 with former staff #8 revealed:</p> <p>- "When I got there (facility), [FC #4] was having seizures one to two times a week and increased to about two (seizures) a day..."</p> <p>- "At the beginning there was a problem with how to take her (FC #4) medication (unknown), they (facility) weren't giving the medication in sequence. The doctor asked (facility) how they were doing the medications and they (facility) were told it (unknown medication) had to be taken the same time every day."</p> <p>- Another medication (unknown) was added to address FC #4's seizures, "since I didn't give it (medication), I don't remember (name of medication)."</p> <p>- Each staff documented in the client's MAR online, "in an online app (application)."</p> <p>Interview on 10/15/25 with staff #5 revealed:</p> <p>- "[Licensee/Director/CEO] keeps up with MARs and doctor's orders (PO), that would be my guess; never told who keeps up with it (MAR), and what we are told is not usually the truth."</p> <p>Attempted interviews on 10/15/25 and 10/22/25 with the facility's Registered Nurse (RN) #1 were unsuccessful due to no return call.</p> <p>Interview on 10/21/25 with the facility's RN #2 revealed:</p> <p>- Checked MARs and made sure physician "orders were put in correctly."</p> <p>- "...they (facility) don't have that (missing initials</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 118	<p>Continued From page 33</p> <p>on MARs) issue and if initials are missing it's because someone forgot to sign off." -If there were initials missing on the MAR, she would "review the MAR to see what happened to determine that the medication was given, who gave the medication and who signed off." -"If the client is out of the facility, we would document (MAR) that way, we would tell (on MAR) exactly what happened." -"I always discontinue the current order, put the new order in and the reason for the discontinue; one of the medications (unsure) didn't discontinue, I made notes to staff and put a 'hold' so the staff wouldn't administer the discontinued medication. Anytime I do that, I definitely discontinue the first order, then put the new order in." -Was not on staff and did not "deal with anything regarding [FC #4]'s seizures...mostly do MARs...making sure the doctor orders and medications match up."</p> <p>Interview on 10/27/25 with the facility's RN #2 revealed: -The Licensee/Director/CEO kept all the physician orders together. -She and the Licensee/Director/CEO would "go over all the orders together...it (PO) should be able to retrieved...not sure why orders were not made available."</p> <p>Interview on 10/13/25 with the Qualified Professional revealed: -Electronic prescriptions are entered on the MAR by the Licensee/Director/CEO. -"There are doctor orders (PO) for client medications; every month when they (PO) are sent, I file escripts (electronic prescriptions)." -The "manager (Associate Professional/House Manager (AP/HM)) or [Licensee/Director/CEO]"</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 118	<p>Continued From page 34</p> <p>were responsible for reviewing and entering information on the client's MARs.</p> <p>Interview on 10/15/25 with the Licensed Professional revealed: -"I don't administer medications and was not aware of clients not getting medications." -When FC #4 "first got there yes, there were problems with medications, but then they (facility) told me she (FC #4) was put on the right medication..." -"I wasn't always updated on when she was having seizures."</p> <p>Interview on 10/1/25 and with the Licensee/Director/CEO revealed: -Confirmed that FC #4's admission date was 7/27/25 and had no explanation for the other dates of admission in FC #4's record. -Client #1 had taken all her morning medications and the facility was waiting on the 10/1/25 United Parcel Service delivery of client #1's medications to resume the evening medications. -Client #1's Aptensio was discontinued, "we (facility) didn't have it in stock (8/28/25-8/31/25)...the pharmacy didn't have it in stock...she was switched to Methylphenidate." -Provided contact information for the RN #1 who did "medication administration training for the staff." -"The nurse (RN #2) checks medications weekly." -The Methylphenidate was listed on the August 2025 MAR twice, "the nurse (RN #2) put it in twice and corrected it when she realized it; I told her it was in there twice...I don't think [electronic health system] will let you remove a duplicate...it can't be deleted, it can only be discontinued." -"Whatever days are blank (on MAR), she (FC #4) was in the hospital..." -On 8/28/25, the "on hold" notation on the MAR</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 118	<p>Continued From page 35</p> <p>for FC#4 "was probably the nurse (RN #2) putting it (Guanfacine) back on the MAR...was the nurse making a change" and there "was an increased dose" in the Zonisamide on 8/28/25. -"Staff did seizure training, I didn't do certificates, but I just trained them on the seizures."</p> <p>Interview on 10/15/25 with the Licensee/Director/CEO revealed: -FC #4 was "having a lot of seizures." -"...we (facility) don't initial if the client was not here to get the medications." -"We have two nurses." -The RN #2 does medication management. -No response to inability to contact RN #1 and no additional contact information for RN #1 was provided.</p> <p>Interview on 10/23/25 with the Licensee/Director/CEO revealed: -There were several staff responsible for documentation and for clients' MARs documentation, "[RN #2] our nurse, and the manager (AP/HM)..." were responsible for reviewing and keeping the MAR updated.</p> <p>Attempted to review POs for client #1 and FC #4's medications requested on 10/1/25, 10/2/25, 10/15/25 and 10/21/25. No documentation was provided prior to survey exit.</p> <p>Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician.</p> <p>Review on 10/28/25 of the Plan of Protection completed by the Licensee/Director/CEO and dated 10/28/25 revealed: "What immediate action will the facility take to</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 118	<p>Continued From page 36</p> <p>ensure the safety of the consumers in your care? 10 A NCAC 27G .0209 Medication -Medication Administration (V118) for A-1 Neglect -Upon receiving notice of the missing signature on the MAR, the facility immediately reviewed the record for the identified consumer. It was verified that the previous resident, [FC #4], was hospitalized during the period in question and did not receive any medications from facility staff during this time. -To ensure the safety of all consumers currently in care: The facility reviewed all active MARs to ensure there were no other documentation gaps or missing signatures. Supporting hospital admission and discharge records were obtained and is being placed in the client ' s file by the director to reflect the hospitalization period. This will be done by 10/31/2025</p> <p>10 A NCAC 27G .0209 Medication -Medication Review (V121) crossed into V118 Medication Administration) -Upon notification of the deficiency, the facility immediately reviewed all client records for individuals prescribed psychotropic medications to determine the status of their required drug regimen reviews. -Any clients who were due or overdue for a six-month drug regimen review is currently being scheduled for immediate review by a qualified physician. The director (Licensee/Director/CEO) is scheduling this. This will be done by October 31st.</p> <p>Describe your plans to make sure the above happens. 10 A NCAC 27G .0209 Medication -Medication Administration (V118) for A-1 Neglect</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 118	<p>Continued From page 37</p> <p>-To prevent future documentation deficiencies and ensure compliance with 10A NCAC 27G .0209, the facility will implement the following corrective measures:</p> <p>-Hospitalization/Absence Notation: In the future, if a client is hospitalized, on home visit, or otherwise not present at the facility, staff will clearly document this on the MAR with a standardized notation (LOA Leave Of Absence) along with the appropriate dates. Supporting hospital or absence documentation will be attached to the client ' s medical record.</p> <p>-Weekly Monitoring: -The Nurse (RN #2) Or Director (Licensee/Director/CEO) conduct weekly MAR checks to verify that all medications are properly documented and signed. The Nurse (RN #2) will perform a weekly quality assurance review of all MARs to identify and correct any omissions.</p> <p>-Accountability & Corrective Action: Any staff found not following MAR documentation protocols will receive immediate coaching and corrective training to ensure continued compliance.</p> <p>10 A NCAC 27G .0209 Medication -Medication Review (V121) crossed into V118 Medication Administration)</p> <p>-Six-Month Drug Regimen Review Tracking: In addition to monthly appointments, the facility will do a 6-month calendar notification reminding its time for a 6-month review of any clients staying longer than 6 months.</p> <p>-Physician Notification: When medical intervention is indicated from the six-month review or monthly appointments, the on-site manager will immediately notify the prescribing physician, and documentation of that communication and any interventions will be kept in the client ' s file."</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 118	<p>Continued From page 38</p> <p>Review on 10/28/25 of the amended Plan of Protection completed by the Licensee/Director/CEO and dated 10/28/25 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? -The facility will immediately review all current client records to identify and obtain any missing physician orders or e-scripts (electronic prescriptions) to ensure that every client has a valid medication order on file. This will be done by the director (Licensee/Director/CEO) or manager (Associate Professional/House Manager (AP/HM)). -All staff will be called in for a meeting immediately about missing signatures. The director (Licensee/Director/CEO) or manager (AP/HM) will explain how to handle anytime a client is absent from our care and how to notate the MAR electronically or manually. -The director (Licensee/Director/CEO) will immediately review all client records for individuals prescribed psychotropic medications to determine the status of their required drug regimen reviews."</p> <p>Review on 10/29/25 of the second amended Plan of Protection completed by the Licensee/Director/CEO and dated 10/29/25 revealed: "What immediateaction will the facility take to ensure the safety of the consumers in your care? -Effective October 31, 2025, Renewed Beginnings Home will implement the following procedures to ensure that all clients currently in care and all future clients have written physician orders for every prescribed and non-prescribed medication administered in the facility. -1. Medication Orders Prior to Admission</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 118	<p>Continued From page 39</p> <p>Beginning October 31, 2025, before any client is admitted into the facility, the Director, [Licensee/Director/CEO], will ensure that all physician orders and e-scripts (electronic prescriptions) are received and documented in the client ' s file.</p> <p>Clients will not be admitted or administered medications without verified written orders from an authorized prescriber.</p> <p>-2. Medication Order Verification for Current Clients</p> <p>Starting October 31, 2025, the Registered Nurse, [RN #2], will review all current client medication records to confirm that each medication administered has a corresponding physician order on file.</p> <p>Going forward, any new or changed medication orders will be verified and documented before the medication is administered.</p> <p>The Manager/AP, [AP/HM], will ensure all medication records are maintained accurately and updated in real time.</p> <p>-3. Weekly MAR Audits</p> <p>Beginning November 1, 2025, the Registered Nurse, [RN #2], will conduct weekly MAR reviews to check for missing initials, complete documentation, and valid physician orders for all medications.</p> <p>The Director, [Licensee/Director/CEO], will review the weekly audit reports to ensure compliance and follow up on any corrections needed.</p> <p>-4. Staff Training & Compliance Meeting</p> <p>A mandatory staff training and compliance meeting will be held on October 31, 2025, at 10:00 AM, led by Director [Licensee/Director/CEO].</p> <p>The meeting will review the following procedures: No medication (prescription or non-prescription) will be administered without a written physician order.</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 118	<p>Continued From page 40</p> <p>Staff must verify the order is on file before giving any medication. All medication administration must be initialed on the MAR immediately after administration. Manager/AP [AP/HM] will document attendance and meeting outcomes and file them in the facility ' s training records.</p> <p>-5. Six-Month Medication Reviews Starting October 31st, 2025, all clients prescribed psychotropic or ongoing medications will be scheduled for six-month medication reviews by a physician. The Director, [Licensee/Director/CEO], will maintain a tracking log and ensure timely scheduling. The AP, [AP/HM], will document each review ' s findings, notify the physician when medical intervention is indicated, and ensure corrective actions are completed.</p> <p>-6. Ongoing Quality Assurance The Director [Licensee/Director/CEO] will oversee implementation of this plan, ensure timely follow-up, and review all documentation during monthly quality assurance meetings. The Manager/AP [AP/HM] will maintain daily oversight of medication documentation procedures to ensure compliance is consistent and sustainable</p> <p>Describe your plans to make sure the above happens. -To ensure full implementation and continued compliance with the Plan of Protection, Renewed Beginnings Home will establish an ongoing monitoring and accountability system beginning October 31, 2025. -Leadership Oversight Director, [Licensee/Director/CEO], will oversee all aspects of implementation to ensure staff are following the established procedures related to</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 118	<p>Continued From page 41</p> <p>medication orders, MAR documentation, and six-month medication reviews.</p> <p>The Director,[Licensee/Director/CEO], will review weekly audit reports submitted by the Registered Nurse, [RN #2], to verify completion, identify any concerns, and ensure timely corrective action.