PRINTED: 11/18/2025
FORM APPROVED

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
	MHL036-429	A. BUILDING: _____ B. WING _____	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAKER HOUSE	1018 BAKER BOULEVARD GASTONIA, NC 28052

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on 10/29/25. The complaint was substantiated (intake #NC00233673). Deficiencies were cited. This facility is licensed for the following service 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for 4 and has a current census of 1. The survey sample consisted of audits of 1 current client and 1 former client.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's	V 105	RECEIVED DEC 01 2025 DHSR-MH Licensure Sect	

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V 105	Continued From page 1 needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105		

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V 105	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to complete a screening assessment of whether or not the facility can provide services to address the individual's needs affecting 1 of 1 current client (Client #1) and 1 of 1 former client (FC#2). The findings are: Review on 10/29/25 of the facility's records revealed: - No documentation of a screening assessment policy. Review on 10/15/25 of Client #1's record revealed: -Date of Admission: 9/5/25. -Diagnoses: Conduct Disorder, Post-Traumatic Stress Disorder, Major Depressive Disorder, Attention Deficit Hyperactivity Disorder. -Age: 17 years. -No documentation of a screening assessment prior to admission to include an assessment of whether or not the facility can provide services to address the individual's needs. Review on 10/16/25 of FC #2's record revealed: -Date of Admission: 8/27/25. -Date of Discharge: 9/18/25. -Diagnoses: Disruptive Mood Dysregulation Disorder, Unspecified Trauma and Stressor Related Disorder, Attention Deficit Hyperactivity Disorder, Diabetes. -Age: 15 years. -No documentation of a screening assessment to include an assessment prior to admission to include an assessment of whether or not the	V 105	**V.105 No documentation of a screening assessment policy.** **1. Corrective Action Taken:** Our Screening Assessment Policy was updated and implemented by 11/21/25. Our post admission reviews were completed for Client #1 and Former Client #2 and added to their records. **2. Measures Taken to Ensure Others Are Not Affected:** All active and recent admissions since we opened, were reviewed to ensure screening assessments were completed, if they weren't then post admission appropriate reviews we completed. **3. Systemic Changes to Prevent Recurrence:** The Screening Assessment Policy was edited in the facility's Policy & Procedure Manual, and the Admission Checklist was updated to require a completed screening assessment prior to admission. Staff responsible for admissions received training on the new policy on 11/12/25. **4. Monitoring to Ensure Ongoing Compliance:** The Executive Director/QP will verify screening assessments for every admission prior to entry. The QA/QI Committee will review all of admission files monthly for continued compliance.	

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V 105	Continued From page 3 facility can provide services to address the individual's needs. Interview on 10/29/25 with the Qualified Professional revealed: -"I didn't know I had to do them (screening assessments),but I see now." -"I didn't realize that these assessments were required ...will start immediately to develop appropriate forms and documents." Interview on 10/27/25 and 10/29/25 with the Executive Director/Licensee revealed: -There was no policy or procedure for screening clients. -"Had I known he (FC #1) was diabetic, I wouldn't have taken him. I didn't know until he got here. My staff isn't knowledgeable." -"Staff had no training on diabetes." This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 105		
V 108	27G .0202 (F-I) Personnel Requirements 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	V 108		

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V 108	Continued From page 4 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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 3 of 3 audited paraprofessionals (Staff #1, #2, and #3) and 2 of 2 former paraprofessionals (Former Staff (FS) #8 and FS #9) received training to meet the MH/DD/SA needs of the clients. The findings are: Review on 10/15/25 of Client #1's record revealed: -Date of Admission: 9/5/25. -Diagnoses: Conduct Disorder, Post-Traumatic Stress Disorder, Major Depressive Disorder, Attention Deficit Hyperactivity Disorder. -Age: 17 years.	V 108		

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V 108	Continued From page 5 -Assessment dated 9/5/25 revealed: Victim of sexual abuse, inappropriate sexual behaviors (pretending the masturbate in public), pornography on electronic devices, temper outburst, physically abusive and verbally aggressive, fights when he feels bullied. History of substance use, running away, self-injurious behavior, fire setting, and stealing. Review on 10/16/25 of Former Client (FC) #2's record revealed: -Date of Admission: 8/27/25. -Date of Discharge: 9/18/25. -Diagnoses: Disruptive Mood Dysregulation Disorder, Unspecified Trauma and Stressor Related Disorder, Attention Deficit Hyperactivity Disorder, Diabetes. -Age: 15 years. -Assessment dated 9/1/25 revealed: Victim of neglect and physical abuse, severe mood swings, elopement, suicide attempts, incident of sexualized behavior (exposing himself and masturbation in front of others), verbally aggressive when upset, drank cleaning supplies and swallows screws in efforts to harm himself, property damage. Review on 10/16/25 of Staff #1's record revealed: -Hire Date: 8/18/25. -Job: Direct Support Staff. -No documentation of training of client specific MH/DD/SA needs training. No training in diabetes, no training in supervising FC #1 with taking blood sugar levels, and no documentation to address the sexually aggressive youth for Client #1 and FC #1. Review on 10/16/25 of Staff #2's record revealed: -Hire Date: 8/18/25. -Job: Direct Support Staff.	V 108		

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V 108	Continued From page 6 - No documentation of training of client specific MH/DD/SA needs training. No training in diabetes, no training in supervising FC #1 with taking blood sugar levels, and no documentation to address the sexually aggressive youth for Client #1 and FC #1. Review on 10/16/25 of Staff #3's record revealed: -Hire Date: 8/18/25. -Job: Direct Support Staff. -No documentation of training of client specific MH/DD/SA needs training. No training in diabetes, no training in supervising FC #1 with taking blood sugar levels, and no documentation to address the sexually aggressive youth for Client #1 and FC #1. Review on 10/16/25 of FS #8's record revealed: -Hire Date: 8/18/25. -Date of Separation: 10/3/25. -Job: Direct Support Staff. - No documentation of training of client specific MH/DD/SA needs training. No training in diabetes, no training in supervising FC #2 with taking blood sugar levels, and no documentation to address the sexually aggressive youth for Client #1 and FC #2. Review on 10/16/25 of FS #9's record revealed: -Hire Date: 8/18/25. -Date of Separation: 9/25/25. -Job: Direct Support Staff. - No documentation of training of client specific MH/DD/SA needs training. No training in diabetes, no training in supervising FC #2 with taking blood sugar levels, and no documentation to address the sexually aggressive youth for Client #1 and FC #2. Interview on 10/15 with Staff #1 revealed:	V 108		

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V 108	Continued From page 7 -"I believe it would be in [electronic computer system] to look at client specifics." Interview on 10/28/25 with Staff #2 revealed: -"Nothing specific (client specific needs) with [Qualified Professional (QP) or Executive Director/Licensee (ED/L)]." -"[FC #1] was diabetic, I tried to work with him and help him understand. One time he refused his insulin which is when he had to go back to the hospital." -"No training with the facility regarding diabetes." Interview on 10/21/25 with Staff #3 revealed: -"There is a book (client record) at the house we can look at, about the client and why they are there." Interview on 10/21/25 with FS #9 revealed: -"We didn't know anything about them (clients) before they (clients) came ...we had to learn everything. It was a complete and utter mess and it made me nervous." -"There wasn't anything (client file) for me to look at. I had to learn him (FC #2) based off communication and asking him (FC #1) questions." -"No training with the facility regarding diabetes." -"No specific training regarding treatment goals." Interview on 10/16/25 and 10/29/25 with the QP revealed: -"[FC #1] checked his own blood sugars, he was prediabetic. When he was dropped off the DSS (Department of Social Services) worker and the case manager told us how to help him with the needle, he would check himself every two hours and would record his blood sugar numbers ...DSS worker and case manager told us to give juice if his blood sugar was low."	V 108	**V.108 No documentation of training for client-specific MH/DD/SA needs.** **1. Corrective Action Taken:** Client-specific MH/DD/SA training was provided to all staff working with the affected client(s) by 11/21/25. Staff training certificates were given, which were placed in the Staff Binder. **2. Measures Taken to Ensure Others Are Not Affected:** A review of all current clients was conducted to verify that client-specific MH/DD/SA training is completed and documented for each assigned staff member. Any missing training was completed immediately and documentation filed. **3. Systemic Changes Implemented to Prevent Recurrence:** Staff Onboarding Checklists were updated requiring client-specific MH/DD/SA training to be completed before staff begin working with a client. Supervisors and QP were trained in the new documentation process. **4. Monitoring to Ensure Ongoing Compliance:** The Executive Director and QP will review client-specific training documentation during monthly QA/QI audits. Any missing training will result in immediate corrective action and retraining. Training documentation will be verified for all newly admitted clients and all newly hired staff.	

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V 108	Continued From page 8 -"In the future, we will implement staff training according to the PCP (person centered plan), sexual aggression ...have a class with the licensed professional..certain medical trainings to be implemented going forward." Interview on 10/27/25 with the ED/L revealed: -"Had I known he (FC #2) was diabetic, I wouldn't have taken him. I didn't know until he got here. My staff isn't knowledgeable." -"Staff had no training on diabetes." -"It's not documented (client specific training) anywhere but we will go over their (clients) person centered plan together." -"I would send a splash message (electronic message) out about a new client and what date (they were being admitted) ...crisis plan, behavior plan is listed under their name asking staff to review." -"They have to review their (clients) entire plan before they can leave (their shift)." -"All staff will be trained moving forward and documentation will be kept in the electronic file or in the staff's personnel file." This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	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	V 109		

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V 109	Continued From page 9 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 employment system in the State Plan for MH/DD/SAS. (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. (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. This Rule is not met as evidenced by: Based on record review and interview, 1 of 1 Qualified Professional (QP) failed to demonstrate the knowledge, skills and abilities to meet the needs of clients. The findings are:	V 109	**V.109 Qualified Professional (QP) failed to demonstrate the knowledge, skills and abilities to meet the needs of clients.** **1. Corrective Action Taken:** The QP received immediate coaching on all client-specific needs, MH/DD/SA service requirements, Level III residential requirements, documentation standards, incident management, and DHHS regulatory expectations. **2. Measures Taken to Ensure Others Are Not Affected:** A review of all current client cases assigned to the QP was completed to ensure service needs, documentation, and interventions were appropriate and consistent with DHHS standards. No additional concerns were identified. Additional client-specific coaching was provided where needed. **3. Systemic Changes Implemented to Prevent Recurrence:** A structured QP Competency Verification Process was established, including: • Monthly supervision with documented competency checks • Quarterly performance reviews focused on knowledge, skills, and abilities • A standardized checklist for QPs was implemented • Supervisory oversight was strengthened to ensure compliance.	

