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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on 2/20/26. The complaints were substantiated (intake #NC00235373, #NC00235470, #NC00235767, #NC00235967. 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 current clients.	V 000		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A	V 109		

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V 109	Continued From page 1 NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record review, observations, and interviews, one of one Associate Professional (AP/House Manager (AP/HM)) failed to demonstrate the knowledge, skills and abilities required for the population served. The findings are: Review on 1/28/26 of the AP/HM's personnel file revealed: -Hired 11/17/25. -Job Title AP. -Responsibilities included: "Supervision of paraprofessional, on call when staff is not available, find replacements for staff calling out, manage DSPs (Direct Support Professionals), hiring, participation in service planning meetings, maintaining staff and client records, managing/creating staff schedules, attending CFT (Child Family Team) meetings, keep home	V 109		

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(facility) clean, assist QP (Qualified Professional) with administrative tasks, attending weekly leadership meetings, create weekly outing schedule, enroll new girls (clients) in schools, handle school issues, taking girls to doctor appointments, connecting with guardians/parents, ensure medications don't run out and demonstrate core skills. Demonstrate the knowledge, skills, and abilities required by the population served, as well as the ability to read and write."

Interview on 2/4/26 with client #1 revealed:
-Did not want to be interviewed.
-"I honestly don't want to talk about this no more; I can't."
-Did not want to continue the interview.

Interview on 2/11/26 with client #1 revealed:
-"I don't really want to talk."
-"Whatever they told you, it's all true. Whatever they said happened, it happened. Yes, to anything you are going to ask me."
-In October, the AP/HM was late picking clients #1, #2, and #3 up from school and told a teacher at the school that the clients lived in a group home and the clients were upset because "the teacher didn't know we were from a group home."

Observations of client #1 on 2/4/26 at approximately 1:30pm and 2/11/26 at approximately 12:30pm revealed:
-2/4/26, Client #1 abruptly ended the interview and left the room.
-2/11/26, Client #1 tearfully ended the interview abruptly and walked away.

Interview on 2/4/26 with client #2 revealed:
-She didn't have issues with staff, "respect is a two way street. I will set boundaries and none of

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the staff raise their voice or have been disrespectful."
-The incident when client #3 eloped in January 2026, "She (client #3) was told she could not have her [laptop]...(client #3) was slamming doors and was standing against the door so [AP/HM] and [staff #5] couldn't come in (client #3's bedroom). She (client #3) pushed them (AP/HM and Staff #5) out of the way and went out the door (eloped)."
-Client #3 didn't like the AP/HM.
-The AP/HM had "lied on me and told my mom I stole something."

Interview on 2/4/26 with client #3 revealed:
-When she eloped on 1/9/26, after the AP/HM took client #3's laptop, client #3 did not want to return to the facility until she knew the AP/HM had gone and was no longer in the facility.
-In November (2025), "me and [AP/HM] got into it (confrontation). I was already mad with something that happened at school and I was trying to fight her (AP/HM)..."
-"If staff had grabbed me or hit me, I would not be here."
-She remembered a restraint when former staff (FS) #13 "held my hand behind my back" and Staff #3 assisted during the confrontation with the AP/HM in November 2025.

Interview on 2/11/26 with client #3 revealed:
-"Imma keep it one hundred with you (be honest)."
-The AP/HM grabbed her when the AP/HM attempted to take the facility telephone from client #3.
-"I asked for my bookbag. I was not in a good mood and [AP/HM] was playing around. I asked to call [Licensee/Director/Chief Executive Officer (CEO)] and my Department of Social Services

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worker (DSS/Legal Guardian (LG) and [AP/HM] said no and started following me around the house."
-FS #13 intervened "because [AP/HM] was yelling, [Client #3] should apologize first. [FS #13] took me for a walk and told me to call my DSS worker. She (AP/HM) grabbed my arm at the wrist, and [FS #13] pulled me away from her (AP/HM) because [AP/HM] was trying to get the phone. [FS #13] took the phone, then [AP/HM] snatched it from [FS #13]."
-"I had never ran away or cussed out anyone, not until she (AP/HM) showed up. Since she showed up, there is negativity."
-In October 2025 The AP/HM told the security guard at the client's school that the clients lived in a group home.
-"The third time (incident), she (AP/HM) kept pulling the cover (blanket) off of me. She was trying to get me to come and eat. I didn't want to be bothered. She (AP/HM) found the laptop."
-"[AP/HM] was giving us (clients) the laptops behind [Licensee/Director/CEO]'s back."
-Clients got in trouble with other staff who were not aware the AP/HM allowed clients to have laptops.
-On 1/9/26 "[AP/HM] came in the room (client #3's bedroom), asked if I was eating and I turned my music up because I didn't want to hear what she was saying. I wanted her to leave me alone and I was ignoring her. I said, f**k you and slammed the door and locked it. [AP/HM] went to get [Staff #5]. [AP/HM] kept messing with me (antagonizing). I was walking away and she followed me."
-The AP/HM "smoked a vape in the house and smoked cigarettes outside in her car."
-The AP/HM "is the only one that yells."
-The AP/HM "was giving me and [client #2] [sleep aid], she would sneak us in the bathroom and

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say, you gotta eat it (sleep aid) in here, in the staff office away from the cameras. [AP/HM] was giving me [sleep aid], when [Licensee/Director/CEO] told her not to."
-"She (AP/HM) is just a liar and a manipulator. She lied to other clients about why we (clients) couldn't have the laptops. She told each of us (clients) a different lie."

Interview on 2/5/26 with anonymous former staff (AFS) #28 revealed:
-Ended employment with the facility "because I didn't like how [AP/HM] was with the girls (clients) and [Licensee/Director/CEO) would brush it (reports) off and didn't address anything (concerns)."
-"[AP/HM] is a trigger to them (clients), like whenever they say they (clients) need space and don't want to talk, she (AP/HM) would go in their room (bedroom) and insist that they talk when they are just not in a mood to talk."
-"She (AP/HM) would get in their (clients) face and say, 'I am the house manager, y'all gone listen to me. I'm not sure what y'all were used to before I got here;' just trying to insert her dominance."
-"In December (2025), [AP/HM] was getting in [client #3]'s face and [client #3] kept walking away. She (AP/HM) told [client #3] it's was best that she walk away and [client #3] turned back around and I took her by the hand and we walked upstairs."
-"[AP/HM] went in their (clients #1 and #3) room (bedroom) to try to talk to her (client #3) again, while I (AFS #28) was calming [client #1] down. They (clients) were all mad...and she (AP/HM) confronted [client #1]'s boyfriend, and told him that all the girls (clients) live in a group home. She (AP/HM) was mad that [client #1] was talking to the boy (student) when she got there (school),

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and end up telling him that they (clients) live in a group home."