</p> <p>-Nursing Review and Documentation The Registered Nurse, [RN #2], will be responsible for conducting weekly MAR and medication order reviews beginning November 1, 2025.</p> <p>The RN (#2) will use a standardized Medication Documentation Audit Form to track compliance, verify that all orders are current, and ensure all medications are signed off appropriately. Any deficiencies identified will be corrected immediately, and re-training will be provided as needed.</p> <p>-Manager (AP/HM) Accountability Manager/AP, [AP/HM], will verify that all new client admissions have complete written physician orders and that any new or changed medication orders are entered into the client record the same day.</p> <p>The Manager will serve as the daily point of contact for ensuring staff follow all medication documentation procedures.</p> <p>-Ongoing Staff Training Following the October 31, 2025 staff meeting, additional refresher trainings will be conducted annually, led by Director [Licensee/Director/CEO] and RN [#2], to reinforce medication administration procedures and documentation standards.</p> <p>Attendance will be documented by [AP/HM], and training records will be maintained in the staff compliance file.</p> <p>-Quality Assurance and Internal Audits The facility will include medication documentation reviews as a standing item on its monthly Quality</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 118	<p>Continued From page 42</p> <p>Assurance (QA) meeting agenda, beginning November 2025.</p> <p>The QA team (Director (Licensee/Director/CEO), RN (#2), and Manager/AP (AP/HM)) will review audit results, identify trends, and implement corrective measures as needed to maintain compliance.</p> <p>-Six-Month Review The Director, [Licensee/Director/CEO], will maintain a Medication Review Tracking Log to ensure each client ' s six-month review is completed by the physician as required.</p> <p>-Continuous Monitoring This plan will remain in effect indefinitely, with ongoing oversight by the Director (Licensee/Director/CEO) and RN (#2) to ensure continued adherence to 10A NCAC 27G .0209. Documentation of all audits, trainings, and six-month reviews will be kept in a compliance binder available for review by the state at any time."</p> <p>This facility served adolescent girls with diagnoses that included Mild and Moderated Intellectual Disability Disorders, Post-Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, Disruptive Mood Dysregulation Disorder, Borderline Personality Disorder, Major Depressive Disorder, Seizures, and Generalized Anxiety Disorder. From March 2025 to September 2025 there were missing physician's orders in clients #1's record. There was no March 2025 MAR for client #1. From April 2025 to September 2025, the facility staff administered medications 460 times to client #1 without a physician order. There was no documentation of a drug regimen review for client #1. FC #4 had an increase in seizure activity and had been prescribed 4 medications-Clobazam, Folic Acid, Fycompa, Zonisamide to address seizure activity.</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 118	<p>Continued From page 43</p> <p>From July 2025 to September 2025 there were missing physician orders in FC #4's record. The facility did not discontinue orders to address changes in FC #4's doses of Zonisamide. From July 2025 to September 2025, the facility staff administered medications 461 times to FC #4 without a physician order. The facility documented that FC #4 had at least 7 seizures between 8/18/25 and 9/12/25. The facility failed to document staff initials to show medication administration and did provide explanation on the MAR as to the reason. The facility failed to have a clear process in place to ensure the medications, the MARs and the medication administration process was monitored on a regular bases to ensure accuracy.</p> <p>This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.</p>	V 118		
V 121	<p>27G .0209 (F) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable.</p>	V 121		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 121	<p>Continued From page 44</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to obtain drug regimen reviews every six months for 1 of 1 current clients (client #1) who received psychotropic drugs. The findings are:</p> <p>Review on 10/7/25 of client #1's record revealed: -Age 15 years old. -Admission on 11/26/24. -Diagnoses: Mild Intellectual Disability Disorder (IDD); Post-Traumatic Stress Disorder (PTSD); Attention-Deficit Hyperactivity Disorder (ADHD); Disruptive Mood Dysregulation Disorder; Borderline Personality Disorder. -There was no documentation of a drug regimen review completed within the last six months.</p> <p>Reviews on 10/1/25 and 10/7/25 of client #1's Medication Administration Record (MAR) from March 2025-September 2025 revealed: -Norethindrone, Aripiprazole, Clonidine, Cyproheptadine, Lamotrigine, and Sertraline were listed as administered. -Aptensio was listed as administered April-August 2025. -Methylphenidate was listed as administered 8/27/25-9/30/25.</p> <p>Requested drug regimen review for client #1 on 10/1/25, 10/15/25, and 10/21/25. No documentation was provided prior to survey exit.</p> <p>Interview on 10/21/25 with the facility's Registered Nurse (RN #2) revealed: -"I'm not sure who does the six month review because we (facility) have not done that. I follow</p>	V 121		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 121	<p>Continued From page 45</p> <p>up (with medications) on a regular basis." -"...I know they had another healthcare provider (RN #1)...I mostly do the MARs, training, and making sure the doctor orders and meds (medications) match up."</p> <p>Interviews on 10/1/25 and 10/29/25 with the Licensee/Director/Chief Executive Officer revealed: -The Qualified Professional "does the 6-month medication review." -"We (facility) keep them in [electronic health record] and I can send those." -"We (facility) check them every week." -Would ensure clients who were administered psychotropic medications were scheduled every six months for the drug regimen review going forward.</p> <p>This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type A1 rule violation and must be corrected within 23 days.</p>	V 121		
V 131	<p>G.S. 131E-256 (D2) HCPR - Prior Employment Verification</p> <p>G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.</p>	V 131		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 131	<p>Continued From page 46</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the North Carolina Health Care Personnel Registry (HCPR) was accessed prior to hire for 6 of 13 staff (Staff #1, #4, #5, and #6, the Associate Professional/House Manger (AP/HM) and the Qualified Professional (QP)). The findings are:</p> <p>Review on 10/8/25 of staff #1's personnel record revealed: -Hired 7/1/24. -Offer letter signed 8/5/24 and dated 7/1/24. -HCPR accessed on 2/14/25.</p> <p>Review on 10/8/25 of staff #4's personnel record revealed: -Hired 9/8/25. -Offer letter signed and dated 9/12/25. -HCPR accessed on 9/12/25.</p> <p>Review on 10/8/25 of staff #5's personnel record revealed: -Hired 9/8/25. -Offer letter signed and dated 10/6/25. -HCPR accessed on 10/6/25.</p> <p>Review on 10/8/25 of staff #6's personnel record revealed: -Hired 7/1/25. -Offer letter signed and dated 7/1/25. -HCPR accessed on 7/10/25.</p> <p>Review on 10/8/25 of the AP/HM's personnel record revealed: -Hired on 10/1/25. -Offer letter signed and dated 10/1/25.</p>	V 131		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 131	<p>Continued From page 47</p> <p>-HCPR accessed on 10/2/25.</p> <p>Review on 10/8/25 of the QP's personnel record revealed: -Hired 7/16/25. -Offer letter undated and signed. -HCPR accessed on 7/17/25.</p> <p>Review on 10/9/25 of the LP's personnel record revealed: -no hire date in file. -Contract signed and dated 8/12/25. -HCPR accessed on 8/12/25.</p> <p>Interview on 10/15/25 with staff #5 revealed: -"I was working with them (facility) back in January (2025) and most recently she (Licensee/Director/Chief Executive Officer (CEO)) asked me to come back...she (Licensee/Director/CEO) reached out to me September 5th (2025)."</p> <p>Interview with 10/15/25 with the LP revealed: -"I have been working since early February of this year (2025)." -"I started communicating with her (Licensee/Director/CEO) on 1/17 (2025) and started working some time after that." -Had signed a "job description dated for August (2025)" and "did not see or sign a job description in January (2025) when I started."</p> <p>Interviews on 10/8/25 and 10/15/25 with the Licensee/Director/CEO revealed: -Was responsible for hiring staff and human resources, "between me, the director (Licensee/Director/CEO) and the AP [AP/HM]." -"Before hiring [AP/HM], I was responsible" for all human resource duties. -The hire date for staff #1, "I think it was</p>	V 131		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 131	<p>Continued From page 48</p> <p>November 20th of last year (2024)...he was hired 7/1/24, we didn't get clients until November (2024) and he started working in November (2024)."</p> <p>-She disputed that staff #5 was hired in January 2025 to work in the facility.</p> <p>-She provided no response to the missing hired date for the LP.</p> <p>-She was aware of the rule that the HCPR needed to be accessed before date of hire.</p> <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 131		
V 133	<p>G.S. 122C-80 Criminal History Record Check</p> <p>G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT.</p> <p>(a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter.</p> <p>(b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned</p>	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 133	Continued From page 49 on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 133	<p>Continued From page 50</p> <p>conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency.</p> <p>(c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant:</p> <ol style="list-style-type: none"> (1) The level and seriousness of the crime. (2) The date of the crime. (3) The age of the person at the time of the conviction. (4) The circumstances surrounding the commission of the crime, if known. (5) The nexus between the criminal conduct of the person and the job duties of the position to be filled. (6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed. (7) The subsequent commission by the person of a relevant offense. <p>The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.</p> <p>(d) Limited Immunity. - A provider and an officer</p>	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 133	<p>Continued From page 51</p> <p>or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for:</p> <p>(1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual.</p> <p>(2) Failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section.</p> <p>(e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article</p>	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 133	<p>Continued From page 52</p> <p>29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.</p> <p>(f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor.</p> <p>(g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met:</p> <p>(1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10.</p> <p>(2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.)</p>	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 133	<p>Continued From page 53</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the state criminal record check was ordered within five business days of making the conditional offer of employment for 5 of 13 audited staff (the Associate Professional/House Manager (AP/HM), the Licensed Professional (LP), Staff #3, #5, and #6). The findings are:</p> <p>Review on 10/8/25 of staff #3's personnel record revealed: -Hired 9/2/25. -Offer letter signed and dated 9/3/25. -Criminal record check accessed on 10/16/25.</p> <p>Review on 10/8/25 of staff #5's personnel record revealed: -Hired 9/8/25. -Offer letter signed and dated 10/6/25. -Criminal record check accessed on 10/6/25.</p> <p>Review on 10/8/25 of staff #6's personnel record revealed: -Hired 7/1/25. -Offer letter signed and dated 7/1/25. -Criminal record check accessed on 7/9/25.</p> <p>Review on 10/8/25 of the AP/HM's personnel record revealed: -Hired on 10/1/25. -Offer letter signed and dated 10/1/25. -Criminal record check accessed on 10/6/25.</p> <p>Review on 10/9/25 of the LP's personnel record revealed: -no hire date in file.</p>	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 133	<p>Continued From page 54</p> <p>-Offer letter signed 8/12/25. -Criminal record check accessed 8/12/25.</p> <p>Interview on 10/15/25 with staff #5 revealed: -"I was working with them (facility) back in January (2025) and most recently she (Licensee/Director/Chief Executive Officer (CEO)) asked me to come back...she (Licensee/Director/CEO) reached out to me September 5th (2025)."</p> <p>Interview with 10/15/25 with the LP revealed: -"I have been working since early February of this year (2025)." -"I started communicating with her (Licensee/Director/CEO) on 1/17 (2025) and started working some time after that." -Had signed a "job description dated for August (2025)" and "did not see or sign a job description in January (2025) when I started."</p> <p>Interview on 10/15/25 with the Licensee/Director/CEO revealed: -Was responsible for hiring staff and human resources, "between me, the director (Licensee/Director/CEO) and the AP [AP/HM]." -"Before hiring [AP/HM], I was responsible" for all human resource duties. -She disputed that staff #5 was hired in January 2025 to work in the facility. -She provided no response to the missing hire date for the LP. -She was aware of the rule that the criminal record check needed to be accessed within 5 business day of conditional offer of employment.</p> <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 293	Continued From page 55	V 293		
