STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601592	A. BUILDING: _____ B. WING _____	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KATRINA RENEE'S SAFE PLACE LLC	5017 ELIZABETH ROAD CHARLOTTE, NC 28269

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual survey was completed on 11/26/2025. 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 4 and currently has a census of 4. The survey sample consisted of audits of 1 current client and 2 former clients.	V 000		
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; (D) date and time the drug is administered; and (E) name or initials of person administering the	V 118		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601592	A. BUILDING: _____ B. WING _____	11/26/2025

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V 118	Continued From page 1 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 observations, record reviews, and interviews, the facility failed to ensure medications were administered on the written order of a physician affecting 1 of 1 Client (Client #1). The findings are: Review on 11/20/2025 of Client #1's record revealed: -Admission date 10/21/2025. -Diagnosed with Unspecified Trauma and Stress Related Disorder and Oppositional Defiant Disorder. -There were no Physician Orders for: -Tizanidine Hydrochloride (HCL) 2 milligram (mg) -Take 1 tablet by mouth once daily before bed. Observation on 11/20/2025 at 3:16 pm of Client #1's medication container revealed: -A bubble pack of Tizanidine 2 mg. Review on 11/20/2025 of Client #1's MARs from 10/21/2025-11/19/2025 revealed: -Tizanidine 2 mg was administered daily from 11/15/2025-11/19/2025. Interview on 11/20/2025 with Client #1 revealed:	V 118		

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V 118	Continued From page 2 -She received her medications as prescribed but did not know the names of medications taken. Interview on 11/24/2025 with the Associate Professional (AP) revealed: -"It is my job to go back and do my checks on the meds (medications) to make sure everything has been documented. I do that in the middle of the week." -She and the Licensee were responsible for ensuring physician orders were present at the facility prior to administering medications. -Would ensure that medication orders were present at the facility prior to administering medications to clients moving forward. Interview on 11/24/2025 with the Qualified Professional revealed: -"[AP] and [Licensee] are responsible (for ensuring orders were present at the facility prior to medication administration)." Interview on 11/26/2025 with the Licensee revealed: -"Orders were sent to the pharmacy. I am going to have to get with the AP to make sure we are not missing anything (orders) and we have what we need." -Would ensure that medication orders were present at the facility prior to administering medications to clients moving forward.	V 118		
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	V 367		

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 367	Continued From page 3 the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (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	V 367		

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V 367	Continued From page 4 (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.	V 367		

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 367	Continued From page 5 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report all level II incidents in the Incident Response Improvement System (IRIS), failed to notify the Local Management Entity (LME)/Managed Care Organization (MCO) responsible for the catchment area where services were provided as required and failed to submit to the LME/MCO upon request other information regarding the incident. The findings are: Review on 11/20/2025 of the facility's incident reports from 08/01/2025 - 11/19/2025 revealed: -There were no incident reports available for review at the facility. Reviews on 11/24/2025 and 11/25/2025 of IRIS revealed: -10/03/2025; Former Client (FC) #2's Absence Without Leave (AWOL) incident with law enforcement involvement. -10/03/2025; FC #4's AWOL incident with law enforcement involvement. -10/12/2025; FC #5's AWOL incident with law enforcement involvement. Reviews on 11/24/2025 and 11/25/2025 of an IRIS Report dated 10/04/2025 for FC #2 revealed: -The incident occurred on 10/03/2025. -The provider learned of the incident on 10/03/2025. -The report was submitted on 10/04/2025. -LME/MCO comments dated 10/06/2025: "Please update the report with any new developments	V 367		

