


Division of Health Service Regulation

|  |  |   |   |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>MHL001-281 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>R<br>02/10/2026 |
|--|--|---|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>A MOTHER'S LOVE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1227 WESTMORELAND DRIVE<br>BURLINGTON, NC 27217 |
|---|--|

| (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<br><br>An annual and follow up survey was completed on February 10, 2026. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents.<br><br>This facility is licensed for 4 and has a current census of 4. The survey sample consisted of audits of 3 current clients.   | V 000 |  |  |
| V 112 | 27G .0205 (C-D)<br>Assessment/Treatment/Habilitation Plan<br><br>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN<br>(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.<br>(d) The plan shall include:<br>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;<br>(2) strategies;<br>(3) staff responsible;<br>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;<br>(5) basis for evaluation or assessment of outcome achievement; and<br>(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 |  |  |

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  


TIT LE  
QP

(X6) DATE  
February 20, 2026

Division of Health Service Regulation

|  |  |   |   |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>MHL001-281 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>R<br>02/10/2026 |
|--|--|---|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>A MOTHER'S LOVE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1227 WESTMORELAND DRIVE<br>BURLINGTON, NC 27217 |
|---|--|

| (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 112 | <p>Continued From page 1</p> <p>This Rule is not met as evidenced by:<br/>Based on record reviews, and interviews, the facility failed to develop and implement treatment goals and strategies to address the needs of one of three audited clients (Client #3). The findings are:<br/>Review on 2/10/26 of Client #3's record revealed:<br/>-Admission date of 7/15/24.<br/>-Diagnoses of Disinhibited Social Engagement Disorder; Attention Deficit Hyperactivity Disorder, Combined Type; Circadian Rhythm Sleep Wake Disorder; Intellectual Disability.<br/>-She was 16 years old.<br/>-The treatment plan had no strategies to address elopement or the stealing of food from the refrigerator.<br/>Review on 2/10/26 of the North Carolina Incident Response Improvement System (IRIS) revealed:<br/>-Incident reports indicating that Client #3 eloped from the facility on the following dates: 8/29/25, 11/29/25, 12/7/25, 12/26/25, 1/19/26, 2/5/26.<br/>Interview on 2/10/26 with Client #3 revealed:<br/>-She liked the facility, staff and other clients.<br/>-Admitted walking away from the facility when upset.<br/>-Did not walk too far from the facility and stayed within the same neighborhood.<br/>Interview on 2/10/26 with the Director revealed:</p> | V 112 | <p>V112</p> <p><b>Corrective Action Taken:</b><br/>The consumer's Person-Centered Plan (PCP) was reviewed and revised to address the deficient area of practice. Two additional treatment goals were developed to specifically target the behaviors of elopement and stealing food from the refrigerator/cabinets. These goals include measurable strategies and staff interventions designed to reduce the frequency of these behaviors and increase appropriate coping and decision-making skills. The updated PCP was reviewed with the consumer and her treatment team on Monday, February 16, 2026. All required signatures for the revised PCP were obtained by Tuesday, February 17, 2026.</p> <p><b>Measures to Prevent Recurrence:</b><br/>The facility has implemented a procedure requiring treatment plans to be reviewed for behavioral trends identified through incident reports and staff observations. Any emerging or recurring behaviors will be addressed through timely treatment plan updates to ensure goals and strategies align with the consumer's current needs. Staff will receive guidance on promptly reporting behavioral patterns to the Qualified Professional (QP) so that treatment planning adjustments occur without delay.</p> <p><b>Monitoring Plan:</b><br/>The Qualified Professional (QP) will be responsible for monitoring the implementation and effectiveness of the new goals addressing elopement and stealing behaviors.</p> <p><b>Frequency of Monitoring:</b><br/>The PCP will be reviewed monthly to assess progress toward the new goals. Progress and ongoing needs will also be discussed during the consumer's monthly Child and Family Team (CFT) meetings. Incident reports related to elopement and stealing will be reviewed as they occur to determine if additional interventions are needed.</p> | 02/17/2026 |
|-------|---|-------|---|------------|

