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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 12/10/25. The complaints were unsubstantiated (intake #NC00233701 and #NC00234816). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children and Adolescents. This facility is licensed for 4 and has a current census of 4. The survey sample consisted of audits of 4 current clients.	V 000		
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present and one shall be awake for one through four	V 296		

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children or adolescents;
(2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and
(3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents.
(d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan.
(e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan.

This Rule is not met as evidenced by:
Based on observation, record reviews, and interviews the facility failed to ensure the minimum staffing ratio of two staff for up to four adolescents. The findings are:

Observation on 12/1/25 of the facility at approximately 3:12pm revealed:
-Licensee/Executive Director/Associate Professional (Licensee/ED/AP) arrived at the facility driving a van alone with three clients (clients #1 #2, #4).

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V 296	Continued From page 2 -No other staff was in the van. Review on 11/18/25 of client #1's record revealed: -Age 16 years old. -Admitted 5/9/25. -History of Self Injurious Behaviors (SIBs), trauma. -Diagnoses: Post Traumatic Stress Disorder (PTSD), With Derealization Symptoms; Major Depressive Disorder (MDD), Recurrent Episode, in Partial Remission. Review on 11/18/25 of client #2's record revealed: -Age 14 years old. -Admitted 3/25/25. -History of aggression, SIBs. -Diagnoses: Adjustment Disorder, with Mixed Disturbance of Emotions and Conduct; Other Trauma and Stressor-Related Disorder; Major Depressive Disorder, Recurrent Episode, Severe, Without Psychotic Features. Review on 11/18/25 of client #3's record revealed: -Age 13 years old. -Admitted 4/8/25. -Discharged 11/17/25. -History of aggression, SIBs. -Diagnoses: Attention Deficit Hyperactivity Disorder (ADHD), Combined Presentation; Oppositional Defiant Disorder (ODD); Unspecified Anxiety Disorder; Unspecified Trauma and Stress Related Disorder; Unspecified Depressive Disorder; Unspecified Disruptive, Impulse and Conduct Disorder. Review on 11/24/25 of client #4's record revealed -Age 14 years old. -Admitted 8/15/25. -History of SIBs, elopement, aggression. -Diagnoses: ADHD, combined presentation;	V 296		

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PTSD; ODD; MDD, Single Episode, Moderate.

Interview on 12/1/25 with client #1 revealed:
-Two staff worked in the morning, "sometimes one (staff) if someone has a family emergency."
-Two staff worked at night.
-Two staff transported "coming from school the two staff are [staff #1] and [staff #3]."
-The "only staff that had worked alone was when [staff #3] was going to get his dog (date unknown) and we (clients) stayed in the car while he got his dogs. We were in the car a few minutes. He (staff #3) lives in an apartment, so it doesn't take long."
-Two staff transported clients, "[Licensee/ED/AP] picks us up (from school) alone, but he counts as two people."

Interview on 12/1/25 with client #2 revealed:
-Two staff worked in the morning "when awake, two staff coming home from school, two staff at night."
-There had never been a time when staff worked a shift alone or a time when one staff was running late for a shift.
-One staff transported.
-"If there is something important going on and [Licensee/ED/AP] had to run out and get something, one staff would be here."

Interview on 12/1/25 with client #3 revealed:
-"Sometimes one" staff worked on shift, "sometimes two, usually at night or sometimes in the morning there would be one staff."
-He (Licensee/ED/AP) wasn't in the facility for one of the fights (date unknown) and he was laughing on the phone over the camera (facility); he was laughing at the situation of me crashing out.

Attempted interview on 12/1/25 with client #4

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revealed:
-Didn't want to talk.
-Refused to be interviewed.

Attempted interview on 12/9/25 with staff #1 unsuccessful due to no callback prior to survey exit.

Interview on 12/5/25 with the AP revealed:
-Two staff worked each shift, two staff at bedtime, two staff in the morning and no one staff working alone.
-Two staff transported clients and "yes, there are times when staff will transport alone and one staff is at the home (facility)."

