Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601625	A. BUILDING: ______ B. WING ______	C 11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIVING HOPE FOR ALL	3715 HUBBARD ROAD CHARLOTTE, NC 28269

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint survey was completed on 11/4/25. The complaint was unsubstantiated (intake #NC00233939). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for 6 and has a current census of 4. The survey sample consisted of audits of 1 former client.	V 000		
V 364	G.S. 122C- 62 Additional Rights in 24 Hour Facilities § 122C-62. Additional Rights in 24-Hour Facilities. (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: (1) Send and receive sealed mail and have access to writing material, postage, and staff assistance when necessary; (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 (3) Contact and consult with a client advocate if there is a client advocate. 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. (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:	V 364		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: QP/Director | (X6) DATE: 11-29-25

RECEIVED
DEC 02 2025
DHSR-MH Licensure Sect

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601625	A. BUILDING: ______ B. WING ______	C 11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIVING HOPE FOR ALL	3715 HUBBARD ROAD CHARLOTTE, NC 28269

(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	Continued From page 1 (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; (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; (3) Communicate and meet under appropriate supervision with individuals of his own choice upon the consent of the individuals; (4) Make visits outside the custody of the facility unless: a. Commitment proceedings were initiated as the result of the client's being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found not guilty by reason of insanity or incapable of proceeding; 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 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; (5) Be out of doors daily and have access to facilities and equipment for physical exercise several times a week; (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; (7) Participate in religious worship; (8) Keep and spend a reasonable sum of his	V 364		

PLAN OF CORRECTION
Deficiency V364 – G.S. 122C-62 – Additional Rights in 24-Hour Facilities: Confidential Telephone Calls

Facility Name: Giving Hope For All

License/ID Number: MHL-606-1625

Survey Date(s): 11-04-2025

Date Plan of Correction Submitted: 11-30-2025

STATEMENT OF DEFICIENT PRACTICE:

During the survey, several residents reported that their phone calls were placed on speaker by staff. Residents are entitled to make and receive confidential telephone calls. Supervision requires staff to remain within proximity of the resident, not to listen to calls unless clinically necessary. Use of speakerphone compromised residents' rights to confidential communication.

1. Corrective Action to Be Accomplished for Those Clients Found to Have Been Affected by the Deficient Practice:

- Effective immediately on 11/20/2025, all staff were verbally re-educated regarding residents' rights to confidential telephone calls per G.S. 122C-62.
- Staff were instructed to discontinue placing resident calls on speakerphone unless there is a documented clinical or safety need specified in the resident's service plan/treatment plan.
- Residents were met with individually by the Qualified Professional (QP) to explain their rights and to ensure they are aware that future calls will be handled confidentially.

2. Measures/Systemic Changes to Ensure the Deficient Practice Will Not Recur:

- The facility's written Telephone Use Policy was revised on 11/29/2025 to include the following:
  - Resident telephone calls shall be conducted in a manner that protects confidentiality.
  - Staff supervision of calls shall occur by remaining within visual proximity of the resident, not by listening to or placing calls on speakerphone.
  - Speakerphone may only be used when there is a documented clinical or safety need and this is reflected in the resident's service plan/treatment plan and progress notes.
- All current staff will receive in-service training on the revised Telephone Use Policy and residents' rights under G.S. 122C-62 no later than 12/10/2025. Attendance will be documented with a sign-in sheet.
- The revised policy and training content will be incorporated into New Employee Orientation so that all newly hired staff receive this training prior to working independently on the floor.

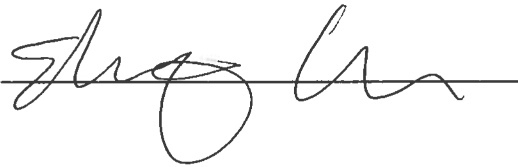
- A Resident Phone Privacy Protocol and Phone Sign-In/Sign-Out Log have been implemented. The log will be used for each resident call and will document: date, time out/time returned, type of call, supervising staff, and confirmation that speakerphone was not used.

3. Monitoring to Ensure the Deficient Practice Is Corrected and Will Not Recur:

- The Program Director/QP will review the Phone Sign-In/Sign-Out Log weekly for eight (8) weeks to verify that speakerphone is not being used except as clinically justified and documented.
- Shift Supervisors will perform and document at least two (2) random observations per week for eight (8) weeks of supervised resident calls to ensure calls are conducted confidentially and in accordance with policy.
- Residents' perceptions of phone privacy will be assessed at monthly community meetings and during individual check-ins. Any concerns reported will be addressed immediately and documented.
- After the initial eight-week period, if compliance is maintained at 100%, monitoring of phone logs and random observations will continue on a monthly basis as part of the facility's ongoing Quality Assurance/Performance Improvement (QA/PI) process.