Interview on 1/29/26 and 2/16/26 with AFS #29 revealed:
-Had worked with the AP/HM in November 2025.
-The AP/HM was "doing rules the way she wanted" and clients were spending most of their time in their rooms when they came in from school.
-"That was one of my big problems because we (staff) weren't interacting with the girls (clients) and [AP/HM] was in there (facility) sleep. I didn't like the new schedule of them being in their room all the time."
-"Everybody (staff) I worked with quit because they didn't want to be involved with the way she (AP/HM) did the kids (clients), it wasn't right."
-"She (AP/HM) yells and cursed at clients...'y'all getting on my d**n nerves,' or stuff like that."
-"She (AP/HM) smokes vapes. I've seen it (vape) in the upstairs living room (in facility). [Client #2] found the vape and smoked the vape, because [AP/HM] left the vape up there (upstairs living room), unintentionally, and one of the kids (unknown client) told and we smelled it when we came upstairs, like tobacco in a vape smell."
-Did not know the date the AP/HM's vape was found in the facility.
-The AP/HM "was giving [client #3] Melatonin (sleep aid) (November 2025), because she (AP/HM) said [client #3] don't sleep at night. That's when she (AP/HM) first came (November 2025) and she was going by her own rules."

Interview on 1/30/26 with the AFS #32 revealed:
-The Licensee/Director/CEO said, "[client #3] is a known liar and I didn't think it was ethical to put everything on their (clients) past behavior."
-The AP/HM questioned a male student at the

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clients' school because he was walking with client #1, and told the student that the clients lived in a group home.
-"She (AP/HM) said (to male student), 'these girls (clients) are in a group home and they can't do what these other students do.' "
-The clients were upset that the AP/HM shared information that they lived in a group home.
-"[AP/HM] was actively vaping outside of the camera area, outside the laundry room...because there are no cameras there. I don't know if it's a nicotine or weed vape but [client #2] already has an issue with vaping and [client #2] told me and [Former Licensed Professional (FLP)] about the vaping (by AP/HM)."
-"I told [Licensee/Director/CEO] that [AP/HM] was triggering the girls (clients). All the girls started acting erratic when [AP/HM] started. She (AP/HM) talks down to them and yells at them."
-"Everything went downhill in November (2025) when [AP/HM] came...it was like a power play with the girls (clients), and she said she didn't want them (clients) to depend on me."
-The Licensee/Director/CEO had dismissed AFS #31's concerns about the AP/HM.

Interview on 2/3/26 with the FLP revealed:
-Ended employment with the facility on 1/16/26.
-"I did not work with [AP/HM], but I heard her (interactions with clients) when I was in the house (facility). I heard her tone, she was abrasive, not workable, almost like there was no compromise. Yes, they (clients) are there for treatment, but there was no understanding (from the AP/HM)."
-"[Client #3] would like to sit in her closet (bedroom), it was her safe place. [AP/HM] would say come out of there. That's what I observed."

Interview on 2/5/26 and 2/6/26 with AS #20 revealed:

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V 109	Continued From page 8 -"[AP/HM] got into it (confrontation) with another, [client #1], she was having mood swings and wanted to be left alone." -Did not recall the date of the incident between the AP/HM and client #1. -The AP/HM attempted to go into client #1's bedroom and client #1 told AP/HM to get out of her bedroom. -"We (staff) know to leave (clients' bedrooms) if they say get out of their room because that's their space. [AP/HM] had her foot on the bottom of the door while [client #1] was pushing back on the other side of the door. [AP/HM] is an enforcer." -Client #1 "was crying a lot because she (client #1) was very upset that night (date unknown)." -The AP/HM "doesn't know how to back off them (clients) when they are over stimulated." -Client #3 stated the AP/HM had breached clients' confidentiality when she (AP/HM) told people at the clients' school that the clients lived in a group home. -"It seems there is only a problem when [AP/HM] forces it. If she tells them to do hygiene and they don't get up and do it right away, when she says, it's a problem. She is aggressive with her tone, 'I mean what I say and I say what I mean.' " -"I can see now how she (AP/HM) doesn't walk away and she calls it line of sight. It's how she enforces the rules, her tone of voice is aggressive, but that's how she talks." -"She's (AP/HM) just aggressive." Interview on 2/2/26 with AS #21 revealed: -Client #3 had talked about client #3's interactions with the AP/HM. -The incident on 1/9/26, Client #3 had a laptop that was supposed to be taken from clients when they came in from school. - Client #3 eloped after AP/HM grabbed the laptop from Client #3.	V 109		

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V 109	Continued From page 9 -"I just feel they have Stockholm Syndrome (unhealthy emotional bond) when it come to her (AP/HM). They (clients) complain about her all the time but when CPS (Child Protection Services) came they (clients) didn't say anything." Interview on 2/11/26 with AS #22 revealed: -"The staff and clients were asked not to talk to you (Division of Health Service Regulation (DHSR)) when you come." -"They (clients) lied for [AP/HM] and now they are mad with her." -Client#3 informed AS #22 about how the AP/HM did things on AP/HM's shift and AS #22 said, "[AP/HM] is not here." -"[AP/HM] said, 'why would you talk about me and tell the girls (clients) I'm not here?' I heard [AP/HM] calling the girls to the phone. It was 10:30 (pm) at night and the girls bedtime was 8:30 (pm)..." -"[AP/HM] took her behind (buttock) and kept pushing into [client #1]'s back (date unknown). She (AP/HM) was constantly pushing in [client #1]'s back, with her behind, yes, with her tail (buttock). Then she (AP/HM) sat her body down on [client #1]'s lap and got up." -Client #1 got up from the chair, causing the AP/HM to lose her balance and when the AP/HM sat back down, "she sat on [client #1]'s lap and started rearing (leaning) herself back. I did not think that was appropriate." -"I have seen [AP/HM]'s vape, it was out on the desk in the office (facility). I said, you need to put that (vape) up. That may be a trigger to one of the clients. She probably do smoke it (vape) in the office, but I've seen her vape (smoking) outside (the facility)." -"[AP/HM] don't need to be here (facility) at all." Interview on 2/11/26 with AS #24 revealed:	V 109		

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V 109	Continued From page 10 -"[AP/HM] lies a lot, so you can get one thing from her and talk to [Licensee/Director/CEO] and get something else." -Had seen the AP/HM "smoke vape at the desk in the office (facility); the day I started and one day last week (2/1/26-2/7/26). I don't know if the clients are aware that she smokes in the house." -"[Staff #5] told me there was an incident (January 2026) between [client #3] and [AP/HM] and she had to step in because [AP/HM] was cussing at [client #3] and [Staff #5] said she (AP/HM) was aggressive." -"I don't know what [AP/HM] smokes in the vape, but I think it is a nicotine vape; one of the ones you buy from the vape store with a cartridge." -The AP/HM "makes me feel uncomfortable, period." -"A lot of the behaviors (client) could have been avoided. There are incidents when kids (clients) had computers (laptops) and had them removed, but [AP/HM] had been giving them (clients) their computers, so they could go to their rooms for quiet time after school." -The AP/HM gave clients laptops, "but the clients then would get in trouble for having them (laptops). She would lie and say it was other staff that said they (clients) couldn't have the laptops, when she (AP/HM) was the only one with authority." -"Things would run a lot smoother if [AP/HM] wasn't here (facility)." -"When you (DHSR Surveyor) first came, [AP/HM] told me not to say anything to you." -"[AP/HM] is a narcissist, the girls (clients) stated they lied to you. From what they (clients) told me, she (AP/HM) told them (clients) not to talk to you." -"This is a good program and I think it would run better if [AP/HM] was not here."	V 109		