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V 367	Continued From page 6 and/or once the client has been located." -The facility did not update the IRIS report at the request of the LME/MCO. Reviews on 11/24/2025 and 11/25/2025 of an IRIS Report dated 10/04/2025 for FC #4 revealed: -The incident occurred on 10/03/2025. -The provider learned of the incident on 10/03/2025. -The report was submitted on 10/04/2025. -LME/MCO comments dated 10/06/2025: "Please update the report with any new developments and/or once the client has been located." -The facility did not update the IRIS report at the request of the LME/MCO. Reviews on 11/24/2025 and 11/25/2025 of an IRIS Report dated 11/24/2025 for FC #5 revealed: -The incident occurred on 10/12/2025. -The provider learned of the incident on 10/12/2025. -The report was submitted on 11/24/2025; 42 days after the incident occurred. Interview on 11/26/2025 with the Licensee revealed: -She submitted the IRIS report for FC #5 prior to 11/24/2025. -"Going forward, when I follow up the guardian, I will also follow up with the LME (MCO)."	V 367		
V 716	27G .0301(c-d) Sanitation and Fire Documentation 10A NCAC 27G .0301 COMPLIANCE WITH BUILDING CODES (c) Each facility shall maintain documented evidence of compliance with applicable fire,	V 716		

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 716	Continued From page 7 sanitation and building codes including an annual fire inspection. (d) As used in these Rules, the term "new facility" refers to a facility that has not been licensed previously and for which an initial license is sought. The term includes buildings converted from another use or containing facilities licensed for a different use than the facility for which an initial license is sought. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to maintain documented evidence of compliance with applicable annual fire extinguisher inspection. Observation on 11/20/2025 at approximately 1:35 pm of the facility's fire extinguisher revealed: -No annual fire extinguisher inspection tag. Review on 11/24/2025 of Email Correspondence from the Division of Health Service Regulations Construction Manager revealed: -"The tags should be provided when you have it serviced yearly. The company that does the service normally provides a tag." Interview on 11/24/2025 with the Associate Professional revealed: -"Usually, we call them (Fire Marshalls) out and they came out this year, and they said they did not give that little sticker." -She was not aware that fire extingishers were serviced at an inspection site. Interview on 11/24/2025 with the Qualified Professional revealed: -"We are responsible for that (ensuring the fire extinguisher was inspected annually)."	V 716		

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V 716	Continued From page 8 Interviews on 11/20/2025 and 11/26/2025 with the Licensee revealed: -"We were told that they (Fire Marshalls) no longer provided that (fire extinguisher annual inspection tag)." -"I will look it up and get the information on where to take it (fire extinguisher) and get it done every year." -"I will take it every November."	V 716		

PLAN OF CORRECTION

Provider Name: Katrina Renee's Safe Place, LLC
Provider Number: MHL0601592
Address: 5017 Elizabeth Road, Charlotte, NC 28269
Tag Number: V716
Survey Date: 11/26/2025
Regulation: 10A NCAC 27G .0301(c–d) – Sanitation and Fire / Compliance with Building Codes

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Deficiency:

Based on observations, record review, and staff interviews, the facility failed to maintain documented evidence of compliance with the required annual fire extinguisher inspection as required by 10A NCAC 27G .0301(c).

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1. Corrective Action Taken:

On **12/01/2025**, the Administrator contacted the facility's fire safety vendor, **Atlas Fire and Security**(8511 Davis Lake Pkwy, Suite C6-171, Charlotte, NC 28269; Phone: 704-675-0252), to schedule the required inspection.

Atlas Fire and Security completed the **annual fire extinguisher inspection** on **12/05/2025**. All extinguishers were inspected, certified, and tagged as compliant.

The **inspection report and certification documentation** were filed in the **Fire and Life Safety Compliance Binder** on **12/05/2025**.

The Administrator verified that all equipment met safety standards and that required records were accessible for regulatory review.

---

2. Systemic Changes to Prevent Recurrence:

A **Fire Safety Compliance Log** was created on **12/06/2025** to track all required fire safety inspections, including extinguishers, smoke detectors, and alarm systems.

The **Administrator** will ensure all annual fire inspections are scheduled every **January**, at least 30 days before expiration.

A **quarterly internal safety audit** will be conducted to verify documentation of inspections and certifications remains current.

Vendor contact information and inspection deadlines have been added to the facility's **Compliance Calendar and Maintenance Checklist.**

---

3. Responsible Party:

Name: [redacted]
Title: Executive Director
Responsibility: Ensure timely completion and documentation of all fire, sanitation, and building safety inspections.