Division of Health Service Regulation

|  |  |   |   |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>MHL001-281 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>R<br>02/10/2026 |
|--|--|---|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>A MOTHER'S LOVE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1227 WESTMORELAND DRIVE<br>BURLINGTON, NC 27217 |
|---|--|

| (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 112              | Continued From page 2<br><br>-She acknowledged Client #3's plan did not have strategies to address eloping and the stealing of food from refrigerator/cabinet.<br>-Treatment Team was scheduled to meet upcoming Friday to discuss her recent behaviors which included eloping and the stealing of food.<br>-Treatment plan was to be updated.<br>-She acknowledged that although Client #3's plan mentioned her stealing, it did not have strategies set in place to address said behavior.  | V 112         |   |                    |
| V 118              | 27G .0209 (C) Medication Requirements<br><br>10A NCAC 27G .0209 MEDICATION REQUIREMENTS<br>(c) Medication administration:<br>(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.<br>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.<br>(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.<br>(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:<br>(A) client's name;<br>(B) name, strength, and quantity of the drug;<br>(C) instructions for administering the drug;<br>(D) date and time the drug is administered; and<br>(E) name or initials of person administering the drug. | V 118         |   |                    |

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION    |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>MHL001-281                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br>R<br>02/10/2026 |
|---|--|--|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>A MOTHER'S LOVE |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1227 WESTMORELAND DRIVE<br>BURLINGTON, NC 27217 |  |   |
| (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 118   | Continued From page 3<br><br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to have physician's orders current affecting one of three clients (Client #3). The findings are:<br>Review on 2/10/26 of Client #3's record revealed:<br>-Admission date of 7/15/24.<br>-Diagnoses of Disinhibited Social Engagement Disorder; Attention Deficit Hyperactivity Disorder, Combined Type; Circadian Rhythm Sleep Wake Disorder; Intellectual Disability.<br>-There were no current physician's orders for the following medications:<br><br>-Hydrocortisone 5 milligrams (mg) (skin)- Take two tablets daily in the morning. Last order written on 10/2/24.<br>-Hydrocortisone 5 mg- Take one tablet daily in the afternoon. Last order written on 10/2/24.<br>-Hydrocortisone 5 mg- Take one tablet daily in the evening at bedtime. Last order written on 10/2/24.<br>-Simvastatin 10 mg (cholesterol)- Take one tablet daily in the evening at bedtime. Last order written on 1/16/25.<br>Observation on 2/10/26 of Client #3's medications revealed:<br>-All medications mentioned were available. | V 118  | V118<br><br><b>Corrective Action Taken:</b><br>The pharmacy was immediately contacted, and updated physician's orders were obtained for Client #3's Hydrocortisone and Simvastatin. All expired prescriptions were replaced with current physician orders. At this time, all medications and prescriptions for Client #3 are current and valid, and the facility is receiving medications as prescribed.<br><br><b>Measures to Prevent Recurrence:</b><br>The facility has implemented a procedure to ensure that all medication orders remain current. All medications are maintained on a four-week cycle through the pharmacy, which requires valid physician orders for continued dispensing. Staff will verify prescription expiration dates during routine medication checks to ensure no medications are administered without a current physician's order.<br><br>In addition, medication records will be reviewed during the pharmacy's scheduled six-month Medication Administration Record (MAR) audit to identify and correct any expired or expiring prescriptions.<br><br><b>Monitoring Plan:</b><br>The Qualified Professional (QP) will be responsible for monitoring medication records to ensure that all physician orders remain current.<br><br><b>Frequency of Monitoring:</b><br>Medication orders will be reviewed during each six-month MAR audit conducted by the pharmacy and as part of ongoing record reviews by the QP. Any expired or expiring orders identified will be addressed immediately by obtaining updated physician orders. | 02/20/2026  |

Division of Health Service Regulation

|  |  |   |   |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>MHL001-281 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>R<br>02/10/2026 |
|--|--|---|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>A MOTHER'S LOVE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1227 WESTMORELAND DRIVE<br>BURLINGTON, NC 27217 |
|---|--|

| (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 118 | Continued From page 4<br><br>Review on 2/10/26 of Client #3's MARs for December 2025 through February 10, 2026 revealed:<br>-All medications mentioned had been marked as administered.<br><br>Interview on 2/10/26 with the Director revealed:<br>-She was not aware that the scripts for Client #3's medications had expired.<br>-She was going to get new orders from Client #3's physician.<br>-She acknowledged the medication orders for Client #3's Hydrocortisone and Simvastatin had expired.<br>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days. | V 118 |  |  |
|-------|---|-------|--|--|