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V 109	Continued From page 11 Interview on 2/12/26 with AS #25 revealed: -Knew the AP/HM prior to the AP/HM being hired at the facility and was aware of "her work ethics...that she would argue back with kids (clients), put her hands on kids; if they (clients) hit her, she (AP/HM) was going to hit them (clients) back and claim she didn't do it...like to argue and fight staff, very unprofessional..." -Shared her concerns and informed the Licensee/Director/CEO and was surprised when the AP/HM was hired. -The AP/HM picked up clients from school and told a boy (student) that client #1 was in a group home, date unknown. -Clients go to bed with their laptops "and [AP/HM] let them. [AP/HM] been doing some crazy stuff...They (management) need to get her out of there (facility)." Interview on 2/3/26 and 2/13/26 with the AS #26 revealed: -Initially reported was "not sure that I've seen [AP/HM] smoked a vape and no vapes were found facility since I've been there." -"I haven't seen staff talking down to clients but yesterday (2/12/26), she (AP/HM) was trigger for girls (clients). One minute she is close to the girls and the next (minute) they are at odds." -"[AP/HM] breaks certain rule and has a problem when one of the staff breaks that same rule. It's like she wants to be the only one to have a bond with the clients." -The AP/HM "will award them (clients) with the laptop, and the rule is that they (clients) are not supposed to have them (laptop). The kids (clients) would ask other staff to have the laptops and when that staff let them (clients) use them (laptops), they (staff) are reprimanded for giving the laptops to the clients." -The AP/HM "reels them in real close and then	V 109		

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does something to remind them she is the real boss. It's like they are not able to be their authentic self."
-The AP/HM "bought all the girls blankets with their faces on them, she takes them to [local restaurant], and then will randomly exert her authority, and the girls can't flip flop like that."
-The AP/HM "wants the kids (clients) to need her."
-The clients "were in a bad mood" and I told her (AP/HM) to give them (clients) space and allow them to express themselves before doing chores."
-The AP/HM said, "all the things I do for y'all and y'all going to disrespect me. I said, 'should we be saying that to them (clients)?,' because we (staff) shouldn't be reminding them of the things we do for them."
-"[AP/HM] definitely has a vape."
-"The other day, [client #3] was having a fit with [AP/HM] and said 'I'm going to tell that lady (DHSR) surveyor) you vape in front of us (clients).'"
-"I asked her (AP/HM) if she had vaped in the house (facility) and she said she had vaped in house when it was snowing. That night ended weird after that (uncomfortable)."
-"The girls (clients) told me [AP/HM] said to lie (to DHSR surveyor), that's what they (clients) told me..."
-"She (AP/HM) said to me, 'I keep their secrets about keeping their laptops, so they should be able to keep mine.'"
-When concerns were shared with the Licensee/Director/CEO, "she said 'yea, I see that, and I'm going to talk to her (AP/HM) about it.' "

Interview on 2/2/26 with the AS #27 revealed:
-"The clients are very honest, very open. I don't think I've been there (facility) long enough to see

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staff interactions."
-Didn't have issues with the AP/HM, "but she just has a very strong personality."

Interview on 2/3/26 with the AP/HM revealed:
-"I am pretty much the operations manager, oversee staff, consumers (clients), condition of the home (facility), make sure the rules, and expectations of the home are complied to, make sure all things are done according to expectations and regulations, go over paperwork to make sure documentation is done completely."
-She nor staff had yelled at or talked down to clients. "Absolutely not."
-There were no significant changes in the clients' behavior, "other than improved."
-Didn't know clients' medications, "not off gate, I know what meds are morning and which are evening. I know that from what is written on the MAR (Medication Administration Record)."
-"No one pulled me to the side (December 2025) to talk about seeing me grab [client #3]; there was no incident of me pushing [client #3] against the wall in the bathroom (December 2025). DSS already did the report, you can read the report."
-"There was not an incident (November 2025). I removed the phone (from client #3) but I didn't grab her (client #3) wrist. You don't have to grab their (client) wrist, you just reach over and take the phone. You don't have to touch them (client) to take the phone, you just take the phone."
-On 1/9/26, "[client #3] came in from school upset, didn't want to talk and had a blanket under her arm. Staff #5 was asking what was going on, talking to her (client #3), and she (client #3) seemed agitated. I went over to the bed and picked up the blanket and she (client #3) had her [laptop] inside the blanket. They (clients) are not supposed to have electronic devices and she (client #3) had hers (laptop). I took it (laptop) from

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V 109	Continued From page 14 her, she (client) got upset, went down the steps and out the door (eloped)." -No one had ever addressed aggressiveness with her, "I am not aggressive." -"I don't use profanity, and yelling only escalates the situation." Interview on 2/5/26 and 2/26/26 with the Licensee/Director/CEO revealed: -No staff smoked or used vapes in or around the facility. -"I can't answer that question (various issues with staff at the facility) until I know exactly what you are referencing (when asked about whether there had been any performance issues with staff)." -Had not received any reports or concerns from staff or clients that the AP/HM had been aggressive in her interactions. -"There was an incident of her (AP/HM) taking the phone (from client #3) in November (2025)." -"Not sure if [AP/HM] uses vape. I never found one in the facility. Just the one (vape) that [client #2] had in November or December of last year (2025); it (vape) came from [client #2]. I have no idea where [client #2] got it from." This deficiency constitutes a recited deficiency and must be corrected within 30 days. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for an Imposed B rule violation and must be corrected within 45 days.	V 109		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS	V 110		

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V 110	Continued From page 15 (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record review and interview, one of two audited former paraprofessional staff (Former Staff (FS) #12) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are:	V 110		

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V 110	Continued From page 16 Finding #1 Review on 2/3/26 of FS #12's personnel file revealed: -Hired 10/22/25. -Date of termination not documented. -Job Title Direct Support Professional (DSP). Review on 2/12/26 of facility records provided by the Licensee/Director/Chief Executive Officer (CEO) on 2/12/26 revealed: -An undated, partial email regarding FS #12's termination with header cut off and was missing the email heading details. -The date of the email, the name of the sender and sender email address, the name of the email recipient and the recipient's email address were missing. -Message in the body of the email read: "Dear [FS #12], This letter serves as formal notice that your employment with the Renewed Beginnings Group Homes is terminated effective immediately (no date). This decision is based on a violation of company policy related to dishonesty and providing false information to leadership. Integrity and honesty are essential requirements of you position, and your actions have resulted in a loss of trust necessary to continue your employment...We wish you the best in your future endeavors. Sincerely [Licensee/Director/CEO]." -No documented date of termination for FS #12. Finding #2 Review on 1/28/26 of client #2's file revealed: -Age 16 years old. -Admitted on 10/4/25. -Diagnoses: Adjustment Disorder; Post Traumatic Stress Disorder, unspecified; Major Depressive Disorder, moderate; Generalized Anxiety Disorder Oppositional Defiant Disorder;	V 110		