Interview on 12/2/25 with the Qualified Profession revealed:
-Two staff worked on each shift.
-"I don't know if staff has worked a shift alone."
-When at the facility two staff worked, "so I can't say if they (facility) have or haven't (worked alone); to my knowledge there are two (staff) when clients are sleeping, but I'm not there on night shift."
-All staff provided transportation and Licensee/ED/AP assisted with transportation to doctor's appointments.
-"I don't know if one staff transport or not. I don't want to give false information, I don't know."

Interviews on 11/18/25 and 12/4/25 with the Licensee/ED/AP revealed:
-Was not aware that the minimum staffing ratio applied to transporting clients in the community.
-Two staff worked each shift.
-There was not a time when staff worked a shift alone.
-"I was in the car with that one incident...that was sometime in November (2025)...staff [staff #1]

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V 296	Continued From page 5 was present, it was a fight (clients #2 and #3)...I was in the car and i was not in the house." -Staff used the van for transportation and two staff "regularly transport, but there is times when one staff will transport clients, that happens very infrequently."	V 296		
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: (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	V 364		

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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 own money;
(9) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes; and
(10) Have access to individual storage space for his private use.

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(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, 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.
Each minor client who is receiving treatment or habilitation from a 24-hour facility has the right to:
(1) Communicate and consult with his parents or guardian or the agency or individual having legal custody of him;
(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
(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 minor client may exercise these rights at all reasonable times.
(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

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the right to:
(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;
(2) Send and receive mail and have access to writing materials, postage, and staff assistance when necessary;
(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 hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over school or therapies;
(4) Receive special education and vocational training in accordance with federal and State law;
(5) Be out of doors daily and participate in play, recreation, and physical exercise on a regular basis in accordance with his needs;
(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;
(7) Participate in religious worship;
(8) Have access to individual storage space for the safekeeping of personal belongings;
(9) Have access to and spend a reasonable sum of his own money; and
(10) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes.
(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

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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 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.

This Rule is not met as evidenced by:
Based on observation, record reviews and interviews the facility failed to ensure client rights to privacy in a 24 hour facility affecting 3 of 4 current clients. The findings are:

Observation at the facility on 12/1/25 at approximately 4:04pm revealed:
-The survey interview was interrupted when the Licensee/Executive Director/Associated Professional (Licensee/ED/AP) entered the

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bedroom of client #1 without knocking.
-Client #1 stopped talking.
-The Licensee/ED/AP upon entering client #1's bedroom stated, "I think this belongs to you", placed a light brown folder on the top of client's dresser, and exited client #1's bedroom.
-Client #1 resumed speaking.

Review on 11/18/25 of client #1's record revealed:
-Age 16 years old.
-Admitted 5/9/25.
-Diagnoses: Post Traumatic Stress Disorder (PTSD), With Derealization Symptoms; Major Depressive Disorder (MDD), Recurrent Episode, in Partial Remission.

Review on 11/18/25 of client #2's record revealed:
-Age 14 years old.
-Admitted 3/25/25.
-Diagnoses: Adjustment Disorder, with Mixed Disturbance of Emotions and Conduct; Other Trauma and Stressor-Related Disorder; Major Depressive Disorder, Recurrent Episode, Severe, Without Psychotic Features.

Review on 11/18/25 of client #3's record revealed:
-Age 13 years old.
-Admitted 4/8/25.
-Discharged 11/17/25.
-Diagnoses: Attention Deficit Hyperactivity Disorder (ADHD), Combined Presentation; Oppositional Defiant Disorder (ODD); Unspecified Anxiety Disorder; Unspecified Trauma and Stress Related Disorder; Unspecified Depressive Disorder; Unspecified Disruptive, Impulse and Conduct Disorder.

Review on 11/24/25 of client #4's record revealed
-Age 14 years old.
-Admitted 8/15/25.

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-Diagnoses: ADHD, combined presentation; PTSD; ODD; MDD, Single Episode, Moderate.