4. Title of Person Responsible for Implementing and Monitoring the Corrective Actions:

- The Program Director/Qualified Professional (QP) is responsible for implementation of this Plan of Correction and ongoing monitoring.
- Shift Supervisors are responsible for daily oversight of staff adherence to the Telephone Use Policy and for completing documented observations as outlined above.

Administrator/Program Director Signature: 

Date: 11-29-2025

PLAN OF CORRECTION
Deficiency V366 – 27G .0603 Incident Response Requirements

Facility Name: Giving Hope For All

License/ID Number: MHL-606-1625

Survey Date(s): 11-04-2025

Date Plan of Correction Submitted: 11-30-2025

STATEMENT OF DEFICIENT PRACTICE:

Based on records review and interviews, the facility failed to implement required written policies for Level I and II incident response. There was no documentation showing the facility: addressed health and safety needs, identified causes, implemented corrective and preventive measures, or assigned responsible staff.

1. Corrective Action to Be Accomplished for Those Clients Found to Have Been Affected by the Deficient Practice:

• The Director/QP completed retroactive Incident Reports and Root Cause Analyses for identified incidents.

• Residents involved were assessed for ongoing safety concerns.

• Incident documentation was updated to include cause determination, corrective actions, preventive measures, and assigned responsible staff.

• Residents received follow-up support regarding emotional impact.

2. Measures/Systemic Changes to Ensure the Deficient Practice Will Not Recur:

• The Incident Response and Reporting Policy has been revised to comply with 27G .0603, including required RCA, corrective measures, staff assignment, and timelines.

• A standardized Incident Report & RCA Form will be completed exclusively by the Director/QP.

• DSPs must provide factual verbal information only.

• Mandatory training will be provided on:

  – Incident definitions (Level I, II, III)

  – DSP reporting expectations

  – Director/QP documentation responsibilities

– Root Cause Analysis

– Corrective and preventive action planning.

3. Monitoring to Ensure the Deficient Practice Is Corrected and Will Not Recur:

• Daily: DSPs notify Director/QP of incidents; Director/QP completes safety response & documentation.

• Weekly: QP reviews all incident reports and RCAs for accuracy.

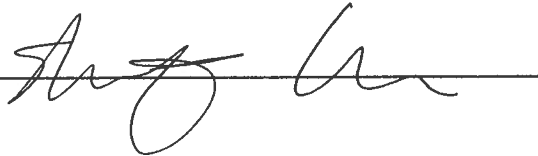
• Monthly: Program Director reviews incident trends and evaluates corrective/preventive measures.

• Quarterly: QA audit conducted by Program Director.

• Monitoring continues until six months of full compliance are demonstrated.

4. Title of Person Responsible for Implementing and Monitoring the Corrective Actions:

- The Program Director/Qualified Professional (QP) is responsible for implementation of this Plan of Correction and ongoing monitoring.

Administrator/Program Director Signature: 
Date: 11-29-25

PLAN OF CORRECTION
Deficiency V367 – 27G .0604 Incident Response Requirements

Facility Name: Giving Hope For All

License/ID Number: MHL-606-1625

Survey Date(s): 11-04-2025

Date Plan of Correction Submitted: 11-30-2025

STATEMENT OF DEFICIENT PRACTICE:

Based on record reviews and staff interviews, the facility failed to report all Level II incidents in the North Carolina Incident Response Improvement System (IRIS) within 72 hours of becoming aware of the incident. Giving Hope For All did not submit incident reports as required. The Director/QP is responsible for completing and submitting all incident reports.

1. Corrective Action to Be Accomplished for Those Clients Found to Have Been Affected by the Deficient Practice:

- The Director/QP reviewed all past incidents identified by DHSR and immediately submitted any missing Level II IRIS reports.
- Residents were assessed for ongoing safety concerns.
- Follow-up support was provided to involved residents.
- Late submissions were documented with clarifying information.

2. Measures/Systemic Changes to Ensure the Deficient Practice Will Not Recur:

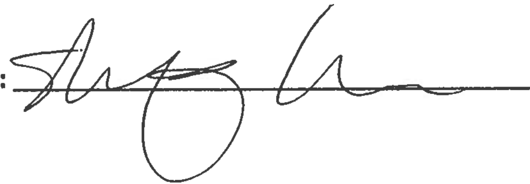
- Updated Incident Reporting and IRIS Submission Policy requiring Level II incidents to be submitted within 72 hours.
- Only the Director/QP completes IRIS submissions; DSPs notify immediately.
- Implementation of an IRIS Submission Tracking Log documenting awareness time and submission time.
- Staff training on incident identification, reporting expectations, and 72-hour IRIS rule.
- Backup Administrator assigned if Director/QP is off-site.

3. Monitoring to Ensure Ongoing Compliance:

- Daily: DSPs notify Director/QP; Director/QP reviews need for IRIS submission.
- Weekly: Director/QP audits IRIS Submission Log.
- Monthly: Program Director conducts IRIS compliance review.
- Quarterly: IRIS timeliness included in QA audit.
- Monitoring continues until six consecutive months of compliance.