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V 110	Continued From page 17 Attention-Deficit/Hyperactivity Disorder, predominately Inattentive Presentation; Parental-Child Relational Problem -Comprehensive Clinical Assessment (CCA) dated 10/15/25 with history of emotional dysregulation, trauma and strained familial relationships...anger, distrust of adults, and a lack of emotional safety...expresses a desire for stability, autonomy and inclusion...multiple placements, depressive symptoms, suicidal ideation (SI) and attempts, and challenges with maintaining peer relationships...history of multiple placements, including higher-level locked facilities, reflects a pattern of emotional and behavioral dysregulation requiring intensive support...low energy, poor appetite, excessive sleep...mood fluctuations, irritability, and episodes of intense emotional overwhelm...relationship with her mother is a significant emotional trigger, contributing to SI and past attempts...hospitalization in June 2025...desire for emancipation and identifies her mother's controlling behavior and lack of emotional support as detrimental to her mental health; SI via cutting wrists and overdose (once), use of nicotine and marijuana via a vape; maternal abuse and long term sexual abuse by family while in father's care; last suicide attempt 6/27/25. Finding #3 Review on 1/28/26 of the facility's internal incident reports from 12/1/25 to 1/28/26 revealed: -"Event date: 1/07/2026, approximately 3:15 a.m.; Discovered Date/Time:1/07/2026 at approximately 3:25 a.m.; AWOL (absent without leave)/Missing Person; Program: Residential Care. -Description of Events: Upon beginning the overnight shift, all residents (clients) were present in the home (facility) and later went to sleep	V 110		

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V 110	Continued From page 18 shortly after 10pm. Earlier in the shift, a resident (unknown) requested to speak privately (unknown staff) and expressed general concerns regarding another resident's behavior. No direct evidence was observed at that time, and no immediate safety concerns were identified. During routine overnight room checks, staff (FS #12) discovered that the resident, [client #2], was not present in her bedroom. Upon entering the room (bedroom), staff (FS #12) observed the bed arranged in a manner that appeared occupied, with the bedroom window open and curtains closed. Staff paused briefly to assess and then conducted an immediate check of the residence (facility). Shortly thereafter, staff heard movement downstairs and observed [client #2] inside the home with personal belongings. [Client #2] re-entered the residence and proceed upstairs to her bedroom. She (client #2) appeared tired and did not exhibit signs of distress or injury at that time. Staff (FS #12) informed her that the situation would be discussed later; however, follow-up did not occur due to the time and circumstances. [Client #2] was accounted for, and no further elopement occurred." -"1/13/26 Incident Report-Staff Policy Violation ([client #2]) -Date of report-1/13/26; staff involved-[FS #12], DSP (former employee) -Description of incident: On or about January 2026, management received information indicating that staff member [FS#12] provided a personal or unauthorized cellular phone to a consumer (client #2). It was further reported that the staff member (FS #12) engaged in inappropriate communication with the consumer and instructed or coached the consumer on what to say to staff upon returning to the facility following an unauthorized absence (elopement). This conduct is a direct violation of facility policy,	V 110		

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which strictly prohibits consumers from possessing unauthorized phones and prohibits staff from engaging in private or secretive communication with consumers or coaching consumers to provide false or misleading information. The reported actions compromised supervision protocols and posed a risk to client safety and program integrity."
-No documented incident report of client #2 leaving the facility on 1/2/26 and returning to the facility at 4am on 1/3/26, with the assistance of FS #12 .

Review on 2/5/26 and 2/6/26 of the facility's records provided by the Licensee/Director/CEO revealed:
-Reporter Notification Letter, undated, of a report made to Department of Social Services on 1/14/26 for FS #12 providing client #2 "with an unauthorized cell phone and failed to report her (client #2) absence from the facility."
-Letter dated 1/22/26 regarding FS #12 from the Health Care Personnel Registry (HCPR) Section of a report made to HCPR, "on or about 1/3/26."

Review on 2/5/26 of the facility's Investigation Report and Findings undated provided by the Licensee/Director/CEO on 2/5/26 revealed:
-An investigation report for client #2's elopement on the night 1/2/26 and return to the facility at 4am on 1/3/26 that was dated to start on 1/4/26 and concluded on 1/13/26.
-"Investigation Report and Findings: Facility: Renewed Beginnings Group Homes; Incident Type: Elopement/Failure to Report/Unauthorized Cell Phone; Client: [#2]; Staff Member Involved: [FS #12]; Date of Incident: January 4, 2026; Date Investigation Concluded: January 13, 2026.
-Purpose of Investigation: The purpose of this investigation was to determine the circumstances

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V 110	Continued From page 20 surrounding the elopement of client [#2] on January 4, 2026, assess staff compliance with reporting requirements, and identify policy violations or corrective actions required to ensure client safety. -Investigation Summary: The investigation began on January 4, 2026, the date of the elopement. During the investigation, it was determined that staff member [FS #12] failed to report the elopement in accordance with facility policy. [FS #12] was immediately removed from the facility pending the outcome of the (worked at sister facility) investigation. During the investigation, [client #2]'s mother contacted the facility and reported that she was in possession of a cell phone belonging to [client #2] (FS #12). This information prompted a formal interview with [FS #12]. During the interview, [FS #12] admitted to giving the phone to [client #2], which was unauthorized and violated facility policy...Investigation Status: Closed on January 13, 2026." Finding #4 Review on 2/5/26 and 2/6/26 of the text messages from the cell phone confiscated by the mother/legal guardian (LG) of client #2 revealed: "1/2/26 8:14pm-8:17pm from (client #2 to FS #12), Hi ma [FS #12]; Ms (correction of ma); It's [client #2]; When are you coming; How far?? 10:37pm-10:38pm, (client #2 to FS #12), I saw you downstairs; (2 crying laughing emojis); Everything ok??; ??? 10:37pm, (FS #12 to client #2), back before 6/7 (am) and when you get close enough call me i'll have my phone on but be safe and have fun! 1/3/26 -4:07am, (client #2 to FS #12), I'm coming back (to facility) right now	V 110		

