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KEYSTONE RIDGE	4770 BAUX MOUNTAIN ROAD WINSTON SALEM, NC 27105

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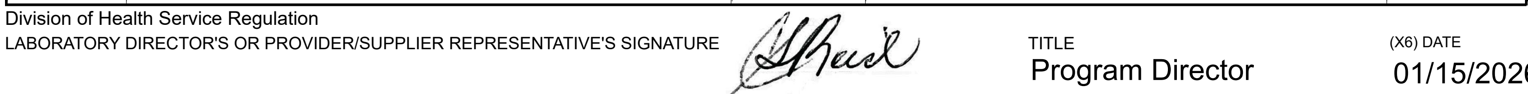
V 000	INITIAL COMMENTS An annual survey was completed on December 31, 2025. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for 3 and has a current census of 2. The survey sample consisted of audits of 2 current clients.	V 000	Plan of Correction Correction of Deficient Practice Personnel files have been reviewed and updated to include required documentation. Prevention of Recurrence Required personnel documentation will be maintained in each employee file. Monitoring Responsibility Program Director. Monitoring Frequency Routine personnel file maintenance.	Feb 28
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 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	V 108		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Program Director — (X6) DATE: 01/15/2026

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V 108	Continued From page 1	V 108		

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 each staff was trained in basic first aid and cardiopulmonary resuscitation (CPR) for 1 of 3 audited staff (Staff #1). The findings are:

Review on 12/31/25 of Staff #1's personnel record revealed:
-Hire date of 12/11/25.
-No certification of basic first aid and CPR training.

Interview on 12/29/25 with Staff #1 revealed:
-He did not have a 2nd staff who worked with him on his shift from 8:00 AM to 4:00 PM.
-He had training in first aid and CPR from his previous employer which was being transferred to his current employer.

Interview on 12/31/25 with the Manager revealed:
-Staff #1 had first aid and CPR training through his previous employer.
-Staff #1 was emailing his training documentation to him but the information had not yet been received.
-He would follow up to ensure he received the training documentation and ensure the training

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V 108	Continued From page 2 was current.	V 108	Correction of Deficient Practice Keystone Ridge has reviewed its medication dispensing procedures. Documentation tools for medication dispensing have been clarified and standardized. A Program Medication Monitor has been appointed to ensure required documentation is completed and maintained. Prevention of Recurrence Staff responsible for medication dispensing will follow existing medication policies and complete required documentation at the time medications are dispensed. Monitoring Responsibility Program Director, with support from the Program Medication Monitor. Monitoring Frequency Periodic review during routine administrative oversight.	Feb 16
V 116	27G .0209 (A) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (a) Medication dispensing: (1) Medications shall be dispensed only on the written order of a physician or other practitioner licensed to prescribe. (2) Dispensing shall be restricted to registered pharmacists, physicians, or other health care practitioners authorized by law and registered with the North Carolina Board of Pharmacy. If a permit to operate a pharmacy is Not required, a nurse or other designated person may assist a physician or other health care practitioner with dispensing so long as the final label, Container, and its contents are physically checked and approved by the authorized person prior to dispensing. (3) Methadone For take-home purposes may be supplied to a client of a methadone treatment service in a properly labeled container by a registered nurse employed by the service, pursuant to the requirements of 10 NCAC 26E .0306 SUPPLYING OF METHADONE IN TREATMENT PROGRAMS BY RN. Supplying of methadone is not considered dispensing. (4) Other than for emergency use, facilities shall not possess a stock of prescription legend drugs for the purpose of dispensing without hiring a pharmacist and obtaining a permit from the NC Board of Pharmacy. Physicians may keep a small locked supply of prescription drug samples. Samples shall be dispensed, packaged, and labeled in accordance with state law and this Rule.	V 116		

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This Rule is not met as evidenced by:
Based on record review, observation and interview, the facility failed to ensure medication dispensing was restricted to registered pharmacists, physicians, or other health care practitioners authorized by law and registered with the North Carolina Board of Pharmacy affecting 2 of 2 clients (Client #1 and Client #2). The findings are:

Review on 12/30/25 of Client #1's record revealed:
-Admission date of 5/5/25.
-Diagnoses of Attention-Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD) and Post-Traumatic Stress Disorder (PTSD).
-Age: 17 years.

