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A BETTER PATH, INC	2106 NEWELL STREET RAMSEUR, NC 27316

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on February 19, 2026. The complaint was substantiated (intake #NC00235306). 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 3. The survey sample consisted of audits of 3 clients.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be	V 112		

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V 112	Continued From page 1 obtained. This Rule is not met as evidenced by: 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 clients (Client #1). The findings are: Review on 2/6/26 of Client #1's record revealed: -Admission date of 7/28/25. -Diagnoses of Disruptive Mood Dysregulation Disorder; Attention Deficit-Hyperactivity Disorder, Predominantly Inattentive Presentation; Unspecified Trauma and Stressor Disorder. -17 years old -The Person Centered Plan (PCP) dated 7/7/25 had no goals or strategies to address elopement. Review on 2/11/26 of facility's internal incident reports revealed: Client #1 eloped from the facility on the following dates: 12/24/25, 1/21/26, 2/6/26: -12/24/25 incident: - Client #1 became upset about being confined to her bedroom due to having the flu. -Client #1 exhibited signs of frustration and emotional distress related to being placed on quarantine precautions. -Client #1 expressed dissatisfaction with	V 112		

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remaining in quarantine and verbalized not wanting to stay in the facility under those conditions.
-Client #1 left the facility without authorization.
-Staff immediately followed elopement protocols, including notifying supervisory staff and contacting local law enforcement.
-After leaving the premises, [Client #1] made contact with a local law enforcement officer and reported suicidal ideation.
-Due to the expressed risk to self, the local law enforcement officer initiated an Involuntary Commitment (IVC).
-Client #1 was transported to local hospital for further psychiatric evaluation and stabilization.

-1/21/26 incident:
-Client #1 had awaken around 3:46 am and began waking up the other clients in the facility.
-Staff attempted to redirect Client #1 and reminded her they had school the next day and to stop trying to wake up her peers
-Client #1 exhibited signs of frustration and anger.
-Staff told client #1 she could talk to staff in the common area if she was having any issues sleeping.
-Client #1 refused to follow redirection.
-Client #1 walked out of the facility.
-Staff attempted redirected Client #1 to return back to the facility and after left the premises 911 was called.
-Staff immediately followed elopement protocols, including notifying supervisory staff and contacting local law enforcement.
-Local law enforcement found Client #1 and she reported having suicidal ideation to them.
-Due to the expressed risk of suicidal ideation, the local law enforcement transported Client #1 to local hospital for a psychiatric evaluation.

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V 112	Continued From page 3 2/6/26 incident: -Client #1 became frustrated and anxious when the DHSR Surveyor arrived for the survey. -Client #1 watched from the hall with concerned. -Client #1 expressed concern that she felt the Surveyor was coming to move her. -Staff reassured her that wasn't the reason for his visit. -While the survey was starting Client #1 walked out the facility and proceeded to walk down the street. -Staff followed Client #1 and attmpted to redirect her. -Staff called 911 -Local law enforcement arrived and Client #1 became aggressive and started to fight the officers -Local law enforcement transported Client #1 to a local hospital for pyschiatric evaluation. -After being evaluated at the local hospital it was determined Client #1 would be transported to a psychiatric treatment center for psychiatric stabilization. Attempted interview on 2/6/26 with Client #1 was unsuccessful due to Client #1 being IVC'd after eloping from the facility on 2/6/26 and is currently hospitalized in a impatient psychiatric facility. Interview on 2/19/26 with the Qualified Professional (QP) revealed: -Client #1's PCP did not have any goals or strategies to address elopements. -"There had been a Crisis Plan developed by Client #1's therapist addressing elopements, but it had not been implemented." -Client #1's PCP will include this information in the next update.	V 112		

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V 118	Continued From page 4	V 118		
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 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:	V 118		

