STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-802	A. BUILDING: _____ B. WING _____	R 12/15/2025

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V 000	INITIAL COMMENTS A annual and follow up survey was completed on December 15, 2025. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for three and currently has a census of two. The survey sample consisted of audits of two current clients.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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V 112	Continued From page 1	V 112		

This Rule is not met as evidenced by:
Based on record review and interviews, the facilty failed to develop and implement treatment plan, goals and strategies based on client needs within 30 days admission for 1 of 2 Clients (#2). The findings are:

Review on 11/10/25 of Client #2's record revealed:
-Admission date of 9/10/25.
-Diagnoses of Attention Deficit Disorder and Oppositional Defiant Disorder.
-History of alcohol and marijuana abuse, struggles with authority figures, stealing, tobacco use and verbal and physical aggression.
-No documentation of a treatment plan.

Interview on 12/3/25 with the Acting Associate Professional (AP) revealed:
-There had been issues communicating with Client #2's Mother/Guardian because she will not return calls.
-"She (Client #2's Mother/Guardian has everything we need but won't send it."
-The Residential Coordinator/Acting Qualified Professional (QP) was responsible for treatment plans.

Interview on 11/10/25 with the Residential Coordinator/Acting QP revealed:
-"We (staff) have been having issues getting his

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V 112	Continued From page 2 (Client #2) information from his guardian (mother)." -It was difficult communicating with Client #2's Mother/Guardian. -"She (Client #2's Mother/Guardian) will say she is going to send us documents and never send them. I have not gotten all of his (Client #2) stuff (previous documents)." -Was responsible for the development of treatment plans. -Would develop a treatment plan with the information he had. Interview on 12/3/25 with the Chief Executive Officer (CEO)/Licensee revealed: -The Residential Coordinator/Acting QP is responsible for treatment plans and coordinating care for Client #2. -Would follow up with the Residential Coordinator/Acting QP to get Client #2 a treatment plan.	V 112		
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.	V 118		

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V 118	Continued From page 3 (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on observation, interviews and record reviews the facility failed to ensure medications were administered on the written order of a physician for 1 of 2 Clients (#2) and failed to keep MARs current for 1 of 2 Clients (#1). The findings are: Cross reference 10A NCAC 27G .1701 Coordination of Services (V293). Based on record review and interview the facility failed to coordinate with other agencies to meet the needs for 1 of 2 clients (#2). Review on 11/10/25 of Client #1's record revealed: -Admission date of 5/8/23. -Age 16 years old.	V 118		

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V 118	Continued From page 4 -Diagnoses of Oppositional Defiant Disorder and Conduct Disorder. -History of behavioral issues, verbal and physical aggression, property destruction, self harm and impulsive behavior. -Physcian Order's dated October 1, 2025 for Qelbree Extended Release (ER) 200 miligrams (mg)g capsules, take one capsule by mouth daily for mood and Risperidone 1mg, one tablet by mouth daily for mood and Fluoxetine 20mg, take one tablet by mouth daily in the morning for mood. -Preceeded PO's dated 3/4/25 for Qelbree ER 200mg capsules, take one capsule by mouth daily for mood and Risperidone 1mg, one tablet by mouth daily for mood and Fluoxetine 20mg, take one tablet by mouth daily in the morning for mood. Review on 11/10/25 of Client #1's MARs from September 1, 2025 to November 10, 2025 revealed: -There was no September 2025 MAR available. -No documentation that Client #1's medications had been administered from September 1-30, 2025. Interview on 11/13/25 with Client #1 revealed: -He got his medications at the appropriate times. -Had not missed any of his medications. Observation on 11/10/25 at 1:24 pm of Client #2's medications revealed: -Risperidone .05mg, take one tablet by mouth twice daily for mood dispensed on 10/14/25. -Trazodone 50mg, take one tablet by mouth at night as directed for insomnia dispensed on 10/14/25. -Amphetamine Salts ER 10mg, take one capsule by mouth in the morning for Attention Deficit	V 118		