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V 110	Continued From page 21 -(FS #12 to client #2), okay i'm up lemme see what i can cuz (because) i don't want you being all that stuff back in too at once; she's (staff #3) in the staff room so we're good -(client #2 to FS #12), Okay; She (staff #3) still in there?? -(FS #12 to client #2), yea she's (staff #3) staying in there to sleep and i just moved out to the loft. -(client #2 to FS #12), Okay what do i do now??; It's (alarm) gonna say back door. -(FS #12 to client #2), you there (back door) now? -(client #2 to FS #12), Yea -(FS #12 to client #2), coming -(client #2 to FS #12), Ok -10:50am, (client #2 to FS #12), Hi; U left?? -10:57am, (FS #12 to client #2), yes they know about you leaving -11:01am, (client #2 to FS #12), no; I'm so happy right now; Tysm (thank you so much) [FS #12] -11:05am, (FS #12 to client #2), i told them idk (I don't know) where you went and how long -1:34pm, (client #2 to FS #12), Lord; U didn't want to tell them i was sleeping??; Cause they got me switching rooms (bedrooms) and shii (s**t) -(FS #12 to client #2), "i told them i didn't know you left; i only know you came in, i told them idk where you went and what you did and that i was that you jumped and i went to go check and you was already outside. they saw i let you in on the cameras so i tried to help and said like you never left. -1:43pm, (FS #12 to client #2), but [Licensee/Director/CEO] called me and said they finna question you now -1:44pm, (client #2 to FS #12), Okay; Ima just say I was talking with you ig (I guess) about some personal stuff; Or should I say something else -1:45pm (FS #12 to client #2), they saw you had a hockey and think you were high -(client #2 to FS #12), High??; I didn't smoke	V 110		

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though??
-(FS #12 to client #2), that's what they told me
-(client #2 to FS #12), Hmm
-(FS #12 to client #2), i didn't smell/see anything; but [client #1] said you told her that's what you was gonna do
-1:46pm, (client #2 to FS #12), Told her wat??
-(FS #12 to client #2), just say you saw your friend/bf (boyfriend) in the neighborhood and got scared and came right back; that you was gonna get high
-(client #2 to FS #12), But how did I get out??
-1:47pm-1:48pm, (FS #12 to client #2), cuz i was sleep from the time you left until the time you came fr (for real) and even the other lady (staff #3) thought you was in bed so you can really say you was barely gone; i said i saw your window open and that i went to go check and you was already outside and i only didn't report it cuz you was tired and that i wanted to talk to you first about it; the camera was triggered at 4am (underlined) so that's what they saw and they saw me and [client #1] leave out the front door to "talk" when i saw you before you left
-1:49pm, (client #2 to FS #12), So i left out the window?; Or back door?
-(FS #12 to client #2), also save my name as something else in case so they don't recognize my number or name
-client #2 to FS #12, Ok
-(FS #12 to client #2), you left out the window but back from back door because you didn't want to stay out long
-1:50pm, (FS #12 to client #2), well i didn't give a reason but i said shortly after i noticed when you were gone i went to check on you outside and you was already there but i told them idk anything about to leaving
-1:51pm-1:55pm, (client #2 to FS #12), Okay; So I was stressed I wanted to get away and I left out

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RENEWED BEGINNINGS HOME INC	13113 LAKEMORE DRIVE CHARLOTTE, NC 28278

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my window to go to the back porch to sit there and journal, I wanted to take a walk but I was scared to walk anywhere since I dont know the neighborhood then after that short time you can outside we talked about me not wanting to be here anymore like at the group home I just want to get away from my life and I just wanted to smoke and chill with my friends but can't because I don't have much freedom and I feel a little isolated; Then we came back and I went to my room to calm down
-(FS #12 to client #2), that's fine but you gotta explain the hickey
-(client #2 to FS #12), Don't have a hickey (2 crying emoji)
-(FS #12 to client #2), i told them you didn't talk to me
-(client #2 to FS #12), Okay, so I just wanted to be alone?
-(FS #12 to client #2), that you wanted to go lay down when you came in; yes you can say you wanted to be alone
-(client #2 to FS #12), Okay
-(FS #12 to client #2), just update me when you can and hide phone. i'm on schedule for tonight unless they tell me not to come
-(client #2 to FS #12), Oh they won't know where it's at
-(FS #12 to client #2), okay good luck they not really mad, they was upset cuz they said you could've got hurt or kidnapped you know
-(client #2 and FS#12), Oh okay; Good
-(FS #12 and client #2), and i'm only in trouble for not reporting you, they don't think i helped you
-1:58pm, (client #2 to FS #12), D**n; Lord; Should I be scared
-2:00pm, (FS #12 to client #2), i wouldn't they were more upset with me if anything just tell [client #1] she really don't know what happened but i told them that she told me you wanted to get

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high and that's why me and her stepped out at 10pm (10pm underlined); all we both know (bullet statements) you left out the window, no one knew, you wanted to be alone, you made noises at the back door, idk what you did while you was out, i let you in, you wanted to go straight to bed, you wasn't gone long.
-2:02pm-2:03pm, (client #2 to FS #12), Okay; Bet
-2:04pm, (FS #12 to client #2) okay and they making write a statement of what happened so i'm writing that too so it'll add up but don't let [client #1] say anything tho cuz they might want to question her and as far as i know [client #3] doesn't know anything.
-4:35pm (client #2 to FS #12), Okay; Sorry I was cleaning
-5:00pm, (FS #12 to client #2), that's okay but they're moving me back to the [sister facility] so i won't be there tonight
-5:54pm, (client #2 to FS #12), Noooooo; Nooooo (2 crying emojis)
-6:57pm, (FS #12 to client #2), i knowwwww
-7:55pm, (client #2 to FS #12), Are you okay
-7:59pm, (FS #12 to client #2), i am!; they still want me so that's a good sign but they prob don't trust me with yall and not even that they said they had to report it so it prob wouldn't have looked good if i stayed (heart emoji response from client #2)
-10:29pm, (client #2 to FS #12), Yes; I get it 2/5/26
-11:00am, from (FS #12 to client #2's mother/LG), Good afternoon, I was reaching out to see if you still had the unlocked phone and was still willing to return it if it was still in working condition."

Interview on 2/4/26 with client #2 revealed:
-"I jumped out the window (facility) and went with my friend and I came back because all my clothes and stuff are here (facility). I didn't get

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hurt."
-"I don't know the time I left (eloped). I was stressed out and wanted to see my friend and I went."
-"We (she and friend) got something to eat and I returned about 12 midnight."
-"I opened the window and there was no screen on the window at the time. I stepped out on like a slanted vent and that's how I got out."
-"I wanted to smoke. I had been stressed out and my grades were dipping, but I didn't smoke. She (friend) knew I was at a group home."
-"[FS #12] and [staff #3] were the staff that worked (1/2/26). [FS#12] aided me. She (FS# 12) pretended to check on me, that's what she told me. I made as if I was in the bed by arranging my pillows and covers to look like I was in bed."
-FS #12 and staff #3 took turns sleeping on the shift.
-FS #12 never provided drugs or alcohol.
-FS #12 was fired after the client #2's elopement, "because she aided me (elopement) and she gave me a phone."
-The facility found out about the phone she had in her possession, "[Associate Professional/House Manager (AP/HM)] told me that [Licensee/Director/CEO's spouse/former Qualified Professional] said there was another device connected to the internet" that detected the use of the cell phone provided to client #2 by FS#12.
-Client #2's mother/LG became aware of the phone from FS #12 "during a home visit (1/3/26-1/4/26)" when the phone's "flashlight came on."