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V 109	Continued From page 10 Review on 10/16/25 of the QP's record revealed: -Date of hire: 8/18/25. Review on 10/29/25 of the QP's job description revealed: - "The QP is responsible for overseeing client care and service delivery in accordance with state regulations, agency policies, and individualized treatment plans. The QP ensures the health, safety, and well-being of residents while providing guidance and supervision to Associate Professionals (AP), Paraprofessionals, and Direct Care Staff. -Key Responsibilities: -Develop, implement, and monitor Person-Centered Plans (PCPs) and service plans in compliance with NC DHHS (North Carolina Department of Health and Human Service) and MCO (Managed Care Organization) standards. -Conduct comprehensive assessments and maintain timely, accurate documentation in client records. -Provide supervision, support, and training to APs and Direct Care Staff to ensure consistent quality of care. -Monitor and document client progress, including behavioral, emotional, and social goals. -Facilitate coordination of services with families, DSS, schools, therapists, and other service providers. -Participate in treatment team meetings, case reviews, and interdisciplinary planning sessions. -Ensure compliance with all licensing regulations, Medicaid requirements, and agency policies. -Serve as an on-call resource for staff during crisis situations and assist with crisis planning. -Advocate for residents" needs while maintaining professional boundaries. -Support the overall mission and values of New Visions Youth Care (Licensee) through ethical	V 109	Continued from page 10 **4. Monitoring to Ensure Ongoing Compliance:** The Executive Director and LP will conduct monthly supervision sessions and review a sample of the QP's documentation for accuracy and compliance. The QA/QI Committee will audit 5% of QP-related documentation monthly and report findings during QA/QI meetings. Any concerns will result in immediate retraining and follow-up reviews.	

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V 109	Continued From page 11 practice and compassionate service delivery." Refer to V105 for evidence that the QP failed to complete screening assessments. Refer to V108 for evidence that the QP failed to ensure staff received client specific training to meet the MH/DD/SA needs of the clients. Refer to V111 for evidence that the QP failed to ensure admission assessments were completed prior to the delivery of services. Refer to V112 for evidence that the QP failed to develop and implement treatment plans with current strategies to address the needs of the clients. Refer to V294 for evidence that the QP failed to ensure the coordination of each child or adolescent's treatment plan and provision of basic care management functions. Refer to V300 for evidence that the QP failed to ensure a service planning meeting was held within 5 business days of an emergency discharge. Interview on 10/29/25 with the QP revealed: -"I was not aware of many of the rules (policies and procedures) discussed today." Interview on 10/29/25 with the Executive Director revealed: -"This (survey) really helped" and "will make corrections starting today and it will not happen again ...will work with [QP] and [Licensed Professional] to make any necessary corrections to the facility."	V 109		

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V 109	Continued From page 12 This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 109		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional.	V 110		

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V 110	Continued From page 13 This Rule is not met as evidenced by: Based on record review and interview 1 of 4 audited paraprofessional staff (Executive Director/Licensee (ED/L)) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are: Review on 10/29/25 of the ED/L record revealed: -Date of Hire: 7/1/25. -Job Title: Executive Director/Licensee. -Job Description: " ...responsible for overall leadership, compliance, program development, staff supervision, financial oversight, and community relations. The Executive Director (ED/L)ensures that the organization delivers high-quality care to youth while maintaining compliance with all state, federal, and accrediting body requirements. Oversee the delivery of high-quality residential, behavioral, and supportive services for youth. Monitor client outcomes, treatment planning, and ensure individualized care is provided. Maintain a safe, structured, and therapeutic environment." Refer to V108 for evidence that the ED/L failed to ensure staff received client specific training to meet the MH/DD/SA needs of the clients. Refer to V109 for evidence that the ED/L failure to ensure the QP performed their duties. Refer to V111 for evidence that the ED/L failed to ensure admission assessments were completed prior to the delivery of services. Refer to V112 for evidence that the ED/L failed to	V 110	**V.110 Paraprofessional staff (Executive Director) failed to demonstrate the knowledge, skills, and abilities required by the population served.** **1. Corrective Action Taken:** The Executive Director relearned the Level III residential requirements, MH/DD/SA client needs, supervision expectations, crisis response procedures, documentation standards, and DHHS regulatory requirements by 11/21/2025. **2. Measures Taken to Ensure Others Are Not Affected:** To ensure no staff or clients were negatively affected, the ED met with all personnel to review proper procedures, chains of command, and expectations for client support. Staff were provided clarification on support strategies and reporting protocols so that service delivery remains consistent and uninterrupted. These actions ensure that the population served continues to receive appropriate and safe care. **3. Systemic Changes Implemented to Prevent Recurrence:** A formal Executive Director Competency Checklist has been created and incorporated into routine administrative operations. Additionally, structured ongoing training has been implemented, including scheduled policy refreshers, review of state requirements, and continued education related to the needs of the population served. These measures establish clearer structure and ensure the ED consistently demonstrates required knowledge and skills.	

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V 110	Continued From page 14 develop and implement treatment plans with current strategies to address the needs of the clients. Refer to V294 for evidence that the ED/L failed to ensure the coordination of each child or adolescent's treatment plan and provision of basic care management functions. Refer to V295 for evidence that the ED/L failed to maintain one staff who met the requirements of an associate professional. Refer to V296 for evidence that the ED/L failed to ensure that 2 direct care staff were present. Refer to V297 for evidence that the ED/L failed to ensure face to face clinical consultation was provided in the facility at least four hours a week by a Licensed Professional (LP). Refer to V300 for evidence that the ED/L failed to ensure a service planning meeting was held within 5 business days of an emergency discharge on September 18, 2025 of Former Client #2. Interview on 10/27/25 and 10/29/25 with ED/L revealed: -The "associate professional will start on Thursday, October 30 with orientation, prior to that, we would not have someone filling that role." -The LP "comes to the home (facility) once per week, provides therapy for at least one hour." -Staff were trained on client goals and needs but its not documented anywhere. -"I do know that it should be two but sometimes its just one (staff on shift)." -"Truly just got lazy on it (ensuring two staff worked per shift) ...got tired."	V 110	Continued from page 14 **4. Monitoring to Ensure Ongoing Compliance:** To ensure continuous compliance, the ED will conduct quarterly self-assessments using the Executive Director Competency Checklist and maintain documentation of all completed competencies and training. The ED will also participate in ongoing professional development and seek consultation when new or complex client needs arise.	

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V 110	Continued From page 15 -No planning meeting within 5 business days was held after Former Client #1's discharge. -"This (survey) really helped and I will make corrections starting today and it (rule deficiencies) will not happen again." This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 110		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.	V 111		

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V 111	Continued From page 16 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure assessments were completed prior to the delivery of services and failed to develop treatment strategies to address clients' needs affecting 1 of 1 current client (Client #1) and 1 of 1 former client (FC #2). The findings are: Review on 10/15/25 of Client #1's record revealed: -Date of Admission: 9/5/25. -Diagnoses: Conduct Disorder, Post-Traumatic Stress Disorder, Major Depressive Disorder, Attention Deficit Hyperactivity Disorder. -Age: 17 years. -No documentation of treatment strategies to address the client's behavior needs that include sexual abuse and sexualized behaviors-masturbate in public, temper outbursts, oppositional, physical and verbal aggression, completed by the facility prior to the delivery of services. Review on 10/16/25 of FC #2's record revealed: -Date of Admission: 8/27/25. -Discharge Date: 9/18/25. -Diagnoses: Disruptive Mood Dysregulation Disorder, Unspecified Trauma and Stressor	V 111	**V.111 The facility failed to ensure assessments were completed prior to the delivery of services and failed to develop treatment strategies to address clients' needs.** **1. Corrective Action Taken:** All overdue assessments were immediately completed for the affected client(s) on 11/10/2025, and updated treatment strategies/interventions were developed and added to the client's Person-Centered Plan and treatment service plan. The QP reviewed the assessment and treatment strategies with staff to ensure proper implementation. Documents were filed in the client record. **2. Measures Taken to Ensure Others Are Not Affected:** All active client files were audited to verify that required assessments were completed and that treatment strategies were present, individualized, and up to date. Any missing or outdated assessments or interventions were corrected immediately. **3. Systemic Changes Implemented to Prevent Recurrence:** The Admission Checklist and QP Checklist were revised to require: • Completion of all assessments before any services begin • Development of treatment strategies following assessment • An admin calendar was implemented to ensure deadlines are met for assessments and treatment plan updates.	

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V 111	Continued From page 17 Related Disorder, Attention Deficit Hyperactivity Disorder, Diabetes. -Age: 15 years. -Assessment completed on 6/25/25 and 8/12/25 by the local hospital revealed: FC #2 has been in the hospital since 5/15/25. He was drinking cleaning solution, he had been licking light sockets and eating paint off the walls. Physical and verbal aggression, property destruction, self-harm, elopement and suspension from school for fighting and disruptions. History of severe out of control moods, fire setting, suicide attempts, distress, aggression to others and episodes of sexualized behaviors of exposing himself and masturbation in front of others. -No documentation of assessment or treatment strategies to address his behavior concerns regarding physical and verbal aggression, property destruction, elopement, sexualized behaviors and fire setting and self injurious behaviors completed by the facility prior to the delivery of services. Interview on 10/29/25 with the Qualified Professional revealed: -"I will start completing assessments to reflect the needs of each client." -"Understand that treatment strategies need to be developed and implemented for client needs during the first 30 days at the facility ..." This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 111	Continued from page 17 **4. Monitoring to Ensure Ongoing Compliance:** The Executive Director and QP will complete weekly audits of new admissions to verify assessments are completed prior to service delivery and that treatment strategies are documented. The QA/QI Committee will audit 10% of client records monthly to ensure ongoing compliance with assessment timelines and treatment planning standards. Any concerns will result in immediate corrective action	
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan	V 112		

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V 112	Continued From page 18 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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop and implement treatment strategies to address the needs of 1 of 1 current client (Client #1). The findings are: Review on 10/15/25 of Client #1's record	V 112	**V.112 The facility failed to develop and implement treatment strategies to address the needs of client.** **1. Corrective Action Taken:** The QP immediately reviewed the client's assessment and Person-Centered Plan and developed individualized treatment strategies to address the client's current needs on 11/11/2025. These strategies were added to the PCP/ treatment plan and reviewed with all assigned staff to ensure proper implementation. Documentation was placed in the client's record. **2. Measures Taken to Ensure Others Are Not Affected:** All active client PCPs were reviewed to confirm that treatment strategies were present, individualized, and reflective of current client needs. Any missing, outdated, or insufficient strategies were updated immediately and reviewed with staff. **3. Systemic Changes Implemented to Prevent Recurrence:** The QP Checklist and PCP/ treatment plans Update Procedures were revised to require that: • Treatment strategies are developed at admission and during every PCP update • Strategies are reviewed for alignment with client assessments and needs Staff receive training on treatment strategies before implementation Additionally, coaching by the LP was provided to the QP on proper development and documentation of treatment strategies on 11/8/25.	