Interview on 12/1/25 with client #1 revealed:
-Able to make phone calls, "staff is there with me, they sometimes supervise us (clients); it's (phone call) not on speaker, it can be on speaker if they (staff) want it to be or if we (clients) want it to be."
-Saw the therapist twice weekly and was able to get a session when she wanted one.
-Was able to talk with the therapist privately.
-Staff had come in her bedroom "because of the bathroom and because they (staff) have to check on us (clients). Sometime, I ask them (staff) to come in (bedroom)."

Interview on 12/1/25 with client #2 revealed:
-Phone calls were made with staff present, but were not placed on speaker.
-Had therapy twice weekly and "it's private."
-Staff would sometimes come in the session, "just in case I need them (staff), I ask them , and when they come in I get more support for me and I feel comfortable."

Interview on 12/1/25 with client #3 revealed:
-"Hardly ever was able to make calls because they (staff) would say 'no, you have to do this or that' and I didn't get the calls the court said I was supposed to get."
-The "court" said she could get thirty minutes phone calls and usually only got five to ten minutes of phone time.
-"They (staff) were sitting on the couch beside me but the call was not on speaker."
-Staff had walked into her therapy sessions.
-"The therapy session was in my room (bedroom) and the staff would walk in and I would ask them to leave and they wouldn't leave. Usually it was [Licensee/Executive Director/Associate

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Professional (Licensee/ED/AP)] and he would sit down and start talking, that would make me stop talking because he was in there (therapy session) and I wouldn't talk at all; the therapist wouldn't say anything they would just talk together, the therapist was [Licensed Professional (LP)]."

Attempted interview on 12/1/25 with client #4 revealed:
-Didn't want to talk.
-Refused to be interviewed.

Interview on 11/21/25 with client #3's Department of Social Services Social Worker (DSS SW) revealed:
-The facility's discipline plan "directly violated court orders that mandated" client #3 have phone and video calls with her legal guardian/mother (LG/mother) "as frequently as possible...these calls included her siblings as well."
-Client #3 had reported requests to call the DSS SW and the facility denied her requests.
-The facility's "unwillingness to comply with contact (phone)...made them come across as unwilling to cooperate with permanency planning and reunification efforts."

Attempted interview on 12/9/25 with staff #1 unsuccessful due to no callback prior to survey exit.

Interview on 12/5/25 with the AP revealed:
-Phone calls were monitored by staff.
-"We (staff) sit with them (clients), they (clients) are also in front room (living room) with staff when they (client) make the call; they are able to call within thirty minutes of request (to make a call)."

Attempted interview on 12/5/25 with the LP was

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unsuccessful due to no callback prior to survey exit.

Interview on 12/4/25 with the Licensee/ED/AP revealed:
-In November 2025 client #3 was upset and requested to call her LG/mother.
-In response to client #3's request to call her LG/mother, "staff replied they (staff) would call, but she (client #3) needed to do her chores because that is the structure, for phone calls to happened after chores."

Interview on 12/9/25 with the Licensee/ED/AP revealed:
-The facility had a behavior point system that restricted client privileges and restriction of phones use was not included.
-Client #3 had been able to call whenever she wanted to make calls.
-"We (facility) don't allow phone calls until after chores are done; that is to everyone that is not as necessary as the legal guardian, like an aunt or cousin, then they (clients) had to finish chores before call them (non-essential family).
-Client #3's commands for staff to call her LG/mother resulted in client #3's regressed behaviors.
-Client #3 wanted to call her LG/mother on 11/13/25, made the request of staff and the request was not granted, "we (staff) felt she (client #3) was manipulating."
-Phone calls were not monitored, "but we only monitor with DSS permission and DSS gave us permission to monitor calls with [client #3]'s LG/mother."
-"Clients definitely have privacy for calls, we (staff) just monitor them (clients) by line of sight so nothing bad happens. We don't put calls on speaker."