|       |   |       |  |  |
|-------|---|-------|--|--|
| V 364 | G.S. 122C- 62 Additional Rights in 24 Hour Facilities<br>§ 122C-62. Additional Rights in 24-Hour Facilities .<br>(a)In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-61, each adult client who is receiving treatment or habilitation in a 24-hour facility keeps the right to:<br>(1)Send and receive sealed mail and have access to writing material, postage, and staff assistance when necessary;<br>(2)Contact and consult with, at his own expense and at no cost to the facility, legal counsel, private physicians, and private mental health, developmental disabilities, or substance abuse professionals of his choice; and<br>(3)Contact and consult with a client advocate if there is a client advocate.<br>The rights specified in this subsection may not be restricted by the facility and each adult client may | V 364 |  |  |
|-------|---|-------|--|--|

Division of Health Service Regulation

|  |  |   |   |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>MHL001-281 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>R<br>02/10/2026 |
|--|--|---|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>A MOTHER'S LOVE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1227 WESTMORELAND DRIVE<br>BURLINGTON, NC 27217 |
|---|--|

| (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 364 | <p>Continued From page 5</p> <p>exercise these rights at all reasonable times.<br/>(b)Except as provided in subsections (e) and (h) of this section, each adult client who is receiving treatment or habilitation in a 24-hour facility at all times keeps the right to:</p> <p>(1)Make and receive confidential telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party;<br/>(2)Receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over therapies;<br/>(3)Communicate and meet under appropriate supervision with individuals of his own choice upon the consent of the individuals;<br/>(4)Make visits outside the custody of the facility unless:</p> <p>a. Commitment proceedings were initiated as the result of the client's being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found not guilty by reason of insanity or incapable of proceeding;<br/>The client was voluntarily admitted or committed to the facility while under order of commitment to a correctional facility of the Division of Adult Correction of the Department of Public Safety; or</p> <p>c. The client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; A court order may expressly authorize visits otherwise prohibited by the existence of the conditions prescribed by this subdivision;<br/>(5)Be out of doors daily and have access to facilities and equipment for physical exercise several times a week;<br/>(6)Except as prohibited by law, keep and use</p> | V 364 | <p>V364</p> <p><b>Corrective Action Taken:</b><br/>The facility immediately unlocked all locking devices from the refrigerator and freezer. Clients' access to food is no longer restricted. The snack cabinet is no longer used to restrict client access to food. All personal snacks have been moved into individual labeled containers for each client.</p> <p>Clients now have access to their personal snacks upon request, and staff provide assistance to ensure snacks are distributed appropriately and safely. The facility continues to prepare meals daily in sufficient quantities to meet the nutritional needs of all clients based on recommended portion sizes.</p> <p>Clients are permitted to prepare their own breakfast and lunch when appropriate, primarily on weekends and when school is not in session, under staff supervision.</p> <p><b>Measures to Prevent Recurrence:</b><br/>The facility has implemented a procedure prohibiting the use of locks or physical barriers to restrict client access to food unless such restriction is clinically justified, documented in the client's treatment plan, and approved by the Human Rights Committee.</p> <p>Any future concerns related to food-related behaviors will be addressed through individualized treatment planning, behavior support strategies, and staff supervision rather than environmental restriction.</p> <p>Treatment plans will be updated to include specific goals and strategies when food-related behaviors are identified. Staff have been instructed that client rights may not be restricted without proper documentation, evaluation, and Human Rights Committee approval.</p> <p><b>Monitoring Plan:</b><br/>The Qualified Professional (QP) will be responsible for monitoring food access practices and treatment plan documentation to ensure compliance with client rights requirements.</p> <p><b>Frequency of Monitoring:</b><br/>The QP will review food access practices weekly and will review treatment plans monthly to ensure that no unauthorized restrictions are in place. Any concerns will be addressed immediately.</p> | 02/20/2026 |
|-------|--|-------|---|------------|