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V 118	Continued From page 5 Based on observation, record reviews and interview, the facility failed to keep the MAR current affecting one of three clients (Client #1). The findings are: Review on 2/5/26 of Client #1's record revealed: -Admission date of 7/28/25. -Diagnoses of Disruptive Mood Dysregulation Disorder; Attention Deficit-Hyperactivity Disorder (ADHD), Predominantly Inattentive Presentation; Unspecified Trauma and Stressor Disorder. -17 years old -Physician order dated 7/27/25: -Escitalopram 10 milligrams (mg) (anxiety), take 1 tablet by mouth every morning - Pantoprazole Sodium 40mg (Gastroesophageal Reflux Disease), take 1 tablet by mouth every day. - Polyethylene Glycol 3350 Powder (constipation), take 17 grams (g) in 8 ounces (oz) of liquid and drink by mouth daily. - Vitamin B12 1,000 micrograms (mcg) (supplement), take 1 tablet by mouth every day. - Vitamin D3 50mcg (supplement), take 1 tablet by mouth every day. - Vraylar 1.5mg (depression), take 1 capsule by mouth every day. - Adapalene 0.3% gel (acne), apply topically to the affected area at bedtime. - Clonidine Hcl Extended Release (ER) 0.1mg (ADHD), take 1 tablet by mouth at bedtime. - Melatonin 10mg (sleep), take 1 capsule by mouth at bedtime. - Prazosin 1mg (Post-Traumatic Stress Disorder), take 1 capsule by mouth at bedtime. - Metformin Hcl 500mg (diabetes), Take 1 tablet by mouth 2 times daily with breakfast and supper. Observation on 2/5/26 at approximately 1:21 PM	V 118		

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V 118	Continued From page 6 of Client #1's medications revealed: -Escitalopram 10mg, take 1 tablet by mouth every morning, dispensed 1/16/26. -Pantoprazole Sodium 40mg, take 1 tablet by mouth every day, dispensed 1/16/26. -Polyethylene Glycol 3350 Powder, take 17g in 8 oz of liquid and drink by mouth daily, dispensed 1/10/26. -Vitamin B12 1,000mcg, take 1 tablet by mouth every day, dispensed 1/16/26. -Vitamin D3 50mcg, take 1 tablet by mouth every day, dispensed 1/16/26. -Vraylar 1.5mg, take 1 capsule by mouth every day, dispensed 1/16/26. -Adapalene 0.3% gel, apply topically to the affected area at bedtime, dispensed 12/22/25. -Clonidine Hcl ER 0.1mg, take 1 tablet by mouth at bedtime, dispensed 1/16/26. -Melatonin 10mg, take 1 capsule by mouth at bedtime, dispensed 1/16/26. -Prazosin 1mg, take 1 capsule by mouth at bedtime, dispensed 1/16/26. -Metformin Hcl 500mg, Take 1 tablet by mouth 2 times daily with breakfast and supper, dispensed 1/16/26. Review on 2/5/26 at approximately 1:08 PM of Client #1's January 2026 MARs revealed: - No staff initials to indicate the following medications were administered as ordered by a physician: -Polyethylene Glycol 3350 Powder: 1/24-1/25 -Vraylar 1.5mg: 1/25 -Adapalene 0.3% gel: 1/24-1/25 -Clonidine Hcl ER 0.1mg: 1/24-1/25 -Melatonin 10mg: 1/23-1/25 -Prazosin 1mg: 1/25 -Metformin Hcl 500mg: 1/24-1/25 in the AM and PM	V 118		

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V 118	Continued From page 7 Interview on 2/5/26 with Client #1 at approximately 9:20 AM revealed: -She had received her medication everyday and had not missed any doses. Interview on 2/5-6/26 with the Associate Professional/House Manager revealed: -She administered the clients' medications. -The clients were administered their medications every day. -She was not aware of any medication errors, including missed doses of medications. Interview on 2/5-6/26 with the Qualified Professional (QP) revealed: -She was not aware of any medication errors, including missed doses of medications, for any of the clients. -The pharmacy gave them a new MAR when there had been a change. -A new MAR for Client #1 was provided to the facility by the pharmacy on 1/26/26. -She was not aware of any missed documentation of medications on either the 1st or 2nd January, 2026 MAR. -She acknowledged that the facility did not keep the MAR current for Client #1.	V 118		
V 293	27G .1701 Residential Tx. Child/Adol - Scope 10A NCAC 27G .1701 SCOPE (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility. (b) Staff secure means staff are required to be	V 293		

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V 293	Continued From page 8 awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to a community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting. (e) Services shall be designed to: (1) include individualized supervision and structure of daily living; (2) minimize the occurrence of behaviors related to functional deficits; (3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting. (f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care.	V 293		

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This Rule is not met as evidenced by:
Based on record reviews and interviews the facility failed to coordinate with other individuals or agencies within the child or adolescent's system of care affecting one of three clients (Client #1). The findings are:

Review on 2/5/26 of Client #1's record revealed:
-Admission date of 7/28/25.
-Diagnoses of Disruptive Mood Dysregulation Disorder (DMDD); Attention Deficit-Hyperactivity Disorder (ADHD), Predominantly Inattentive Presentation; Unspecified Trauma and Stressor Disorder.
-17 years old