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V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by:	V 366		

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(1) immediately securing the client record by:
(A) obtaining the client record;
(B) making a photocopy;
(C) certifying the copy's completeness; and
(D) transferring the copy to an internal review team;
(2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:
(A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;
(B) gather other information needed;
(C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and
(D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the

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LME may give the provider an extension of up to three months to submit the final report; and
(3) immediately notifying the following:
(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;
(B) the LME where the client resides, if different;
(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;
(D) the Department;
(E) the client's legal guardian, as applicable; and
(F) any other authorities required by law.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to implement written policies governing their response to level I, II incidents affecting 4 of 4 current clients. The findings are:

Review on 11/24/25 of the facility's internal incident reports revealed:
-9/2/25, client #4 self-injurious behaviors (SIBs).
-9/7/25, client #4 attempted to take vacuum cord from client #3 and in the tugging back and forth client #4 tripped over the vacuum.
-9/11/25, client #3 bruised arm at playground.
-9/18/25, client #3 SIBs.
-9/18/25, client #4 SIBs.
-9/20/25, client #3 SIBs
-9/21/25, client #3 and client #4 were verbally

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arguing, client #4 hit client #3 resulting in a physical altercation. Client #2 joined client #4 in fighting client #3.
-9/21/25, client #4 SIBs.
-9/22/25, client #2 aggressive behavior, restraint.
-9/29/25, verbal altercation between client #4 and client #3, client #4 threw a shoe hitting client #3 in the face, resulting in a physical altercation.
-10/15/25, clients #1, #3, and #3 engaged in "consenting kissing behavior."
-10/20/25, "During [client #4]'s medication-management appointment, the client became visibly distressed when discussion turned towards incident or trauma-related history. The client abruptly exited the provider's office without permission. Staff (Licensee/Executive Director/Associate Professional (Licensee/ED/AP)) followed and observed the client retrieving a bottle of alcohol from an outdoor area and briefly consuming some of it (alcohol). Staff immediately intervened, secured the bottle, and transported the client to the local emergency department for evaluation per facility protocol. the client was medically cleared and received no treatment. No injuries or further behavioral escalation occurred. The client returned safely to the facility, where staff provided support and reviewed coping strategies.
-10/29/25, client #4 aggressive behavior, destruction of property, bit finger of staff, restraint
-No documentation for physical between client #3 and client #2 on 11/13/25.

Review on 12/10/25 of the facility's restrictive intervention log revealed:
Restrictive interventions had been performed on the following dates:
-8/8/25, client #2 was physically aggressive toward a peer (unknown).
-9/21/25, client #4 became physically aggressive

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with peer (client #3).
-9/21/25, client #2 became physically aggressive with a peer (client #3).
-9/22/25, client #2 engaged in unsafe property destruction and physical aggression.
-9/29/25, client #4 became physically aggressive with a peer (client #3).
-10/29/25, client #4 engaged in property destruction and became physically aggressive with staff (Associate Professional).
-11/7/25, client #4 escalated from verbal aggression into self-harming.
-11/14/25, client #3 became verbally aggressive and engaged in property destruction.

Review on 11/14/25 of the North Carolina Incident Response Improvement System (NC IRIS) revealed:
-8/11/25 client #1, physical aggression, elopement.
-8/20/25 client #1, elopement.
-9/2/25 client #3 elopement, law enforcement contacted and client #3 allegation that bruise on her arm from 8/28/25 altercation with a peer was caused by the Licensee/ED/AP grabbing her.
-10/10/25 client #4 physical aggression, destruction of property, elopement, suicidal ideation (SI), law enforcement contacted.
-10/18/25, client #2 elopement.
-11/6/25 client #4 SIBs, SI, destruction of property, law enforcement contacted.
-11/13/25 client #3 destruction of property, law enforcement contacted.
-No level ll incident report for client #3 bruising her arm at the playground on 9/11/25.
-No level ll incident reports for the physical aggression of client #4 on client #3 on 9/21/25 and 9/29/25.
-No level ll incident reports for the physical aggression of client #4 and client #2 on client #3

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on 9/21/25.
-No level ll incident report for client #4 observed retrieving a bottle of alcohol from an outdoor area and consuming it on 10/20/25.
-No level ll incident report for physical aggression between client #3 and client #2, when law enforcement was called on 11/13/25.
-No level ll incident reports for restraints performed on 8/8/25, 9/21/25, 9/22/25, 9/29/25, 10/29/25, 11/7/25 and 11/14/25.