Review on 12/31/25 of Client #2's record revealed:
-Admission date of 5/27/25.
-Diagnoses of ADHD, PTSD, Generalized Anxiety Disorder, and Other specified disruptive, impulse-control and conduct disorder.
-Age: 14 years.

Observation on 12/29/25 beginning at 1:06 pm of Client #1's and Client #2's medications revealed:
-At least 4-5 plastic weekly medication dispensers for Client #1 with one dispenser having contained AM (morning) and PM (evening) medications.
-At least 4-5 plastic weekly medication dispensers for Client #2 with one dispenser having contained AM (morning) and PM (evening) medications.

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V 116	Continued From page 4 -Each medication dispenser was labeled Monday through Saturday and with AM and PM doses. Interview on 12/29/25 with the Qualified Professional/Owner revealed: -Client #1 started with 3 medications at his admission and was currently taking 6 medications. -Client #2's medication dispenser contained his medication, but she would be filling up his medication dispenser again on 12/30/25. -Use of the medication dispensers was "easier" for staff to give Client #1 and Client #2 their medications. -She was concerned not using the medication dispensers would result in medication errors. -She filled Clients #1's and #2's medication dispensers once a month from each client's medication bottle.	V 116	Correction of Deficient Practice Medication Administration Records (MARs) were reviewed and corrected where incomplete. Staff were reminded of documentation expectations related to medication administration. A Program Medication Monitor has been appointed to ensure required documentation is completed and maintained on a weekly basis. Prevention of Recurrence Staff will continue to document medication administration as required by rule and facility policy. Monitoring Responsibility Program Medication Monitor Program Director. Monitoring Frequency Ongoing review as part of routine program oversight.	Jan 31
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	V 118		

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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 record review and interview, the facility failed to ensure prescribed drugs were administered to each client on the written order of a person authorized to prescribe drugs and failed to ensure administered medications were immediately recorded after administration affecting 2 of 2 clients (Client #1 and Client #2).
The findings are:

Review on 12/30/25 of Client #1's record revealed:
-Admission date of 5/5/25.
-Diagnoses of Attention-Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD) and Post-Traumatic Stress Disorder (PTSD).
-Age: 17 years.
-No written or electronic medication orders by a person authorized to prescribe drugs were

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present in the facility.

Reviews on 12/30/25 and 12/31/25 of Client #2's record revealed:
-Admission date of 5/27/25.
-Diagnoses of ADHD, PTSD, Generalized Anxiety Disorder, and Other specified disruptive, impulse-control and conduct disorder.
-Age: 14 years.
-No written or electronic medication orders by a person authorized to prescribe drugs were present in the facility.

Review on 12/30/25 of Client #1's MARs from 10/1/25-12/30/25 revealed:
-Each MAR page documented at least 1 medication for daily administration.
-d-amphetamine Salt Combination Extended Release (ER) (ADHD), 30 milligram (mg) capsule (cap) for AM (morning) dose time had:
 -10/11/25 and 10/12/25 with a line marked through the time given, dose given, and name and signature of person giving the medication. No reason was documented to explain why the information was marked through.
 -10/3/25 through 10/21/25 had one dose of this medication recorded daily as administered whereas, 10/22/25 through 11/11/25 had two doses of this medication recorded daily as administered.
 -The MAR page for this medication with beginning date of 10/22/25 had this medication at 1 dose and was listed as "D- Amphetamine ER + (plus) Qelbree 100 mg (Total 30 mg)" for AM dose time. Due to the failure to accurately document administration of these 2 medications, it could not be determined if Client #1 received accurate medication and dosage.
 -The December 2025 MAR for this medication listed the medication dosage of 20 mg instead of