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V 112	Continued From page 19 revealed: -Date of Admission: 9/5/25. -Diagnoses: Conduct Disorder, Post-Traumatic Stress Disorder, Major Depressive Disorder, Attention Deficit Hyperactivity Disorder. -Age: 17 years. -Treatment plan dated and signed on 8/26/25 prior to admission date when he was at the local hospital. -No documentation of treatment strategies developed or implemented to address the client's behavior needs that include sexual abuse and sexualized behaviors (masturbate in public), temper outbursts, oppositional, physical and verbal aggression. Interview on 10/21/25 with Staff #3 revealed: -Goals for Client #1 include doing his work at school and getting a job. Interview on 10/16/25 with the Qualified Professional revealed: -Part of her duties included treatment team meetings. -Will "update parents with what is going on and will look at revise the person centered plan (treatment plan) with any goals which are needed." -"Only had one child and family team meeting for [Client #1] and the school led it...discussed group home goals and updated the person centered plan." -"[Client #1's] goals are to work on anger management, other ways than just the stress balls and music (for coping skills). He needs new coping mechanisms." -"I will start completing treatment plans to reflect the needs of each client..understand that treatment strategies need to be developed and implemented for client needs during the first 30	V 112	Continued from page 19 **4. Monitoring to Ensure Ongoing Compliance:** The ED/QP will review all PCPs during monthly audits to verify that individualized, appropriate treatment strategies are documented and implemented. The QA/QI Committee will review 10% of PCPs monthly to ensure compliance, accuracy, and implementation. Any identified issues will result in immediate corrective coaching.	

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V 112	Continued From page 20 days at the facility as well as after the treatment plan is developed. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope V(293) for a Type A1 rule violation and must be corrected within 23 days.	V 112		
V 117	27G .0209 (B) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner.	V 117		

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V 117	Continued From page 21 This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to maintain pharmacy packaging labels with clear directions for administration as required for each prescription medication dispensed for 1 of 1 client (Client #1). The findings are: Review on 10/15/25 of Client #1's record revealed: -Date of Admission: 9/5/25. -Diagnoses: Conduct Disorder, Post-Traumatic Stress Disorder, Major Depressive Disorder, Attention Deficit Hyperactivity Disorder. Age: 17 years. -Physician's order dated 10/9/25 for the following: -Clindamycin 1% lotion apply to face every morning. Observation on 10/27/25 at approximately 10:35am of Client #1's medications revealed: -A clear plastic bag containing the Clindamycin 1% lotion with a pharmacy label that revealed: dispensed on 10/9/25 with instructions to apply topically to the affected area on scalp once daily. Interview on 10/27/25 with the Qualified Professional revealed: -"[Executive Director/Licensee (ED/L)] will get correct label information on the Clindamycin and all labels will be carefully monitored moving forward." Interview on 10/27/25 with the ED/L revealed: -"I called the dermatologist and the pharmacist	V 117	**V.117 The facility failed to maintain pharmacy packaging labels with clear directions for administration as required for each prescription medication dispensed.** **1. Corrective Action Taken:** All medication packaging with unclear or missing labels was immediately replaced with correctly labeled pharmacy packaging on 10/24/25. Executive Director verified that every prescription medication has a complete, legible pharmacy label with accurate administration instructions. Staff were immediately reeducated on proper medication storage and labeling requirements. **2. Measures Taken to Ensure Others Are Not Affected:** A facility-wide audit of all medication packets—including bubble packs, topical medications, PRNs, and controlled substances—was completed to ensure that each medication had a valid pharmacy label. Any items missing labels or having unclear directions were returned to the pharmacy for correction and replaced. **3. Systemic Changes Implemented to Prevent Recurrence:** The medication administration and storage procedure requires: • Verification of pharmacy labels upon receipt of every medication • Immediate return of any medication missing a complete label • Staff may not administer any medication until the correct label is present • All medication-trained staff were retrained on pharmacy labeling requirements, including daily label checks and proper medication handling.	

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V 117	Continued From page 22 about a new prescription. The pharmacist said that it (Clindamycin) was fine to use it as is without a new label." -"I will make sure all medication labels on medication will be accurate and reflect the doctor's orders." -"I will make sure and get accurate label information from the pharmacy today." This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type B rule violation and must be corrected within 45 days.	V 117	Continued from page 22 **4. Monitoring to Ensure Ongoing Compliance:** The Executive Director will conduct weekly medication audits to confirm proper labeling on all prescriptions. The QA/QI Committee will complete a monthly medication storage audit that includes checking for pharmacy labels, expiration dates, and accuracy of directions. Any discrepancies will result in immediate corrective action and staff retraining.	
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug;	V 118		

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V 118	Continued From page 23 (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that medications were only administered by staff who were trained by a registered nurse, pharmacist, or other legally qualified person affecting 5 of 5 audited current staff (Staff #1, #2, #3, Qualified Professional (QP), and Executive Director/Licensee (ED/L) and 1 of 2 audited former staff (FS #8), failed to ensure medication was administered on the written order of a person authorized by law to prescribe medications affecting 1 of 1 former client (FC #2), and failed to keep the MARs current affecting 1 of 1 current client (Client #1) and 1 of 1 former client (FC #2). The findings are: Cross Reference: 10A NCAC 27G .0209 Medication Requirements (V117). Based on observation, record review and interview, the facility failed to maintain pharmacy packaging labels with clear directions for administration as required for each prescription medication dispensed for 1 of 1 client (Client #1). Cross Reference: 10A NCAC 27G .0209 Medication Requirements (V123). Based on	V 118	**V.118 Facility failed to ensure that medications were only administered by staff who were trained by a registered nurse, pharmacist, or other legally qualified person.** **1. Corrective Action Taken:** All staff who administered medications without proper training were immediately removed from medication duties. ED was retrained by a licensed pharmacist the same day this was identified during the survey. A Registered Nurse provided full Medication Administration Training on 10/17/2025, and competency validation forms were completed. Medication was reviewed to ensure ALL medications had valid written prescriber orders on file. MARs were updated immediately and audited for accuracy. All missing signatures, times, and entries were corrected by 11/21/2025. **2. Measures Taken to Ensure Others Are Not Affected:** A full audit of all staff files was completed to ensure only RN-trained staff are assigned medication responsibilities. Any staff missing certification were retrained. All current client records were reviewed to verify medications: • Had current, valid prescriber orders • Matched the pharmacy label • Were reflected correctly on the MAR • Had no gaps or missing entries No additional clients were found to be affected.	

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V 118	Continued From page 24 record review and interview, the facility failed to ensure medication errors were reported immediately to a physician or pharmacist affecting 1 of 1 client (Client #1). Finding 1 Review on 10/15/25 of Staff #1's personnel record revealed: -Date of Hire: 8/18/25. -Job Title: Direct Support Staff. -Date of Medication Administration Training Certificate: 5/24/25. Review on 10/15/25 of Staff #2's personnel record revealed: -Date of Hire: 8/18/25. -Job Title: Direct Support Staff. -Date of Medication Administration Training Certificate: 7/28/25. Review on 10/15/25 of Staff #3's personnel record revealed: -Date of Hire: 8/18/25. -Job Title: Direct Support Staff. -Date of Medication Administration Training Certificate: 8/4/25. Review on 10/15/25 of FS #8's personnel record revealed: -Date of Hire: 8/18/25. -Date of Separation: 10/3/5. -Job Title: Direct Support Staff. -Date of Medication Administration Training Certificate: 7/28/25. Review on 10/15/25 of the QP's personnel record revealed: -Date of Hire: 8/18/25. -Job Title: QP -Date of Medication Administration Training	V 118	Continued from page 24 **3. Systemic Changes Implemented to Prevent Recurrence:** The Medication Administration Policy requires: • RN-led Medication Administration Training BEFORE any staff handle medications • Mandatory competency checks annually and after any medication error • Verification of prescriber orders BEFORE adding medications to the MAR • Immediate correction of any MAR discrepancies • Weekly internal medication audits • Staff not trained by an RN/pharmacist cannot participate in any med-related tasks **4. Monitoring to Ensure Ongoing Compliance:** The Executive Director will perform weekly medication audits to ensure: • Only RN-trained staff administer medications • All medications have valid prescriber orders • MARs are complete, accurate, and up to date The QA/QI Committee will perform a monthly medication compliance audit, reviewing staff files, prescriber orders, MARs, and pharmacy packaging. Any deviation will result in immediate corrective action, retraining, and re-audit to ensure sustained compliance.	

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V 118	Continued From page 25 Certificate: 5/24/25. Review on 10/15/25 of ED/L's personnel record revealed: -Date of Hire: 7/21/25. -Date of Medication Administration Training Certificate: 5/24/25. Interview on 10/15/25 with Staff #1 revealed: -He administered medications. -"The lady (who taught the medication administration training) was going through the information packet ...had to take a test ...I believe she was a Registered Nurse (RN)." -"The first time I passed (administered) meds (medications) [ED/L or QP] watched me do it ... [QP] watched me each shift for the first couple of weeks. We always do it right in front of the camera." -"The RN never watched me administer medications after the medication training class." Interview on 10/28/25 with Staff #2 revealed: -"An RN taught the class (medication administration) and completed a paperwork test. Initially I was not required to show a competency return for medication administration but about one or two weeks ago the RN returned to the facility and ensured all staff completed a medication administration competency." Interview on 10/21/25 with Staff #3 revealed: -"Medication administration was done virtual." -An RN did not watch her complete a medication administration pass as part of the training. Interview on 10/21/25 with FS #8 revealed: -"Medication administration training was done in person, it was brief and not very thorough...make sure you have the right person (client) and	V 118		

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V 118	Continued From page 26 stuff...did not really show you how to do anything...she (woman teaching the training) did not observe an acutal medication pass." Interview on 10/16/25 with the QP revealed: -"The RN didn't watch them pass (administer) medication ...no observation of administering medications." Interview on 10/16/25 with the ED/L revealed: -"She (RN) pulled out a MAR and she went over the MAR, she explained to us how to initial where they give meds (administer medications) and on the back there's a key for notes. Discussed PRN (As needed) medications." -There was not a medication administration requirement as part of the training, " ...I do not believe so." -Had Medication Administration training with Staff #1 and QP before receiving the licensure from the state. Interview on 10/29/25 with the ED/L revealed: -"Staff have been re-trained in medication administration by an RN and all new staff will be trained by an RN and from now on all staff will be expected to complete a competency check for medication administration with an RN or pharmacist and all currently trained staff will be retrained by the RN in medication administration and will complete a competency check for medication." Finding 2 Review on 10/15/25 of FC #2's record revealed: -Date of Admission: 8/27/25. -Date of Discharge: 9/18/25. -Diagnoses: Disruptive Mood Dysregulation Disorder, Unspecified Trauma and Stressor Related Disorder, Attention Deficit Hyperactivity	V 118		

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V 118	Continued From page 27 Disorder (ADHD), Diabetes. -Age: 15 years. -No physician's orders. -Medications upon admission to the facility were: -Clonidine Hydrochloric acid (HCL) .1 milligram (mg) (ADHD). -Clonidine HCL .3mg -Divalproex Sodium 500mg (Bi-polar). -Ferrous Sulfate 325mg -Flintstones Iron Tab Chew -Metformin HCL 500mg (diabetes). -Olanzapine 10mg (antipsychotic). -Check blood sugars every two hours. -Sertraline HCL 100mg (depression). Review on 10/22/25 of FC #2's August 27-September 18, 2025 MARs of medications that had been initialed as being administered revealed: -Clonidine Hydrochloric acid (HCL) .1 milligram (mg) (ADHD) one tablet by mouth once daily in the morning. -Clonidine HCL .3mg one tablet by mouth once daily in the morning. -Divalproex Sodium 500mg (Bi-polar) One tablet by mouth twice daily. -Ferrous Sulfate 325mg one tablet by mouth once daily. -Flintstones Iron Tab Chew one tablet by mouth once daily. -Metformin HCL 500mg (diabetes) one tablet by mouth twice daily with meals.. -Olanzapine 10mg (antipsychotic) one tablet by mouth twice daily. -Sertraline HCL 100mg (depression) one tablet by mouth once daily. Finding 3: Review on 10/16/25 of FC #2's record revealed:	V 118		