V 293	<p>27G .1701 Residential Tx. Child/Adol - Scope</p> <p>10A NCAC 27G .1701 SCOPE</p> <p>(a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility.</p> <p>(b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section.</p> <p>(c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services.</p> <p>(d) The children or adolescents served shall require the following:</p> <ol style="list-style-type: none"> (1) removal from home to a community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting. <p>(e) Services shall be designed to:</p> <ol style="list-style-type: none"> (1) include individualized supervision and structure of daily living; (2) minimize the occurrence of behaviors related to functional deficits; (3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (5) support the child or adolescent in 	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 293	<p>Continued From page 56</p> <p>gaining the skills needed to step-down to a less intensive treatment setting.</p> <p>(f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to operate within the scope of their license and failed to provide services designed to include individualized supervision and structure of daily living, minimize the occurrence of behaviors related to functional deficits, ensure safety and deescalate out of control behaviors including frequent crisis management, assist the adolescent in the acquisition of adaptive functioning in self-control, communication, and social skills and support the adolescent in gaining the skills needed to step-down to a less intensive treatment setting affecting 1 of 1 current client (client #1) and 3 of 3 former clients (FC #4, FC#5, and FC #6) and failed to coordinate with other individuals within the adolescent's system of care affecting 1 of 3 former client (FC #4). The findings are:</p> <p>Cross Reference: 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109). Based on</p>	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 293	<p>Continued From page 57</p> <p>record reviews and interviews the facility failed to develop and implement policies and procedures for the initiation of an individualized supervision plan for the Associate Professional House Manager (AP/HM) and the Qualified Professional (QP) failed to supervise the AP (AP/HM). The findings are:</p> <p>Cross Reference: 10A NCAC 27G .205 Assessment and Treatment/Habilitation or Service Plan (V112). Based on record review and interviews, the facility failed to develop and implement treatment plan, goals and strategies based on client needs after 30 days admission for 1 of 3 former client (FC #4).</p> <p>Cross Reference: 10A NCAC 27G .1703 Requirements for Associate Professionals (V295). Based on record reviews and interviews, the facility failed to ensure it had at least one full time direct care staff who meets or exceeds the requirements of an Associate Professional (AP).</p> <p>Cross Reference: 10A NCAC 27G .1704 Minimum Staffing Requirements (V296). Based on observations and interviews the facility failed to ensure the minimum staffing ratio of two staff for up to four adolescents.</p> <p>Cross Reference: 10A NCAC 27G .1704 Requirements of Licensed Professionals (V297). Based on record reviews and interviews the facility failed to ensure face to face clinical consultation was provided in the facility at least four hours a week by a Licensed Professional (LP).</p> <p>Cross Reference: G.S. 122C - 62 Additional Rights in 24-Hr Facility (V364). Based on record reviews and interviews, the facility failed to</p>	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 293	<p>Continued From page 58</p> <p>ensure client rights to privacy in a 24 hour facility affecting 1 of 1 clients (#1) and 2 of 3 former client (FC #4 and #5).</p> <p>Cross Reference: 10A NCAC 27G .0603 Incident Response Requirements (V366). Based on record reviews and interviews, the facility failed to implement a policy governing their response to Level I and II incidents as required and failed to immediately notify the Local Management Entity/Managed Care Organization (LME/MCO) within the facility's catchment area of all level I and II incidents.</p> <p>Cross Reference: 10A NCAC 27G .0604 Incident Reporting Requirements (V367). Based on record reviews and interviews, the facility failed to report level I incidents and 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.</p> <p>Cross Reference: 10A NCAC 27E .0107 Client Rights-Training on Alternatives to Restrictive Interventions (V536). Based on record reviews and interviews, the facility failed to ensure 2 of 6 paraprofessional staff (#3, and #4), received initial training in alternatives to restrictive interventions.</p> <p>Interview on 10/22/25 with the Local Management Entity/Managed Care Organization Care Manager for FC #4 revealed: -Had asked for copies of client information " It took a long time for them (facility) to give it to me...and it was after she (FC #4) was discharged, after asking multiple times....they finally provided it to me."</p> <p>Interview on 10/24/25 with the Department of</p>	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 293	<p>Continued From page 59</p> <p>Social Services Social Worker (DSS SW) for FC #4 revealed:</p> <ul style="list-style-type: none"> -FC #4's Legal Guardian/mother (LG/mother) had preference for hospital where FC #4 was working with a neurologist. -"There have been times when staff, and [Licensee/Director/CEO] too, have told mom (LG/mother), based on mom ' s preference to have [FC #4] go to the hospital in [city] for her (FC #4) neurologist...told mom she would have to go sit with the client (FC #4) at the hospital. They (facility) would say they didn't have staff to take her (FC #4) 45 minutes away (preferred hospital). They (facility) threatened mom with abandonment if she didn't come to the hospital to supervise [FC #4]." -She did not receive information about the staff ' s ability to handle seizures, "the question was asked of [Licensee/Director/CEO], what she would do in an emergency. We (DSS SW and LG/mother) were under the impression that there was a nurse onsite. She [Licensee/Director/CEO] said they (facility) had a nurse onsite, which reassured mom (LG/mother), knowing client ' s (FC #4) history. We felt they had everything lined up; thought there was a regular staff (nurse) there that would assist them." <p>Review on 11/25/25 of the initial Plan of Protection signed by the Licensee/Director/CEO and dated 11/25/25 revealed:</p> <p>"What immediate action will the facility take to ensure the safety of the consumers in your care? V109 - 10A NCAC 27G .0203 Competencies of QP and AP (AP/HM) Deficiency: QP oversight of AP not documented as required. How it will be corrected: -The QP will provide monthly supervision and oversight of the AP.</p>	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 293	<p>Continued From page 60</p> <p>-Face-to-face supervision meetings will occur monthly and be documented on a standardized supervision form. Who is responsible: Director [Licensee/Director/CEO] Starting date: December 5, 2025 V112 - 10A NCAC 27G .0205 Assessment & Treatment / Service Plan Deficiency: PCP (Person Centered Plan (treatment plan)) format not compliant. How it will be corrected: -All Person-Centered Plans (treatment plans) for future consumers will be converted to the NC-approved PCP template. -Plans will be updated, signed, and uploaded to clinical charts. Who is responsible: Director [Licensee/Director/CEO] Completion date: December 5, 2025 V295 - 10A NCAC 27G .1703 Requirements for Associate Professionals Deficiency: Each location must have its own AP. How it was corrected: -A separate AP was assigned to each location to ensure compliance. Who was responsible: Director [Licensee/Director/CEO] Correction date: November 21, 2025 (Already corrected prior to submission) V296 - 10A NCAC 27G .1704 Minimum Staffing Requirements Deficiency: Staffing patterns not compliant. How it will be corrected: -Two staff members will be on shift at all times, regardless of census or acuity. -Revised staffing schedule implemented. Who is responsible: Director [Licensee/Director/CEO] Completion date: January 06,2026 (If you want exact date, tell me exit date and I'll</p>	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 293	<p>Continued From page 61</p> <p>calculate it.) V297 - 10A NCAC 27G .1704 Requirements of LP Deficiency: LP involvement not meeting required standards. How it will be corrected: -LP will provide: -2 hours of therapy onsite -1 hour clinical documentation -1 hour psychiatric/PhD (Doctor of Philosophy) med-management collaboration and clinical trainings with staff -LP schedule and logs will be maintained monthly. Who is responsible: Director [Licensee/Director/CEO] Completion date: December 5, 2025 V364 - G.S. 122C-62 Additional Rights in 24-Hr (Hour) Facility Deficiency: Calls were placed on speaker, violating privacy rights. How it will be corrected: -Phone calls will no longer be placed on speaker unless resident requests and signs consent, or court ordered. -Staff meeting occurred 10/30/2025 Who is responsible: Director [Licensee/Director/CEO] Completion date: December 5, 2025 V366 - 10A NCAC 27G .0603 Incident Response Requirements Deficiency: Incident response timelines not followed. How it will be corrected: -All Type 2 and Type 3 incidents will be reported within 72 hours through IRIS. -Incident reports an records will be kept in our records. Who is responsible: Director [Licensee/Director/CEO]</p>	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 293	<p>Continued From page 62</p> <p>Completion date: December 5, 2025 V367 - 10A NCAC 27G .0604 Incident Reporting Requirements Deficiency: (You didn't specify - I can fill in if you want) Suggested correction language if acceptable: -All incidents will be reported according to state requirements and documented in IRIS with follow-up and resolution records. Who is responsible: Director [Licensee/Director/CEO] Completion date: December 5, 2025 (If you want exact deficiency wording added, tell me what surveyor cited.) V536 - 27E .0107 Client Rights - Training on Alternatives to Restrictive Intervention Deficiency: Instructor training expired / not compliant. How it will be corrected: -A new external trainer will be secured which will be [Training Instructor] under the same company that I used to get training. -If recommended for staff to be retrained, [Licensee/Director/CEO] will retrain staff. -Training certificates will be filed in HR (Human Resources) records. Who is responsible: Director [Licensee/Director/CEO] Completion date: January 5, 2026</p> <p>Describe your plans to make sure the above happens.</p> <p>1. Scheduling Two Staff on Shift To ensure compliance with staffing requirements: -The schedule will always show two staff on every shift -If someone calls out, another staff will be assigned before the shift starts</p> <p>2. Two Binder System To keep documentation simple without extra</p>	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 293	<p>Continued From page 63</p> <p>work:</p> <ul style="list-style-type: none"> -Client Binders <p>Each client has their own binder containing:</p> <ul style="list-style-type: none"> -updated PCP using NC template -clinical documents related to care -rights acknowledgements -Staff Compliance Binder <p>One binder will contain:</p> <ul style="list-style-type: none"> -staffing schedules showing two staff per shift -QP/AP monthly supervision check-off -LP onsite hour logs -copies of incident reports emailed to Director [Licensee/Director/CEO] -confirmation that IRIS reporting was completed within timeframe -copy of phone privacy reminder -RI (Restrictive Intervention) instructor retraining certificate <p>3. Staff Meeting Held</p> <ul style="list-style-type: none"> -A staff meeting occurred on November 10, 2025 to inform staff of: -no speakerphone calls -notifying leadership immediately for incident reporting -awareness of RI alternatives and calming strategies <p>4. Simple Check-Off Forms:</p> <p>To avoid time-consuming documentation:</p> <ul style="list-style-type: none"> -One-page check-off forms will be used for: -monthly QP supervision of AP -LP hours completed at the home -incident reporting compliance <p>Each form takes less than one minute</p> <p>5. IRIS Completion Assurance</p> <p>To ensure incidents are properly reported:</p> <ul style="list-style-type: none"> -The QP will email the Director (Licensee/Director/CEO) a copy of every incident report -This email serves as: -notification 	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 293	<p>Continued From page 64</p> <ul style="list-style-type: none"> -verification -documentation <p>The Director will then confirm IRIS submission and place the emailed copy in the staff compliance binder</p> <p>This ensures incidents are reported within 72 hours without extra systems</p> <p>6. Phone Privacy Sign</p> <ul style="list-style-type: none"> -A sign will be posted by the phone reading: "No speakerphone unless the resident requests it and consents." <p>This serves as:</p> <ul style="list-style-type: none"> -action taken -reminder -compliance evidence <p>7. RI Instructor Requirement</p> <ul style="list-style-type: none"> -A new trainer will be secured -Instructor retraining will occur within the required timeframe -Certificate will be placed in the staff compliance binder <p>8. Single Point of Accountability</p> <ul style="list-style-type: none"> -Director [Licensee/Director/CEO] is responsible for: <ul style="list-style-type: none"> -ensuring two staff are scheduled -maintaining both binder types -receiving incident reports by email -confirming IRIS submission -placing documentation as it occurs" <p>Review on 11/26/25 of the Amended Plan of Protection signed by the Licensee/Director/CEO and dated 11/26/25 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care?"</p> <p>V109 - 10A NCAC 27G .0203 Competencies of QP and AP Immediate date: 11/26/2025 V112 - 10A NCAC 27G .0205 Assessment & Treatment / Service Plan</p>	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 293	<p>Continued From page 65</p> <p>How it will be corrected: -All Person-Centered Plans will be converted to the NC PCP template. Immediate date: 11/26/2025 V295 - 10A NCAC 27G .1703 Requirements for Associate Professionals Deficiency: Each location must have its own AP. -A separate AP was assigned to each location. [newly hired AP] is new AP V296 - 10A NCAC 27G .1704 Minimum Staffing Requirements Immediate date: 11/26/2025 V297 - 10A NCAC 27G .1704 Requirements of LP Immediate date: 11/26/2025 V364 - G.S. 122C-62 Additional Rights in 24-Hr Facility -Staff retraining conducted and documented. Immediate date: 11/26/2025 V366 - 10A NCAC 27G .0603 Incident Response Requirements Immediate date: 11/26/2025 V367 - 10A NCAC 27G .0604 Incident Reporting Requirements Immediate date: 11/26/2025 V536 - 27E .0107 Client Rights - Training on Alternatives to Restrictive Intervention Deficiency: Instructor training expired / not compliant. How it will be corrected: -A new external trainer will be secured. -Staff will be retrained as an instructor within 30 days of exit. Immediate date: 11/26/2025</p> <p>Describe your plans to make sure the above happens. 