Review on 2/11/26 of the facility incident report dated 12/24/25 revealed:
-The incident occurred at 9:30 AM.
-"On 12/24/2025, [Client #1] exhibited signs of frustration and emotional distress related to recently recovering from the flu and being placed on quarantine protocol. The client expressed dissatisfaction with remaining in quarantine and verbalized not wanting to stay in the facility under those conditions."
-"Following this, [Client #1] left the premises without authorization. Staff immediately followed elopement protocols, including notifying supervisory staff and contacting [Local Law Enforcement]."
-"After leaving the premises, [Client #1] made contact with [Local Law Enforcement] and reported suicidal ideation. Due to the risk to self,

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the [Local Law Enforcement initiated an Involuntary Commitment (IVC). The client was transported to [local hospital] for further psychiatric evaluation and stabilization."

Review on 2/5/26 of the Local Law Enforcement police report revealed:
-A call was received at 8:58 AM on 12/24/25 with Associate Professional/House Manager (AP/HM), facility staff, reporting that Client #1 made a suicide threat and was then walking on local street.
-AP/HM reported that "she (Client #1) will try to get a hold of anything she (Client #1) can to hurt herself."
-Law Enforcement Officer (LEO) responded to the call.
-Client #1 was located by LEO on local street walking northbound.
-LEO approached Client #1 after exiting his patrol car and attempted to talk to her.
-Client #1 refused to stop and kept walking northbound on local street
-"I grabbed the female party (Client #1) by the right arm and attempted to get her to stop walking and to speak with me."
-Client #1 stopped and told LEO that he (LEO), "shouldn't grab her that way due to the fact, she has the flu."
-LEO asked Client #1 what had happened today.
-Client #1 stated that she left the facility because, "they would not allow her to come out of her bedroom due to flu exposure."
-'[Client #1] stated that this infuriated her, she left the facility and she wanted to harm herself."
-"I asked [Client #1] if she still wished to harm herself and if so how she planned on doing it. [Client #1] stated that her plan was to 'continue walking northbound until she approached Highway 64 and prayed that she would be struck

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by a vehicle'."
-"[Client #1] was placed into custody."
-LEO then spoke with the caller, AP/HM, "who was now on the scene."
-"[AP/HM] confirmed [Client #1]'s story"
-LEO informed AP/HM that due to Client #1's statement she would be transported to the local hospital for emergency commitment and further evaluation.
-LEO told AP/HM that she "would also need to be at the hospital to assist with providing information"
-"[Client #1] was transported to the local hospital and was turned over to their care for further evaluation."

Review on 2/12/26 of hospital's summary archive records for Client #1 revealed:
-She was transported by Sheriff's Deputy for an Involuntary Commitment (IVC) due to suicidal ideations.
-Client #1 was admitted to the Emergency Department (ED) at 9:36 AM on 12/24/25, and completed triage at 9:44 AM.
-She was seen by the primary medical provider at 9:50 AM.
-The ED personnel referred client #1 for a telehealth evaluation by a psychiatric provider at 9:50 AM.
-Client #1 had used a spoon from her lunch tray to try to cut herself on the arms at 1:15 PM.
-Security had to remove the spoon from Client #1.
-She calmed down and was provided "Christmas pages" to color.
-Client #1 was evaluated by the psychiatric provider over telehealth beginning at 2:31 PM.
-Psychiatric provider noted that Client #1 "endorses that she instructed police that she was 'feeling suicidal', thus was brought in."
-"Expanding on this, patient endorses that 'but I

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was not suicidal, I just told them that because I wanted to go to the hospital, because I did not want to spend Christmas in my room ...but I want to go back now, I don't want to spend Christmas here anymore'.'"
-"Promoted to clarify, patient affirms that she lied about having suicidal ideations to the police, and upon direct questioning if she was experiencing any current suicidal or homicidal ideations, or instability of her mental health, patient adamantly stated that she is not, and that again, she wants to return back to her group home because, 'I would rather be back in my room then here'.'"
-"Redirected and prompted to discuss recent behavior earlier today, i.e., the patient scratching herself with a spoon from her lunch tray while in the emergency department, patient endorses that, 'I just did it because when I put on the scrubs I feel like I have to act out because it is required'.'"
-Psychiatric provider contacted facility Qualified Professional (QP) for collateral information as well as to discuss client being psychiatrically cleared.
-Client #1 was cleared for discharge from the ED at 3:09 PM.
-The QP requested that client be held longer to ensure that she is not a danger to harm herself or others.
-The psychiatric provider stated to the QP that this request was "not appropriate" as Client #1 had been medically and psychiatrically cleared for discharge.
-The QP was called by ED Nurse starting at 3:28 PM 4 times to inform her that Client #1 was ready for discharge and awaiting pickup. There was no answer.
-The ED Nurse called the QP and Client #1's Department of Social Services (DSS) Legal Guardian at 3:51 PM with no answer. A message