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V 118	Continued From page 28 -MARs were not kept current. Review on 10/22/25 of FC #2's handwritten paper MAR dated September 1- September 30, 2025 and interview with the ED/L revealed: - The MARs was for August 2025 and not for September 2025. -The dates were documented incorrectly on the bottom of the MAR. Interview on 10/29/25 with the ED/L revealed: -" ... will make sure all MARs are kept current - will not accept clients without medication orders." Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician. Review on 10/16/25 of the Plan of Protection dated and signed by the ED/L on 10/16/25 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? [ED/L] will get signed off by a Registered Nurse who will watch him do a physical med pass for [Client #1]. Then each staff member will be monitored by this Registered Nurse and they will also get a signed declaration proving they have been monitored. -Describe your plans to make sure the above happens. "[ED/L] will take [Client #1] to this Nurse today to have a med pass observed & notated. Then susequently do the same with all other staff." Review on 10/29/25 of the second Plan of Protection dated and signed by the ED/L on 10/29/25 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care?	V 118		

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V 118	Continued From page 29 [ED/L] on Oct (October)16th (2025) went to [Pharmacy] and was monitored by [Pharmacist] passing (administering) meds. [ED/L] was signed of and approved for medication administration. Oct 17th (2025) [Registered Nurse] did a complete medication administration class for the majority of staff. [ED/L] called [Pharmcy] and got medication sent to home with correct label on 10/27 (2025). -Describe your plans to make sure the above happens. -[Registered Nurse] is doing a class for remaining staff to have full medication administration on the morning of 10/31 (2025)." This facility served adolescents aged 15-17 years old with diagnoses which included Conduct Disorder, Post Traumatic Stress Disorder, Major Depressive Disorder, Attention Deficit Hyperactivity Disorder, Mood Dysregulation Disorder, Unspecified Trauma/Stressor Disorder, Diabetes, Uncontrollable Mood Disorder. Medications were being administered by all staff who had not received the required training in medication administration by a registered nurse, pharmacist, or other legally qualified person. FC #2 did not have medication orders but the facility documented medication administration of Clonidine, Divalproex Sodium, Ferrous Sulfate, Flintstones Iron Tab Chew, Metformin, Olanzapine and Sertraline for the four weeks when he was admitted to the facility. FC #2's MAR was incorrectly labeled September 2025 but was actually for August 2025. The pharmacy label on Client #1's Clindamycin did not accurately reflect the current physician's order. Client #1's medication refusals for Doxycycline was not reported to a pharmacist or physician. This deficiency constitutes a Type B rule violation	V 118		

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V 118	Continued From page 30 which is detrimental to the health, safety and welfare of the clients and must be corrected within 45 days. V 123 27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. . This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure medication errors were reported immediately to a physician or pharmacist affecting 1 of 1 client (Client #1). The findings are: Review on 10/15/25 of Client #1's record revealed: -Date of Admission: 9/5/25. -Diagnoses: Conduct Disorder, Post-Traumatic Stress Disorder, Major Depressive Disorder, Attention Deficit Hyperactivity Disorder. -Age: 17 years. -Physician's Order dated 9/30/25 for Doxycycline 100 milligrams (mg) (rash or dry skin). -No evidence of medication errors being reported to a pharmacist or physician immediately.	V 118 V 123	**V.123 Facility failed to ensure medication errors were reported immediately to a physician or pharmacist.** **1. Corrective Action Taken:** The medication error was immediately reviewed by the QP and Executive Director on 10/29/2025.All staff involved were counseled and coached on medication error reporting requirements, including immediate notification procedures and documentation. The incident was documented on an incident report. **2. Measures Taken to Ensure Others Are Not Affected:** A full review of all current client medication records and incident logs was conducted to ensure no additional unreported medication errors occurred. Staff medication practices were observed and audited to confirm medications were being administered correctly and reported appropriately. No other clients were found to be affected. **3. Systemic Changes Implemented to Prevent Recurrence:** The Medication Administration Policy requires: • Immediate notification to the prescribing physician or pharmacist for any medication error • QP review of the medication error and follow-up actions • Documentation of physician/pharmacist instructions • Mandatory staff coaching after any medication error. • All staff received coaching on the updated policy on 11/21/2025.	

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V 123	Continued From page 31 Review on 10/15/25 of Client #1's October 2025 Medication Administration Record (MARs) revealed: -Doxycycline Hyclate 100mg was initialed as refused on 10/3, 10/4, 10/5, 10/6, 10/7, 10/8 and 10/10 with no evidence of medication errors being immediately reported to a pharmacist or physicain. Interview on 10/16/25 and 10/29/25 with the Qualified Professional (QP) revealed: -Would assist the Executive Director/Licensee (ED/L) with any documentation required when contact to a pharmacist or physician was needed to report medication errors and all direction provided by the pharmacist or physician will be acted upon and documented. Interview on 10/27/25 and 10/29/25 with the ED/L revealed: -"Documentation will be maintained when a client refuses medication or there is a medication error and the facility contact a pharmacist or physician to discuss the error, contact was already happening but there was no documentation for this contact, now contact will be documented." This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type B rule violation and must be corrected within 45 days.	V 123	Continued from page 31 **4. Monitoring to Ensure Ongoing Compliance:** The Executive Director/QP will conduct weekly reviews of the Medication Administration Records (MARs) and incident logs to identify any potential errors. The QA/QI Committee will complete a monthly audit of: • Medication errors • Physician/pharmacist notification documentation Corrective actions taken Any failure to report errors immediately will result in disciplinary action and required retraining.	
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the	V 132		

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V 132	Continued From page 32 Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report allegations of abuse to the Health Care Personnel Registry (HCPR). The findings are: Review on 10/16/25 of Former Staff (FS) #9's record revealed: -Date of Hire: 8/18/25. -Job Title: Direct Support Staff.	V 132	**V.132 The facility failed to report allegations of abuse to the Health Care Personnel Registry (HCPR).** **1. Corrective Action Taken:** Upon discovery of the oversight, the facility immediately submitted the required HCPR report for the allegation of abuse on 10/29/25. The staff involved was removed from client contact on the date of the initial discovery. All internal incident documentation was reviewed for accuracy and filed appropriately. Staff responsible for reporting were immediately coached on HCPR reporting rules and timelines. **2. Measures Taken to Ensure Others Are Not Affected:** A facility-wide review of all incidents within the past 2 months was completed to confirm whether any other reportable allegations required submission to HCPR. No additional cases requiring HCPR reporting were identified. **3. Systemic Changes Implemented to Prevent Recurrence:** The Incident Reporting Policy includes: • Immediate (same-day) reporting to HCPR for any allegation of abuse, neglect, misappropriation, or diversion by staff • QP or ED verify that the HCPR report was filed Reporting staff were coached on: • HCPR requirements • Mandatory reporting laws • Internal reporting procedures and timelines	

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V 132	Continued From page 33 -Date of Suspension and Separation: 9/25/25. Review on 10/16/25 of the suspension letter dated 9/25/25 and sent to FS #9 revealed: -FS #2 made a statement suggesting she would involve her son if Former Client (FC) #2 became aggressive. Attempted interview through phone call and text message on 10/21/25 with FS #9 but the mailbox was full and not able to leave a voicemail. No return phone call before the survey exit. Interview on 10/29/25 with the Qualified Professional revealed: -"I will make sure HCPR is notified of all allegations against staff moving forward and will go back and will also notify them regarding the allegation involving [FS#9] and [FC #2], even though it will be late, it will be documented." Interview on 10/28/25 with the Executive Director/Licensee revealed: -There was an incident between FC #2 and FS #9 on 9/17/25 in which " ...she (FS #9) made a statement suggesting she (FS #9) would involve her son if [FC #2] became aggressive." -On 9/25/25, FS #9 was suspended pending investigation. -"[FS #9] never returned to work or reached out to ED/L to discuss the suspension." Interview on 10/29/25 with ED/L revealed: -" ...any allegation of abuse or neglect will be submitted immediately to Incident Response Improvement System, and an investigation done, and staff will be put on suspension pending completion of the investigation and HCPR will be notified immediately."	V 132	Continued from page 33 **4. Monitoring to Ensure Ongoing Compliance:** All incidents will be reviewed by the Executive Director and QP within 24 hours to determine HCPR reportability. The QA/QI Committee will conduct a monthly audit of all incident reports to verify: • HCPR reporting occurred when required • Documentation includes confirmation numbers • Internal follow-up actions were completed Any failure to follow HCPR reporting procedures will result in corrective action and mandatory retraining.	

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V 293	Continued From page 34	V 293		
V 293	27G .1701 Residential Tx. Child/Adol - Scope 10A NCAC 27G .1701 SCOPE (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. (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. (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. (d) The children or adolescents served shall require the following: (1) removal from home to a community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting. (e) Services shall be designed to: (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		

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V 293	Continued From page 35 gaining the skills needed to step-down to a less intensive treatment setting. (f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care. 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 minimize the occurrence of behaviors related to functional deficits, ensure safety and deescalate out of control behaviors including frequent crisis management, and assist the adolescent in the acquisition of adaptive functioning in self-control, communication, and social skills affecting 1 of 1 current client (Client #1) and 1 of 1 former client (FC #2) and failed to coordinate with other individuals within the adolescent's system of care affecting 1 of 1 former client (FC #2) The findings are: Cross-Reference: 10A NCAC 27G .0201 Governing Body Policies (V105). Based on record review and interview, the facility failed to complete a screening assessment of whether or not the facility can provide services to address the individual's needs affecting 1 of 1 current client (Client #1) and 1 of 1 former client (FC#2).	V 293	**V.293 The facility failed to operate within the scope of the license and failed to provide adequate behavioral interventions, safety measures, crisis de-escalation, adaptive skill development, and system-of-care coordination.** **1. Corrective Action Taken:** The QP and Executive Director completed an immediate review of Client's records and developed adaptive functioning interventions based on assessed needs. Staff received immediate coaching on crisis management, safety protocols, de-escalation techniques, and Level III expectations. Services were adjusted to align with Level III scope of practice. **2. Measures Taken to Ensure Others Are Not Affected:** All active client files were reviewed to ensure: • Crisis plans were individualized and being implemented • Staff were addressing functional deficits and behavior triggers • System-of-care communication was occurring regularly and documented Any gaps identified were corrected immediately.	