Interview on 12/5/25 with the AP revealed:
-Staff on duty complete internal incident reports.
-"[Licensee/ED/AP] does IRIS."

Interview on 12/2/25 with the Qualified Professional revealed:
-"[Licensee/ED/AP] is responsible for reporting in IRIS."
-Internal incident reports were completed by staff involved "then the IRIS report is completed by [Licensee/ED/AP] most of the time."

Interview on 12/4/25 with the Licensee/ED/AP revealed:
-"I believe" the AP is responsible for IRIS reporting, "but when she is not available I help."
-Did not think that the client aggression should be submitted as a level ll report in IRIS.
-Thought level II incidents were reported in IRIS if law enforcement was called or if clients received treatment at the hospital.
-Had not documented risk cause analysis to describe how the facility attended to the health and safety needs of clients involved, determined the cause of the incident, developed and implemented measures to prevent similar incidents or assigned person(s) responsible for implementation of the corrective and preventive measures.

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V 367	27G .0604 Incident Reporting Requirements	V 367		

10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS

(a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:

(1) reporting provider contact and identification information;
(2) client identification information;
(3) type of incident;
(4) description of incident;
(5) status of the effort to determine the cause of the incident; and
(6) other individuals or authorities notified or responding.

(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:

(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.

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(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).
(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:
(1) medication errors that do not meet the definition of a level II or level III incident;
(2) restrictive interventions that do not meet 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

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(a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to report all level II incidents in the Incident Response Improvement System (IRIS) and failed to notify the the Local Management Entity (LME)/ Managed Care Organization (MCO) responsible for the catchment area where services are provided within 24 hours and 72 hours of becoming aware of the incident. The findings are:

Review on 11/24/25 of the facility's internal incident reports revealed:
-9/2/25, client #4 self-injurious behaviors (SIBs).
-9/7/25, client #4 attempted to take vacuum cord from client #3 and in the tugging back and forth client #4 tripped over the vacuum.
-9/11/25, client #3 bruised arm at playground.
-9/18/25, client #3 SIBs.
-9/18/25, client #4 SIBs.
-9/20/25, client #3 SIBs
-9/21/25, client #3 and client #4 were verbally arguing, client #4 hit client #3 resulting in a physical altercation. Client #2 joined client #4 in fighting client #3.
-9/21/25, client #4 SIBs.
-9/22/25, client #2 aggressive behavior, restraint.
-9/29/25, verbal altercation between client #4 and client #3, client #4 threw a shoe hitting client #3 in the face, resulting in a physical altercation.

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V 367	Continued From page 23 -10/15/25, clients #1, #3, and #3 engaged in "consenting kissing behavior." -10/20/25, "During [client #4]'s medication-management appointment, the client became visibly distressed when discussion turned towards incident or trauma-related history. The client abruptly exited the provider's office without permission. Staff (Licensee/Executive Director/Associate Professional (Licensee/ED/AP)) followed and observed the client retrieving a bottle of alcohol from an outdoor area and briefly consuming some of it (alcohol). Staff immediately intervened, secured the bottle, and transported the client to the local emergency department for evaluation per facility protocol. the client was medically cleared and received no treatment. No injuries or further behavioral escalation occurred. The client returned safely to the facility, where staff provided support and reviewed coping strategies. -10/29/25, client #4 aggressive behavior, destruction of property, bit finger of staff, restraint Review on 12/10/25 of the facility's restrictive intervention log revealed: Restrictive interventions had been performed on the following dates: -8/8/25, client #2 was physically aggressive toward a peer (unknown). -9/21/25, client #4 became physically aggressive with peer (client #3). -9/21/25, client #2 became physically aggressive with a peer (client #3). -9/22/25, client #2 engaged in unsafe property destruction and physical aggression. -9/29/25, client #4 became physically aggressive with a peer (client #3). -10/29/25, client #4 engaged in property destruction and became physically aggressive with staff (Associate Professional).	V 367		

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-11/7/25, client #4 escalated from verbal aggression into self-harming.
-11/14/25, client #3 became verbally aggressive and engaged in property destruction.