Interview on 2/10/26 with client #2 revealed:
-"The facility knew I eloped the next day (1/3/26). They knew about the phone that same day

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(1/3/26)."
-"Yes, [FS #12] assisted me in getting back in (facility). She opened the back door and let me in."
-"[AP/HM] talked with me the next day (1/3/26) about the elopement, she asked did I leave, I told her yes. She asked what time I left and I didn't tell her what time I left."
-"[FS #12] was there when I came back (4am, 1/3/26). I went to sleep. [AP/HM] came in the next day (1/3/26)."
-"I didn't have a phone number...she [FS #12] completely cleared it (phone) out and she gave it to me to have. She gave it (phone) to me because I was asking for it because she had given it to another consumer (client) to use at the other group home (sister facility)...It was cleared of everything when I got it."
-"My mother (mother/LG) has the phone because it's mine. I don't know if [FS #12] asked for it back. If she did (ask for it back), it's mine, she gave it to me, why would she ask for it back?"
-"She gave it (phone) to me when I asked because she had another phone and I'm about to get emancipated, and I don't want to have to buy a phone."

Interview on 2/5/26 with the mother/LG for client #2 revealed:
-"On January (2026) the first (1/2/26) she (client #2) jumped out of a window" to elope from the facility.
-Client #2 "was gone (from the facility) from 9pm (1/2/26)."
-Received a call from the AP/HM on 1/3/26 and was informed that client #2 eloped on 1/2/26 and returned to the facility on 1/3/26.
-"The day after it (elopement) came out (1/3/26), that the child (client #2) left (eloped 1/2/26), [AP/HM] called me and said the child left, they

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(facility) are dealing with the situation (elope) and they were gathering more information."
-Requested the facility to schedule an appointment for client #2 at the gynecologist.
-Client #2 informed that she and her girlfriend had sex while away from the facility on 1/2/26-1/3/26.
-"She (client #2) had a gynecologist appointment that was made per my request (to AP/HM), because after jumping out the window and they (client #2 and her female friend) did what they did (had sex); she went to go have sex with her friend, a female; they did sexual intercourse."
-Client #2 had a bacterial infection, went to a gynecologist on 1/16/26 and was treated with an antibacterial medication. "that was January 16th (2026)...one of the staff took her to the appointment."
-FS #12 had given a phone to client #2.
-FS #12 texted the phone provided to client #2 on 2/5/26 to request the return of the phone.
-She refused to return the phone, "No, I'm not giving it (phone) back to her (FS #12). She (FS #12) told the child (client #2) to come back at 6 to 7 in the morning."
-"My daughter (client #2) had tucked the phone under her arm. [FS #12] had prewarned her, stating that they were doing a search of her (client #2) room. The phone was blinking under her (client #2) armpit when we (mother/LG and client #2) were on the way to church on that Sunday 1/4 (2026). I retrieved the phone (from client #2) and informed the facility (AP/HM) (1/4/26)."
-"I had read (AP/HM and the Licensee/Director/CEO) the text message from staff (FS #12)."
-"The facility (Licensee/Director/CEO and AP/HM) knew about the phone, it was the weekend after New Years (1/3/26-1/4/26)."
-"I called (1/4/26) and they (Licensee/Director/CEO and AP/HM) told me to

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V 110	Continued From page 28 give it (phone) back to [FS #12]. [AP/HM] and [Licensee/Director/CEO] kept pleading for me to give the phone back. I drive trucks and I was leaving out that Monday (1/5/26). I didn't give it back and I still have it." -"They (Licensee/Director/CEO and AP/HM) was saying give the phone back to [FS #12]. [AP/HM] asked for the phone to be returned. That's when I learned it was [FS #12]'s phone and I said let me see what's on it (phone) that they want it back so bad." -"I went through the phone, and around December 25th (2025) the child (client #2) was communicating and messaging to different people and was doing the most with the phone. We almost had a statutory rape charge when I looked at what was on that phone (due to people client #2 had contact with)." Interview on 2/10/26 and 2/12/26 with the mother/LG for client #2 revealed: -"I honestly believe they (facility staff) knew about the phone before I knew, [AP/HM] said the kids (clients) were saying she (client #2) had the phone. They (facility staff) did a check when she (client #2) was gone with me (home visit) that Saturday the 3rd (1/3/26)." -The elopement (1/2/26-1/3/26) was on the facility camera. "[AP/HM] said they (facility) had footage on camera because the child (client #2) tripped the camera and [FS #12] assisted her. They (facility staff) said they didn't know what time she (client #2) left and how long she'd been out...the child (client #2) left around 9 (pm), the child said it. The person (female friend) said she picked up [client #2] around 9:30ish, 10 (pm). The person (girlfriend) told me that." -"I'm going to be honest with you, [AP/HM] showed me the footage from the facility camera and that was not 2 weeks later (after elopement).	V 110		

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V 110	Continued From page 29 She (AP/HM) showed me and [client #2] the footage and told me not to tell because she wasn't supposed to show it (camera footage)." -"They (Licensee/Director/CEO and AP/HM) are a bunch of liars, they knew about the phone the same day (1/2/26) or the day after the elopement (1/3/26). They even asked that lady (FS #12) to sign a report, they (facility) didn't show you the report the lady wrote? They did not find out two weeks later, it was immediately and they (facility) had the footage (camera) of it." -Had never given client #2 a phone while at the group home, "I would never give her a phone. We've had too many problems for eight years with phones." Interview on 2/2/26 with FS #12 revealed: -Was hired in October (2025) and was terminated in January (2026), "I got terminated for not reporting something." -Worked the overnight shift 10pm to 7am. -Was terminated for not reporting client #2's elopement on 1/3/26, "I knew when she (client #2) came back in (facility) at 4am (1/3/26) and I was going to report it that morning (1/3/26). I was trying to let her (client #2) sleep it off and they (AP/HM and Licensee/Director/CEO) found out the next morning." -The facility camera caught her letting client #2 back into the facility. -"I was told she (client #2) jumped out the window. She (client #2) was a little hurt; I want to say she hurt her leg. She was touching her leg. I sent her straight to bed." -"Her (client #2) injury was not attended to that night or that morning." -"That morning (1/3/26), she (client #2) was still sleep and I got switched (to sister facility) so I don't know what happened afterwards when she came back in (facility)."	V 110		

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V 110	Continued From page 30 -Client #2 "had covered her window with the curtain and stuffed her bed so me and the other staff (#3) didn't know (eloped) until she came back in (facility)." -Staff #3 was working with FS #12 when client #2 eloped and staff #3 was asleep in the facility. -FS #12 and staff #3 took turns watching the clients. -One staff would be awake and the other would be asleep, switching every 5 hours. -"I had an extra phone that I kept on me and the client (#2) was adamant about wanting to use the phone. The clients could only call parents after 6pm, and [client #2]'s parent (mother/LG) knew that I allowed [client #2] to use the extra phone, and knew that she (client #2) was communicating (on the phone) without staff knowing." -"I'm not sure how staff found out or how [Licensee/Director/CEO] discovered the phone." -"I heard that [client #3] left (eloped 1/9/26), but I was already at the [sister facility]." -"I got moved to [sister facility], so maybe I left January 15th (2026). I was never removed from the working schedule." Interview on 2/16/26 with anonymous staff (AS) #15 revealed: - On 11/6/25, client #2's bedroom was searched and a "weed (marijuana) pen and a [cell phone]..." were found. - A report was writen on November 6th at 7:48pm in the electronic medical record. - Client #2 wrote a note "... that on this date (11/6/25)... (phone and weed pen were found) in her room..." which client #2 signed, and the note was sent it to the Licensee/Director/CEO. -"Found it (phone and weed pen) 11/6 (2025) and she (client #2) had it 10/24-10/26 (2025), no one (staff) had done a room search. I stripped down her whole room, [client #2] was there. First I went	V 110		

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in and talked to her, asked for it (phone and weed pen) and she gave it to me."
-"I took a picture (of phone and weed pen) and sent to [Licensee/Director/CEO]. That was the weekend [AP/HM] started and the kids were telling her that [client #2] had weed pens."