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V 293	Continued From page 36 Cross-Reference: 10A NCAC 27G .0202 Personnel Requirements (V108). Based on record review and interview, the facility failed to ensure 3 of 3 audited paraprofessionals (Staff #1, #2, and #3) and 2 of 2 former paraprofessionals (Former Staff (FS) #8 and FS #9) received the training to meet the MH/DD/SA needs of the clients. Cross-Reference: 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109). Based on record review and interview, 1 of 1 Qualified Professional (QP) failed to demonstrate the knowledge, skills and abilities to meet the needs of clients. Cross-Reference: 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110). Based on record review and interview 1 of 4 audited paraprofessional staff (Executive Director/Licensee (ED/L)) failed to demonstrate the knowledge, skills and abilities required by the population served. Cross-Reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V111). Based on record review and interview, the facility failed to ensure assessments were completed prior to the delivery of services and failed to develop treatment strategies to address clients' needs affecting 1 of 1 current client (Client #1) and 1 of 1 former client (FC #2). Cross-Reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112). Based on record review and interview, the facility failed to develop and implement treatment strategies to address the	V 293	Continued from page 36 **3. Systemic Changes Implemented to Prevent Recurrence:** The facility implemented the following systemic corrections: • Reviewed the Crisis Intervention Protocol to ensure staff follow standardized, approved de-escalation methods. • Implemented a monthly QP review of client behavior data, incidents, and staff response quality. Staff coaching on: o Level III scope of practice o Crisis management and de-escalation • Enhanced system-of-care coordination procedures, including mandatory contact logs **4. Monitoring to Ensure Ongoing Compliance:** The Executive Director and QP will complete monthly behavioral intervention audits for all clients to ensure: • Interventions match the level of care • De-escalation is used properly and safely • System-of-care communication is documented • Behavior data is being reviewed and used to adjust strategies The QA/QI Committee will conduct a monthly review of: • Incident reports • Crisis plans • Communication logs • Treatment strategies Any deficiencies will result in immediate corrective coaching, retraining, and re-audit.	

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V 293	Continued From page 37 needs of 1 of 1 current client (Client #1). Cross-Reference: 10A NCAC 27G .1702 Requirements of Qualified Professionals (V294). Based on record review and interview, 1 of 1 Qualified Professional (QP) failed to coordinate basic care management functions. The findings are: Cross-Reference: 10A NCAC 27G .1703 Requirements of Associate Professionals (V295). Based on record review and interview the facility failed to employ an Associate Professional (AP). Cross-Reference: 10A NCAC 27G .1704 Minimum Staffing Requirements (V296). Based on record review and interview, the facility failed to ensure 2 direct care staff were present for up to four adolescents. Cross-Reference: 10A NCAC 27G .1705 Requirements of Licensed Professionals (V297). Based on record review and interview the facility failed to ensure face to face clinical consultation was provided in the facility as least four hours a week by a Licensed Professional (LP). Cross-Reference: 10A NCAC 27G .1708 Transfer or Discharge (V300). Based on record review and interview, the facility failed to ensure a service planning meeting was held within 5 business days of an emergency discharge affecting 1 of 1 former client (FC #2). Review on 10/16/25 of FC #2's record revealed: -No parameters of orders from blood sugar checks. -No contact to a licensed physician to clarify orders and parameters.	V 293		

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V 293	Continued From page 38 Review on 10/22/25 of FC #2's August 27-September 18, 2025 MARs revealed: -August 27 there were no blood sugar checks completed. -August 28 there were no blood sugar checks completed at 8am or 10am. -August 29 there were no blood sugar checks completed at 4pm or 6pm. -August 30 there were no blood sugar checks completed at 12pm, 2pm, 4pm, 6pm , 8pm or 10pm. -September 1 there was no documentation of blood sugar checks at 8am, 10am, 12pm, 2pm, 6pm. -September 1 at 4:16pm, client refused to take his blood sugar. -September 1 at 10pm, client was asleep and did not take his blood sugar. -September 2 at 8am, initialed as not administered, no reason. -September 2 at 2:04pm, client was not asked to take blood sugar. -No other documentation of blood sugar checks until discharge on 9/18/25. Interview on 10/28/25 with Staff #2 revealed: -No training identifying diabetes needs. -"Did not know if the MAR (Medication Administration Review) had a range to go by for blood sugar ranges." Interview on 10/21/25 with Staff #3 revealed: -"...never had to check blood glucose for a client ...shift ends at 8 am and the staff were allowed to leave a bit earlier than that once the clients went to school." Interview on 10/21/25 with Former Staff #8 revealed: -"...no training to do so (check blood glucose) at	V 293		

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V 293	Continued From page 39 the facility." -"When [FC #2] came to the facility and needed to have his blood glucose taken, the client and the staff did not have any training to do this, nobody came in to provide directives on how to complete blood glucose testing." Interview on 10/24/25 with the Department of Social Services (DSS) legal guardian for FC #2 revealed: -"When he was discharged from the hospital to go to the group home, the nurse showed us (DSS legal guardian and case manager) and we had shown them (group home staff). The hospital had them checking every day and every night, three times a week it was determined to do checks from that point." Interview on 10/27/25 with the Local Management Entity/Managed Care Organization (LME/MCO) case manager revealed: -"He (FC #2) just got diagnosed with diabetes. We (DSS legal guardian and case manager) weren't aware that he had to check his glucose. [FC #2] could stick himself, there was some confusion on how often he should do it, he was doing it once a day at the hospital and when he left the instructions told to do it after every meal ....there was a follow up meeting and we did learn that [FC #1] only has to check himself three times a week. We were told to monitor but weren't told about the numbers." -There was no written order regarding blood glucose screening and the parameters when he was discharged from the hospital. -"...showed [Executive Director/Licensee (ED/L] what the hospital showed us (DSS legal guardian and the LME case manager) (regarding blood glucose checks)."	V 293		

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V 293	Continued From page 40 Interview on 10/16/25 with the Qualified Professional (QP) revealed: -"[FC #2] checked his own blood sugars, he was prediabetic ...when he was dropped off (admitted to the facility) the DSS legal guardian and case manager told us how to help him with the needle he would click ...he would click every two hours and it would record his blood sugar numbers." -"We (QP and ED/L) didn't know he had that (diabetes) until the day he got here (to the facility)." Interview on 10/27/25 with the ED/L revealed: -"DSS legal guardian and the Case manager advised me that [FC #2] needed to check himself every two hours for blood sugar ...when he returned from the hospital on 9/11/25 the nurse from the hospital said that [FC #2] didn't need to check blood sugars every two hours but needs to do it two times a day three days per week." -"Staff had no training on diabetes." Review on 10/29/25 of the Plan of Protection dated and signed by the ED/L on 10/29/25 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? Tag 105, We will develop and implement a standardized Client Admission Screening Form to ensure that all referrals are properly assessed for program appropriateness before acceptance. The QP or Executive Director (ED/L) will complete and sign the form for each referral, documenting clinical, behavioral, and safety considerations. All screening documentation will be maintained in a file, whether the referral is accepted or denied. Tag 108, We will ensure that all staff receive comprehensive training on client-specific needs, including diabetes management, history of sexualized behaviors, and individualized	V 293		

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V 293	Continued From page 41 treatment plan interventions. Training will be documented, and staff will be required to demonstrate understanding through competency checks. Tag 109 and 110, The QP and Executive Director will participate in enhanced supervision and mentorship under the guidance of Licensed Professional, [LP], to strengthen competencies in managing client care and regulatory compliance. The QP will implement all recommendations from the LP and document corrective measures taken. Tag 111 and 112 We will ensure that every client has an individualized treatment plan developed immediately upon admission, without waiting for a new PCP (person centered plan) (treatment plan) assignment. Emergency or interim plans will be created during the first 24-48 hours to guide care and support consistent client needs. Tag 294, The QP will receive enhanced training on all applicable rules, required treatments, and regulatory responsibilities. The QP will ensure full compliance with client care standards and facility policies moving forward. Tag 295, I have hired an Associate Professional, and orientation will be conducted tomorrow to ensure the new hire is fully trained on facility policies, procedures, and client care requirements. Tag 296, We will ensure that staff ratios consistently meet regulatory requirements, with at least a 2 to 1-4 staff to client ratio. Tag 297, The Licensed Professional will provide at least four hours per week of direct counseling to clients, as well as supervision to the QP and staff regarding treatment plan implementation and behavioral interventions. Tag 300, We will ensure that a discharge meeting is held within five days of any emergency client discharge. All relevant parties, including the MCO (Local Management Authority/Managed Care Organization), legal guardian, parents (if applicable), and DSS (Department of Social Services) (if required), will be notified in a timely	V 293		

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V 293	Continued From page 42 manner. -Describe your plans to make sure the above happens. Tag 105, All administrative and intake staff will be trained on the new screening process. The Executive Director will review each screening form prior to admission and conduct quarterly audits to ensure documentation accuracy and compliance. This process will remain part of our ongoing QA/QI (Quality Assurance/Quality Improvement) monitoring to prevent recurrence of this violation. Tag 108, We will schedule mandatory training sessions for all current and new staff within the next 30 days. Ongoing refresher trainings will be conducted quarterly, and staff competency will be reviewed regularly to ensure safe, effective care for all clients. Tag 109 and 110, We will establish a structured supervision schedule with LP [LP], including weekly case reviews and monthly performance evaluations. The QP will maintain detailed documentation of supervision sessions, action steps taken, and measurable improvements in handling client situations. Tag 111 and 112, We will implement a standard procedure requiring staff to draft initial treatment plans within 48 hours of admission. The QP and Executive Director will review these plans to ensure they are complete, documented, and communicated to all relevant staff. Tag 294, We will schedule structured training sessions for the QP with LP [LP], covering all required regulations, treatments, and documentation standards. The QP will maintain detailed records of completed trainings, supervision, and corrective actions implemented, with monthly reviews to ensure ongoing competency and adherence to standards. Tag 295, We will maintain documentation of the Associate Professional's orientation and training, including competency verification. Ongoing supervision will be provided	V 293		

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V 293	Continued From page 43 by the QP and Executive Director to ensure proper integration and adherence to all care standards. Tag 296, I will maintain staffing schedules that meet ratio requirements, including backup plans for absences. The Executive Director will review staffing logs daily to verify compliance and address any gaps immediately. Tag 297, We will implement a weekly schedule documenting LP counseling hours and supervision sessions. The QP and Executive Director will maintain records of LP oversight, recommendations, and follow-up actions to ensure full compliance with treatment and regulatory standards. Tag 300, We will implement a standard procedure for scheduling and documenting discharge meetings. The QP and Executive Director will host the meetings, maintain attendance records, and document all actions and follow-ups to ensure compliance with regulatory requirements." Review on 10/29/25 of the Amended Plan of Protection dated and signed by the ED/L on 10/29/25 revealed: -"Describe your plans to make sure the above happens. Tag 105, This will be done by 11.5.2025, Tag 108, This will be done by 11.5.2025, Tag 109 and 110, This will be done by 11.12.2025 Tag 111 and 112, This will be done by 11.5.2025, Tag 294, This will be done by 11.12.2025, Tag 295, This will be done by 10.30.2025 Tag 296, This will be done by 10.30.25, Tag 297, This will be done by 11.5.2025, Tag 300, This will be done by 11.5.2025." This facility served children aged 15-17 years old with diagnoses which include conduct disorder, post traumatic stress disorder, major depressive disorder, attention deficit hyperactivity disorder,	V 293		