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V 118	Continued From page 5 Disorder dispensed on 10/14/25. Review on 11/10/25 of Client #2's MARS from September 11, 2025 to November 10, 2025 revealed there were no initials for administration for the following medications for client #2: -Risperidone 0.05mg on 10/8/25- 10/17/25, 10/26/25- 10/31/25 and 11/5/25 - 11/10/25 (total 26 days). -Amphetamine Salts ER 10mg on 10/8/25- 10/17/25 and 10/26/25 - 10/31/25 (total 14 days). -Trazodone 50mg 10/8/25- 10/16/25 and 10/29/25 - 10/31/25. (total 11 days). Interview on 12/8/25 the the Dispensing Pharmacy revealed: -"If a person (client) missed doses of Qelbree, Risperidone and Fluoxetine they may experience some withdrawal symptoms such as fatigue, irritability, nausea, change in appetite etc." -"If they (client) missed doses of Risperidone, Trazodone and Amphetamine Salts ER they may experience some withdrawal symptoms such as fatigue, irritability, nausea, change in appetite etc." Interview on 12/8/25 with Client #2's Doctor/Prescriber revealed: -Prescribed Trazodone and Risperidone to stabilize mood and the Amphetamine Salts to help with concentration if a patient has Attention Deficit Disorder. -Clients are scheduled biweekly to monitor how they are responding to medications. -Client #2 is scheduled biweekly but could not provide further information without consent. Interview on 11/13/25 with Client #2 revealed: -Denied missing any medication. -Denied the facility had ever ran out of his	V 118		

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V 118	Continued From page 6 medications. Interview on 12/3/25 with the Acting Associate Professional revealed: -Client #1's September 2025 MAR was completed. -Client #1's September 2025 MAR was not provided prior to the survey exit date. -There were problems getting Client #2 to his prescriber/doctor every two weeks. -The Doctor/Prescriber would not refill Client #2's prescriptions if he (Client #2) did not come to his appointments. Interview on 12/8/25 with the Residential Coordinator/Acting QP revealed: -Did not know where the September 2025 MAR for Client #1 was. -"It (September 2025 MAR for Client #1) may have been misplaced." -He was responsible for making sure clients had medications available for administration. 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 12/11/25 of the Plan of Protection dated 12/11/25 and signed by the Residential Coordinator/Acting QP revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? As of today, December 11, 2025 we (CEO/Licensee) will be switching prescriber (Doctor/Prescriber) to ensure medication management in a timely fashion. He (Client #2) is scheduled for an appointment Monday December 15th, 2025. We will also coordinate with the	V 118		

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V 118	Continued From page 7 guardian to get the insurance reinstated. Describe your plans to make sure the above happens. We will meet with mom to assist with getting the insurance reinstated and utilize a new prescriber (Doctor/Prescriber) to prevent delays." Review on 12/12/25 of the 1st amended Plan of Protection dated 12/12/25 and signed by the Residential Coordinator/ Acting QP revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? As of today, December 11, 2025, [CEO/Licensee]. will be switching prescriber (Doctor/Prescriber) to ensure medication management for [Client #2's] is done in a timely fashion. [Client #2] is scheduled for an appointment with the new prescriber (Doctor/Prescriber Monday, December 15th, 2025. The CEO (Chief Executive Officer/Licensee) and QP (Residential Coordinator/Acting QP) will also coordinate with [Client #2's] guardian to get the insurance reinstated. The QP (Residential Coordinator/Acting QP) will start making a copy of MARs to keep in his records so if a MAR is misplaced, he will have a copy as of today December 11, 2025. Describe your plans to make sure the above happens. The CEO (CEO/Licensee) and QP (Residential Coordinator/Acting QP) will meet with [Client #2] mom and utilize a new prescriber (Doctor/Prescriber) to prevent delays in filling his medication. The QP (Residential	V 118		

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V 118	Continued From page 8 Coordinator/Acting QP) will use a new filing system to assure all MARs are accounted for and keep them in his records." Review on 12/12/25 of the 2nd amended Plan of Protection dated 12/12/25 and signed by the Residential Coordinator/Acting QP revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? As of December 11, 2025, [Licensee] will be switching prescriber (Doctor/Prescriber) to ensure medication management for [Client #2] is done in a timely fashion. [Client #2] is scheduled for an appointment with the new prescriber (Doctor/Prescriber) Monday, December 15th, 2025. The Residential Coordinator (Residential Coordinator/Acting QP) will be sure to get a copy of the Doctor's orders from the new prescriber (Doctor/Prescriber) at each visit going forward. The Residential Coordinator (Residential Coordinator/Acting QP) will start making a copy of MARs to keep in his records so if a MAR is misplaced, he will have a copy as of December 11, 2025. Describe your plans to make sure the above happens. The CEO (CEO/Licensee) and Residential Coordinator (Residential Coordinator/Acting QP) will meet with [Client #2's] mom (Guardian) and utilize a new prescriber (Doctor/Prescriber) to prevent delays in filling his medication. The Residential Coordinator (Residential Coordinator/Acting QP) will get a copy of the Doctor's (Doctor/Prescriber) orders on December 15, 2025 at [Client #2]' doctor's appointment, and will use a new filing system to assure all MARs are accounted for and keep them in his records."	V 118		