Division of Health Service Regulation

|  |  |   |   |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>MHL001-281 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>R<br>02/10/2026 |
|--|--|---|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>A MOTHER'S LOVE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1227 WESTMORELAND DRIVE<br>BURLINGTON, NC 27217 |
|---|--|

| (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 364 | <p>Continued From page 6</p> <p>personal clothing and possessions, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002;</p> <p>(7) Participate in religious worship;</p> <p>(8) Keep and spend a reasonable sum of his own money;</p> <p>(9) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes; and</p> <p>(10) Have access to individual storage space for his private use.</p> <p>(c) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-57 and G.S. 122C-59 through G.S. 122C-61, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to have access to proper adult supervision and guidance. In recognition of the minor's status as a developing individual, the minor shall be provided opportunities to enable him to mature physically, emotionally, intellectually, socially, and vocationally. In view of the physical, emotional, and intellectual immaturity of the minor, the 24-hour facility shall provide appropriate structure, supervision and control consistent with the rights given to the minor pursuant to this Part. The facility shall also, where practical, make reasonable efforts to ensure that each minor client receives treatment apart and separate from adult clients unless the treatment needs of the minor client dictate otherwise.</p> <p>Each minor client who is receiving treatment or habilitation from a 24-hour facility has the right to:</p> <p>(1) Communicate and consult with his parents or guardian or the agency or individual having legal custody of him;</p> <p>(2) Contact and consult with, at his own expense or that of his legally responsible person and at no cost to the facility, legal counsel, private</p> | V 364 |  |  |
|-------|---|-------|--|--|

Division of Health Service Regulation

|  |  |   |   |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>MHL001-281 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>R<br>02/10/2026 |
|--|--|---|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>A MOTHER'S LOVE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1227 WESTMORELAND DRIVE<br>BURLINGTON, NC 27217 |
|---|--|

| (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 364 | <p>Continued From page 7</p> <p>physicians, private mental health, developmental disabilities, or substance abuse professionals, of his or his legally responsible person's choice; and (3)Contact and consult with a client advocate, if there is a client advocate.</p> <p>The rights specified in this subsection may not be restricted by the facility and each minor client may exercise these rights at all reasonable times. (d)Except as provided in subsections (e) and (h) of this section, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to:</p> <p>(1)Make and receive telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party;</p> <p>(2)Send and receive mail and have access to writing materials, postage, and staff assistance when necessary;</p> <p>(3)Under appropriate supervision, receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over school or therapies;</p> <p>(4)Receive special education and vocational training in accordance with federal and State law;</p> <p>(5)Be out of doors daily and participate in play, recreation, and physical exercise on a regular basis in accordance with his needs;</p> <p>(6)Except as prohibited by law, keep and use personal clothing and possessions under appropriate supervision, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002;</p> <p>(7)Participate in religious worship;</p> <p>(8)Have access to individual storage space for the safekeeping of personal belongings;</p> <p>(9)Have access to and spend a reasonable sum</p> | V 364 |  |  |
|-------|---|-------|--|--|

Division of Health Service Regulation

|  |  |   |   |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>MHL001-281 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>R<br>02/10/2026 |
|--|--|---|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>A MOTHER'S LOVE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1227 WESTMORELAND DRIVE<br>BURLINGTON, NC 27217 |
|---|--|

| (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 364 | Continued From page 8<br><br>of his own money; and<br>(10)Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes.<br>(e)No right enumerated in subsections (b) or (d) of this section may be limited or restricted except by the qualified professional responsible for the formulation of the client's treatment or habilitation plan. A written statement shall be placed in the client's record that indicates the detailed reason for the restriction. The restriction shall be reasonable and related to the client's treatment or habilitation needs. A restriction is effective for a period not to exceed 30 days. An evaluation of each restriction shall be conducted by the qualified professional at least every seven days, at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's record. Restrictions on rights may be renewed only by a written statement entered by the qualified professional in the client's record that states the reason for the renewal of the restriction. In the case of an adult client who has not been adjudicated incompetent, in each instance of an initial restriction or renewal of a restriction of rights, an individual designated by the client shall, upon the consent of the client, be notified of the restriction and of the reason for it. In the case of a minor client or an incompetent adult client, the legally responsible person shall be notified of each instance of an initial restriction or renewal of a restriction of rights and of the reason for it. Notification of the designated individual or legally responsible person shall be documented in writing in the client's record. | V 364 |  |  |
|-------|--|-------|--|--|