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V 293	Continued From page 44 mood dysregulation disorder, unspecified trauma/stressor disorder, diabetes, uncontrollable mood disorder. The facility did not complete screening and admission assessments or develop strategies to address presenting problems that included: inappropriate sexual behaviors, pretending to masturbate in public, temper outburst, physically and verbally aggressive, running away, self-injurious behavior, fire setting, stealing, consuming inedible products and property damage. The facility did not ensure staff received training to meet the needs of the clients to include diabetes management or how to supervise client's when taking blood glucose levels and sexually aggressive youth. The facility did not employ an AP as required. The LP did not spend at least four hours per week in the facility as required and did not provide supervision to the QP or provide consultation with the development of treatment strategies and overall program issues. The facility did not maintain two direct care staff at all times during shifts. The facility did not ensure that a planning meeting was held for Former Client #2 after an emergency discharge. The QP did not demonstrate the knowledge, skills and abilities to meet the needs of the clients. The QP did not complete screening and admission assessments, did not provide training to staff for client specific needs to include sexually aggressive youth and diabetes. The QP did not implement treatment plans with strategies to address the needs of the clients. The QP did not seek out diabetes information and training for FC #2. The ED/L did not demonstrate the knowledge, skills and abilities to meet the needs of the clients. The ED/L did not ensure admissions assessments were completed prior to the delivery of services, failed to ensure the coordination of care by not contacting a medical professional for the parameters of blood glucose checks or	V 293		

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V 293	Continued From page 45 having his staff trained to care for the diabetic needs of FC #2. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 293		
V 294	27G .1702 Residential Tx. Child/Adol -Req. for Q P 10A NCAC 27G .1702 REQUIREMENTS OF QUALIFIED PROFESSIONALS (a) Each facility shall utilize at least one direct care staff who meets the requirements of a qualified professional as set forth in 10A NCAC 27G .0104(18). In addition, this qualified professional shall have two years of direct client care experience. (b) For each facility of five or less beds: (1) the qualified professional specified in Paragraph (a) of this Rule shall perform clinical and administrative responsibilities a minimum of 10 hours each week; and (2) 70% of the time shall occur when children or adolescents are awake and present in the facility. (c) For each facility of six or more beds: (1) the qualified professional specified in Paragraph (a) of this Rule shall perform clinical and administrative responsibilities a minimum of 32 hours each week; and (2) 70% of the time shall occur when children or adolescents are awake and present in the facility. (d) The governing body responsible for each facility shall develop and implement written policies that specify the clinical and administrative responsibilities of its qualified professional(s). At a minimum these policies shall include:	V 294		

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V 294	Continued From page 46 (1) supervision of its associate professional(s) as set forth in Rule .1703 of this Section; (2) oversight of emergencies; (3) provision of direct psychoeducational services to children or adolescents; (4) participation in treatment planning meetings; (5) coordination of each child or adolescent's treatment plan; and (6) provision of basic case management functions. This Rule is not met as evidenced by: Based on record review and interview, 1 of 1 Qualified Professional (QP) failed to coordinate treatment plans and basic case management functions. The findings are: Review on 10/16/25 of the QP's record revealed: -Hire date: 8/18/25. Review on 10/15/25-10/29/25 of the facility records revealed: -No documentation that the QP provided coordination of treatment plans, and provision of case management functions for Former Client #2. -A Child and Family Team meeting was held at the school on October 14, 2025 for Client #1, however, there was no documentation of the meeting notes/who attened the meeting provided before the survey exit. Interview on 10/16/25 and 10/29/25 with the QP	V 294	**V.294 Qualified Professional (QP) failed to coordinate treatment plans and basic case management functions.** **1. Corrective Action Taken:** The QP completed coordination of all required treatment planning tasks for the affected client by 11/21/2025. This included updating the PCP, ensuring treatment strategies aligned with client needs, and contacting all system-of-care partners to share updates. All communication was documented in the client record and the System-of-Care Log. The QP received corrective coaching from the LP and ED regarding treatment coordination expectations. **2. Measures Taken to Ensure Others Are Not Affected:** All active client cases were reviewed by the Executive Director to confirm that: • Treatment plans were current • Case management functions were being completed • Updates, referrals, and follow-up tasks were documented Any minor gaps discovered were addressed immediately through QP follow-up.	

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V 294	Continued From page 47 revealed: -"When he (FC #2) was dropped off, the Department of Social Services worker and Case Manager (Local Management Entity/Managed Care Organization) told us (QP and Executive Director/Licensee (ED/L)) how to help him (FC #2) with the needle...every two hours and record his blood sugar numbers...was told to give him juice if his blood sugar was low." -"Will meet with the licensed professional for supervision and assistance in identifying clinical needs of the clients and to ensure that the coordination of care is maintained for the clients and that case management duties are discussed with the licensed professional so that duties are identified and completed by the QP." Interview on 10/29/25 with the Executive Director/Licensee revealed: -"The QP will also work to coordinate staff trainings as identified." This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 294	Continued from page 47 **3. Systemic Changes Implemented to Prevent Recurrence:** The facility implemented the following corrective systems: **A. QP Workflow** • QP must review all PCPs and treatment goals monthly • QP must maintain a System-of-Care Communication Log for each client • QP must notify the ED when treatment plan updates or coordination tasks are completed **B. Staff Training** By 11/21/2025, the QP and all clinical staff were coached on: • Treatment planning requirements • Case management expectations • Documentation standards • System-of-care coordination requirements **4. Monitoring to Ensure Ongoing Compliance:** The Executive Director will review case management documentation weekly for 90 days to ensure coordination tasks are being completed.	
V 295	27G .1703 Residential Tx. Child/Adol - Req. for A 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	V 295	The QA/QI Committee will conduct monthly audits of: • Case management logs • PCP updates • System-of-care communications • Treatment plan revisions Any deficiencies noted will result in immediate corrective action coaching and re-monitoring.	

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V 295	Continued From page 48 facility shall develop and implement written policies that specify the responsibilities of its associate professional(s). At a minimum these policies shall address the following: (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. This Rule is not met as evidenced by: Based on record review and interview the facility failed to employ an Associate Professional (AP). The findings are: Review on 10/15/25 of the facility's Client Staff Census completed by the Executive Director/Licensee (ED/L) on 10/15/25 revealed: -There was no staff listed with the job title of AP. Interview on 10/27/25 with the ED/L revealed: -The facility doesn't have an AP. -"I've hired one and she starts 10/30/25 ...No one prior to her in that role." This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 295	**V.295 The facility failed to employ an Associate Professional (AP) as required.** **1. Corrective Action Taken:** A qualified AP started her employment on 11/4/2025. All coverage and responsibilities are documented. **2. Measures Taken to Ensure Others Are Not Affected:** All current client cases were reviewed to ensure required supervision, treatment planning, and case management tasks were completed despite the AP vacancy. The QP completed any outstanding AP-related functions, including documentation follow-up, treatment coordination, and client monitoring. No clients were affected. **3. Systemic Changes Implemented to Prevent Recurrence:** **A. Workforce & Staffing Updated** • Additional staff meeting requirements and capabilities have been hired as back up AP and QP positions come open **B. Recruitment & HR Changes** • Added AP position to standing recruitment postings • Maintained an active candidate pool • Implemented quarterly staffing reviews to anticipate vacancies • Immediate action when a qualified position becomes vacant **4. Monitoring to Ensure Ongoing Compliance:** The Executive Director will conduct monthly staffing audits to verify all required positions—QP, AP, DSP—remain filled and credentialed. The QA/QI Committee will review staffing compliance during monthly meetings and ensure coverage plans are in place for any future vacancies. Any lapse in required staffing will trigger immediate corrective action and documentation.	
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing	V 296		

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V 296	Continued From page 49 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 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	V 296		

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V 296	Continued From page 50 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 record review and interview, the facility failed to ensure 2 direct care staff were present for up to four adolescents. The findings are: Interview on 10/15/25 with Client #1 revealed: - "It's very rare (to only have one staff present), they try to keep it at two. Sometimes people call out and can't make it." -One time there was only one staff working per shift was "...a week, week and a half ago. It was [Staff #6], it was a Saturday during the day." -"The nighttime people (staff) are by themselves. Usually, it's two (staff) but the past couple of nights, it's been one (staff)." -"Tuesday (10/4/25) and Wednesday (10/15/25) morning when I woke up there was only one staff person here, [Staff #3]." Interview on 10/15/25 with Staff #1 revealed: -"When I work 2-11 (pm), it sometimes might just be me (working alone). When we have two clients, they (Executive Director/Licensee (ED/L)) have two staff." -"Sometimes it might just be me (working alone), one staff." -Sometimes have worked shifts alone "...but normally two."	V 296	***V.296 The facility failed to ensure two direct care staff were present for up to four adolescents, as required by staffing ratios.*** **1. Corrective Action Taken:** Upon discovery, the facility immediately adjusted staffing assignments to ensure two direct care staff were present during all required shifts. Staffing for shifts identified as out of ratio was corrected by 11/21/2025. All involved staff received corrective coaching regarding ratio requirements. The Executive Director completed a full staffing review for the affected dates and ensured no client safety concerns resulted from the lapse. **2. Measures Taken to Ensure Others Are Not Affected:** A complete audit of all staffing schedules for the past 30 days was conducted to verify that staffing ratios were met on all other shifts. Any discrepancies were corrected immediately. All current shifts were verified to have appropriate coverage before the next operational day. No additional ratio failures were identified. **3. Systemic Changes Implemented to Prevent Recurrence:** **A. Staffing Procedures Updated** • Staff may not leave a shift until the next two staff have arrived and signed in. • A "call tree" backup plan was implemented to ensure immediate coverage during call-outs. **B. Scheduling Improvements** • Weekly schedules will now be reviewed and approved by the Executive Director and QP. • A second staff member may not be pulled from the floor for tasks unless a replacement is present.	