Review on 11/14/25 of the North Carolina Incident Response Improvement System (NC IRIS) revealed:
-No documentation of a level II report submitted for client #3 bruising her arm at the playground on 9/11/25.
-No documentation of a level II report submitted the physical aggression of client #4 on client #3 on 9/21/25 and 9/29/25.
-No documentation of a level II report submitted for the physical aggression of client #4 and client #2 on client #3 on 9/21/25.
-No documentation of a level II report submitted for client #4 observed retrieving a bottle of alcohol from an outdoor area and consuming it on 10/20/25.
-No documentation of a level II report submitted for physical aggression between client #3 and client #2, when law enforcement was called on 11/13/25.
-No documentation of a level II report submitted for restraints performed on 8/8/25, 9/21/25, 9/22/25, 9/29/25, 10/29/25, 11/7/25 and 11/14/25.

Interview on 12/5/25 with the AP revealed:
-Staff on duty complete internal incident reports.
-"[Licensee/ED/AP] does IRIS."

Interview on 12/2/25 with the Qualified Professional revealed:
-"[Licensee/ED/AP] is responsible for reporting in IRIS."
-Internal incident reports were completed by staff involved "then the IRIS report is completed by [Licensee/ED/AP] most of the time."

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V 367	Continued From page 25 Interview on 12/4/25 with the Licensee/ED/AP revealed: -"I believe" the AP is responsible for IRIS reporting, "but when she is not available I help." -Did not think that the client aggression should be submitted as a level II report in IRIS. -Did not report in IRIS for client aggression "because any aggressive or destructive act that does not require police constitutes level I." -Understood "threat to health and safety" as "like I am profusely bleeding or can't walk." -Thought level II incidents were reported in IRIS if law enforcement was called or if clients received treatment at the hospital. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 367		
V 521	27E .0104(e9) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (9) Whenever a restrictive intervention is utilized, documentation shall be made in the client record to include, at a minimum: (A) notation of the client's physical and psychological well-being; (B) notation of the frequency, intensity and duration of the behavior which led to the intervention, and any precipitating circumstance contributing to the onset of the behavior; (C) the rationale for the use of the intervention, the positive or less restrictive interventions	V 521		

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considered and used and the inadequacy of less restrictive intervention techniques that were used;
(D) a description of the intervention and the date, time and duration of its use;
(E) a description of accompanying positive methods of intervention;
(F) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate or reduce the probability of the future use of restrictive interventions;
(G) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if determined to be clinically necessary; and
(H) signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention.

This Rule is not met as evidenced by:
Based on record reviews and interview, the facility failed to ensure the necessary documentation was in the client record when a restrictive intervention was utilized affecting 4 of 4 current clients. The findings are:

Review on 11/18/25 of client #1's record revealed:
-Age 16 years old.
-Admitted 5/9/25.
-Diagnoses: Post Traumatic Stress Disorder (PTSD), With Derealization Symptoms; Major Depressive Disorder (MDD), Recurrent Episode, in Partial Remission.

Review on 11/18/25 of client #2's record revealed:
-Age 14 years old.

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-Admitted 3/25/25.
-Diagnoses: Adjustment Disorder, with Mixed Disturbance of Emotions and Conduct; Other Trauma and Stressor-Related Disorder; Major Depressive Disorder, Recurrent Episode, Severe, Without Psychotic Features.

