STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 000	INITIAL COMMENTS An annual and complaint survey was completed on 2/16/26. The complaint was substantiated (intake #NC00234334). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for 4 and has a current census of 3. The survey sample consisted of audits of 2 current clients and 1 former client.	V 000		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration. (1) Prescription and nonprescription 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	V 118		

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V 118	Continued From page 1 (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 medications were administered on the written order of a physician and the MAR was kept current affecting 3 of 3 audited clients (Client #1, Client #3, Former Client (FC) #4). The findings are: Review on 12-17-25, 12-19-25, 1-5-26 and 1-7-26 of Client #1's record revealed: -Admission date of 6-9-25. -16 years old. -Diagnoses of: Attention Deficit Hyperactivity Disorder (ADHD), Generalized Anxiety Disorder (GAD), Disruptive Mood Dysregulation Disorder (DMDD). -Physician's orders for the following medications: -9-30-25: Clonidine HCL 0.1mg (milligram) (ADHD) Take one tablet by mouth every day at night. -8-27-25: Guanfacine HCL 4mg (ADHD) Take one tablet by mouth everyday in the morning. -11-25-25: Duloxetine HCL 30mg (GAD)Take one capsule by mouth every day. -11-25-25: Lamotrigine 150mg (mood) Take one tablet by mouth every morning. -No Physician's order found in the facility for	V 118		

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V 118	Continued From page 2 Melatonin 5mg (sleep) take one by mouth at bedtime (PRN). -No Physician's order for Minerin Cream PRN (eczema) apply 1 application on skin twice a day as needed for eczema. Review on 12-17-25, 12-19-25, 1-5-26 and 1-7-26 of Client #1's MAR for 9-1-25 to 12-18-25 revealed: -Duloxetine: Initialed as administered from 9-1-25 to 11-24-25 without a physician's order. -Melatonin: Initialed as administered from 9-1-25 to 11-28-25, 12-1-25 to 12-17-25 without a physician's order. -Lamotrigine: Initialed as administered from 9-1-25 to 11-25-25 without a physician's order. -Minerin Cream: Initialed as administered from 9-1-25 to 9-30-25 without a physician's order. -Minerin Cream: Not documented on the 10-1-25 to 12-31-25 MAR. No documentation of a discontinue order. Review on 12-17-25, 12-19-25, 1-5-26 and 1-7-26 of Client #3's record revealed: -Admission Date of 12-12-25. -13 years old. -Diagnosis of Oppositional Defiant Disorder, Moderate. -Physicians' order dated 12-11-25 for the following medications: -Guanfacine 3mg (ADHD) Take one tablet by mouth at bedtime. -Risperidone 0.5 (anxiety) Take one tablet by mouth daily. -Cholecalciferol 50mcg (vitamin D3) (supplement) Take one tablet by mouth daily. -No physicians' order for Melatonin 5mg Take one by mouth at bedtime (PRN). Review on 12-17-25, 12-19-25, 1-5-26 and 1-7-26	V 118		

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V 118	Continued From page 3 of Client #3's MAR for 12-12-25 to 12-18-25 revealed: -Melatonin 5mg initialed as administered on 12-12-25. -No initials for administration of medications on the following days: -Guanfacine (ADHD): 12-12 to 12-16-25. -Risperidone (anxiety) : 12-12 to 12-16-25. -Cholecalciferol (supplement): 12-13 to 12-16-25. Review on 12-17-25, 12-19-25, 1-5-26 and 1-7-26 of FC #4's record revealed: -Admission date of 6-17-25. -Discharge date of 10-19-25. -16 years old. -Diagnoses of Autistic Disorder; ADHD, Combined Type; DMDD. -Physician's orders dated 6-13-25: -Paliperidone (mood/aggression) 6mg take one tablet by mouth at bedtime. -Oxcarbazepine (seizure) 300mg take 1 ½ tablet by mouth daily. -Trazadone (sleep) 10mg take two tables by mouth at bedtime. -Paliperidone 6mg (mood/aggression) take one tablet by mouth at bedtime. -Oxcarbazepine (seizure) 600mg take one tablet by mouth at bedtime. -Guanfacine HCL (ADHD) 4mg take one tablet by mouth at bedtime. -Vitamin B12 (supplement) 1,000mg take one tablet by mouth daily. -Docusate sodium (constipation) 100mg take one capsule by mouth daily. -Ferrous Sulfate (iron supplement) 325mg take one tablet by mouth daily. -Metformin HCL 500mg (weight management) take one tablet by mouth twice daily with meals. -Bupropion HCL XL (mood) 300mg take one tablet by mouth daily.	V 118		