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V 118	Continued From page 7 30 mg at the AM dose time. -Risperidone (mood stabilizer).05 mg had no documentation whether this medication was administered on 12/24/25, 12/25/25 and 12/27/25 at the PM (evening) dose time. -Prazosin (sleep) 1 mg had no documentation whether this medication was administered on 11/14/25 at the PM dose time. -Qelbree (ADHD) 100 mg ER cap was listed on December 2025's MAR as 10 mg. Review on 12/30/25 of Client #2's MARs from 10/1/25-12/30/25 revealed: -Each MAR page documented at least 1 medication for daily administration. -Guanfacine (ADHD) 1 mg had a line marked through the time given, dose given, and name and signature of person giving the medication. No reason was documented to explain why the information was marked through. -Dexmethylphenidate 10 mg had a line marked through the time given, dose given, and name and signature of person giving the medication on 10/2/25. No reason was documented to explain why the information was marked through. -There was no documentation whether this medication was administered on 11/3/25 and 11/22/25 and no reason to explain why there was no documentation of whether the medication was administered. -Trazodone (sleep) 50 mg had no documentation had no documentation whether this medication was administered on 11/14/25 at the PM dose time. Interview on 12/29/25 with Client #1 revealed: -He took Adderall (d-amphetamine) for his ADHD, Risperidone as a mood stabilizer, a medication for his stomach acid and sleep medication. -About 1 ½ months ago, he was put on new	V 118		

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V 118	Continued From page 8 medications; he did not recall the names of the new medications. -His medications were at the facility to take, and staff administered his medications to him. Interview on 12/29/25 with Client #2 revealed: -He took Vyvanse and Guanfacine for his ADHD, Abilify and Fluoxetine for depression, Clonidine for sleep, 2 different inhalers for bronchitis and asthma, and ear drops. -His medications were at the facility to take, and staff administered his medications to him. Interview on 12/30/25 with the Qualified Professional/Owner revealed: -No written or electronically signed because the prescriber and pharmacy did not provide her with copies of medication orders when she requested the information. -She would immediately work on getting signed copies of Client #1's and Client #2's medication prescriptions. -She would ensure there were signed medication orders at the facility before or at the time of new client admissions. -Each client MAR had 1 medication for daily recording medication administration. -She did not know what it meant when staff drew a line through Client #1's and Client #2's medications on their MARs. -She did not know why Client #1's October-November MAR with beginning date of 10/22/25 had listed "D- Amphetamine ER + (plus) Qelbree 100 mg (Total 30 mg)" at the top of the page. She was unable to determine if both these medications were administered to Client #1 at the same time. -No documentation on Client #1's and Client #2's MARs of medication administration were due to staff having forgotten to initial each client's	V 118		

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V 118	Continued From page 9 medication. -She believed Client #1 and Client #2 received their medications. -She was implementing a new MAR form. -She planned to have a staff meeting on 1/5/26 to go over medication administration procedures. -She would have staff re-trained on medication administration as soon as possible.	V 118		
V 119	27G .0209 (D) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction. (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge.	V 119	Correction of Deficient Practice Medication disposal procedures were reviewed. Required disposal documentation will be completed and retained. Controlled substance medications will be turned over as waste to law enforcement or a pharmacy. Prevention of Recurrence Medication disposal will be documented in accordance with existing policy whenever medications are discontinued or expired. Monitoring Responsibility Program Medication Monitor. Program Director Monitoring Frequency As medication disposal occurs.	Feb 28

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This Rule is not met as evidenced by:
Based on observation, record review and interview, the facility failed to dispose of prescription medication to guard against diversion or accidental ingestion. The findings are:

Observation on 12/29/25 of Client #1's medications revealed:
-Amitriptyline (depression) 25 milligrams (mg) with a pharmacy dispensed date of 11/24/25.

Review on 12/30/25 of Client #1's MARs for October-November 2025 revealed:
-Amitriptyline 10 mg was listed on the MARs and administered to Client #1 once daily from 10/1/25 through 11/10/25 at the evening (PM) dose time. A handwritten note on the MAR had the medication was stopped 12/2/25.