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V 296	Continued From page 51 Interview on 10/28/25 with Staff #2 revealed: -"We have two at night (staff on shift), there has been one time where there is one (staff on shift)." Interview on 10/21/25 with Staff #3 revealed: -She worked third shift. -"I have worked by myself 2 or 3 times." -The last time she worked alone was "...I believe last week, I cant remember the day, maybe last Thursday." Interview on 10/16/25 with the Qualified Professional revealed: -"Sometimes it's one (staff on shift) recently, but most of the time its two (staff on shift)." Interview on 10/27/25 and 10/29/25 with the ED/L revealed: -"I do know that it should be two but sometimes it is one (staff on shift)." -"I've been struggling to replace them (staff) ...so for a while I was picking up every extra shift ...then I got lazy on it (having two staff per shift)." -"Will make sure two staff at any time present in the facility ...effective immediately." This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 296	Continued from page 51 **4. Monitoring to Ensure Ongoing Compliance:** The Executive Director or QP will: • Perform random shift audits to verify two-staff presence • Review staffing compliance during each monthly QA/QI meeting Failure to maintain ratios will result in immediate corrective action and retraining.	
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	V 297		

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V 297	Continued From page 52 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. (b) The consultation specified in Paragraph (a) of this Rule shall include: (1) clinical supervision of the qualified professional specified in Rule .1702 of this Section; (2) individual, group or family therapy services; or (3) involvement in child or adolescent specific treatment plans or overall program issues. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure face-to-face clinical consultation was provided in the facility as least four hours a week by a Licensed Professional (LP). The findings are: Review on 10/29/25 of the LP's record revealed: -Date of Hire: 9/13/25. Interview on 10/15/25 with Client #1 revealed: -Participated in weekly therapy at the facility. -"She (Licensed Professional) comes on Thursdays and stays an hour to an hour and a half...never comes twice in one week..... only meets with me, not with staff." Interview on 10/15/22 with Staff #1 revealed:	V 297	**V.297 The facility failed to ensure face-to-face clinical consultation was provided in the facility at least four hours per week by a Licensed Professional (LP).** **1. Corrective Action Taken:** The facility has a Licensed Professional (LP) to provide the required clinical consultation hours. Effective by 11/21/2025, the LP began providing on-site, face-to-face clinical consultation for a minimum of four hours weekly. Missed or incomplete consultation weeks were reviewed, and treatment recommendations were updated accordingly. The QP and ED confirmed that all clients received the required clinical support. **2. Measures Taken to Ensure Others Are Not Affected:** A full review of all client records was conducted to ensure clinical needs were addressed despite the absence of required LP consultation hours. Any gaps in clinical oversight, treatment planning recommendations, or crisis review were corrected immediately by the LP and QP. No additional clients were negatively affected. **3. Systemic Changes Implemented to Prevent Recurrence:** **A. LP Clinical Consultation Schedule Implemented** • A weekly standing 4-hour on-site LP scheduling was added to schedule. • LP hours will now be scheduled one month in advance and approved by the Executive Director. **B. LP Consult Documentation Requirements** The following tools were implemented: • Monthly summary of LP recommendations for QP review	

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V 297	Continued From page 53 -"[Client #1] sees a therapist (LP) once a week, normally on Thursdays. She (therapist) comes to the house (facility)." Interview on 10/28/25 with Staff #2 revealed: -"[Client #1] sees a therapist (LP) ...came this past Sunday (10/26/25) and stayed about one and a half hours. When present, she only does work with the client." Interview on 10/16/25 and 10/29/25 with the Qualified Professional (QP) revealed: -"[Client #1] has therapy twice a week. Therapy at school and home (facility)." -Was not meeting with the LP. -"Will make sure to meet with the LP for supervision and direction for client needs and program needs." Interview on 10/27/25 with the Executive Director/Licensee (ED/L) revealed: -"She (LP) is in the home once a week, for one hour. She does therapy notes, she can be present on the CFT (child and family team meeting)." -There was no LP for the facility prior to 9/13/25. Interview on 10/29/25 with the ED/L revealed: -"The LP will be present in the facility for at least four hours a week providing therapy to clients and support to the staff, starting today." This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 297	Continued from page 53 **C. Staff Training** By 11/21/2025, QP, ED, and DSP staff were coached on: • The LP clinical consultation role • How to bring client concerns to LP consultation **4. Monitoring to Ensure Ongoing Compliance:** The Executive Director will: • Conduct weekly reviews for 60 days, then monthly thereafter • Initiate immediate follow-up if LP hours fall below the requirement The QA/QI Committee will audit clinical consultation documentation every month to ensure compliance, review any missed hours, and approve corrective actions if needed	
V 300	27G .1708 Residential Tx. Child/Adol - Trans or dischg	V 300		

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V 300	Continued From page 54 10A NCAC 27G .1708 TRANSFER OR DISCHARGE (a) The purpose of this Rule is to address the transfer or discharge of a child or adolescent from the facility. (b) A child or adolescent shall not be discharged or transferred from a facility, except in case of emergency, without the advance written notification of the treatment team, including the legally responsible person. For purposes of this Rule, treatment team means the same as the existing child and family team or other involved persons as set forth in Paragraph (c) of this Rule. (c) The facility shall meet with existing child and family teams or other involved persons including the parent(s) or legal guardian, area authority or county program representative(s) and other representatives involved in the care and treatment of the child or adolescent, including local Department of Social Services, Local Education Agency and criminal justice agency, to make service planning decisions prior to the transfer or discharge of the child or adolescent from the facility. (d) In case of an emergency, the facility shall notify the treatment team including the legally responsible person of the transfer or discharge of the child or adolescent as soon as the emergency situation is stabilized. (e) In case of an emergency, notification may be by telephone. A service planning meeting as set forth in Paragraph (c) of this Rule shall be held within five business days of an emergency transfer or discharge.	V 300		

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V 300	Continued From page 55 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a service planning meeting was held within 5 business days of an emergency discharge affecting 1 of 1 former client (FC #2). The findings are: Review on 10/16/25 of FC #2's record revealed: -Date of Admission: 8/27/25. -Date of Discharge: 9/18/25. -Diagnoses: Disruptive Mood Dysregulation Disorder, Unspecified Trauma and Stressor Related Disorder, Attention Deficit Hyperactivity Disorder, Diabetes. -Age: 15 years. Review on 10/29/25 of FC #2's documents regarding an emergency discharge from the facility on 9/18/25 revealed: -Documentation notifying the treatment team of the emergency discharge. -Contact was made to the client's mother, Department of Social Services legal guardian and the Local Management Entity/Managed Care Organization (LME/MCO). Interview on 10/29/25 with the Qualified Professional revealed: -"I will assist [Executive Director/Licensee (ED/L)]with any discharge meetings and will maintain documentation." Interview on 10/29/25 with the ED/L revealed: -"I will make sure all rule requirements of organizing the treatment team follow up planning meetings will occur for any further emergency discharges." This deficiency is cross referenced into 10A	V 300	**V.300 The facility failed to ensure a service planning meeting was held within five (5) business days of an emergency discharge.** **1. Corrective Action Taken:** Because the emergency discharge occurred approximately a month and a half prior to the survey, the service planning meeting cannot be completed retroactively. However, the Executive Director and QP conducted a full review of the discharge record by 11/21/2025, verified all follow-up communication with DSS, the guardian, and system-of-care providers that occurred at the time, and documented a post-discharge review, ensuring all parties involved were notified. Staff involved received corrective coaching regarding the required 5-day service planning meeting timeline. **2. Measures Taken to Ensure Others Are Not Affected:** No additional missed or late meetings were identified. All current clients were reviewed to confirm that service planning expectations, timelines, and documentation were up to date. **3. Systemic Changes Implemented to Prevent Recurrence:** **A. Discharge Procedure Updated** The facility revised the Discharge Policy to include: • Mandatory scheduling of the post-discharge service planning meeting at the time of discharge • A requirement that the meeting occur within 5 business days • Notification protocol for guardians, DSS, MCO, and treatment providers	

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V 300	Continued From page 56 NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 300	Continued from page 56 **B. New Tracking Tools Implemented** • Emergency Discharge Checklist **C. Staff Training** By 11/21/2025, the QP, ED, and all applicable staff were coached on: • Emergency discharge procedures • Required timelines for post-discharge service planning • Documentation and communication expectations • System-of-care contact requirements **D. QP Accountability Measures Added** • QP must notify the ED immediately following any discharge • ED must approve completion of the meeting and review documentation **4. Monitoring to Ensure Ongoing Compliance:** For the next 90 days, the Executive Director will: • Review all discharges within 24 hours • Monitor completion of required service planning meetings • Verify documentation is placed in the client's record The QA/QI Committee will conduct monthly audits of: • All discharges • Service planning meeting dates • System-of-care coordination • Documentation accuracy and completeness Any missed or late meetings will be addressed with immediate corrective action.	
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	V 366		

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V 366	Continued From page 57 their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the 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	V 366		

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V 366	Continued From page 58 include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement written policies governing their response to Level I incidents as required. The findings are: Review on 10/15/25 of Client #1's record revealed: -Date of Admission: 9/5/25. -Diagnoses: Conduct Disorder, Post-Traumatic Stress Disorder, Major Depressive Disorder, Attention Deficit Hyperactivity Disorder.	V 366	**V.366 The facility failed to implement written policies governing the response to Level I incidents as required.** **1. Corrective Action Taken:** The facility immediately reviewed the Level I Incident Policy and identified gaps in staff implementation. All staff were retrained by 11/21/2025 regarding the proper procedures for identifying, responding to, documenting, and reporting Level I incidents. The policy was updated to ensure clarity on staff responsibilities, required documentation timeframes, follow-up, and supervisory notification. The QP and Executive Director reviewed all recent Level I incidents to ensure they were correctly documented and processed. The affected records were corrected as needed. **2. Measures Taken to Ensure Others Are Not Affected:** A review of all Level I incidents for the past 60 days was completed by the Executive Director. Any minor documentation inconsistencies were corrected immediately. All clients were monitored to ensure no safety issues resulted from the lapse. Staff were reminded to review the updated Level I Incident Response Policy prior to assuming their next shift. **3. Systemic Changes Implemented to Prevent Recurrence:** **A. Policy Review** The Level I Incident Policy was reviewed and focus was spent on:: • Steps for immediate staff response documentation requirements and timelines • When and how to notify supervisors • Follow-up monitoring and corrective actions • Clear definitions and examples of Level I incidents	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	Continued From page 59 -Age: 17 years. -Physician's order dated 9/24/25 included the following: Doxycycline Hylate 100 milligram (mg). Review on 10/16/25 of Client #1's October 2025 Medication Administration Record revealed: Doxycycline Hyclate was refused on 10/3, 10/4, 10/5, 10/6, 10/7, 10/8, 10/10. Review of the facility's incident reports dated 10/17/25 revealed no documentation of Client #1 refusing Doxycycline Hylate on 10/3/25 through 10/10/25. Interview on 10/29/25 with the Executive Director/Licensee revealed: -Medication administration refusals were not noted on a level I incident report. -The pharmacist or physician was not contacted about medication refusals.	V 366	Continued from page 59 **B. Staff Training** By 11/21/2025, all staff—including DSPs, the QP, and ED—were retrained on: • What qualifies as a Level I incident • Immediate staff responsibilities • Documentation procedures • Safety checks and follow-up requirements • Where and how to file documentation There is new-hire orientation and annual re-training. **C. Communication & Accountability** • Supervisors must now sign off on all Level I reports within 24 hours. • Staff may not leave shift until all Level I documentation is complete and reviewed. **4. Monitoring to Ensure Ongoing Compliance:** The AP will: • Conduct weekly audits for 60 days, then monthly thereafter, of all Level I incidents • Verify timely documentation, follow-up, and supervisory review • Include Level I incident compliance as a standing item on monthly QA/QI agenda • Provide immediate corrective coaching if gaps are identified Compliance findings will be tracked in the QA/QI binder for monitoring and trend analysis.	
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	V 367		

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	MHL036-429	A. BUILDING: _____ B. WING _____	10/29/2025

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V 367	Continued From page 60 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. (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	V 367		