Review on 11/18/25 of client #3's record revealed:
-Age 13 years old.
-Admitted 4/8/25.
-Discharged 11/17/25.
-Diagnoses: Attention Deficit Hyperactivity Disorder (ADHD), Combined Presentation; Oppositional Defiant Disorder (ODD); Unspecified Anxiety Disorder; Unspecified Trauma and Stress Related Disorder; Unspecified Depressive Disorder; Unspecified Disruptive, Impulse and Conduct Disorder.

Review on 11/24/25 of client #4's record revealed
-Age 14 years old.
-Admitted 8/15/25.
-Diagnoses: ADHD, combined presentation; PTSD; ODD; MDD, Single Episode, Moderate.

Review on 11/24/25 of the facility's internal incident reports revealed:
-9/22/25, "Around about 6:30pm, staff instructed everyone in the house (facility) to return items that were given to others to share. During the process of the exchange, [client #2] grew upset that she had to return things. She (client #2) started to throwing the items, which resulted in staff intervening again and ask for the things to be given directly to staff. She (client #2) grew more agitated saying she wanted to fight other clients. Staff restrained [client #2] and asked others to go into their rooms. Staff restrained [client #2] until she calmed down (under 1 min (minute)). Once she was calm, we (staff) spoke

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V 521	Continued From page 28 with her about her actions and she apologized. Follow up action [client #2] placed on red (behavior point) until October (2025). Staff continue to monitor client and ensured a safe environment." -10/29/25, "Staff informed [client #4] that it was time for his scheduled therapy session. [Client #4] appeared agitated and frustrated from an earlier situation at school. When reminded about therapy, he stated he did not want to participate and requested ten additional minutes. Staff allowed this extension, but when the time elapsed and therapy was prompted again, [client #4] became more irritable and defiant, asking for another ten minutes. Staff and the therapist attempted to verbal de-escalation the client by calmly engaging [client #4], checking in about his emotions, and offering supportive statements. [Client #4] responded by raising his voice, saying, 'Get the hell out of my room,' and slammed his bedroom door. Staff continued using a calm tone and encouraged him to utilize his resources and discuss his feelings. At that point, [client #4] became physically aggressive, charging toward Staff and throwing her (staff) laptop onto the floor, causing property damage. Staff assessed that [client #4] was escalating toward unsafe behaviors and that his actions posed a risk of harm to himself and others. Given [client #4]'s known history of head-banging and self-harm when upset, Staff initiated a therapeutic hold in accordance with [restrictive training provider] protocol to ensure client safety. During the hold, [client #4] bit Staff's finger (causing visible bite marks) but no break in the skin. Staff maintained composure, ensured [client #4]'s airway and body were safe, and released the hold as soon as [client #4] de-escalated. [Client #4] then ran to the garage area to calm down, where he later re-entered the home (facility) and apologized to	V 521		

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Staff for his behavior."

Review on 12/10/25 of the facility's restrictive intervention log revealed:
Restrictive interventions had been performed on the following dates:
-8/8/25, client #2 was physically aggressive toward a peer (unknown).
-9/21/25, client #4 became physically aggressive with peer (client #3).
9/21/25, client #2 became physically aggressive with a peer (client #3).
-9/22/25, client #2 engaged in unsafe property destruction and physical aggression.
-9/29/25, client #4 became physically aggressive with a peer (client #3).
-10/29/25, client #4 engaged in property destruction and became physically aggressive with staff (Associate Professional).
-11/7/25, client #4 escalated from verbal aggression into self-harming.
-11/14/25, client #3 became verbally aggressive and engaged in property destruction.

Review on 11/24/25 of facility records revealed:
-No notation of the clients physical and psychological well being.
-No notation of the frequency, intensity, and duration of the behavior which led to the intervention, and any precipitating circumstance contributing to the onset of the behavior.
-The rationale for the use of the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used.
-No notion of the description of the restrictive intervention, or the date, time, and duration of its use.
-No notion of a description of accompanying