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V 118	Continued From page 4 -Escitalopram 20mg (mood) take one tablet by mouth daily. Review on 12-17-25, 12-19-25, 1-5-26 and 1-7-26 of FC #4's MARs from 6-18-25 to 10-18-25 revealed: -No initials for administration of medications on the following days: -Paliperidone: 6-17-25 to 6-18-25, 7-29-25 to 7-30-25. -Oxcarbazepine 300mg: 6-18-25, 7-27-25 and 7-29-25, 8-1-25, 8-3-25 to 8-8-25, 8-10-25 to 8-12-25, 8-14-25 to 8-16-25, 8-22 to 8-23-25, 8-29-25 to 8-30-25. 9-5-25 to 9-13-25, 9-16-25 to 9-17-25, 9-22-25 to 9-25-25, 9-28-25 to 9-30-25, 10-8 -25 to 10-10-25. -Trazadone: 6-17-25, 7-29-25 to 7-30-25. -Paliperidone: 6-17-25 to 6-18-25, 7-29-25 to 7-30-25. -Oxcarbazepine 600mg: 6-17-25 to 6-18-25, 7-29-25 to 7-30-25. -Guanfacine HCL: 6-17-25 to 6-18-25, 7-29-25 to 7-30-25. -Vitamin B12: 7-27-25, 7-29 to 7-30-25, 8-1-25, 8-3-25, 8-7-25 to 8-8-25, 8-10 to 8-12-25, 8-14-25 to 8-16-25, 8-22-25 to 8-23-25, 8-29-25 to 8-30-25, 9-16-25 to 9-17-25, 9-22-25 to 9-25-25, 9-29-25 to 9-30-25, 10-8-25 to 10-10-25, 10-14-25 to 10-15-25. -Docusate Sodium: 6-17-25 to 6-18-25, am 7-27-25, am/pm 7-29-25 to 7-29-25, pm 7-31-25, am 8-1-25-25, am 8-3-25, am 8-7-25 to 8-8-25, am 8-10-25 to 8-12-25, am 8-14-25 to 8-15-25, am 8-22-25 to 8-23-25, am 8-29-25 to 8-30-25, pm 8-31-25. -Ferrous Sulfate: 6-18-25, 7-27-25, 7-29-25 to 7-30-25, 8-1-25, 8-3-25, 8-7-25 to 8-8-25, 8-10-25 to 8-12-25, 8-14-25 to 8-16-25, 8-22-25 to 8-23-25, 8-29-25 to 8-30-25, 9-6-25 to 9-8-25, 9-15-25 to 9-17-25, 9-22-25 to 9-25-25, 9-29-25	V 118		