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4. Completion Dates:

Contacted vendor: **12/01/2025**

Fire inspection completed: **12/05/2025**

Preventive system implemented: **12/06/2025**

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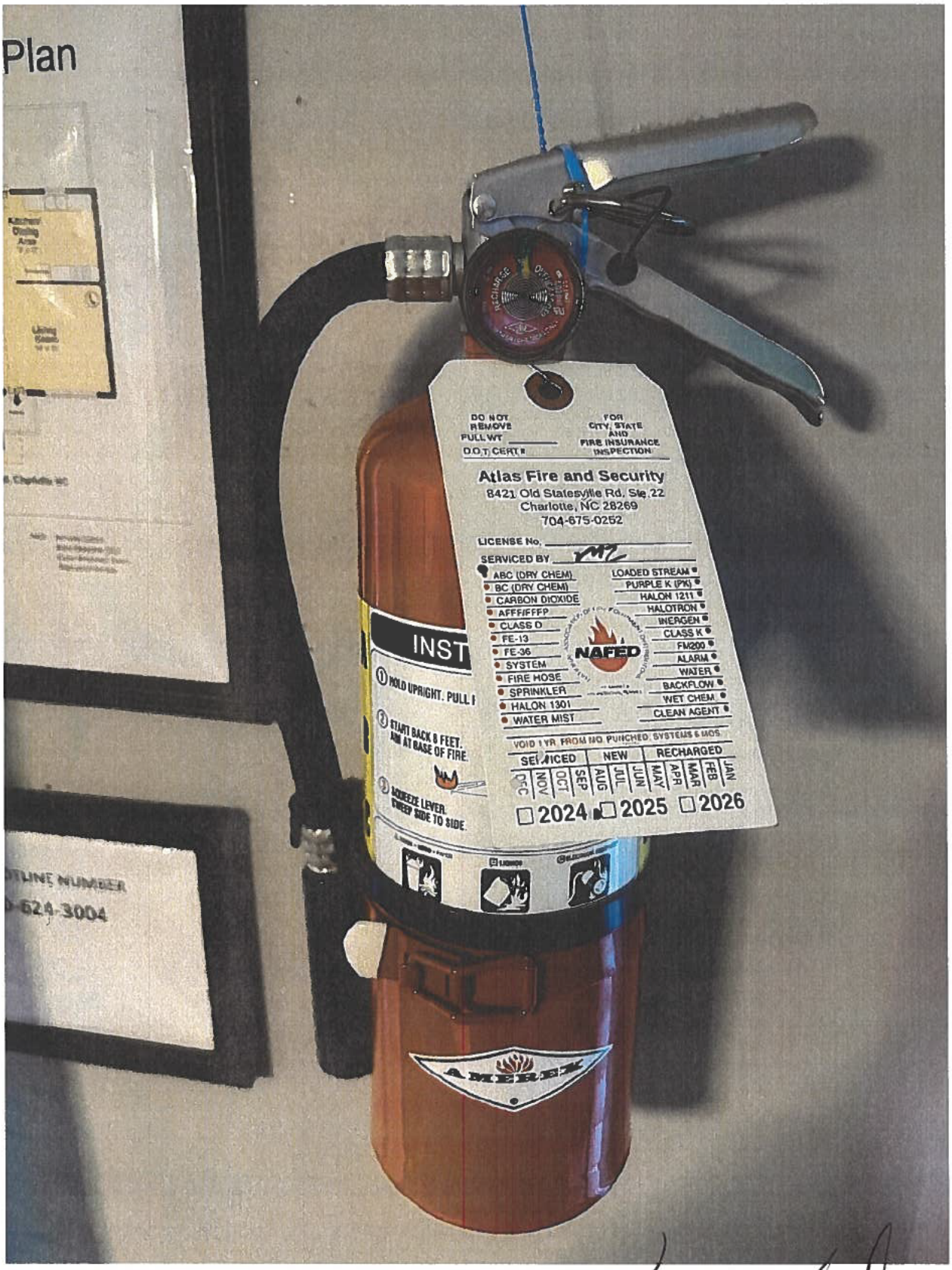
5. Verification:

As of **12/05/2025**, the facility is in full compliance with annual fire extinguisher inspection requirements under 10A NCAC 27G .0301(c–d). Documentation is maintained on-site and reviewed during quarterly audits to ensure ongoing compliance.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FOR CITY, STATE AND FIRE INSURANCE INSPECTION
Atlas Fire and Security
8421 Old Statesville Rd, Ste 22
Charlotte, NC 28269
704-675-0252
LICENSE No.
SERVICED BY
ABC (DRY CHEM)
BC (DRY CHEM)
CARBON DIOXIDE
AFFF/FFFP
CLASS D
FE-13
FE-36
SYSTEM
FIRE HOSE
SPRINKLER
HALON 1301
WATER MIST
LOADED STREAM
PURPLE K (PK)
HALON 1211
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INERGEN
CLASS K
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2024 2025 2026
INST
1 HOLD UPRIGHT. PULL
2 START BACK 8 FEET. AIM AT BASE OF FIRE.
3 SQUEEZE LEVER. SWEEP SIDE TO SIDE.
AMEREX

12/6/25

Katrina Renee's Safe Place

5017 Elizabeth Rd
Charlotte, NC 28269

Plan of Correction

Plan of Correction for Tag V118 – 27G .0209 (C) – Medication Requirements

Regulation Summary:
According to 27G .0209 (C), medication and treatment shall be administered, recorded, and monitored according to accepted professional standards and in compliance with applicable laws and regulations.

Deficiency:

1. Deficiency Description

Surveyors found that the program failed to meet medication requirements under 27G .0209 (C). Specifically, one or more of the following may have been identified:

Medications were not properly documented on the MAR (Medication Administration Record).

Staff did not follow physician orders as prescribed.

Medication errors were not reported or followed up appropriately.

Medication storage and disposal did not meet regulatory standards.

It was identified that a prescribed medication was present in the facility; however, it was overlooked due to the difference in the generic name of the medication versus the prescribed brand name on the physician's order.

2. Corrective Action Taken for the Identified Issue

The staff involved were immediately re-educated on proper medication administration and documentation procedures.

The medication error or missing documentation was corrected the same day.

Pharmacy and clinical staff reviewed all medication logs for accuracy.

All medication storage areas were inspected to ensure compliance with storage and security requirements.

3. Measures to Ensure the Deficiency Will Not Reoccur

Medication Administration Policy review and update were completed to align with 27G .0209 requirements.

Training: All staff administering medication will complete annual competency training focusing on:

Documentation accuracy

Medication rights (right patient, right medication, right dose, right time, right route)

Error reporting procedures

Monitoring: The QP/AP or clinical staff will conduct **weekly medication audits** for the next 90 days, then monthly thereafter.

Performance Evaluation: Medication administration will be reviewed as part of employee monthly and annual performance reviews.

4. Responsible Party

Executive Director / Associate Professor/ Qualified Professional will be responsible for the implementation and ongoing monitoring of this corrective plan.

Additional Action Taken:

The physician's order was immediately reviewed and verified with the prescribing provider to confirm that the generic medication on hand matched the prescribed brand-name medication. The Medication Administration Record (MAR) was updated to clearly list both the brand and generic names of the

medication. The order and medication were rechecked for accuracy and compliance.

Measures to Prevent Recurrence:

All staff responsible for medication administration have been re-trained on recognizing both the brand and generic medication names.

A brand/generic reference list has been created for all client medications and will be kept with each MAR for reference.

Medication verification now includes a double-check process at intake, during refills, and at each med pass to ensure proper documentation and compliance with physician orders.

Monitoring to Ensure Ongoing Compliance:

The QP/ AP will perform **weekly medication audits** to ensure all medications on hand align with active physician orders and that both brand and generic names are documented.
Findings will be reviewed monthly during staff meetings for continued education and quality improvement.