Interview on 2/2/26 with staff #3 revealed:
-Was an on call employee and had not worked at the facility in the past 3 weeks.
-Had worked one or two shifts with FS #12.
-Had worked the overnight shift with FS #12 on 1/2/26 when client #2 eloped.
-Room check was done every 30 minutes to an hour.
-"I was told this (client #2 eloped) the day after (1/3/26) because I was not aware."
-"We (staff #3 and FS #12) rotated so this was happening when I was in the house and I was in a different room in and out of sleep."
-"What I was told was that she (client #2) climbed out a window, that's why no alarms were set off. I was not aware that she harmed herself jumping out the window."

Interview on 2/12/26 with AS #25 revealed:
-FS #12 "told me they (facility) took her off the schedule because one of the girls (client #2) jumped out the window and she (FS #12) got blamed. They put her at the [sister facility] on third shift, she worked a couple of nights (dates unknown)."
-"I was told that the girl's (client #2) momma (mother/LG) gave her the cell phone, even on the notes (staff notes) it says that she been had a cell phone and her mom gave her the cell phone. I read in the notes months ago they (staff) think she (client #2) had a cell phone."
-She hadn't heard that the cell phone was given to client #2 by FS #12.

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V 110	Continued From page 32 Interview on 2/2/26 with the AS #28 revealed: -Was informed of the 1/2/26 elopement by client #2 in the January 2026. -"They (facility staff) didn't say the name of the staff. They didn't say she (client #2) got hurt, but they did say she (client #2) got marijuana and alcohol. They said she got it from the staff member (FS #12) that was fired. The client's (#2) mom (mother/LG) said that (marijuana and alcohol). I don't know if that was speculation or the details of what happened." -The facility didn't dispute the mother/LG's report that marijuana and alcohol were provided by FS #12, "they (facility staff) only said the staff member (FS #12) was no longer working there." Interview on 2/2/26 with the AP/HM revealed: -"[Client #2], eloped a couple of days before on Jan 7th (2026). I was not in the group home (facility), this was the 3rd shift and I got a call that morning 1/8 (2026) saying she (client #2) was missing, had left the home (facility), by the time I got the call she was back already; not sure of cause (of elopement); it (call) was a notification for me." -"Staff working was [FS #12]." -"[Client #2] received red status (behavior system), in room 1 hour in, 1 hour out, no privileges, if girls (clients) went out (outing), staff would stay behind with her (client #2), those were her only consequences." -"I was the supervisor, staff (FS #12) said she didn't know how long she (client #2) had been gone. She (FS #12) did a room check, don't know the time." Interview on 2/5/26 with the Licensee/Director/CEO revealed: -"[FS #12] gave a phone to [client #2] and we	V 110		

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V 110	Continued From page 33 (facility) don't allow electronic devices, the girls (clients) can't have phones. She (FS #2) said she left the phone, but I bet she gave it to her (client #2)." -"Once [client #2] had the phone she texted [FS #12] to let her know the night she eloped (1/2/26) that she was back in the facility (1/3/26) and [FS #12] opened the door (facility)." -"With [FS #12], when all that happened (elopement), I did the investigation and found out she (FS #12) gave her (client #2) the phone, two weeks later (after elopement)." -FS #12 "was removed from the schedule and terminated. It (termination) wasn't the same day but she was removed from the schedule. Whatever day we called DSS, the dates are on the DSS letter. No, she was not working at the other facility (sister facility) because she was terminated." Interview on 2/6/26 with the Licensee/Director/CEO revealed: -"[FS #12] did not assist with the elopement of [client #2], but assisted her (client #2) with getting back to the facility (1/3/26), unless you know more." -"I wasn't suspicious that she (FS #12) assisted, but she didn't let us (facility staff) know that it (elopement) happened, as I said, the mother didn't talked to us, so I don't know anything about her (FS #12) assisting her (client #2)." -"It is unclear on how she (client #2) left. She's not being truthful, maybe she crawled, maybe she jumped. No, the [doorbell] camera (facility) didn't catch her leaving. [Doorbell] camera and cameras in the facility have live feed only." -"Room checks are done every 30 minutes but the way she (client #2) made her bed was like a person was there (in bed) when they (staff #3 and FS #12) checked.	V 110		

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V 110	Continued From page 34 Review on 2/19/26 of the Plan of Protection signed and dated by the Licensee/Director/CEO on 2/19/26 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Upon identification of the deficiency, the director, [Licensee/Director/CEO] immediately as of 2/19/2026 took the following actions to ensure consumer safety: -The Director conducted an immediate review of all active staff schedules to confirm that paraprofessionals are working only under the supervision of a Qualified Professional or Associate Professional in accordance with 10A NCAC 27G .0104. -The Program Director (Licensee/Director/CEO) verified that all paraprofessionals currently providing direct care have completed required training, competency verification, and orientation specific to the population served. -Supervision coverage was immediately confirmed for all shifts to ensure that clinical oversight is continuously available to address consumer needs, behavioral concerns, and crisis situations. -No paraprofessionals are permitted to provide services independently or beyond their defined role. -The facility verified that no consumers were placed at risk as a result of the identified deficiency. Describe your plans to make sure the above happens. The director will review staffing assignments weekly starting on 2/22/2025 to ensure paraprofessionals are properly supervised at all times. -Monthly personnel file audits will be conducted	V 110		

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V 110	Continued From page 35 by the Program Director (Licensee/Director/CEO) to verify competency documentation and supervision compliance. -Monthly meeting will be held with Paraprofessionals to ensure they understand their job role and demonstrate knowledge, skills, and abilities required for the population served prior to providing independent direct care duties. -The facility has reinforced its policy prohibiting privileging requirements for paraprofessionals and clarified staff roles and responsibilities. -Ongoing supervision sessions and performance monitoring will ensure staff continue to demonstrate required competencies including technical, interpersonal, communication, and clinical skills." Review on 2/19/26 of the first amended Plan of Protection signed and dated by the Licensee/Director/CEO on 2/19/26 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? -Upon identification of the deficiency, the Director, [Licensee/Director/CEO], immediately implemented corrective actions on February 19, 2026, to address staffing concerns and ensure the safety of all consumers. -Immediate actions included scheduling and preparing to conduct a staff meeting on Monday, February 23, 2026, to review and reinforce company policies related to consumer safety. Topics to be addressed include supervision expectations, the prohibition of consumer possession of cell phones, procedures for preventing and responding to elopement, and staff responsibilities for maintaining continuous supervision. -Staff were informed that adherence to supervision and safety policies is mandatory, and any violations will be addressed promptly through	V 110		