1. Identification of Required Clinical Roles The following individuals are currently assigned to required positions:</p>	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 293	<p>Continued From page 66</p> <ul style="list-style-type: none"> -Associate Professional (AP): [Newly hired AP] -Qualified Professional (QP): [QP] -Licensed Professional (LP): [LP] <p>These assignments are active and recognized by the facility.</p> <p>2. New Contracts and Job Descriptions</p> <ul style="list-style-type: none"> -New contracts are being issued and job descriptions have been updated to include required duties, scope of responsibility, supervision expectations, and documentation standards. <p>Implementation Date: November 26, 2025 Responsible Party: Director [Licensee/Director/CEO]</p> <p>3. Start Date for Supervision</p> <ul style="list-style-type: none"> -Supervision between the QP and AP will begin immediately. -Start date for supervision: November 26, 2025 -Supervision will occur face-to-face monthly and will be documented and placed in the staff compliance binder. <p>4. PCP Completion Timeline</p> <ul style="list-style-type: none"> -All Person-Centered Plans will be updated using the NC template. -Completion date for updated PCPs: October 31, 2025 -Updated PCPs will be verified by the Director and placed in individual client binders who are currently enrolled in program. <p>5. Staffing Presence in the Facility</p> <ul style="list-style-type: none"> -Two staff are scheduled on every shift to ensure continuous coverage. -The revised staff schedule was implemented on November 26, 2025 and created and posted by Director [Licensee/Director/CEO]. -To ensure staffing presence, the facility has established a call-out coverage list, designated backup staff, and will not open a shift unless two staff are physically present. -Schedules will be kept in the staff compliance 	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 293	<p>Continued From page 67</p> <p>binder.</p> <p>7. Documentation Responsibility -All logs, schedules, supervision forms, incident reports, and IRIS confirmations will be maintained by: Director: [Licensee/Director/CEO] -Documentation will be stored in digital individual client files and in the staff compliance binder.</p> <p>8. Incident Response and Reporting -The facility will respond to incidents based on severity and regulatory requirements. -Internal incident reports will be completed for all incidents. -The QP will send the Director a copy of each incident report by email to ensure IRIS submission. -IRIS reports will be submitted based on incident type within required timelines. -Law enforcement will be contacted if safety concerns, criminal activity, or mandated reporting thresholds are met. -This aligns with the requirements in 10A NCAC 27G .0603 and 10A NCAC 27G .0604.</p> <p>9. External RI Trainer -An external restrictive intervention trainer will be secured by November 26, 2025. -The Director will complete instructor training. -Staff training will begin immediately after instructor certification. -Training certificates will be placed in the staff compliance binder."</p> <p>Review on 11/26/25 of the 2nd Amended Plan of Protection signed by the Licensee/Director/CEO and dated 11/26/25 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? V112 - 10A NCAC 27G .0205 Assessment & Treatment / Service Plan -All current enrolled consumers and all future consumers will have their Person-Centered Plans</p>	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 293	<p>Continued From page 68</p> <p>converted to the NC PCP template. The Qualified Professional will ensure that each plan is developed based on the client's assessment and completed in partnership with the client, the legally responsible person, or both. For consumers receiving services beyond 30 days, the PCP will be completed within 30 days of admission to meet regulatory requirements. V295 - 10A NCAC 27G .1703 Requirements for Associate Professionals</p> <p>A separate Associate Professional (AP) was assigned to each licensed location to ensure compliance with the requirement that each facility have at least one full-time direct care staff who meets or exceeds AP qualifications as defined in 10A NCAC 27G .0104(1). [AP] has been designated as the new Associate Professional for the facility. This correction was completed on November 21, 2025.</p> <p>In addition to assigning a separate AP, the governing body has developed and implemented written policies that specify the duties and responsibilities of the Associate Professional in accordance with rule requirements. The written policy includes the following required elements:</p> <ol style="list-style-type: none"> 1. Management of the day-to-day operations of the facility, including oversight of direct care staff, daily routines, documentation flow, and communication between staffing shifts. 2. Supervision of paraprofessional staff related to responsibilities involving implementation of each child or adolescent's treatment plan, including guidance, monitoring, and ensuring adherence to service expectations. 3. Participation in service planning meetings, including attendance, collaboration with the Qualified Professional, and contributing information relevant to progress, needs, and treatment adjustments. <p>These responsibilities have been assigned to the</p>	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 293	<p>Continued From page 69</p> <p>AP and acknowledged in writing. Who was responsible: Director [Licensee/Director/CEO] V296 - 10A NCAC 27G .1704 Minimum Staffing Requirements How it will be corrected:The facility will ensure that staffing levels meet the minimum requirements outlined in the rule for both awake hours and sleep hours. The revised staffing schedule was implemented on November 26, 2025 by Director [Licensee/Director/CEO] and ensures that the number of direct care staff present corresponds to the number of children or adolescents in the facility at any given time. The facility will maintain the following staffing standards:</p> <ol style="list-style-type: none"> 1. When children or adolescents are awake: <ul style="list-style-type: none"> - Two direct care staff will be present when there are one to four children - Three direct care staff will be present when there are five to eight children - Four direct care staff will be present when there are nine to twelve children 2. During sleep hours: <ul style="list-style-type: none"> - Two direct care staff will be present, with at least one awake, when there are one to four children - Two direct care staff will be present, and both shall be awake, when there are five to eight children - Three direct care staff shall be present when there are nine to twelve children, with two awake and one permitted to sleep <p>The facility currently serves no more than three residents; therefore, at no time will fewer than two staff be scheduled on any shift, whether during awake or sleep hours. The staffing schedule reflects this requirement and ensures continuous presence of direct care staff. A call-out coverage process has been established</p>	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 293	<p>Continued From page 70</p> <p>to prevent any shift from beginning unless the required number of staff are physically present. Revised schedules are posted and maintained in the staff compliance binder. Director [Licensee/Director/CEO] is responsible for maintaining schedules and confirming coverage. V297 - 10A NCAC 27G .1705 Requirements of LP</p> <p>The Licensed Professional (LP) will provide weekly services in the facility to ensure compliance with the rule requirements for clinical consultation and involvement in treatment delivery and oversight. The LP will provide two hours per week of onsite therapy to residents, which meets the requirement for individual, group, or family therapy services as described in the rule. The LP will also provide one hour per week of clinical oversight in consultation with the Qualified Professional (QP), which meets the requirement for clinical supervision of the QP and participation in program-related clinical needs. 1 hour of treatment planning by reviewing clinical needs.</p> <p>The consultation and services provided by the LP will address the components outlined in the rule, including:</p> <ol style="list-style-type: none"> 1. Clinical supervision and guidance to the Qualified Professional regarding clinical direction, treatment implementation, documentation standards, and behavioral support needs. 2. Delivery of therapy services onsite to children or adolescents as indicated in their Person-Centered Plans. 3. Involvement in treatment planning by reviewing clinical needs, contributing to updates to service strategies, and providing input into overall program issues affecting client care. <p>V364 - G.S. 122C-62 Additional Rights in 24-Hr Facility Phone calls will no longer be placed on speaker</p>	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 293	<p>Continued From page 71</p> <p>unless the resident specifically requests it and signs consent, or when such monitoring is required by court order. This corrective action ensures that clients are able to make and receive confidential telephone calls as required by G.S. 122C-62, and maintains the resident's right to private communication without unnecessary restriction. For minor clients, calls will only be monitored when clinically justified or required by a legally responsible person, and only to the extent allowable under the law. Staff will be instructed that only calls involving minors may be supervised, and only when supervision is appropriate for protection, safety, or treatment needs.</p> <p>This action ensures compliance with the rule by:</p> <ol style="list-style-type: none"> 1. Protecting the right of adult clients to make and receive confidential phone calls without the facility listening or placing calls on speaker, unless consent is given. 2. Allowing minor clients to communicate with parents, guardians, legally responsible persons, attorneys, advocates, or treatment providers, consistent with their rights and developmental needs. 3. Preventing the facility from restricting communication rights unless restrictions are made by the Qualified Professional, are clinically justified, documented, time-limited, and reviewed in accordance with subsection (e) of the statute. 4. Ensuring that any restriction, if ever required, is written in the client record, reviewed every seven days, does not exceed 30 days, and is communicated to the legally responsible person as required by the rule. <p>A written reminder has been posted at the facility phone stating that calls may not be placed on speaker without signed consent.</p> <p>V366 - 10A NCAC 27G .0603 Incident Response Requirements</p>	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 293	<p>Continued From page 72</p> <p>-The facility will develop and implement written policies that meet the requirements for responding to Level I, II, and III incidents. The policy will ensure that the response to any incident includes attending to the immediate health and safety needs of the individuals involved, determining the cause of the incident, developing corrective measures within established timeframes not to exceed 45 days, and developing preventive measures within the same timeframe to reduce the likelihood of recurrence. The policy will also identify the person responsible for implementing corrective and preventive actions and ensure adherence to all confidentiality requirements under G.S. 75 Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3, and 45 CFR Parts 160 and 164.</p> <p>-Documentation will be maintained showing that the facility has completed each of the required components, including the health and safety response, the cause determination, corrective measures, preventive measures, assigned responsibility, and confidentiality compliance. Documentation will be stored in a digital file, and the Director, [Licensee/Director/CEO], will be responsible for ensuring completion and retention of incident response records.</p> <p>V367 - 10A NCAC 27G .0604 Incident Reporting Requirements</p> <p>-All incidents that fall under the state definitions of Level II and Level III incidents will be reported in accordance with 10A NCAC 27G .0604. The facility will ensure that all Level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the premises, and all Level III incidents and Level II deaths involving clients served within the previous 90 days, are reported to the LME responsible for the catchment area within 72 hours of the facility becoming aware of the incident. Incident reports</p>	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 293	<p>Continued From page 73</p> <p>will be submitted through IRIS using the form and submission method approved by the Secretary. The report will include all required information as specified in the rule and will be documented with follow-up and resolution records.</p> <p>-The Qualified Professional will send a copy of each incident report to the Director by email to ensure that the incident has been identified, reported, and documented. The Director will confirm that the incident was reported within the required 72-hour reporting timeframe and that all required follow-up and resolution information is entered into IRIS. The facility will maintain copies of all IRIS submissions, follow-up notes, correspondence, corrective actions, and resolution documentation in the Staff Compliance Binder to demonstrate compliance with state reporting requirements.</p> <p>V536 - 27E .0107 Client Rights - Training on Alternatives to Restrictive Intervention</p> <p>-A new external trainer will be secured on Monday, December 1, 2025 from the same approved training company, and the instructor will be retrained in accordance with the instructor qualification and competency requirements outlined in the rule. The instructor will train all current staff no later than January 1, 2026. Training certificates for the instructor and all staff trained will be filed in the HR records to verify compliance.