Observation on 12/29/25 of Client #2's medication revealed:
-Aripiprazole (depression) 5 mg with a pharmacy dispense date of 8/24/25, take 1 tablet (tab) at bedtime.
-Guanfacine (ADHD) 1 mg with a pharmacy dispense date of 8/24/25, 1 tab every morning.
-Clindamycin phosphate gel United States Pharmacopoeia (usp)(rash) 1% topical cream.
-Ketaconzole Shampoo (head sores) 2 % 120 milliliters.
-Ondansetron Orally disintegrating tablet (ODT) (nausea due to virus), dissolve 1 tab on tongue every 6 hours for 7 days and a pharmacy dispense date of 12/1/25.

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V 119	Continued From page 11 Interview on 12/30/25 with the Manager revealed: -"I don't believe we have one (policy on unused medications)." Interview on 12/30/25 with the Qualified professional/Owner revealed: -Client #1's Amitriptyline was replaced on 12/3/25 with Propranolol because the Amitriptyline "messed with his stomach." -Client #2 no longer took the following medications: -Aripiprazole 5 mg because his dosage amount had changed. -Guanfacine 1 mg was changed to sustained release. -Clindamycin phosphate because he no longer had a rash. -Ketaconzole Shampoo because he no longer had a problem with head sores. -Ondansetron because he finished his 7-day dose. -"I'm not sure we have a policy about medications no longer needed." -"I want a policy to tell me what to do (medication disposal) instead of throwing it (medication) away." -She and the Manager would develop a policy on medication disposal and train staff on medication disposal procedures.	V 119		
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	V 295	Correction of Deficient Practice Documentation verifying the Associate Professional's qualifications and supervision has been compiled and placed in the personnel file. Prevention of Recurrence Required qualification and supervision documentation will be maintained in personnel files. Monitoring Responsibility Program Director. Monitoring Frequency As part of routine personnel file maintenance.	

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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 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 ensure at least one full-time direct care staff who meets the requirements of an Associate professional (AP). The findings are:

Review on 12/29/29 of the Staff Census revealed:
-1 staff with the job title of an AP.

Review on 12/31/25 of 1 staff with the job title of an AP revealed:
-Hire date of 7/1/24.
-AP job description signed and dated 7/1/24.
-Graduated 3/5/24 with a Bachelor of Business Administration which did not meet the educational requirements.

Interview on 12/30/25 with the staff with the job title of an AP revealed:

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KEYSTONE RIDGE	4770 BAUX MOUNTAIN ROAD WINSTON SALEM, NC 27105

(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 295	Continued From page 13 -He had a bachelor's degree in accounting with 4 years of work experience as a teacher. -His usual work hours were "as needed, it varies, work some weekends and during the week, mostly fill-in." -His job duties included work as direct care staff and he supervised the direct care staff. -He had been out on medical leave since October 2025, but had returned to work two weeks ago to onboard a new direct care staff. -He identified the Manager and Qualified Professional/Owner (QP/O) as the staff responsible for the day-to-day operations of the facility. Interview on 12/31/25 with the Manager revealed: -He believed the staff with the AP title met the AP educational and work requirements. Interview on 12/31/25 with the QP/O revealed: -She and the Manager would consider another staff who met AP requirements.	V 295		
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or	V 296	Correction of Deficient Practice Staff will alert the appropriate staff supervisor when an emergency or sickness has occurred and are unable to meet the needs of staff/client ratio requirements. Prevention of Recurrence Schedules will be posted weekly. Program Coordinator will monitor availability for emergency fill ins in case of call outs. Monitoring Responsibility Program Coordinator. Monitoring Frequency Ongoing as schedules are prepared.	Jan 31

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V 296	Continued From page 14 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 are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure the minimum staffing ratio of 2	V 296		

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V 296	Continued From page 15	V 296		

staff for up to 4 adolescents. The findings are:

Observation of the facility on 12/29/25 at 10:30 am revealed:
-Staff #1 was the only staff present in the facility with Client #1 until the Qualified Professional/Owner (QP/O) arrived at the facility at approximately 11:53 am.