Division of Health Service Regulation

|  |  |   |   |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>MHL001-281 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>R<br>02/10/2026 |
|--|--|---|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>A MOTHER'S LOVE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1227 WESTMORELAND DRIVE<br>BURLINGTON, NC 27217 |
|---|--|

| (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 364 | <p>Continued From page 9</p> <p>This Rule is not met as evidenced by:</p> <p>Based on observation, record reviews and interviews, the facility restricted the rights of three of three audited clients (#1, #2 and #3) by restricting their access to food. The findings are:</p> <p>Observation on 2/10/26 at 2:45 pm of the facility's kitchen revealed:</p> <ul style="list-style-type: none"> <li>-Refrigerator had three locking cables attached to its door. A key was needed to open the refrigerator. Cables were unlocked at the time of observation.</li> <li>-Cabinets- One of the cabinets was labeled "Snacks" and had a lock attached to the door. Cabinet door was locked.</li> </ul> <p>Review on 2/10/26 of Client #1's record revealed:</p> <ul style="list-style-type: none"> <li>-Admission date of 11/14/24.</li> <li>-Diagnoses of Major Depressive Disorder, Recurrent, Moderate; Oppositional Defiant Disorder; Unspecified Trauma and Stressor Related Disorder; Post Traumatic Stress Disorder; Disruptive Mood Dysregulation Disorder; High Risk Sexual Behavior; Child Sexual Abuse, Suspected, Subsequent Encounter.</li> <li>-There was no documentation of detailed reason for the restriction and no evaluation of the restriction.</li> <li>-No documentation of approval from the Human Rights Committee for restriction of clients accessing the refrigerator or snack cabinet.</li> </ul> <p>Review on 2/10/26 of Client #2's record revealed:</p> <ul style="list-style-type: none"> <li>-Admission date of 9/21/25.</li> <li>-Diagnoses of Adjustment Disorder with Mixed Disturbance &amp; Conduct; Trauma Related Stress Disorder; Generalized Anxiety Disorder; Child in DSS Custody.</li> </ul> | V 364 |  |  |
|-------|---|-------|--|--|

Division of Health Service Regulation

|  |  |   |   |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>MHL001-281 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>R<br>02/10/2026 |
|--|--|---|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>A MOTHER'S LOVE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1227 WESTMORELAND DRIVE<br>BURLINGTON, NC 27217 |
|---|--|

| (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 364 | <p>Continued From page 10 -There was no documentation of detailed reason for the restriction and no evaluation of the restriction.</p> <ul style="list-style-type: none"> <li>-No documentation of approval from the Human Rights Committee for restriction of client accessing the refrigerator.</li> </ul> <p>Review on 2/10/26 of Client #3's record revealed:</p> <ul style="list-style-type: none"> <li>-Admission dated of 7/15/24.</li> <li>-Diagnoses of Disinhibited Social Engagement Disorder; Attention Deficit Hyperactivity Disorder, Combined Type; Circadian Rhythm Sleep Wake Disorder; Intellectual Disability.</li> <li>-Treatment plan dated 1/21/26 did not include documentation of food related behaviors.</li> <li>-There was no documentation of detailed reason for the restriction and no evaluation of the restriction.</li> <li>-No documentation of approval from the Human Rights Committee for restriction of client accessing the refrigerator.</li> </ul> <p>Interview on 2/10/26 with Client #1 revealed:</p> <ul style="list-style-type: none"> <li>-She had seen the refrigerator locked.</li> <li>-She had heard that Client #3 had been taking people's food from the refrigerator.</li> <li>-Facility normally always gave them their meals.</li> </ul> <p>Interview on 2/10/26 with Client #2 revealed:</p> <ul style="list-style-type: none"> <li>-Facility always gave them their meals.</li> <li>-Facility mostly made enough meal for the day and did not refrigerate left overs.</li> <li>-She had seen the refrigerator being locked.</li> <li>-If she wanted one of her snacks, she would ask staff to grab it.</li> </ul> <p>Interview on 2/10/26 with Client #3 revealed:</p> <ul style="list-style-type: none"> <li>-She had seen the refrigerator being locked.</li> <li>-Facility gave clients their meals. Clients did not prepare meals.</li> </ul> | V 364 |  |  |
|-------|--|-------|--|--|