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was left that Client #1 is ready for discharge and awaiting pickup.
-The ED Nurse again called the QP starting at 4:58 PM 4 times with no answer. A welfare check to the facility was called in by ED Nurse as advised by her Supervisor.
-LEO called the ED at 5:15 PM to inform them that a welfare check had been performed and there was no answer at the facility. The Officer had called the QP and left a message that Client #1 was discharged and ready to be picked up at the ED.
-ED Nurse called the QP and the DSS Legal Guardian at 5:20 PM with no answer and messages left for a return call on the voicemails.
-LEO called the ED Nurse and reported that he would perform another welfare check at a later time. The ED Nurse requested that a welfare check be performed at the QP's personal residence to get in touch with her.
-The ED Nurse contacted the DSS After Hours line in an attempt to speak with Client #1's DSS Legal Guardian about the situation.
-DSS On-Call personnel reported that he would look into the situation and contact his Supervisor. No return call was received.
-LEO contacted the ED at 6:55 PM and confirmed that a welfare check had been performed by law enforcement at the QP's personal residence but there was no answer.
-The ED Nurse called the QP on 12/25/25 at 10:00 AM, 10:43 AM, 11:25 AM, 1:00 PM and 6:08 PM with no answer and voicemails requesting a return call and that Client #1 was ready to be picked up were left.
-The ED Nurse called and spoke with the QP at 1:00 PM on 12/26/25.
-The QP reiterated that DSS is the Guardian and that she was told by DSS that "they are working on something to keep her (Client #1) there."

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V 293	Continued From page 14 -The ED Nurse called the QP on 12/27/25 at 8:00 AM, 9:00 AM, 10:00 AM, 11:00 AM, 12:00 PM and 1:19 PM with no answer and voicemails requesting a return call and that Client #1 was ready to be picked up were left at all times above except 12:00 PM when the voicemail was full. -The ED Nurse called the DSS Legal Guardian at 8:45 AM on 12/29/25, left a message to return the call and received a call back at 8:50 AM. -The DSS Legal Guardian was informed that Client #1 had been discharged 12/24/26 and was ready to be picked up. -The DSS Legal Guardian arranged transportation for Client #1, and she was transported back to the facility on 12/29/25 at 3:00 PM by the DSS Legal Guardian. Interview on 2/5/26 with the Hospital Director of Nursing Support and Acting Supervisor in the ED on 12/24/25 revealed: -The hospital had been contacted by the local County Magistrate on 12/25/25. -The local County Magistrate called the hospital ED and stated that "an outside entity called the Magistrate saying that the hospital was not meeting their obligation for an IVC." -She reviewed what had been done in the ED and noted that they had met their obligations by clearing Client #1 medically and psychiatrically through the telemed evaluation. Interview on 2/5/26 and 2/16/26 with the Hospital Director of Case Management revealed: -She reported Client #1 had been moved from an ED bed to a room with a door, though the door had to be kept open due to the hospital protocol for Client #1's reported suicidal ideations at intake and history of self-injurious behavior. -Client #1 was in a room from 12/24/25 to 12/29/25 with no structured activities and no	V 293		

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V 293	Continued From page 15	V 293		

television.
-Client #1 was provided "coloring books and could talk with the sitter at her door" to pass the time.
-She reported that Client #1 was "calm and cooperative" throughout her stay.
-There was no reported aggressive behavior from Client #1 throughout her stay (12/24/25-12/29/25).

Interview on 2/10/26 with the local County Magistrate revealed:
-She received a call from the facility QP on 12/24/25.
-She was the only Magistrate working that day and it was very busy.
-This occurred "possibly in the afternoon."
-The QP told her that the hospital was trying to discharge Client #1 without getting her a behavioral health/mental health evaluation.
-She called the hospital to help Client #1 get evaluated.
-The DSS On-Call worker was added to the call with the QP.
-"As far as she knew the hospital had not done a behavioral health/mental health evaluation for [Client #1] yet and was refusing to do one because they thought Client #1 was exhibiting attention seeking behaviors."
-She told the QP and the On-Call DSS personnel that the best option was to contact the custodian (DSS Legal Guardian) to help coordinate Client #1's hospitalization.
-She thought the issue had been settled, that the hospital would do the evaluation and it was taken care of. "I had not heard anything else (of this situation) until my Supervisor told me that a complaint had been filed."