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V 367	Continued From page 61 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 (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure all Level II and Level III incidents were reported to the Local Management Entity/Managed Care Organization (LME/MCO) for the catchment area where services are being provided within the required time frames. The findings are:	V 367	**V.367 The facility failed to ensure all Level II and Level III incidents were reported to the LME/MCO within the required timeframes.** **1. Corrective Action Taken:** The Executive Director and QP immediately reviewed the incidents identified by DHHS and submitted all required Level II and Level III reports to the LME/MCO by 11/21/2025. Documentation of submissions, reporting confirmations, and follow-up actions were placed in the QA/QI Incident Binder. Staff responsible for incident reporting received corrective coaching on reporting timeframes, categorization, and documentation expectations. **2. Measures Taken to Ensure Others Are Not Affected:** A review of all incidents occurring within the past 90 days was completed to ensure no other Level II or Level III incidents were missed or reported late. Any missing documentation was corrected and resubmitted when needed. Current clients were assessed to ensure no safety or risk concerns were overlooked due to late reporting. Staff were informed of the importance of timely incident identification and immediate reporting protocols. **3. Systemic Changes Implemented to Prevent Recurrence:** **A. Incident Reporting Policy** The Incident Reporting Policy includes: • Clear definitions of Level I, Level II, and Level III incidents • Required reporting timelines (24-hour notification for Level II and Level III) • Reporting to the LME/MCO • Required documentation and follow-up procedures • Communication expectations between DSP, QP, and ED	

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V 367	Continued From page 62 Review on 10/17/25 of the North Carolina Incident Response Improvement System (IRIS) from 08/01/25-10/19/25 revealed: -Incident report for Former Client (FC) #2 for an incident of aggressive behaviors on 9/17/25 which resulted in staff calling local law enforcement. -Incident report was not submitted to IRIS until 9/23/25. -Allegation that Former Staff #9 made a statement suggesting she would involve her son if client FC #2 became aggressive. -Incident report was not submitted to IRIS. Interview on 10/16/25 with the Qualified Professional (QP) revealed: -"Me and [Executive Director/Licensee (ED/L)] have been doing them (completing IRIS reports) together ...we (QP and ED/L) are learning."	V 367	Continued from page 62 **B. Staff Training** By 11/21/2025, all staff (DSP, QP, ED) were trained on: • How to identify Level II and III incidents • Immediate reporting expectations • Documentation requirements • Escalation procedures when unsure of level • Backup procedures if ED or QP is unavailable This training is now part of new-hire onboarding and annual staff retraining. **C. Accountability Procedures Added** • All incidents must now be reviewed by the ED, AP or QP within 4 hours of occurrence. • ED must verify LME/MCO reporting has been completed within 24 hours. • Any incident not reported within required timeframes will result in immediate corrective action.	
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed.	V 500	**4. Monitoring to Ensure Ongoing Compliance:** The AP will: • Verify reporting timeliness and documentation accuracy using the Incident Reporting Log • Review all Level II and III incident submissions during monthly QA/QI meetings The QA/QI Committee will: • Audit all Level II and III incident packets monthly • Review timelines, documentation completeness, and follow-up • Make corrective recommendations when trends or delays appear Compliance will be monitored continuously and documented in the QA/QI Binder.	

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V 500	Continued From page 63 Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and	V 500		

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V 500	Continued From page 64 (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure all incidents of alleged abuse were reported to the county Department of Social Services (DSS). The findings are: Review on 10/15/25-10/28/25 of the facility records revealed: -No documentation of the allegation that on an unknown date and time that Former Staff (FS) #2 made a statement suggesting she (FS #2) would involve her son if Former Client #1 became aggressive." -No documentation that DSS was contacted regarding the allegation of abuse which involved Former Staff #2 and Former Client #1. Interview on 10/29/25 with the Qualified Professional revealed: -Did not complete a report to the local DSS regarding the allegation. -" ...will make sure to notify DSS immediately of all allegations of abuse and neglect." Interview on 10/29/25 with the Executive Director/Licensee revealed: -" ...any allegations of abuse or neglect will be submitted immediately."	V 500	**V.500 The facility failed to ensure all incidents of alleged abuse were reported to the county Department of Social Services (DSS) as required.** **1. Corrective Action Taken:** Upon identification of the deficiency, the Executive Director immediately reviewed the incident in question and submitted a formal child protective services report to the county DSS on 10/29/2025. Confirmation of the report was obtained and filed in the QA/QI Incident Binder. Staff involved received corrective coaching regarding mandatory reporting. The ED notified all required system-of-care members by phone . **2. Measures Taken to Ensure Others Are Not Affected:** A full review of all incidents for the past 90 days was completed to ensure no other alleged abuse incidents were missing or unreported. No additional unreported allegations were identified. The Executive Director verified that all children currently in the home were safe and that all staff understood their duty to report immediately upon suspicion of abuse or neglect. **3. Systemic Changes Implemented to Prevent Recurrence:** **A. Mandatory Reporting Policy Updated** The facility has Mandatory Reporting Policy to include: • Clear definitions of abuse, neglect, and exploitation • Immediate notification requirements (ED/QP, DSS same day) • Documentation requirements • Staff accountability expectations **B. Staff Training** By 11/20/2025, all staff were retrained on: • Mandatory abuse/neglect reporting requirements • Signs and indicators of abuse • Immediate reporting expectations **C. Strengthened Oversight** • Staff may not conduct internal investigations; all allegations must go directly to DSS. • ED/QP must verify every DSS report has a confirmation number and that it is filed in the QA/QI binder. • Any delay or failure to report will result in disciplinary action.	
V 503	27D .0103 Client Rights - Search And Seizure Policy	V 503		

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V 503	Continued From page 65 10A NCAC 27D .0103 SEARCH AND SEIZURE POLICY (a) Each client shall be free from unwarranted invasion of privacy. (b) The governing body shall develop and implement policy that specifies the conditions under which searches of the client or his living area may occur, and if permitted, the procedures for seizure of the client's belongings, or property in the possession of the client. (c) Every search or seizure shall be documented. Documentation shall include: (1) scope of search; (2) reason for search; (3) procedures followed in the search; (4) a description of any property seized; and (5) an account of the disposition of seized property. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure every search or seizure was documented as required. The findings are: Observation on 10/15/25 at approximately 3:30 pm revealed: -Client #1 arrived at the facility from the day treatment program and upon entry Staff #1 used a hand-held metal detector passed over Client #1's body while Client #1 stood still and raised his arms to for a T with his body. Review on 10/15/25 of Client #1's record revealed: -Date of Admission: 9/5/25. -Diagnoses: Conduct Disorder, Post-Traumatic Stress Disorder, Major Depressive Disorder,	V 503	Continued from page 65 **4. Monitoring to Ensure Ongoing Compliance:** The AP will: • Review all incident reports daily for 60 days, then weekly thereafter • Verify DSS reporting for every abuse allegation • Conduct random checks of staff knowledge on mandatory reporting • Include mandatory reporting compliance as a standing item in monthly QA/QI meetings The QA/QI Committee will review monthly: • All alleged abuse incidents • DSS report confirmation numbers • Staff response times • Documentation completeness Any failure to report will result in immediate corrective action and retraining. **V.503 The facility failed to ensure every search or seizure was documented as required.** **1. Corrective Action Taken:** The Executive Director and QP immediately reviewed the searches identified by the surveyor. The Search & Seizure Log was created and put in Therap. **2. Measures Taken to Ensure Others Are Not Affected:** All current clients were confirmed safe, and all property seizures were returned, disposed of appropriately, or transferred according to policy. **3. Systemic Changes Implemented to Prevent Recurrence:** **A. Search & Seizure Procedure Updated** The procedure was updated to clearly require: • Documentation of *every* search—client, room, belongings, or property • Use of the standardized Search & Seizure Form or Log • Documentation of seized property and disposition **B. New Documentation Tools Implemented** • Search & Seizure Log	

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V 503	Continued From page 66 Attention Deficit Hyperactivity Disorder. Age: 17 years. Review on 10/15/25 of the facility's records revealed: -No documentation of the facility's daily searches of Client #1. -No documentation of a policy regarding seatch and seizure. Interview with the Qualified Professional on 10/29/25 revealed: -"I will start a log immediately ...today ...regarding any search and seizure and will document all requirements identified in the rule." Interview on 10/29/25 with the Executive Director/Licensee revealed: -Was not aware of the documentation that had to be completed.	V 503	Continued from page 66 **C. Staff Training** By 11/21/2025, all staff were coached on: • When searches are permitted • How to conduct trauma-informed searches • Required legal/ethical considerations • Mandatory documentation fields Training now occurs during new hire onboarding and annually. **D. Strengthened Procedures** • No staff may leave a shift until all search documentation for that shift is completed. QP must review all searches weekly for accuracy. **4. Monitoring to Ensure Ongoing Compliance:** The AP will: • Review the Search & Seizure Log daily for 30 days, then weekly for 60 days • Verify each search contains all required elements • Review seized property procedures for compliance • Discuss search trends during monthly QA/QI meetings The QA/QI Committee will complete a monthly audit of: • 5% of searches and seizures • Documentation completeness • Policy adherence • Follow-up actions Any missed or incomplete documentation will trigger immediate corrective action and retraining.	
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure facility grounds were maintained in an attractive manner. The findings are: Observation on 10/16/25 at 12:30 pm of the interior of the home revealed: -In bedroom #1, there was damage to the wall with 10-15 scratches measuring approximately 1	V 736	**V.736 The facility failed to ensure the facility grounds were maintained in an attractive manner.** **1. Corrective Action Taken:** On 10/30/2025, damage to the paint on wall in the youth bedroom was repaired immediately. Repairs included patching holes, sanding, repainting, and restoring the wall to its original safe and attractive condition. Furniture was repositioned properly, and the room was inspected by the Executive Director to ensure it met safety and appearance standards.	

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V 736	Continued From page 67 inch in diameter and paint scratched off of the doorway trim and window trim approximately 10 scratches measuring the size of a dime. Interview on 10/29/25 with the Executive Director/Licensee revealed: -No comment as to why the damaged and scratched walls had not been fixed. -"Will get right on it."	V 736	Continued from page 67 **2. Measures Taken to Ensure Others Are Not Affected:** The ED conducted a full walkthrough of all bedrooms and shared living areas to identify any additional wall damage or environmental concerns. Any minor cosmetic issues (scuffs, loose trim, chipped paint) were repaired the same day. All rooms were confirmed safe, clean, and compliant. Clients were reminded of facility expectations regarding care of personal and shared spaces. **3. Systemic Changes Implemented to Prevent Recurrence:** **A. AP Interior Maintenance Oversight** The Facility Maintenance: • Weekly inspection of all bedrooms and common areas • Schedule immediate repair of any wall or structural damage • Supervisor sign-off for all repairs made in client rooms **B. New Monitoring Tools Implemented** Facility implemented: • House Condition Log These steps were added to program structure and daily supervision expectations. **4. Monitoring to Ensure Ongoing Compliance:** The AP will: • Conduct weekly bedroom inspections for 60 days Track all wall repairs • Review facility condition during monthly QA/QI meetings Any future wall or structural damage will be repaired immediately and reviewed for potential behavioral contributing factors.	