Division of Health Service Regulation

|  |  |   |   |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>MHL001-281 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>R<br>02/10/2026 |
|--|--|---|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>A MOTHER'S LOVE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1227 WESTMORELAND DRIVE<br>BURLINGTON, NC 27217 |
|---|--|

| (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 364 | <p>Continued From page 11 -She did not know why the refrigerator was being locked.<br/>-Staff locked their snacks in the kitchen.</p> <p>Interview on 2/10/26 with the Director revealed:<br/>-She was not aware that the refrigerator could not be locked.<br/>-Facility staff had placed the locking cables to curb Client #3's behavior of stealing other client's foods.<br/>-Client's snacks were also locked to prevent clients from eating other client's snacks.<br/>-"If clients ever needed anything, like water and snacks, staff would just assist the client and give them what they needed."<br/>-When the clients were in school, the facility provided breakfast, two snacks and dinner for the day.</p> <p>Interview on 2/10/26 with the Owner revealed:<br/>-She was planning on appealing deficiency cited.<br/>-Facility had to place the lock cables on the refrigerator because Client #3 was taking the other client's food and rubbing it on her private areas and placing it back in.<br/>-She did not know other ways to curb said behavior.<br/>-She had not contacted disability rights committee to receive approval to lock the refrigerator or snack cabinet.<br/>-Clients at the facility were never allowed to use the refrigerator or to have direct access to foods as they tried to prevent food being contaminated by the client's hands.<br/>-Clients were not allowed to fix meals.<br/>-She acknowledged there was no documentation placed on each of the client's treatment plans indicating the restriction to the refrigerator or snack cabinet.</p> | V 364 |  |  |
|-------|---|-------|--|--|

Division of Health Service Regulation

|  |  |   |   |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>MHL001-281 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>R<br>02/10/2026 |
|--|--|---|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>A MOTHER'S LOVE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1227 WESTMORELAND DRIVE<br>BURLINGTON, NC 27217 |
|---|--|

| (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 736              | Continued From page 12   | V                | <b>V736</b>   |                    |
| V 736              | <p>27G .0303(c) Facility and Grounds Maintenance</p> <p>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS</p> <p>(c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.</p> <p>This Rule is not met as evidenced by:</p> <p>Based on observation and interview, the facility and its grounds were not maintained in a clean, attractive, and orderly manner. The findings are:</p> <p>Observation on 2/10/26 of the facility at about 2:45 pm revealed:</p> <ul style="list-style-type: none"> <li>-Hall bathroom- Vanity lamp had two burnt light bulbs.</li> <li>-Client #3's bedroom- The outside bottom pane glass for the left window was cracked/broken. Tape was on top of the cracked glass.</li> <li>-Back Deck- The wood was weathered. Paint had been worn off from about a quarter of the deck exposing the wood to the elements.</li> </ul> <p>Interview on 2/10/26 with the Director revealed:</p> <ul style="list-style-type: none"> <li>-Acknowledged the window in Client #3's bedroom was cracked. An order was placed, but it was taking long to repair.</li> <li>-She was not aware the light bulbs in the bathroom had burnt.</li> <li>-Acknowledged wood on back deck was weathered and in need of repainting.</li> </ul> <p>Interview on 2/10/26 with the Owner revealed:</p> <ul style="list-style-type: none"> <li>-She had placed an order to repair the window in Client #3's bedroom, but things were now taking longer to fix than before. She would follow up to</li> </ul> | 736<br><br>V 736 | <p><b>Corrective Action Taken:</b></p> <p>The facility immediately replaced the burnt-out light bulbs in the hall bathroom vanity fixture.</p> <p>The facility has scheduled repairs for the cracked window in Client #3's bedroom. The window will be replaced within the required 60-day correction period. The facility has also scheduled repainting of the back deck. The deck will be repainted within the required 60-day correction period to protect the wood from further weathering and deterioration.</p> <p><b>Measures to Prevent Recurrence:</b></p> <p>The facility has implemented a routine environmental inspection process to identify maintenance concerns such as lighting, windows, and exterior structures. Maintenance needs will be reported promptly and addressed in a timely manner to ensure the facility remains clean, attractive, and orderly.</p> <p>Staff have been instructed to report maintenance concerns immediately to administration so that repairs can be initiated without delay.</p> <p><b>Monitoring Plan:</b></p> <p>The Director and QP will be responsible for monitoring the condition of the facility and ensuring that maintenance issues are corrected.</p> <p><b>Frequency of Monitoring:</b></p> <p>The facility will be inspected weekly by the Director or designee to identify and address maintenance concerns. All identified issues will be tracked until resolved.</p> | 04/11/2026         |

Division of Health Service Regulation

|  |  |   |   |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>MHL001-281 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>R<br>02/10/2026 |
|--|--|---|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>A MOTHER'S LOVE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1227 WESTMORELAND DRIVE<br>BURLINGTON, NC 27217 |
|---|--|

| (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 736 | Continued From page 13<br>have it repaired soon. | V 736 |  |  |
|-------|--|-------|--|--|