Interview with the QP on 2/9/26 revealed:

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V 293	Continued From page 16 -Client #1 was IVC'd at a pyschiatric treatment center after eloping from the facility on 2/6/26 and was not available to be interviewed. Interview on 2/5/26 and 2/6/26 with the Associate Professional/House Manager (AP/HM) revealed: -LEO was called for Client #1 on 12/24/26 when Client #1 left the facility without permission. -When LEO found Client #1 she told them that she felt suicidal. -LEO "took her (Client #1) to the ER (Emergency Room)" and informed the facility staff "to meet him there." -AP/HM and another facility staff member met LEO and Client #1 at the ED. -"They (LEO) told us (facility staff) we could go (leave) because she (Client #1) did not want us there." -Facility staff left the hospital without providing any information about Client #1 to the hospital personnel. -"I thought the Social Worker (hospital) was probably told about her (Client #1) and would get involved." -'I didn't hear anything else about [Client #1] until she (Client #1) came back a few days later." -She was not involved in Client #1's hospitalization and time in the ED. She also did not answer any calls or receive any messages from the ED on the facility's landline phone. Interview on 2/5/26, 2/6/26, 2/9/26, 2/11/26, 2/16/26, 2/17/26 and 2/19/26 with the QP revealed: -Client #1 was angry that she had to isolate in her bedroom over Christmas because she had tested positive for the flu on 12/21/25. -Client #1 eloped from the facility without permission on 12/24/25. -Client #1 was located by LEO, who had been	V 293		

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V 293	Continued From page 17 called by facility staff, and Client #1 told LEO that she felt suicidal. -Client #1 was taken to the ED and staff (AP/HM and another staff member) from the facility met them at the ED. -"The Police (LEO) told them (facility staff) to leave because Client #1 was being aggressive towards them." -Client #1 "was being aggressive" towards LEO, so much so that "she (Client #1) had to be restrained" by LEO and ED staff. -"She (Client #1) was at the hospital for a few days." -"The hospital had difficulty and did not follow the proper protocols, and the Magistrate got involved." -She was in contact with DSS On-Call personnel and the hospital staff "to help her (Client #1) get the proper services." -The hospital did not complete the "correct" behavioral health services and "called (the facility) to pick her (Client #1) up less than 1 hour" from arriving at the ED. -She informed the hospital personnel that DSS was the legal guardian of Client #1, not the facility. -She refused to pick Client #1 up because "the hospital did not fulfill their obligation to thoroughly evaluate her (Client #1) for the IVC," which she stated to the ED personnel. -She told DSS and the Magistrate that the hospital "dropped the ball" regarding not having Client #1 get a behavioral health/mental health evaluation. -"[Client #1] was only at the ED for less than 1 hour" and ED personnel "tried to have her (Client #1) discharged without being seen by behavioral health" for an evaluation. -"She (Client #1) refused for (facility) staff to bring her back" to the facility from the ED.	V 293		

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V 293	Continued From page 18 -An ED Nurse "slipped and told me (QP) that this (situation) was because it (the ED) was overcrowded and them (ED personnel) wanting to free up the bed she (Client #1) was using." -When she (QP) had been in contact with DSS "I was told by DSS not to pick her (Client #1) up and that they would handle it." -"I did not recall being called 23 times by the ED to pick up [Client #1], though I did contact DSS after getting multiple calls and messages from the ED." -She repeatedly told ED personnel that she was not the guardian and that DSS was the legal Guardian. -She gave hospital personnel the DSS Legal Guardian' s phone number as well as the DSS On-Call phone number to hospital personnel. Interview on 2/10/26 and 2/13/26 with the DSS On-Call worker revealed: -He received a call on 12/24/25 by the ED personnel and was told that Client #1 needed to be picked up. -He spoke with the QP and ED personnel on 12/24/25. -He called his Supervisor to advise him and to assist with the situation. -"The [QP] was trying to get [Client #1] assessed." -The facility QP "was not pleased" with the ED and the services provided to Client #1. -Once his Supervisor was involved he "passed it to her." Attempts to contact the DSS On-Call Supervisor were unsuccessful. Messages were left on her voicemail 2/10/26, 2/12/26 and 2/17/26 with no return call prior to survey exit. Interview on 2/10/26 with the local County	V 293		