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V 118	Continued From page 9 The facility served clients with diagnoses of Oppositional Defiant Disorder, Conduct Disorder and Attention Deficit Disorder. Client #1's September MAR was missing and there was no documentation that Client #1 received his medications from September 1-30, 2025 (30 days). Client #2 missed 14 days of his medications in October 2025 and missed his doses of Risperidone 5 days in November 2025 due to the facility not following up with his Prescriber/Doctor biweekly. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients and must be corrected within 45 days.	V 118		
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	V 293		

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V 293	Continued From page 10 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 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 review and interview the facility failed to coordinate with other agencies to meet the needs for 1 of 2 clients (#2). The findings are: Review on 11/10/25 of Client #2's record	V 293		

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V 293	Continued From page 11	V 293		

revealed:
-Admission date of 9/10/25.
-Age 16 years old.
-Diagnoses of Attention Deficit Disorder and Oppositional Defiant Disorder.
-History of alcohol and marijuana abuse, struggles with authority figures, stealing, tobacco use and verbal and physical aggression.
-No documentation of Physician's Order and coordination of care for medication management biweekly visits for medication.

Interview on 12/3/25 with the Acting Associate Professional revealed:
-"He (Client #2) had to go (to see his prescriber/doctor) every 2 weeks and he missed some appointments due to staff scheduling."
-"We (staff) would have to call and remind her (Client #2's Mom/Guardian) to send the orders (physician's orders) to the pharmacy."
-The Residential Coordinator/Acting Qualified Professional (QP) was responsible for scheduling medical appointments and making sure clients have medications in stock.

Interview on 12/3/25 with the Chief Executive Officer (CEO)/Licensee revealed:
-Did not participate in the operations of the facility.
-The Residential Coordinator/Acting QP was responsible for operations and coordination of care.
-The Residential Coordinator/Acting QP was responsible for making sure the clients have their medications.

Interview on 12/8/25 with the Residential Coordinator/Acting QP revealed:
-Client #2 saw the Doctor/Prescriber his Mother/Guardian wanted him to see, not the

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V 293	Continued From page 12 Doctor/Prescriber the facility used. -"[Client #2's] Prescriber (Doctor/Prescriber) does not send his prescriptions to the pharmacy in a timely manner." "I have to call and remind her (Doctor/Prescriber) to send his (Client #2) prescriptions to the pharmacy." -"She (Doctor/Prescriber) wanted to see him (Client #2) every two weeks and sometimes it is hard to get him (Client #2) there." -There were staffing problems preventing Client #2 from making all of his appointments with the Doctor/Prescriber. -He was responsible for coordination of services and care. -Would be switching Doctor/Prescriber to ensure Client #2 can get his medication as prescribed. 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 293		
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	V 366		

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V 366	Continued From page 13	V 366		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-802	A. BUILDING: _____ B. WING _____	R 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATER MILL HOME	6801 WATER MILL COURT CHARLOTTE, NC 28215

(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 14 follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the 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	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 366	Continued From page 15 (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 ensure Level I incident reports were completed for any medication errors for 2 of 2 clients . The findings are: Review on 11/12/25 of the facility's internal incident reports from 9/1/25- 11/10/25 revealed: -There was no documentation of response to the following incidents: -Client #2's MARS from September 11, 2025 to November 10, 2025 revealed there were no initials for administration of Risperidone 0.05mg on 10/8/25- 10/17/25, 10/26/25- 10/31/25 and 11/5/25- 11/10/25 (total 26 days), Amphetamine Salts ER 10mg on 10/8/25- 10/17/25 and 10/26/25- 10/31/25 (total 14 days) and Trazadone 50mg 10/8/25- 10/16/25 and 10/29/25- 10/31/25. (total 11 days). -There was no documentation that supported the facility: -Attended to the health and safety needs of clients;. -Developed and implemented corrective measures. -Developed and implemented measures to prevent similar incidents. -Assigned a person to be responsible for implementation of the corrections and preventive measures. Interview on 11/13/25 with Client #1 revealed:	V 366		

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V 366	Continued From page 16 -He got his medications at the appropriate times. -Had not missed any of his medications or ran out. -"If a medication runs out it's only for a day." Interview on 11/13/25 with Client #2 revealed: -Denied missing any medication. -Denied the facility had run out of his medications. Interview on 12/3/25 with the Acting Associate Professional (AP) revealed: -All staff were responsible for incident reporting. -Was not aware medication errors had to be reported to a medical professional. Interview on 12/3/25 with the Chief Executive Officer (CEO)/Licensee revealed: -Did not participate in the operations of the facility. -All staff were responsible for incident reporting. -Was not aware medication errors had to be reported to a medical professional. Interview on 12/8/25 with the Residential Coordinator/Acting Qualified Professional revealed: -Was not aware medication errors had to be reported to a medical professional. -All staff were responsible for reporting and responding to incidents. -Would make sure all medication errors are reported to a medical professional.	V 366		