Observation of the facility on 12/30/25 at 10:47 am revealed:
-The QP/O was present at the facility with Client #1 until Staff #1 arrived approximately 30 minutes later.

Interview on 12/29/25 with Client #1 revealed:
-There was usually 2 staff present at the facility on each shift.
-1 staff was out for the Christmas break the reason there was 1 staff present.

Interview on 12/29/25 with Client #2 revealed:
-When he woke up in the mornings, there was 2-3 staff present at the facility.
-When he went to bed at night, there was 1-2 staff present at the facility.

Interview on 12/29/25 with Staff #1 revealed:
-He began working at the facility about 3 weeks ago.
-He worked the 8 AM-4 PM shift for 2-3 days a week.
-He relieved Staff #3 when he came on shift this morning.
-"I don't have another staff working with me" when asked about a 2nd staff who worked with him on shift.
-Client #1 was at the facility and in his room.
-Client #2 was at his day treatment program and expected to return to the facility around 2:00 PM.

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V 296	Continued From page 16 Interview on 12/31/25 with the Qualified Professional/Owner revealed: -She was aware of the staffing ratio of 2 staff for one to four adolescents. -She worked as the 2nd staff when no other staff were available to work. -She came into work with Staff #1 on 12/29/25. -She would ensure the staffing ratio was met as required.	V 296		
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 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.	V 297	Correction of Deficient Practice Documentation verifying licensed professional involvement has been updated and retained. Prevention of Recurrence Licensed professional documentation will continue to be maintained in accordance with rule requirements fulfilling the required hours as mandated. Monitoring Responsibility Program Director. Monitoring Frequency Routine administrative review.	Jan 31

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V 297	Continued From page 17 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 at least 4 hours a week by a Licensed Professional (LP). The findings are: Review on 12/30/25 of Client #1's record revealed: -Admission date of 5/5/25. -Diagnoses of Attention-Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD) and Post-Traumatic Stress Disorder (PTSD). -Age: 17 years. Review on 12/31/25 of Client #2's record revealed: -Admission date of 5/27/25. -Diagnoses of ADHD, PTSD, Generalized Anxiety Disorder, and Other specified disruptive, impulse-control and conduct disorder. -Age: 14 years. Interview on 12/29/25 with Client #1 revealed: -A therapist came to the facility once a week to talk with him about anger management and emotional control. -"Maybe an hour she's here" when asked how long the LP stayed at the facility. Interview on 12/29/25 with Client #2 revealed: -The LP came to the facility once since his admission. -The last time the LP was at the facility was 1 month ago. Interview on 12/30/25 with the LP revealed: -She was a Licensed Clinical Social Worker.	V 297		

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V 297	Continued From page 18 -She started as the LP for the facility in August 2025. -The last time she saw Clients #1 and #2 was toward the end of August or first of September 2025. -She was present at the facility once a month and saw Clients #1 and #2 weekly through a remote technology platform. -Her LP duties included "seeing" clients weekly for individual therapy, providing monthly clinical supervision to the Manager and Qualified Professional/Owner (QP/O), making herself available for consultation in the event of a client emergency, and writing the comprehensive clinical assessments for Clients #1 and #2 when needed. -"I am going to have to work it out with [QP/O] and [Manager] with 4 hours a week in the group home." Interview on 12/29/25 with the QP/O revealed: -Confirmed the LP came to the facility once a month and provided virtual individual therapy with Clients #1 and #2 the other 3 weeks of a month.	V 297	V536 10A NCAC 27E .0107 Training on Alternatives to Restrictive Interventions	Feb 28
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and	V 536	Plan of Correction Correction of Deficient Practice Training records were reviewed and updated to document staff training on alternatives to restrictive interventions. Prevention of Recurrence Training documentation will be maintained in personnel files. Monitoring Responsibility Program Director. Monitoring Frequency Routine administrative oversight.	