4. Title of Person Responsible for Implementing and Monitoring the Corrective Actions:

- The Program Director/Qualified Professional (QP) is responsible for implementation of this Plan of Correction and ongoing monitoring.

Administrator/Program Director Signature: 

Date: 11-29-2025

PLAN OF CORRECTION
Deficiency V500 – 27D .0101(a-e) – Client Rights – Policy on Rights

Facility Name: Giving Hope For All

License/ID Number: MHL-606-1625

Survey Date(s): 11-04-2025

Date Plan of Correction Submitted: 11-30-2025

STATEMENT OF DEFICIENT PRACTICE:

Based on record review and interviews, the facility failed to ensure that all incidents of alleged abuse were reported to the county DSS as required.

1. Corrective Action to Be Accomplished for Those Clients Found to Have Been Affected by the Deficient Practice:

- The Program Director/QP reviewed all allegations identified by DHSR and ensured DSS was notified.
- Residents were reassessed for safety.
- Follow-up communication was provided to DSS for any unresolved matters.
- The alternate reporter was removed from reporting responsibilities.

2. Measures/Systemic Changes to Ensure the Deficient Practice Will Not Recur:

- The Abuse, Neglect, Exploitation Reporting Policy was updated.
- Only the Program Director/QP may make DSS reports.
- DSPs must immediately notify the Director/QP of allegations.
- Mandatory Reporting Checklist created.
- Training will be provided to all staff no later than 12/10/2025.

3. Monitoring to Ensure the Deficient Practice Is Corrected and Will Not Recur:

- 24/7 reporting protocol implemented.
- Reporting Log created to track allegation status.
- 72-hour DSS update rule implemented.
- Internal audits cross-check incident and DSS documentation.

4. Monitoring To Ensure Ongoing Compliance:

• Daily: Director/QP reviews shift logs for concerns.

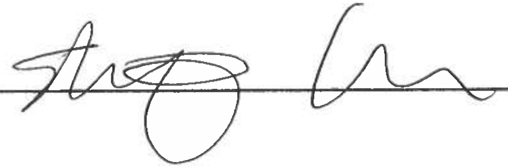
• Weekly: Program Director reviews Reporting Log.

• Monthly: Mandatory Reporting Compliance Review.

• Quarterly: QA audit of all reporting activity.

4. Title of Person Responsible for Implementing and Monitoring the Corrective Actions:

- The Program Director/Qualified Professional (QP) is responsible for implementation of this Plan of Correction and ongoing monitoring.

Administrator/Program Director Signature: 

Date: 11-29-25

PLAN OF CORRECTION
Deficiency V503 – 27D .0103– Client Rights – Search and Seizure Policy

Facility Name: Giving Hope For All

License/ID Number: MHL-606-1625

Survey Date(s): 11-04-2025

Date Plan of Correction Submitted: 11-30-2025

STATEMENT OF DEFICIENT PRACTICE:

Based on record review and interviews, the facility failed to ensure that every search or seizure was documented as required. Searches were conducted without completing the mandatory documentation.

1. Corrective Action to Be Accomplished for Those Clients Found to Have Been Affected by the Deficient Practice:

- The Program Director/QP reviewed all undocumented searches and completed Search Documentation Forms.
- Residents involved were reassessed for safety and rights awareness.
- Staff responsible were immediately re-educated on search procedures and documentation requirements.

2. Measures/Systemic Changes to Ensure the Deficient Practice Will Not Recur:

- Search & Seizure Policy was revised.
- Only safety-based searches permitted.
- Standard Search Documentation Form created.
- DSPs must notify Director/QP before searches unless safety requires immediate action.
- Comprehensive staff training implemented.

3. Monitoring to Ensure the Deficient Practice Is Corrected and Will Not Recur:

- Search Documentation Log created.
- Daily shift checklist updated to include search verification.
- Two-step Director/QP verification: daily form check + shift log check.

4. Monitoring to Ensure Ongoing Compliance:

• Daily: Director/QP reviews shift logs and search forms.

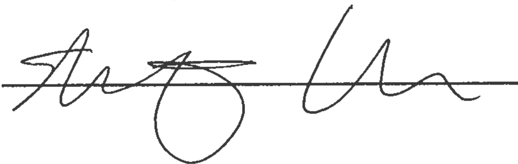
• Weekly: Audit of Search Documentation Log.

• Monthly: Search & Seizure Compliance Review.

• Quarterly: QA audit of search practices.

5. Title of Person Responsible for Implementing and Monitoring the Corrective Actions:

- The Program Director/Qualified Professional (QP) is responsible for implementation of this Plan of Correction and ongoing monitoring.

Administrator/Program Director Signature: 

Date: 11-29-2025