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V 521	Continued From page 30 positive methods of intervention. -No notion of debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate or reduce the probability of the future use of restrictive interventions. -No description of the debriefing and planning with the clients and their legally responsible person for the planned use of seclusion, physical restraint or isolation time out if determined to be clinically necessary and -No documentation of the signature and title of the facility employee who initiated the use of the restrictive interventions. Interview on 2/10/25 with the Licensee/ED/AP revealed: -Was unaware that the above information needed to be documented in the client record. -Would ensure that all that information would be documented going forward.	V 521		
V 539	27F .0102 Client Rights - Living Environment 10A NCAC 27F .0102 LIVING ENVIRONMENT (a) Each client shall be provided: (1) an atmosphere conducive to uninterrupted sleep during scheduled sleeping hours, consistent with the types of services being provided and the type of clients being served; and (2) accessible areas for personal privacy, for at least limited periods of time, unless determined inappropriate by the treatment or habilitation team. (b) Each client shall be free to suitably decorate his room, or his portion of a multi-resident room, with respect to choice, normalization principles,	V 539		

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and with respect for the physical structure. Any restrictions on this freedom shall be carried out in accordance with governing body policy.

This Rule is not met as evidenced by:
Based on observation, record reviews, and interviews, the facility failed to ensure there was an atmosphere conductive to uninterrupted sleep during scheduled sleeping hours and accessible areas for personal privacy affecting 2 of 4 clients (#1 and #3). The findings are:

Observation on 11/14/25 in the facility at approximately 5:20pm revealed:
-Locked bathroom in the bedroom occupied by client #1 and client #3.
-Staff #1 used a key to locked the bathroom in the bedroom occupied by client #1 and client #3.
-Toilet paper, paper towels, small clear plastic cups, and paper cups were stored in the bathroom in the bedroom occupied by client #1 and client #3.

Review on 11/18/25 of client #1's record revealed:
-Age 16 years old.
-Admitted 5/9/25.
-Diagnoses: Post Traumatic Stress Disorder (PTSD), With Derealization Symptoms; Major Depressive Disorder (MDD), Recurrent Episode, in Partial Remission.

Review on 11/18/25 of client #3's record revealed:
-Age 13 years old.
-Admitted 4/8/25.
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-Diagnoses: Attention Deficit Hyperactivity Disorder (ADHD), Combined Presentation;

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Oppositional Defiant Disorder (ODD); Unspecified Anxiety Disorder; Unspecified Trauma and Stress Related Disorder; Unspecified Depressive Disorder; Unspecified Disruptive, Impulse and Conduct Disorder.

Interview on 12/1/25 with client #1 revealed:
-The bathroom was used by staff and staff came in her bedroom "because of the bathroom."
-"When we're (clients #1 and #3) asleep, they (staff) will go to the bathroom or we will step out of the room (bedroom)."

Interview on 11/14/25 with staff #1 revealed:
-The bathroom in the bedroom occupied by client #1 and client #3 was not a staff bathroom.
-The bathroom in the bedroom occupied by client #1 and client #3 was used for storage by staff.
-Clients were able to request use of the bathroom in the bedroom occupied by client #1 and client #3, "and staff will unlock it."
-Clients "only use the toilet and sink" in the bathroom in client #1 and client #3's bedroom.

Interview on 12/5/25 with the Associate Professional (AP) revealed:
-"Yes, the staff use the bathroom in [client #1]'s bedroom, we (staff) enter her (client #1) bedroom and use the key for the bathroom door when she is sleeping."
-Clients were only permitted to use the bathroom in client #1's bedroom when the client bathroom on the hallway was in use.
-"They (clients) don't shower in there (bathroom in client #1's bedroom) and the door is always locked."

Interview on 12/4/25 with the Licensee/Executive Director/AP revealed:
-"That bathroom is just storage. I don't know

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V 539	Continued From page 33 what bathroom the staff use when working. Let me ask the team. The other bath (client bathroom on hallway) is client specific." -Asked staff and replied, "yes, they (staff) use the one (bathroom) in the bedroom (client #1). -"Staff would have to go into her (client #1) bedroom while she is sleeping to use the bathroom and we (staff) are still watching them (clients) as they sleep."	V 539		