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other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented.
(c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered.
(d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
(e) Formal refresher training must be completed by each service provider periodically (minimum annually).
(f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.
(g) Staff shall demonstrate competence in the following core areas:
(1) knowledge and understanding of the people being served;
(2) recognizing and interpreting human behavior;
(3) recognizing the effect of internal and external stressors that may affect people with disabilities;
(4) strategies for building positive relationships with persons with disabilities;
(5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;
(6) recognizing the importance of and assisting in the person's involvement in making decisions about their life;
(7) skills in assessing individual risk for

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V 536	Continued From page 20 escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of:	V 536		

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(A) understanding the adult learner;
(B) methods for teaching content of the course;
(C) methods for evaluating trainee performance; and
(D) documentation procedures.
(6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach.
(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.
(8) Trainers shall complete a refresher instructor training at least every two years.
(j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.
(1) Documentation shall include:
(A) who participated in the training and the outcomes (pass/fail);
(B) when and where attended; and
(C) instructor's name.
(2) The Division of MH/DD/SAS may request and review this documentation any time.
(k) Qualifications of Coaches:
(1) Coaches shall meet all preparation requirements as a trainer.
(2) Coaches shall teach at least three times the course which is being coached.
(3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.
(l) Documentation shall be the same preparation as for trainers.

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V 536	Continued From page 22 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure each staff was trained in Alternatives to Restrictive Interventions for 1 of 3 audited staff (Staff #1). The findings are: Review on 12/31/25 of Staff #1's personnel record revealed: -Hire date of 12/11/25. -No certification of formal training in Alternatives to Restrictive Interventions. Interview on 12/29/25 with Staff #1 revealed: -He had training in NCI Plus from his previous employer which was being transferred to his current employer. Interview on 12/31/25 with the Manager revealed: -Staff #1 was emailing the training documentation to him but the information had not yet been received. -He was not concerned he had not yet received the training documentation. -"We were in desperate need of help this Christmas. We had 2 people (staff) on leave. We had no choice but to put [Staff #1] to work." -He would follow up with Staff #1 to get the required training documentation.	V 536		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO	V 537	V537 10A NCAC 27E .0108 Plan of Correction Correction of Deficient Practice Training documentation has been updated to reflect required training completion. Prevention of Recurrence Training records will be maintained as required. Monitoring Responsibility Program Director. Monitoring Frequency Routine review during administrative oversight.	Feb 28

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10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT

(a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually.

(b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated.

(c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions.

(d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.

(e) Formal refresher training must be completed by each service provider periodically (minimum annually).

(f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.

(g) Acceptable training programs shall include, but are not limited to, presentation of:

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V 537	Continued From page 24 (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program	V 537		

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teaching the use of seclusion, physical restraint and isolation time-out.
(3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.
(4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
(5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule.
(6) Acceptable instructor training programs shall include, but not be limited to, presentation of:
(A) understanding the adult learner;
(B) methods for teaching content of the course;
(C) evaluation of trainee performance; and
(D) documentation procedures.
(7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule.
(8) Trainers shall be currently trained in CPR.
(9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach.
(10) Trainers shall teach a program on the use of restrictive interventions at least once annually.
(11) Trainers shall complete a refresher instructor training at least every two years.

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V 537	Continued From page 26 (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure each staff was trained in Restrictive Interventions for 1 of 3 audited staff (Staff #1). The findings are: Review on 12/31/25 of Staff #1's personnel record revealed: -Hire date of 12/11/25. -No certification of formal training in Restrictive Interventions. Interview on 12/31/25 with the Manager revealed: -Staff #1 was emailing the training documentation	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-424	A. BUILDING: ______ B. WING ______	12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE RIDGE	4770 BAUX MOUNTAIN ROAD WINSTON SALEM, NC 27105

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V 537	Continued From page 27 from his previous employer but he had not yet received the information. -He was not concerned he had not yet received the training documentation. -"We were in desperate need of help this Christmas. We had 2 people (staff) on leave. We had no choice but to put [Staff #1] to work." -He would follow up with Staff #1 to get the required training documentation.	V 537		