Responsible Party:

Signature: [redacted]
Title: *Executive Director*
Date: *December 06, 2025*

Katrina Renee's Safe Place

5017 Elizabeth Rd
Charlotte, NC 28269

Plan of Correction

Tag Number: V367
Regulation: 27G .0604 – Incident Reporting Requirements
Survey Date: November 26, 2025

Deficiency:

The facility did not fully comply with 27G .0604 Incident Reporting Requirements. An incident occurred that met the definition of a reportable event; however, it was not reported to the designated oversight agency within the required timeframe.

Corrective Action Taken:

Upon discovering the oversight, the incident was promptly reported to the appropriate agency. The report included all required details, and supporting documentation was completed and filed. The responsible staff member received immediate coaching on the incident reporting policy and documentation expectations.

Measures to Prevent Recurrence:

All staff have been re-educated on **incident reporting timelines and procedures** as required by 27G .0604.

The **Incident Reporting Policy and Procedure** has been updated to include a clear reminder of reporting timeframes and to define what qualifies as a reportable incident.

A **designated Incident Report Log** has been implemented to document the date and time each incident occurs and when it is reported to the appropriate authorities.

QP/ AP will review incident documentation promptly to ensure timely and correct submission.

Monitoring to Ensure Ongoing Compliance:

The Executive Director or Qualified Professional will conduct a **monthly review** of the incident log to confirm compliance with reporting requirements and timeframes.

Any missed or delayed reports will be addressed immediately through retraining and corrective action as appropriate.

Compliance trends will be discussed during staff meetings and quality improvement reviews each month.

Responsible Party:

Signature: [redacted]
Title: *Executive Director*
Date: *December 06, 2025*

KRSP Incident Report Form

Section 1: General Information

- **Date of Report:** _____
- **Date of Incident:** _____
- **Time of Incident:** _____
- **Location of Incident:** _____
- **Program / Site:** _____

Section 2: Individuals & Staff Involved

- **Individual(s) Involved:** _____
- **DOB(s):** _____
- **Staff Involved / Witnesses:** _____

Section 3: Type of Incident

(Check all that apply) - [ ] **Critical Incident** - [ ] Hospitalization - [ ] Serious Injury - [ ] Allegation of Abuse/Neglect/Exploitation - [ ] Missing Person / Elopement - [ ] Law Enforcement Involvement - [ ] Other: _____

- ☐ **Level II Incident**
  - ☐ Medication Error
  - ☐ Moderate Property Damage
  - ☐ Behavior Posing Safety Risk
  - ☐ Other: _____
- ☐ **Level I Incident**
  - ☐ Minor Injury
  - ☐ Minor Behavior Episode
  - ☐ Minor Property Damage
  - ☐ Other: _____

Section 4: Description of Incident

Provide a factual, objective description. Do not include opinions or assumptions.

Section 5: Immediate Actions Taken

Describe all actions staff took during and immediately after the incident.

Section 6: Notifications

(Record who was notified and when) - **Guardian/Parent:** _____ Date/Time: _____ - **Supervisor/On-Call:** _____ Date/Time: _____ - **DSS:** _____ Date/Time: _____ - **Law Enforcement:** _____ Date/Time: _____ - **LME/MCO (if required):** _____ Date/Time: _____ - **Other (Specify):** _____ Date/Time: _____

Section 7: Injury Details (if applicable)

- **Was anyone injured?** [ ] Yes [ ] No
  If yes, describe:

- **First Aid Provided:** _____
- **Medical Care Required?** [ ] Yes [ ] No
  If yes:
- **Hospital/Clinic Name:** _____
- **Time Transported:** _____

Section 8: Follow-Up / Corrective Action

Describe actions to prevent recurrence, staff retraining, environment changes, etc.

Section 9: Signatures

- **Staff Completing Report:** _____ Date: _____
- **Supervisor Review:** _____ Date: _____
- **Administrator/QA Review:** _____ Date: _____