</p> <p>-The retraining process will ensure that the instructor meets all elements of the rule, including demonstrating competence by scoring 100 percent on testing in a program focused on preventing, reducing, and eliminating the need for restrictive interventions, and achieving a passing score in an instructor training program. The instructor training will be competency-based, include measurable learning objectives, written and observed performance testing, and include</p>	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 293	<p>Continued From page 74</p> <p>measurable methods to determine passing or failing, in compliance with the rule requirements. -The training content used by the instructor will be approved by the Division and will include instructional components required by the rule, including understanding the adult learner, methods for teaching course content, methods for evaluating trainee performance, and documentation procedures. The instructor will also meet the rule requirement of having coached experience in teaching at least once with positive review, and will teach at least one restrictive intervention training annually, with refresher instructor training completed at least every two years. -Documentation required by the rule will be maintained for at least three years and will include the names of participants, pass or fail outcomes, instructor certification records, and refresher training records. All documentation will be stored in the Staff Compliance Binder and HR files. The Director, [Licensee/Director/CEO], will be responsible for ensuring the completion, filing, and maintenance of all instructor and staff training documentation Immediate date: 12/1/2025</p> <p>Describe your plans to make sure the above happens. 5. Staffing Presence in the Facility- Schedules will be kept in the staff compliance binder. 9. External RI Trainer An external restrictive intervention trainer will be secured by December, 1st 2025. The Director will complete instructor training by December 16th, 2025 Staff training will begin immediately after instructor certification which is December 20th (2025) Training certificates will be placed in the staff</p>	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 293	<p>Continued From page 75</p> <p>compliance binder and completed by January 1st 2026."</p> <p>This facility served adolescent girls ranging in age from 14 to 16 years old, with diagnoses that included Mild and Moderated Intellectual Disability Disorders, Post-Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, Disruptive Mood Dysregulation Disorder, Borderline Personality Disorder, Major Depressive Disorder, Seizures, and Generalized Anxiety Disorder. The facility did not train staff in client needs prior to staff working with clients. FC #4 had a history of seizures, FC #5 had a history aggressive behaviors and suicidal ideation, and FC #6 had a history of self-harming behaviors, suicidal ideation, verbal and physical aggression. Former client #4 had been admitted in the facility more than 30 days and she did not have a treatment plan after 30 days based on her admission assessment. There were no goals and strategies to address FC #4's increasing seizure activities. The facility noted that her seizure activity would not be added to the treatment plan because it was a medical, not a behavioral concern. The LP, the QP and the AP were not performing clinical and administrative responsibilities as required and were not present in the facility for the required amount of time as their hours were divided by were also working in a sister facility. The LP was not in the facility for 4 hours face-to-face clinical consultation weekly and reported she had not provided supervision to the QP. Between 9/1/25 and 10/15/25, the LP reported she had not provided services in the facility for a period of about 3 weeks. The facility had no policy and procedure for the supervision plan of the AP by the QP and was unable to verify that supervisions had occurred. Staff reported that since client #1 was the only client at the</p>	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 293	<p>Continued From page 76</p> <p>facility, services were primarily delivered at the sister facility. Client #1 was only at the facility for bedtime and to get ready for school. With one client in the facility, only one staff worked in the facility with client #1. The facility failed to provide coordination of care as clients had missed therapy appointments and the LP reported difficulty scheduling therapy appointments due to issues with staffing. The facility failed to provide documentation of Child Family Team meetings to support treatment planning for clients. The clients had phone calls that were placed speaker and the phone call monitored by staff. There was no documentation of restrictive intervention training for staff #4. Staff #3 had restrictive training completed after the documented hired date. The facility did not complete and maintain all level I and II incidents and had incidents that were reported late in IRIS.</p> <p>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 293		
V 295	<p>27G .1703 Residential Tx. Child/Adol - Req. for A P</p> <p>10A NCAC 27G .1703 REQUIREMENTS FOR ASSOCIATE PROFESSIONALS (a) In addition to the qualified professional specified in Rule .1702 of this Section, each facility shall have at least one full-time direct care staff who meets or exceeds the requirements of an associate professional as set forth in 10A NCAC 27G .0104(1). (b) The governing body responsible for each facility shall develop and implement written policies that specify the responsibilities of its</p>	V 295		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 295	<p>Continued From page 77</p> <p>associate professional(s). At a minimum these policies shall address the following:</p> <ul style="list-style-type: none"> (1) management of the day to day day-to-day operations of the facility; (2) supervision of paraprofessionals regarding responsibilities related to the implementation of each child or adolescent's treatment plan; and (3) participation in service planning meetings. <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure it had at least one full time direct care staff who meets or exceeds the requirements of an Associate Professional (AP). The findings are:</p> <p>Review on 10/1/25 of the facility's Client Staff Census revealed: -Census was completed by Licensee/Director/Chief Executive Officer (CEO). -Staff #1 was initially listed as the facility's AP.</p> <p>Review on 10/8/25 of the AP/House Manager (AP/HM)'s personnel record revealed: -Hired 10/1/25. -Offer letter and job description for Associate Professional/Group Home Manager (AP/HM) signed and dated 10/2/25. -Scheduled hours Monday-Friday 4:00pm-10:00pm and Saturday 8:00am-8:00pm. -Responsibilities included "...supervision of paraprofessionals regarding responsibilities related to the implementation of each child or adolescent's treatment plan...assisting QP</p>	V 295		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 295	<p>Continued From page 78</p> <p>(Qualified Professional) with administrative tasks. Attending weekly leadership meetings with owners and QP...Supervision shall be provided by a Qualified Professional with experience serving the population until you reach four (4) years of experience. An individualized plan will be developed upon hiring and reviewed annually by both parties..."</p> <p>Interview on 10/10/25 with the Former Residential Director revealed: -"I worked 10 days, from 8/25 (2025) until 9/5 (2025)." -"When I was there was no AP (AP/HM) only a QP."</p> <p>Interview on 10/15/25 with staff #1 revealed: -Husband to the Licensee/Director/CEO . -Was the AP for the facility "up until January 2025." -"I report to the current AP, [AP/HM]."</p> <p>Interview on 10/14/25 with staff #4 revealed: -"I don't know who the AP is; all I know is [Licensed Professional]."</p> <p>Interview on 10/15/25 with staff #5 revealed: -Worked Sundays 8am-8pm and Tuesday through Thursday 2pm-10pm. -"I have been working with [sister facility] for 4 weeks." -Had never met the AP/HM until "about two Sundays ago" when two clients at the sister facility "ran away...that was the first time I talked with [AP/HM]...I don't know when she started." -The "only staff in Lakemore is staff that's there when [client #1] is sleeping."</p> <p>Interviews 10/14/25 and 10/16/25 on with staff #6 revealed:</p>	V 295		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 295	<p>Continued From page 79</p> <ul style="list-style-type: none"> -Worked daily from 2pm-9:30pm or 10pm. -Did not know who the AP/HM was for the facility. -The "AP (AP/HM) is [QP], sorry she is the QP and the AP is [AP/HM]." -"[AP/HM] just started" and was in the facility "from time to time...she is not there everyday; she's in and out." -"I really didn't even know what her (AP/HM) position was, she started like October 2nd...she is a teacher in the daytime at the high school." -Was not aware that staff #1 had previously been the AP/HM for the facility. <p>Interview on 10/13/25 with the AP/HM revealed:</p> <ul style="list-style-type: none"> -"I am the House Manager. I started on 10/2/25, so I am really new." -"I have not been to Lakemore since my date of hire (10/1/25)." -Was "mainly been supporting [sister facility city] location" -The facility was "in the process of hiring another house manager so there can be one in each home (facility)." -"[Licensee/Director/CEO] does my supervision." -"I believe the AP is [QP]. I'm not sure, my apology, she [QP] is the QP; I'm not sure of the AP (who the AP was)." -Had not had supervision with the QP. -Did not know who the AP was, was not aware that she was the AP, was not aware the QP was to provide her supervision. -A plan for supervision with the QP had not been discussed with her. <p>Interview on 10/13/25 with the QP revealed:</p> <ul style="list-style-type: none"> -Her work hours "varies; not really set, according to how many residents" are in the facility. -"My time is split between 2 locations (facility and sister facility)." -"I'm on site for interventions...they (facility staff) 	V 295		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 295	<p>Continued From page 80</p> <p>have 24/7 access to me...they know to call me for de-escalation." -"Oversee" the direct support staff. -Did not do unannounced visits at the facility, "they (staff) are always aware that I am coming." -"Don't really do supervision, but if I need to provide training or show them (staff) how to do something, in that respect I provide supervision." -"I'm not sure who the AP (AP/HM) is; we (facility) did have an AP, but I am not sure the status of how long it will be for her (Licensee/Director/CEO) to refill that position (AP/HM)."</p> <p>Interview on 10/15/25 with the Licensed Professional revealed: -"...they (facility) just got [AP/HM] and I'm not sure if she is the QP.</p> <p>Interviews on 10/8/25 and 10/14/25 with the Licensee/Director/CEO revealed: -Staff #1 was the AP (AP/HM) and was "no longer the AP, has not been the AP since March (3/19/25) of this year." -Did not respond as to why she put staff #1's name on the staff census as the AP. -"[AP/HM] works full-time" and "became the AP (AP/HM) on October the first (2025)." -"...she (AP/HM) was hired as the AP slash House Manager (AP/HM). Most people don't know what the official title is." -"I went over that (AP/HM title and job description) with her when she was initially hired...she is the AP (AP/HM) and I will go over that with her again."</p> <p>Interview on 10/15/25 with the Licensee/Director/CEO revealed: -The AP/HM was "just hired..."</p>	V 295		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 295	<p>Continued From page 81</p> <p>Interview on 10/23/25 with the Licensee/Director/CEO revealed: -The Human Resources duties were "between me, the director and the AP, [AP/HM]. -Before [AP] was hired, she was responsible for hiring, staff training and scheduling staff. -"Our QP does supervise the AP, I can get the policy procedure for you. -AP/HM attended Child Family Team Meetings.</p> <p>Interview on 10/29/25 with the Licensee/Director/CEO revealed: -Was not aware that a full-time AP was required for each facility.</p> <p>This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type B rule violation and must be corrected within 45 days.</p>	V 295		
V 296	<p>27G .1704 Residential Tx. Child/Adol - Min. Staffing</p> <p>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.</p>	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 296	<p>Continued From page 82</p> <p>(c) The minimum number of direct care staff during child or adolescent sleep hours is as follows:</p> <p>(1) two direct care staff shall be present and one shall be awake for one through four children or adolescents;</p> <p>(2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on record observation and interviews the facility failed to ensure the minimum staffing ratio of two staff for up to four adolescents. The findings are:</p> <p>Observation on 10/20/25 from approximately</p>	V 296		