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V 118	Continued From page 5 to 9-30-25, 10-8-25 to 10-10-25, 10-14-25 to 10-15-25. -Metformin HCL: pm 6-17-25, am/pm 6-18-25, am 7-29-25, am/pm 7-29-25 to 7-30-25, pm 7-31-25, am 8-1-25, am 8-3-25, am 8-7-25 to 8-8-25, am 8-10-25 to 8-12-23-25, am 8-14-25 to 8-16-25, am 8-22-25 to 8-23-25, am 8-29-25 to 8-30-25, pm 8-31-25, am 9-16-25 to 9-17-25, am 9-22-25 to 9-25-25, am 9-27-25, am 9-29-25 to 9-30-25, am 10-8-25. 25 to 10-10-25, am 10-14 to 10-15-25. -Bupropion HCL XL: 7-27-25, 7-29-25 to 7-30-25, 8-1-25, 8-3-25, 8-7 to 8-8-25, 8-10-25 to 8-12-25, 8-14-25 to 8-15-25, 8-22-25 to 8-23-25, 8-29-25 to 8-30-25, 9-15-25 to 9-17-25, 9-22-25 to 9-25-25, 9-27-25, 9-29-25 to 9-30-25 10-8-25 to 10-10-25, 10-14-25 to 10-15-25. -Escitalopram: 6-18-25, 7-27-25, 7-29-25 to 7-30-25, 8-1-25, 8-3-25, 8-7-25 to 8-8-25, 8-10-25 to 8-12-25, 8-14-25 to 8-16-25, 8-22-25 to 8-23-25, 8-29-25 to 8-30-25, 9-15-25 to 9-17-25, 9-22-25 to 9-25-25, 9-27-25, 9-29-25 to 9-30-25, 10-3-25 to 10-10-25, 10-14-25 to 10-15-25. Due to failure to accurately document medication administration, it could not be determined if the clients received their medications as ordered by the physician. Interview on 2-16-26 with Client #1 revealed: -The only time he did not receive his medications was when he "ran out." -"I ran out a couple of times (dates unknown) It was not the group home's fault." -"Sometimes the pharmacy doesn't give refills." -Once, "about a month ago", he went a week without a medication (unknown medication) and "felt awful" like he was going to "throw up." -Ran out of an unknown medication another time for one day.	V 118		

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V 118	Continued From page 6 Interview on 2-16-26 with Client #3 revealed: -Received all of his medications every day. -Denied ever running out of medications. -Did not see staff sign the MAR when medications were administered. Attempted interview with FC #4 was unsuccessful due to inability to determine his current placement. Interview on 2-16-26 with Staff #2 revealed: -Was responsible for administering medications. -Denied failing to initial the MAR when administering medications. -Did not know why the MAR was missing initials. -Had no knowledge of clients missing any medications. -Denied any clients ran out of medications. Interview on 2-16-26 with Staff #3 revealed: -Responsible for administering morning medications. -"I always initial on the same day." -Denied any clients ran out of medications. Interview on 2-16-26 with the Associate Professional (AP) revealed: -"We (staff) got complacent about documenting meds (medications) at one point." -"Meds were given just not documented." -Had taken action to ensure that MARs were being kept up to date. -Denied any clients ran out of medications. -Had obtained physician's orders for all current medications. Interview on 2-16-26 with the Executive Director/Qualified Professional (ED/QP) revealed: -Staff had been administering medications	V 118		

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V 118	Continued From page 7 without signing the MAR. -Did not have physician's orders for Client #1's medications on 12/17/25. Only had a list. -Had obtained physician's orders for all current medications except Melatonin. -Client #1 and Client #3 had medical appointments on 2-17-26 to obtain orders for Melatonin. -Denied any clients ran out of medications.	V 118		
V 293	27G .1701 Residential Tx. Child/Adol - Scope 10A NCAC 27G .1701 SCOPE (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility. (b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall 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	V 293		

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V 293	Continued From page 8 structure of daily living; (2) minimize the occurrence of behaviors related to functional deficits; (3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting. (f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care. This Rule is not met as evidenced by: Based on record review and interview the facility failed to coordinate with other individuals and agencies within the clients system of care affecting 1 of 3 audited clients (Former Client (FC) #4). The findings are: Review on 12-17-25, 12-19-25, 1-5-26 and 1-7-65 of FC #4 record revealed: -Admission date of 6-17-25. -Discharge date of 10-19-25. -16 years old. -Diagnoses of Autistic Disorder; ADHD,	V 293		