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V 293	Continued From page 19 Magistrate revealed: -She received a call from the QP on 12/24/25. -The QP told the local County Magistrate the ED was trying to discharge Client #1 without getting her a behavioral health/mental health evaluation. -The local County Magistrate called the ED to help Client #1 get evaluated. -"As far as I knew they (ED) had not done a mental health evaluation for [Client #1] and were refusing to do one because they thought she (Client #1) was attention seeking." -She told the QP and the On-Call DSS personnel that the best option was to contact the custodian (DSS Legal Guardian) to help coordinate. Interview on 2/10/26 with the DSS Legal Guardian revealed: -She reported that the facility QP had documented the situation. -She was unavailable during the situation on 12/24/26, because DSS had been closed for the holiday when it occurred. -She was contacted by the ED Nurse on 12/29/25 and informed that Client #1 was discharged and ready to go back to the facility. -The facility was not able to transport Client #1 so DSS Legal Guardian arranged transport for Client #1 back to the facility on 12/29/25. -The ED Nurse told her that Client #1 had been ready for discharge since "12/25 or 12/24" and had been trying to contact DSS. -She was told by the QP that the hospital had not done their part to honor the IVC despite being told by the Magistrate to do so. -She was told there had been a text chain between QP and DSS On-Call about the situation. -Once the hospital made contact with her on 12/29/25 she told them that DSS had been closed and they should have been calling the DSS	V 293		

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V 293	Continued From page 20 On-Call phone number. Review on 2/19/26 of the Plan of Protection dated 2/19/26 written by the AP/HM revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? To ensure client safety and clarification of communication a new form and checklist has been created to address concerns additionally with 3rd party involvement with more details. Staff training on the new implementation. "Describe your plans to make sure the above happens. Plan to Ensure Client Safety, Authority Clarity, and Regulatory Compliance A Better Path, Inc. (licensee) is committed to maintaining the safety of all individuals served while operating in full compliance with the standards established by the North Carolina Department of Health and Human Services (NCDHHS) for Level III (.1700) Crisis Stabilization Services. The agency recognizes that it does not hold legal guardianship for any client served. All medical, placement, and long-term treatment decisions remain the responsibility of the legally appointed guardian. A Better Path, Inc. functions solely as a crisis stabilization and coordination provider. I. Clear Delineation of Authority To ensure there is no ambiguity regarding decision-making authority: 1. All care coordination and emergency forms include a written statement clarifying that: o A Better Path, Inc. is not the legal guardian. o Guardians retain authority over treatment decisions, medication consent, hospital discharge, and placement. o Staff may act without guardian consent only	V 293		

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V 293	Continued From page 21 in emergency situations where there is imminent risk of harm, in accordance with NCDHSR Rules and Regulations and North Carolina State law. 2. Guardian contact information is verified upon admission and reviewed at least quarterly. 3. Hospitals and third-party agencies are formally notified in writing that discharge planning must occur with the guardian with emergency consent to ensure client care is done properly. Client #1 had diagnoses of DMDD; ADHD, Predominantly Inattentive Presentation; Unspecified Trauma and Stressor Disorder. Client #1 was taken by LEO to the ED on 12/24/25 due to verbalizing suicidal ideations after having left the facility without permission. During the telemed evaluation Client #1 denied having any suicidal ideation and had told LEO that so she could go to the hospital. She was medically, and psychiatrically cleared for discharge on 12/24/25. The QP from the facility refused to pick up Client #1 from the ED. The ED Nurse made 23 phone calls to the QP from 12/24/25 to 12/28/25 to have facility staff come and pick up Client #1. The ED Nurse left messages with the QP regarding Client #1 needing to be picked up from the ED . The QP returned no more than 2 of the calls. The QP did not coordinate between the ED and local DSS to ensure that Client #1 received treatment, regarding discharge and transportation back to the facility. Client #1 remained in the ED from 12/24/25 to 12/29/25 and until her local DSS Legal Guardian picked her up on 12/29/25 and transported her back to the facility. During Client #1's stay in the hospital she was in a room in the ED without any structured activities or a television. She was only provided coloring books throughout the day as activities.	V 293		

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V 293	Continued From page 22 This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients and must be corrected within 45 days.	V 293		