-------	--	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 296	<p>Continued From page 83</p> <p>3:02pm to 5:10pm in the facility revealed: -At approximately 3:02pm, staff #6 arrived at the facility driving the white SUV. -Staff #6 parked the SUV in the facility driveway, staff #6 and three clients (client #1 and two new client admissions) exited the SUV . -Staff #6 was alone in the SUV with 3 clients and entered the facility alone with three clients. -There was no other staff in the facility with staff #6 and 3 clients. -3:59pm overheard staff #6, "[Associate Professional/House Manager (AP/HM)] is coming." -5:10pm, no additional staff arrived at the facility. -Staff #6 was alone in the facility with 3 clients from approximately 3:02pm until 5:10pm..</p> <p>Observation on 10/29/25 at approximately 2:44pm-2:48pm in the facility revealed: -Approximately 2:43pm-2:45pm, the facility's white SUV was parked a block from the facility, at the corner, entering the neighborhood subdivision. -At approximately 2:45pm, a school bus arrived and three clients (client #1 and two new admissions) exited the bus, walked to the white SUV, got into white SUV and were driven to the facility. -The SUV was driven to the facility and was parked in the facility driveway. -Staff #2 was driving the SUV alone with 3 clients. -At approximately 2:48pm, staff #2 and three clients got out of the SUV and entered the facility. -Staff #2 was driving and was the only staff in the white SUV with three clients.</p> <p>Interviews on 10/1/25 and 10/20/25 with client #1 revealed: -Two staff worked at night and "two staff in the morning when I wake up."</p>	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 296	<p>Continued From page 84</p> <p>- "There are two staff, the people who came in the morning are here until 8pm, [staff #6], just [staff #6] was here (night shift)."</p> <p>- "[Unidentified female staff] is here in the morning, we get on the bus at 6:30am, get off the bus at 2:30pm and [staff #6] is here, so just one staff are here (facility)."</p> <p>- One staff transports clients.</p> <p>Interview on 10/22/25 with the Legal Guardian/Mother for FC#4 revealed: - "The first time she (FC #4) was to the hospital there was not staff (facility) there (hospital); I don't know the dates but CPS (Child Protection Services) was involved..."</p> <p>Interview on 10/24/25 with FC #4's Department of Social Services Social Worker revealed: - "They (facility) would say they didn't have staff to take her (FC #4) forty-five minutes away. They threatened mom (LG/Mother) with abandonment if she (LG/Mother) didn't come to the hospital to supervise [FC #4]."</p> <p>Interview on 10/10/25 with the Former Residential Director revealed: - Saw staff "working alone on shift and was able to get access to staff schedules." - Only one staff worked on the overnight shift was "[staff #9], and [staff #9] would leave at 4 am." - The Licensee/Director/CEO would place herself on the schedule "to fill in the gaps and staff stated that she did not come to work the shift." - Expressed her concerns about staffing to the Licensee/Director/CEO, "I stated that there were clients with seizures, SIBs (self injurious behaviors), and elopements...you gotta' have people there (facility), you have client with acute needs." - Staff #6 "would be there (facility) by herself and I</p>	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 296	<p>Continued From page 85</p> <p>would call [former staff] to go in and work with her."</p> <p>-When a staff's shift ended, "staff didn't feel comfortable leaving because there was no one to relieve...[former female staff] ended up staying overnight (August 2025) to work with the overnight person and she [past female staff] had already worked 12 hours."</p> <p>-Two staff would transport clients.</p> <p>Interview on 10/29/25 with former staff #8 revealed:</p> <p>-"I worked the overnight shift (9pm-6:30am), a few times and I worked alone...the last 3 times I was there (facility) by myself; one lady (staff) had quit after I started, a couple of ladies (staff) quit."</p> <p>-In September 2025, FC #4 was left alone at the hospital, "staff (unknown) went to the hospital with her (FC #4) and changed shifts so the staff couldn't stay and had to leave, the other staff person (unknown) had not arrived..."</p> <p>Interview on 10/14/25 with staff #4 revealed:</p> <p>-"I work 10:30pm to 8:30am; I replace one staff and her (staff) hours are 3pm-12am, then I'm by myself (12am-8:30am) and I wake the girls (clients) up at 6:30am."</p> <p>-Worked "mostly" at the sister facility.</p> <p>-"...now that there is one client (#1) there is only one lady (staff) there during the day, [staff #6]."</p> <p>Interview on 10/15/25 with staff #5 revealed:</p> <p>-Worked Sundays 8am-8pm, Tuesday through Thursday 2pm-10pm, "supposed to be 2(pm) to 9(pm), but my relief would not get there until 10(pm); I was working the shift alone."</p> <p>-"I was told that [FC #4] was taken to the hospital without staff accompanying (date unknown)."</p> <p>-The facility had issues with staff turnover.</p>	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 296	<p>Continued From page 86</p> <p>Interviews on 10/14/25 and 10/16/25 with staff #6 revealed: -Worked 2pm until 9:30-10pm, "there are always two staff" on shift. -There were "two or three (staff) on each shift." -When client #1 was the only client in the facility staff #6 was by herself "it was just me...there was one staff with [client #1]." -A former staff "was sick and I was there (alone) with [client #1] about three or four days." -"I work Monday to Friday, 2pm to 10:30pm; only time I worked alone was when all the other girls (clients) left (discharged) and [client #1] was the only client." -No clients were left alone at the hospital, "not on my watch." -"...if a child goes to the hospital, one staff goes to the hospital and one staff stays at the facility with the others (clients), we (staff) never take kids (clients) to the hospital."</p> <p>Interview on 10/13/25 with the AP/HM revealed: -Had not been at the facility since she was hired on 10/1/25.</p> <p>Interview on 10/13/25 with the Qualified Professional revealed: -There were at least two staff on every shift and there had not been a shift with just one staff, "not to my knowledge." -Had "never known" FC #4 to be at the hospital alone, "the only time (alone)" was when FC #4's "mother insisted on [FC #4] going to the hospital about an hour away; I believe that was 9/4 (2025)." -The facility did not have staff to travel with and stay with FC #4 at the hospital.</p> <p>Interviews on 10/1/25 and 10/23/25 with the Licensee/Director/Chief Executive Officer (CEO)</p>	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 296	Continued From page 87 revealed: -Was responsible for scheduling staff on each shift. -Shifts are Monday through Friday, 2pm-9pm; 9pm-6:30am; 6:30am-2pm, "no one is at the facility for this (6:30am-2pm) shift, but I'm on call." -FC #4's LG/Mother had a hospital preference but taking FC #1 to a hospital close to the facility had been discussed prior to FC #4's admission. --FC #4 was never alone at the hospital. -"Typically" two staff were on shift and "...two staff scheduled for 2nd shift and two staff overnight." -Staff from the sister facility may cover shifts. -Was not aware of staff working alone. -The facility SUV is used for client transportation. -Two staff drove clients to outings. -There were former employees that had made false complaints. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type B rule violation and must be corrected within 45 days.	V 296		
V 297	27G .1705 Residential Tx. Child/Adol - Req. for L P 10A NCAC 27G .1705 REQUIREMENTS OF LICENSED PROFESSIONALS (a) Face to face clinical consultation shall be provided in each facility at least four hours a week by a licensed professional. For purposes of this Rule, licensed professional means an individual who holds a license or provisional license issued by the governing board regulating a human service profession in the State of North Carolina. For substance-related disorders this shall include a licensed Clinical Addiction Specialist or a certified Clinical Supervisor.	V 297		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 297	<p>Continued From page 88</p> <p>(b) The consultation specified in Paragraph (a) of this Rule shall include:</p> <p>(1) clinical supervision of the qualified professional specified in Rule .1702 of this Section;</p> <p>(2) individual, group or family therapy services; or</p> <p>(3) involvement in child or adolescent specific treatment plans or overall program issues.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure face to face clinical consultation was provided in the facility at least four hours a week by a Licensed Professional (LP). The findings are:</p> <p>Review on 10/7/25 of client #1's record revealed: -Age 15 years old. -Admission on 11/26/24. -Diagnoses: Mild Intellectual Disability Disorder (IDD); Post-Traumatic Stress Disorder (PTSD); Attention-Deficit Hyperactivity Disorder (ADHD); Disruptive Mood Dysregulation Disorder; Borderline Personality Disorder. -No documentation to support that Individual/Group/Family therapy was being provided.</p> <p>Review on 10/9/25 of the LP's personnel record revealed: -no hire date in file. -Contract signed and dated 8/12/25, "...you will be responsible for providing psychological and counseling services to individuals, groups and families within the scope of your professional</p>	V 297		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 297	<p>Continued From page 89</p> <p>training and licensure..."</p> <p>-Job duties and responsibilities included: "conduct three 45-minute sessions for each resident each month, three 30 minute weekly individual sessions for residents; attend and facilitate one mandatory staff training per month, provide additional services as needed."</p> <p>Interview on 10/15/25 with the LP revealed: -Worked at the facility once a week in the evening as a contract therapist, "completed assessments and conducted individual therapy sessions." -Her hours were worked between the facility location and a sister facility location. -Conducted a weekly therapy group, "if there is more than one (client)." -"I am in the facility about an hour, hour and a half, sometimes two (hours); when at capacity (three clients) about two (hours)...so, I would say about two (hours per week)." -Had not been to the facility in "three weeks" due to "new staff (staff turnover)." -She had "not been able to get in touch with staff, and staff didn't have [client #1] there (facility)...haven't been able to get a hold of anyone, that's been the barrier, if I'm being honest." -"I currently do not supervise any staff. I don't supervise any one and I haven't supervised anyone either." -Was not sure who was assigned as the Qualified Professional (QP) at the facility, "they just got [Associate Professional/House Manager] and I'm not sure if she is the QP." -"I'm not in their (facility) day to day functions." -"[Licensee/Director/Chief Executive Officer (CEO)] spoke to me within in the last week or two about supervising the QP; she (Licensee/Director/CEO) just mentioned this to me and we need to finalize that."</p>	V 297		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 297	<p>Continued From page 90</p> <p>-"I did not know the QP had been working since July (2025)."</p> <p>-The "four hours of face to face" clinical consultation the facility weekly, "has not been happening."</p> <p>-Was never given information about LP requirements in a group home facility, "I didn't have the information."</p> <p>Interview on 10/1/25 with the Licensee/Director/CEO revealed:</p> <p>-The LP "is in the facility twice a week.:</p> <p>-The LP "does not provide supervision for the QP, I do that."</p> <p>-"I have formal supervision weekly with the QP, every Monday ...they are documented in calendar (application)...no, the LP doesn't provide supervision; no, I'm not an LP. I'm the director, we (Licensee/Director/CEO and the QP) meet everyday."</p> <p>-No documentation of the LP's clinical supervision.</p> <p>Interview on 10/23/25 with the Licensee/Director/CEO revealed:</p> <p>-"I supervise the QP; our LP is supervising the QP...but I also supervise her as well."</p> <p>-No documentation of the QP's supervision and no documentation to verify 4 hours of face to face clinical consultation in the facility by the LP.</p> <p>This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type B rule violation and must be corrected within 45 days.</p>	V 297		
V 364	<p>G.S. 122C- 62 Additional Rights in 24 Hour Facilities</p> <p>§ 122C-62. Additional Rights in 24-Hour</p>	V 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 364	<p>Continued From page 91</p> <p>Facilities.</p> <p>(a) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-61, each adult client who is receiving treatment or habilitation in a 24-hour facility keeps the right to:</p> <p>(1) Send and receive sealed mail and have access to writing material, postage, and staff assistance when necessary;</p> <p>(2) Contact and consult with, at his own expense and at no cost to the facility, legal counsel, private physicians, and private mental health, developmental disabilities, or substance abuse professionals of his choice; and</p> <p>(3) Contact and consult with a client advocate if there is a client advocate.</p> <p>The rights specified in this subsection may not be restricted by the facility and each adult client may exercise these rights at all reasonable times.</p> <p>(b) Except as provided in subsections (e) and (h) of this section, each adult client who is receiving treatment or habilitation in a 24-hour facility at all times keeps the right to:</p> <p>(1) Make and receive confidential telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party;</p> <p>(2) Receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over therapies;</p> <p>(3) Communicate and meet under appropriate supervision with individuals of his own choice upon the consent of the individuals;</p> <p>(4) Make visits outside the custody of the facility unless:</p> <p>a. Commitment proceedings were initiated as the result of the client's being charged with a violent crime, including a crime involving an</p>	V 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 364	<p>Continued From page 92</p> <p>assault with a deadly weapon, and the respondent was found not guilty by reason of insanity or incapable of proceeding;</p> <p>b. The client was voluntarily admitted or committed to the facility while under order of commitment to a correctional facility of the Division of Adult Correction of the Department of Public Safety; or</p> <p>c. The client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; A court order may expressly authorize visits otherwise prohibited by the existence of the conditions prescribed by this subdivision;</p> <p>(5) Be out of doors daily and have access to facilities and equipment for physical exercise several times a week;</p> <p>(6) Except as prohibited by law, keep and use personal clothing and possessions, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002;</p> <p>(7) Participate in religious worship;</p> <p>(8) Keep and spend a reasonable sum of his own money;</p> <p>(9) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes; and</p> <p>(10) Have access to individual storage space for his private use.</p> <p>(c) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-57 and G.S. 122C-59 through G.S. 122C-61, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to have access to proper adult supervision and guidance. In recognition of the minor's status as a developing individual, the minor shall be provided opportunities to enable him to mature physically, emotionally, intellectually, socially, and vocationally. In view of the physical, emotional,</p>	V 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 364	<p>Continued From page 93</p> <p>and intellectual immaturity of the minor, the 24-hour facility shall provide appropriate structure, supervision and control consistent with the rights given to the minor pursuant to this Part. The facility shall also, where practical, make reasonable efforts to ensure that each minor client receives treatment apart and separate from adult clients unless the treatment needs of the minor client dictate otherwise.