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V 293	Continued From page 9 Combined Type; DMDD. -Intake assessment dated 6-17-25: FC #4 "is physically and verbally aggressive, has problems regulating mood and emotions." -Physician's orders dated 6-13-25: -Paliperidone (mood/aggression) 6mg take one tablet by mouth at bedtime. Review on 12-17-25, 12-19-25, 1-5-26 and 1-7-26 of FC #4's MARs from 9-1-25 to 10-18-25 revealed: -Paliperidone initialed as administered daily. Interview on 2-16-26 with Client #1 revealed: -When FC #4 punched his mother/legal guardian on 10-18-25, he had been refusing his medications for about a week. -Staff #1 told FC #4's mother/legal guardian that he did not have his medications for a week. Attempted interview with FC #4 was unsuccessful due to inability to determine his current placement. Interview on 12-18-25 with FC #4's mother/legal guardian revealed: -Provided the facility with enough medication at the time of admission to have time to get FC #4 established with a local doctor. -FC #4 had a physical in July 2025 and the primary care provider was able to provide medication refills until he could get into a psychiatrist for medication management. -The Executive Director/Qualified Professional (ED/QP) was supposed to make arrangements for FC #4 to go to a local psychiatric provider. -Initially, FC #4's mother/guardian and the ED/QP attempted to get FC #4 into medication management with the previous psychiatric	V 293		

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provider, however the previous provider did not feel they could provide services to FC #4 due to the distance.
-FC #4 had a physical in July 2025 and at the physical his primary care provider was able to provide him with enough medications until he could get a psychiatric provider established.
-"During that time, (July to October 17) she (ED/QP) didn't make me aware, she didn't say that [FC #4] needed more medication, she didn't say that he was out of anything (medications).
-"So [FC #4] started to have a lot of outburst, a lot of behavioral issues there (facility) where she (ED/QP) and her staff didn't feel like he needed to be there."
-"She (ED/QP) was calling me telling me he was having these outburst but never mentioned that he was out of medications or anything ..."
-On Friday 10-17-25 FC #4's mother/legal guardian called the ED/QP to discuss picking FC #4 up on 10-18-25 for a therapeutic leave visit. During the phone call the ED/QP informed the guardian that FC #4 was out of his Paliperidone.
-"It was Friday the 17th (10-17-25) that she (ED/QP) said he was out of his mood stabilizer (paliperidone), and that was the only med she said he was out of."
-The ED/QP said, 'Well I was hoping that he would just make it until Tuesday."
-The ED/QP did not say how long FC #4 had been out of the medication."
-FC #4's mother/legal guardian called the primary care provider to see if she could get a refill but the primary care provider had already left for the day and she could not get the refill.

Interview on 12-18-25 with FC #4's Primary Care Provider revealed:
-"[FC #4's mother/legal guardian] expressed concerns to us (primary care provider) on

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10-18-25 that he (FC #4) had not been receiving his medications and that he was having behaviors at the group home."
-"I did a review of his chart and based on my review all of his medications were sent in (to pharmacy for refill) on 8-27-25 with a 30 day supply. This indicates that the patient (FC #4) was out of his medication for multiple weeks leading to an altercation between he and his mother on 10-18-25."
-No one from the facility contacted or informed the primary care provider of a need for a refill.
-FC #4 is seen in the office for a check up every 6 months with the last visit on 7-28-28.

Interview on 12-18-25 with Pharmacist #1 revealed:
- Paliperidone filled and picked up on 8-27-25 for a 30 day supply and not filled again until 10-20-25 and picked up on 10-29-25 (7 day supply).

Interview on 1-6-25 with Pharmacist #2 revealed:
-One prescription for paliperidone for 30 pills was filled on 6-14-25 and picked up on 7-31-25.

Interview on 2-16-26 with Staff #2 revealed:
-Was responsible for administering medications.
-Had no knowledge of clients missing any medications.
-Denied any clients ran out of medications.

Interview on 2-16-26 with Staff #3 revealed:
-Responsible for administering morning medications.
-Denied any clients ran out of medications.

Interview on 2-16-26 with the Associate Professional (AP) revealed:
-Denied any clients ran out of medications.
-Medications were reordered from the pharmacy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL090-221	A. BUILDING: _____ B. WING _____	02/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPENDORS	715 SUMMIT STREET MONROE, NC 28112

(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 293	Continued From page 12 when they ran low. -FC #4's mother/legal guardian took him to appointments and communicated with his doctors. -There was a "communication gap" with FC #4's mother/legal guardian. -Relied on FC #4's mother/legal guardian to ensure medications orders were in place and medications were available. Interview on 12-17-25 with the ED/QP revealed: -Denied FC #4 ran out of any medications. -Received two bubble packs at FC #4's admission. One was dated May (2025) which contained 8 paliperidone pills and one was dated June 2025 which had 30 pills. "This is what we were using to give him his medications." -FC #4's mother/legal guardian was handling his medication refills. "We would call her when he got low and let her know and she was working with his primary care doctor so she would call the doctor and get the script (prescription), pick up the meds (medications) from the pharmacy and bring the meds to us." -"[FC #4's mother/legal guardian] had a stash of his meds at her house that she had from when he was living with her and if she couldn't get them from the doctor she would bring us meds from what she kept at home." -After the initial 38 pills the facility received from the previous provider that came with the client at admission, there is documentation of two 30 day supplies refilled at pharmacy #1 and pharmacy #2 with the last 30 day refill on 8-27-25. This should have run out on or about 9-27-25. -FC #4's mother/legal guardian worked at FC #4's primary care provider's office. -FC #4's mother/legal guardian very involved in his medical needs and was picking him up and taking him to his appointments.	V 293		

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V 293	Continued From page 13 -The only appointment the facility staff took FC #4 to was for labs.	V 293		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be	V 367		

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V 367	Continued From page 14	V 367		

erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).
(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:
(1) medication errors that do not meet the definition of a level II or level III incident;
(2) restrictive interventions that do not meet the definition of a level II or level III incident;
(3) searches of a client or his living area;
(4) seizures of client property or property in the possession of a client;
(5) the total number of level II and level III incidents that occurred; and

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V 367	Continued From page 15 (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a level II incident report was submitted to the Local Management Entity/Managed Care Organization (LME/MCO) within 72 hours as required. The findings are: Review on 2-12-26 of the North Carolina Incident Response Improvement System (IRIS) from 6-1-25 to 12-18-25 revealed: -No report submitted for the incident on 10-18-25. Review on 2-16-26 of the facility's internal incident report dated 10-18-25 revealed: -"[FC #4's mother/legal guardian] picked [FC #4] up for Therapeutic Visit/ Leave. [FC #4's mother/legal guardian] called to return [FC #4] within 30 minutes of pick up time due to [FC #4] being verbal + (and) physical aggressive w/ (with) [FC #4's mother/legal guardian]. [FC #4's mother/legal guardian] reported that [FC #4] punched her in the car. When [FC #4's mother/legal guardian] arrived at the group home and was talking with staff [FC #4] punched her in nose and began to fight [FC #4's mother/legal guardian]. [FC #4's mother/legal guardian] return	V 367		

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V 367	Continued From page 16 hits to [FC #4]. Situation was deescalated and police were called." Interview on 12-17-25 and 12-19-25 with the ED/QP revealed: "It (incident) didn't happen in the home. He was technically on TL (Therapeutic Leave) so I didn't know we needed to report it." Further interview on 2-16-26 with the ED/QP revealed: -Was responsible for completing all IRIS reports. -Would complete IRIS reports in the future for all incidents involving the police at the facility.	V 367		