</p> <p>Each minor client who is receiving treatment or habilitation from a 24-hour facility has the right to:</p> <p>(1) Communicate and consult with his parents or guardian or the agency or individual having legal custody of him;</p> <p>(2) Contact and consult with, at his own expense or that of his legally responsible person and at no cost to the facility, legal counsel, private physicians, private mental health, developmental disabilities, or substance abuse professionals, of his or his legally responsible person's choice; and</p> <p>(3) Contact and consult with a client advocate, if there is a client advocate.</p> <p>The rights specified in this subsection may not be restricted by the facility and each minor client may exercise these rights at all reasonable times.</p> <p>(d) Except as provided in subsections (e) and (h) of this section, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to:</p> <p>(1) Make and receive telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party;</p> <p>(2) Send and receive mail and have access to writing materials, postage, and staff assistance when necessary;</p> <p>(3) Under appropriate supervision, receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two</p>	V 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 364	<p>Continued From page 94</p> <p>hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over school or therapies;</p> <p>(4) Receive special education and vocational training in accordance with federal and State law;</p> <p>(5) Be out of doors daily and participate in play, recreation, and physical exercise on a regular basis in accordance with his needs;</p> <p>(6) Except as prohibited by law, keep and use personal clothing and possessions under appropriate supervision, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002;</p> <p>(7) Participate in religious worship;</p> <p>(8) Have access to individual storage space for the safekeeping of personal belongings;</p> <p>(9) Have access to and spend a reasonable sum of his own money; and</p> <p>(10) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes.</p> <p>(e) No right enumerated in subsections (b) or (d) of this section may be limited or restricted except by the qualified professional responsible for the formulation of the client's treatment or habilitation plan. A written statement shall be placed in the client's record that indicates the detailed reason for the restriction. The restriction shall be reasonable and related to the client's treatment or habilitation needs. A restriction is effective for a period not to exceed 30 days. An evaluation of each restriction shall be conducted by the qualified professional at least every seven days, at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's record. Restrictions on rights may be renewed only by a written statement entered by the qualified professional in the client's record that states the reason for the renewal of the restriction. In the case of an adult</p>	V 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 364	<p>Continued From page 95</p> <p>client who has not been adjudicated incompetent, in each instance of an initial restriction or renewal of a restriction of rights, an individual designated by the client shall, upon the consent of the client, be notified of the restriction and of the reason for it. In the case of a minor client or an incompetent adult client, the legally responsible person shall be notified of each instance of an initial restriction or renewal of a restriction of rights and of the reason for it. Notification of the designated individual or legally responsible person shall be documented in writing in the client's record.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure client rights to privacy in a 24 hour facility affecting 1 of 1 clients (#1) and 2 of 3 former client (FC #4 and #5). The findings are:</p> <p>Review on 10/7/25 of client #1's record revealed: -Age 15 years old. -Admission on 11/26/24 -Diagnoses: Mild Intellectual Disability Disorder (IDD); Post-Traumatic Stress Disorder (PTSD); Attention-Deficit Hyperactivity Disorder (ADHD); Disruptive Mood Dysregulation Disorder; Borderline Personality Disorder.</p> <p>Review on 10/7/25 of FC #4's record revealed: -Age 16 years old. -Admission on 7/27/25 (other admission dates in the record were 7/20/25 and 7/25/25). -Discharged on 9/22/25. -Diagnoses: PTSD; ADHD; Major Depressive</p>	V 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 364	<p>Continued From page 96</p> <p>Disorder; Moderate IDD; Seizures.</p> <p>Interview on 10/1/25 with client #1 revealed: -" I can use the phone; calls are monitored; we (client #1 and staff) just put it on speaker phone and the staff listens."</p> <p>Attempted interview on 10/13/25 with the Legal Guardian (LG) for client #1 was unsuccessful and there was no return call prior to survey exit.</p> <p>Attempted interview on 10/22/25 with FC #4 was unsuccessful because FC #4 had eloped from her current placement.</p> <p>Interview on 10/22/25 with the LG/Mother for FC #4 revealed: -During phone calls with FC #4, "staff was right there; not sure if it was on speaker."</p> <p>Interview on 10/24/25 with the Department of Social Services (DSS) Social Worker (SW) for FC #4 revealed: -"When we (DSS) had virtual calls, a staff member was sitting right there with her (FC #4) when she first got to the group home (facility)." -"There were times when they (facility) were going to church and [FC #4] didn't want to go... [Licensee/Director/CEO] stated the girls (clients) go to church on Sunday. I didn't think it would be an issue since [FC #4] was going to church with her grandmother, but later when [FC #4] didn't want to go (church with facility), she would then have seizures and I didn't know she (FC #4) still had to attend (church)."</p> <p>Interview on 10/14/25 with staff #4 revealed: -"I don't think they (phone calls) are being monitored because they (facility) said if [FC #5] gets upset, give her the phone and she (FC #5)</p>	V 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 364	<p>Continued From page 97</p> <p>would go to her room.</p> <ul style="list-style-type: none"> -Clients attended the Licensee/Director/CEO's church. -Did not know clients' rights; "no I don't know any, not that I can think of." <p>Interviews on 10/14/25 and 10/24/25 with staff #6 revealed:</p> <ul style="list-style-type: none"> -Client rights included "privacy on the phone and privacy in their room." -"Yes, calls are monitored" by staff. -Staff "get the phone, look in the call book at the approved call list...dial the number, put it (phone) on speaker and sit in the room with them (clients) while they're on the phone." -Clients attended church and had "no choice because it's [Licensee/Director/CEO]'s church. -Clients were "from out of the area so they don't know other churches" to attend. -"It is a requirement that everyone (clients) go to church, from what [Licensee/Director/CEO] said." <p>Interview on 10/29/25 with the Licensee/Director/CEO revealed:</p> <ul style="list-style-type: none"> -Would not acknowledge that client phone calls were being monitored. -Was not aware that staff could not monitor clients' phone calls. -Clients were not required to attend church. -Clients had a right to choose, "and we make sure the LG signed" giving permission for church attendance. -Clients knew that they have the choice to go or not to go to church. <p>This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type B rule violation and must be corrected within 45 days.</p>	V 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 366	Continued From page 98	V 366		
V 366	<p>27G .0603 Incident Response Requirements</p> <p>10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS</p> <p>(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:</p> <p>(1) attending to the health and safety needs of individuals involved in the incident;</p> <p>(2) determining the cause of the incident;</p> <p>(3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;</p> <p>(4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;</p> <p>(5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;</p> <p>(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</p> <p>(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.</p> <p>(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.</p> <p>(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</p>	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 366	<p>Continued From page 99</p> <p>by:</p> <p>(1) immediately securing the client record</p> <p>by:</p> <p>(A) obtaining the client record;</p> <p>(B) making a photocopy;</p> <p>(C) certifying the copy's completeness; and</p> <p>(D) transferring the copy to an internal review team;</p> <p>(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:</p> <p>(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;</p> <p>(B) gather other information needed;</p> <p>(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</p> <p>(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</p>	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 366	<p>Continued From page 100</p> <p>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</p> <p>(3) immediately notifying the following:</p> <p>(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;</p> <p>(B) the LME where the client resides, if different;</p> <p>(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;</p> <p>(D) the Department;</p> <p>(E) the client's legal guardian, as applicable; and</p> <p>(F) any other authorities required by law.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement a policy governing their response to Level I and II incidents as required and failed to immediately notify the Local Management Entity/Managed Care Organization (LME/MCO) within the facility's catchment area of all level I and II incidents. The findings are:</p> <p>Review on 10/2/25 of the facility's incident reports from August 2025 to September 2025 revealed: -9/8/25 at 3:55pm, FC #4, headache, blurred vision, vomited, "due to persistence of her symptoms", evaluated by healthcare providers and hospitalized 9/8/25-9/10/25. -9/17/25 at 10:20am, FC #4, received call from</p>	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 366	<p>Continued From page 101</p> <p>school, was picked up and taken to the hospital with complaint of "blurry vision in left eye" seen by hospital healthcare provider.</p> <p>-9/23/25 at 5:04pm-5:45pm, FC #5 Restraint Type-"CPI Children's Control Position" (staff #6); "refused to eat lunch...explained she (FC #5) could eat her lunch but not select an alternative meal", starting yelling, to doors and went to open the garage door...staff (#6) had to physically intervene, "restrain" for safety.</p> <p>-9/27/25 at 1:35pm-3:10pm FC #5, Self injury, suicidal ideation, Restraint Type-"CPI Children's Control Position" (staff #6); became upset because she couldn't call her boyfriend, "took the cord from the back of the TV and tied it around her neck...making threats to the staff...started digging in her skin with the back of the cord" and was IVC'd (involuntarily committed).</p> <p>-No level I documentation of FC #4's aggressive behaviors and attempted elopements as described above.</p> <p>-No level I documentation of FC #6's incidences of "threats to herself, staff, and other residents...multiple attempts to elope from the facility and elopement from the facility on 8/17/25 and as described above.</p> <p>-No level II documentation for FC #5's 9/27/25 self harm and suicidal ideation as described above.</p> <p>-No level II documentation for restraints used by staff #6 with FC #5 on 9/23/25 and 9/27/25.</p> <p>Review on 10/2/25 of the facility's records revealed:</p> <p>-There was no documentation of response to the above incidents that support the facility:</p> <ul style="list-style-type: none"> -Attended to the health and safety needs of clients; -Determined the cause of the incident. -Developed and implemented corrective 	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 366	<p>Continued From page 102</p> <p>measures.</p> <ul style="list-style-type: none"> -Developed and implemented measures to prevent similar incidents. -Assigned a person to be responsible for implementation of the corrections and preventive measures. <p>Interview on 10/24/25 with FC #4's Department of Social Services (DSS) Social Worker (SW) revealed: -"...from what I gathered from the staff and the director things were going well (for FC #4) until they weren't." -Was informed of FC #4's discharge and "behaviors which included physical aggression toward peers...attempts to elope and staff would follow."</p> <p>Interview on 10/16/25 with FC #5's DSS SW revealed: -FC #5 was admitted on 9/3/25 and discharged on 9/27/25. -There were "no issues, nothing we were made aware of." -Had talked with FC #5 on "that Friday before the incident (9/26/25); she (FC #5) had gone to school" and "was surprised she had a psychotic break (9/27/25)." -The facility had concerns "about her (FC #5) behaviors when she attempted to harm herself (9/27/25)...the discharge was based on her behaviors."</p> <p>Attempted interviews on 10/23/25 and 10/24/25 with FC #6's DSS SW was unsuccessful due to no return call prior to survey exit.</p> <p>Interview on 10/23/25 with the Licensee/Director/Chief Executive Officer (CEO) revealed:</p>	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 366	Continued From page 103 -Was not aware of restraints with FC #5, "I'll need to look at that." -"The director (Licensee/Director/CEO) does investigations." -She was the person responsible for attending to the health and safety needs of clients., determining cause of incidents, developing and implementing corrective measures, measures to prevent similar incidents and assigning person(s) to be responsible for implementation of the corrections and preventive measures. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type B rule violation and must be corrected within 45 days.	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;	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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	<p>Continued From page 104</p> <p>(2) client identification information;</p> <p>(3) type of incident;</p> <p>(4) description of incident;</p> <p>(5) status of the effort to determine the cause of the incident; and</p> <p>(6) other individuals or authorities notified or responding.</p> <p>(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:</p> <p>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or</p> <p>(2) the provider obtains information required on the incident form that was previously unavailable.</p> <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <p>(1) hospital records including confidential information;</p> <p>(2) reports by other authorities; and</p> <p>(3) the provider's response to the incident.</p> <p>(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).</p> <p>(e) Category A and B providers shall send a</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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	<p>Continued From page 105</p> <p>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:</p> <ol style="list-style-type: none"> (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report level I incidents and 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:</p> <p>Review on 10/7/25 of former client (FC) # 4's record revealed: -Age 16 years old. -Admission on 7/27/25, other admission dates in</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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	<p>Continued From page 106</p> <p>the record were 7/20/25 and 7/25/25. -Discharged on 9/22/25. -Discharge Summary dated 9/22/25, "...emergency discharge...due to ongoing, frequent and severe seizures that presented significant safety concerns...the severity and frequency of the seizures created medical and safety risks beyond the scope of care that can be provided in the group home setting." -Diagnoses: Post Traumatic Stress Disorder (PTSD); Attention Deficit Hyperactivity Disorder (ADHD); Major Depressive Disorder; Moderate Intellectual Disability Disorder (IDD); Seizures. -Emergency Department (ED) visits on 8/18/25, 8/23/25, 9/1/25, 9/2/25, 9/4/25, 9/8/25, 9/17/25, 9/18/25 and 9/20/25.</p> <p>Review on 10/7/25 of FC # 5's record revealed: -Age 15 years old. -Admission on 9/5/25. -Discharged on 9/27/25. -Discharge Summary dated 9/27/25, "...paramedics were called...in response to [FC #5] experiencing a psychotic break with suicidal and homicidal ideations...due to the severity of the psychiatric crisis and [FC #5]'s inpatient admission...requesting and proceeding with an emergency discharge...due to...hospitalization and the need for extended inpatient treatment." -Diagnoses: Mood Dysregulation Disorder; Generalized Anxiety; ADHD, Combined Type; IDD, Mild, Adjustment with Mixed Disturbance of emotions and conduct; PTSD.</p> <p>Review on 10/8/25 of FC # 6's record revealed: -Age 14 years old. -Admission on 8/9/25. -Discharged on 9/2/25. -Discharge Summary dated 9/2/25, "...emergency discharge due [FC #6]'s ongoing threats to</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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	<p>Continued From page 107</p> <p>herself, staff, and other residents...multiple attempts to elope from the facility, posing a continued safety concern for both herself and others."</p> <p>-Diagnoses: ADHD, Combined Type; PTSD, unspecified; Mood Dysregulation Disorder; Mild IDD.</p> <p>Reviews on 10/2/25 of the facility's incident reports from August 2025 to September 2025 revealed:</p> <p>-9/8/25 at 3:55pm, FC #4, headache, blurred vision, vomited, "due to persistence of her symptoms", evaluated by healthcare providers and hospitalized 9/8/25-9/10/25.</p> <p>-9/17/25 at 10:20am, FC #4, received call from school, was picked up and taken to the hospital with complaint of "blurry vision in left eye" seen by hospital healthcare provider.</p> <p>-9/23/25 at 5:04pm-5:45pm, FC #5 Restraint Type-"CPI Children's Control Position" (staff #6); "refused to eat lunch...explained she (FC #5) could eat her lunch but not select an alternative meal", starting yelling, to doors and went to open the garage door...staff (#6) had to physically intervene, "restrain" for safety.</p> <p>-9/27/25 at 1:35pm-3:10pm FC #5, Self injury, suicidal ideation, Restraint Type-"CPI Children's Control Position" (staff #6); became upset because she couldn't call her boyfriend, "took the cord from the back of the TV and tied it around her neck...making threats to the staff...started digging in her skin with the back of the cord" and was involuntarily committed.</p> <p>-No level II documentation of FC #4's aggressive behaviors and attempted elopements as described in FC #4's discharge summary.</p> <p>-No level II documentation of FC #6's incidences of "threats to herself, staff, and other residents...multiple attempts to elope from the</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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	<p>Continued From page 108</p> <p>facility, described in FC #6's discharge summary. -No level II documentation of FC #6's elopement from the facility on 8/17/25</p> <p>Review on 10/2/25 and 10/29/25 of the IRIS from 8/1/25-10/2/25 revealed: -9/8/25, submitted 9/13/25, provider learning of incident 9/8/25 FC #4 "suffers from epilepsy and had a recurrent seizure that required medical intervention at the hospital for stabilization." -9/4/25, submitted 9/12/25, provider learned of incident 9/4/25 FC # 4 "suffers from epilepsy and had a recurrent seizure that required medical intervention at the hospital for stabilization." -9/2/25, submitted 10/29/25, provider learned of incident 9/2/25 FC # 6 throwing rocks at staff, eloped and was found by police, began assaulting police and paramedics -8/23/25, submitted 9/12/25, provider learned of incident 8/23/25 FC # 4 "suffers from epilepsy and had a recurrent seizure that required medical intervention at the hospital for stabilization." -8/22/25, submitted 9/12/25, provider learned of incident 8/22/25 FC # 4 "suffers from epilepsy and had a recurrent seizure that required medical intervention at the hospital for stabilization." -8/20/25, submitted 9/12/25, provider learned of incident 8/20/25 FC # 4 "suffers from epilepsy and had a recurrent seizure that required medical intervention at the hospital for stabilization." -8/18/25, submitted 9/12/25, provider learned of incident 8/18/25 FC # 4 "suffers from epilepsy and had a recurrent seizure that required medical intervention at the hospital for stabilization." -No level II submission for FC #5's 9/27/25 self harm and suicidal ideation -No level II submissions for restraints used by staff #6 with FC #5 on 9/23/25 and 9/27/25.</p> <p>Interview on 10/24/25 with the Department of</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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	<p>Continued From page 109</p> <p>Social Services Social Worker for FC #4 revealed: - "...from what I gathered from the staff and the director things were going well until they weren't." - Was informed of FC #4's discharge and "behaviors which included physical aggression toward peers and one of the staff (unknown), attempts to elope and staff would follow.</p> <p>Interview on 10/16/25 with the DSS SW for FC #5 revealed: - There were "no issues, nothing we were made aware of." - Had talked with FC #5 on "that Friday before the incident (9/26/25); she (FC #5) had gone to school" and "was surprised she had a psychotic break."</p> <p>Attempted interviews on 10/23/25 and 10/24/25 with the DSS SW for FC #6 was unsuccessful due to no return call.</p> <p>Interview on 10/10/25 with the Former Residential Director revealed: - The police were called on 9/2/25 when FC #6 was "throwing rocks... the staff was [#2 and #6]... [Licensee/Director/Chief Executive Officer (CEO)] told them (staff #2, #6) to take her (FC #6) to the hospital and leave." - The report for 9/2/25 "was not put in IRIS correctly..." - The Qualified Professional (QP) handled incident reports." - Had asked the QP "if she reported when [FC #6] found a screw and tried to put it through her nose (date unknown)" - Had also followed up with the Licensee/Director/CEO and "asked if the incident report was done, asked for copy and never got it." - The QP sent her "a screenshot of incident for</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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	<p>Continued From page 110</p> <p>either the screw incident or [FC #6] eloping on 9/2 (2025)."</p> <p>Interview on 10/15/25 with staff #1 revealed: -The QP was responsible for reporting incidences in IRIS, "but I took over recently to make sure everything is done correctly." -Had done "a couple of IRIS" submissions, "if behavior is severe its reported to IRIS; restraints is a level II, aggressive or minor stuff is level I."</p> <p>Interviews on 10/14/25 and 10/16/25 with staff #6 revealed: -FC #4 had "multiple seizures, in the bathtub, in the car, on outings and in school too." -The "9/12/25 incident, she (FC #4) had come back from the hospital and had had about 4 seizures that day." -The police were called "about [FC #5], that was it, we (facility) called the ambulance to come and get her (9/25/25)." -On 9/27/25, "[FC #5] had a crisis..."that was the day I restrained her, I put both of my hands and put it under her arms and held her arms...I was behind her and I did a hug, like a bear hug under her arms around her body and held her wrists because she was taking the cord from the TV (television) and digging in her skin on her leg. -The hold lasted "like no more than a good 4 minutes, she (FC #5) agreed to stop. I was talking to her to calm her down, trying to de-escalate her."</p> <p>Interview on 10/13/25 with the QP revealed: -"[Licensee/Director/CEO] does her IRIS reports and I only support when she gets overwhelmed. I do the internal incidents." -There have been no incidents "because we have only had one (client)."</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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	<p>Continued From page 111</p> <p>Interviews on 10/15/25 and 10/23/25 with the Licensee/Director/CEO revealed: -"We all do level I incident reports...QP and the board, me or [staff #1], it's a combination of all of us that report to IRIS...MCO (Local Management Entity/Manage Care Organization)." -Had no response for missing IRIS submissions. -Was not aware of restraints with FC #5. -Was not aware of late IRIS submissions. -"I'll need to look at that."</p> <p>This deficiency constitutes a re-cited deficiency.</p> <p>This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type B rule violation and must be corrected within 45 days.</p>	V 367		
V 536	<p>27E .0107 Client Rights - Training on Alt to Rest. Int.</p> <p>10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS</p> <p>(a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions.</p> <p>(b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented.</p> <p>(c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered.</p>	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 536	<p>Continued From page 112</p> <p>(d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.</p> <p>(e) Formal refresher training must be completed by each service provider periodically (minimum annually).</p> <p>(f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.</p> <p>(g) Staff shall demonstrate competence in the following core areas:</p> <ol style="list-style-type: none"> (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). 	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 536	<p>Continued From page 113</p> <p>(h) Service providers shall maintain documentation of initial and refresher training for at least three years.</p> <p>(1) Documentation shall include:</p> <p>(A) who participated in the training and the outcomes (pass/fail);</p> <p>(B) when and where they attended; and</p> <p>(C) instructor's name;</p> <p>(2) The Division of MH/DD/SAS may review/request this documentation at any time.</p> <p>(i) Instructor Qualifications and Training Requirements:</p> <p>(1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.</p> <p>(2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.</p> <p>(3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.</p> <p>(4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule.</p> <p>(5) Acceptable instructor training programs shall include but are not limited to presentation of:</p> <p>(A) understanding the adult learner;</p> <p>(B) methods for teaching content of the course;</p> <p>(C) methods for evaluating trainee performance; and</p> <p>(D) documentation procedures.</p> <p>(6) Trainers shall have coached experience teaching a training program aimed at preventing,</p>	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 536	<p>Continued From page 115</p> <p>facility failed to ensure 2 of 6 paraprofessional staff (#3, and #4), received initial training in alternatives to restrictive interventions. The findings are:</p> <p>Review on 10/8/25 of staff #3's personnel record revealed: -Hired 9/2/25. -Received initial training in Adaptive De-escalation Alternatives to restrictive interventions 9/7/25.</p> <p>Review on 10/8/25 of staff #4's personnel record revealed: -Hired 9/8/25. -No documentation of initial training in alternatives to restrictive intervention.</p> <p>Attempted interview on 10/15/25 with staff #3 was unsuccessful due to no call back prior to survey exit.</p> <p>Interview on 10/14/25 with staff #4 revealed: -Had not had de-escalation training. -Had "never used restraints, have not had the training; they (facility) are supposed to be setting up training. I don't need the training. At this moment I don't do restraints because they (clients) don't give me a problem."</p> <p>Interview on 10/8/25 with the Licensee/Director/CEO revealed: -Her husband (staff #1) did her initial training in Adaptive De-escalation Alternatives to restrictive interventions, "no, he did not have the instructor training." -Was not aware that staff #4 did not have documentation for initial training in alternatives to restrictive interventions, "I will get that for you."</p>	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RENEWED BEGINNINGS HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13113 LAKEMORE DRIVE CHARLOTTE, NC 28278
--	--

(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 536	<p>Continued From page 116</p> <p>No documentation of staff #4's initial training in alternatives to restrictive interventions was submitted prior to survey exit.</p> <p>This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type B rule violation and must be corrected within 45 days.</p>	V 536		