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V 110	Continued From page 36 progressive corrective action, including counseling, written warnings, and termination if necessary. Describe your plans to make sure the above happens. -To ensure this deficiency does not recur, the Director (Licensee/Director/CEO) will implement ongoing corrective measures focused on monthly staff meetings educating staff on our policy as it relates to elopement and cell phone policy. The director is repsonisble and the meeting will be held on monthly startly Feb 23rd (2026). -A staff meeting will be conducted by the Director (Licensee/Director/CEO) on February 23, 2026, to review and reinforce facility policies regarding consumer safety, including procedures for addressing consumer possession of cell phones, supervision expectations, and protocols for preventing and responding to elopement incidents within the home. -During this meeting, staff will receive clear instruction on their responsibilities for maintaining continuous supervision, following safety procedures, and complying with facility policies and regulatory requirements. -The Director (Licensee/Director/CEO) will continue to monitor staff compliance through ongoing supervision, regular staff meetings, and review of staffing practices to ensure policies are consistently followed and consumer safety is maintained at all times." Review on 2/20/26 of the second amended Plan of Protection signed and dated by the Licensee/Director/CEO on 2/20/26 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? -Immediate actions included scheduling and preparing to conduct a staff meeting on Monday,	V 110		

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V 110	Continued From page 37 February 23, 2026, to review and reinforce company policies related to consumer safety. Topics to be addressed include supervision expectations, the prohibition of consumer possession of cell phones, procedures for preventing and responding to elopement, staff responsibilities for maintaining continuous supervision, and the strict prohibition against staff sharing personal items with consumers, including electronic devices. -Staff will be reminded that sharing personal property with consumers, particularly electronic devices such as cell phones, tablets, or other communication devices, is not permitted, as it poses safety, boundary, and supervision risks. Describe your plans to make sure the above happens. -To ensure this deficiency does not recur, the (Director Licensee/Director/CEO) will implement ongoing corrective measures focused on monthly staff meetings to educate staff on facility policies related to elopement prevention, supervision expectations, and consumer cell phone restrictions. The Director (Director Licensee/Director/CEO) is responsible for ensuring these measures are implemented, and monthly meetings will begin on February 23, 2026, and continue thereafter. -A staff meeting will be conducted by the Director on February 23, 2026, to review and reinforce facility policies regarding consumer safety. Topics will include procedures for addressing consumer possession of cell phones, supervision expectations, protocols for preventing and responding to elopement incidents within the home, and the prohibition against staff sharing personal items with consumers, including electronic devices such as cell phones, tablets, or other communication devices.	V 110		

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V 110	Continued From page 38 -During this meeting, staff will receive clear instruction on their responsibilities for maintaining continuous supervision, following safety procedures, maintaining professional boundaries, and complying with facility policies and regulatory requirements. -The Director will continue to monitor staff compliance through ongoing supervision, regular monthly staff meetings, and review of staffing practices to ensure policies are consistently followed and consumer safety is maintained at all times." The facility serves adolescents ages 15-16 years with diagnoses including Borderline Personality Disorder, Attention Deficit Hyperactivity Disorder, Post Traumatic Stress Disorder, Major Depressive Disorder, Generalized Anxiety Disorder, Oppositional Defiant Disorder, and Adjustment Disorder. On an unknown date, Former Staff #12 provided Client #2 with an unauthorized personal cell phone. While the facility documented multiple dates for client #2's elopement (1/3/26, 1/4/26, 1/7/26), text messages between Former Staff #12 and client #2 revealed that client left the facility on the night 1/2/26 and return around 4am on 1/3/26. Client #2 eloped from the facility by jumping out of her second floor bedroom window. Former Staff #12 stated that the facility cameras were triggered at 4am, the time of client #2's return to the facility. While away from the facility, Client #2 communicated with Former Staff #12 through text messages which detailed how Former Staff #12 assisted in the elopement, client #2's return to the facility and how client #2 was to respond to facility staff when questioned about the elopement. By providing a cell phone to client #2, Former Staff #12 did not demonstrate competence in attending to the client #2's needs, safety and well being.	V 110		

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V 110	Continued From page 39 Former Staff #12 did not use the clinical skills and analytical skills needed to review the risk of negative impact involved when she provided client #2 with a cell phone. Also, she did not use decision making skills to protect client #2 from the risk of harm related to client #2's elopement. This deficiency constitutes a Type B rule violation and must be corrected within 45 days.	V 110		
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 obtained.	V 112		

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V 112	Continued From page 40	V 112		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to develop and implement with treatment strategies to address clients' needs in partnership with the legally responsible person for two of three clients (#1 and #2). The findings are:

Review on 1/28/26 of client #1's file revealed:
-Age 16 years old;
-Admitted on 12/2/24.
-Diagnoses: Borderline Personality Disorder; Attention Deficit Hyperactivity Disorder; Post Traumatic Stress Disorder; Major Depressive Disorder, Recurrent, Moderate; Generalized Anxiety Disorder; Oppositional Defiant Disorder.
-Comprehensive Clinical Assessment (CCA) dated 4/29/24 with history of fights and school suspensions; anger, physical aggression, elopement, non-compliance, and mood swings; difficulty with peer relationships, communicating needs appropriately, and self-advocacy.
-Treatment Plan dated 12/1/25, increase compliance with all school rules and activities; learn to adopt coping skills.
-Treatment Plan had no effective date, no signature page with legal guardian's (LG) signature.
-No goals and strategies to address history of escalating defiant behaviors, aggression, school fights, and suspensions, mood swings; substance use, domestic violence, and plan for reunification.

Review on 2/12/26 of client #1's Clinical

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V 112	Continued From page 41 Assessment Addendum dated 2/1/26 provided by the Licensee/Director/Chief Executive Office (CEO) revealed: -Dated 2/1/26 and signed by the Licensed Professional. -"This addendum supplements the prior comprehensive clinical assessment (4/29/24) due to escalating defiant behaviors, substance use, and a change in educational placement. The juvenile (client #1) has demonstrated increased oppositional behaviors and confirmed marijuana use, resulting in impaired academic and behavioral functioning. As a result, the juvenile is being referred to a therapeutic day treatment program in lieu of traditional public-school attendance. Within the last week the client (#1) had to be taken to the emergency room twice following the client ingesting cannabis-infused substances, as well as smoking marijuana and utilizing vaporizing devices (vapes) indicating ongoing substance use concerns. -Risk Assessment: Current Risk Level: High; Primary Risk: Substance use (marijuana in school setting), Behavioral dysregulation, and poor response to authority, which may escalate to aggression or self-harm. -Protective Factors: Structured group home environment; Access to medication management and therapeutic supports; Previous attendance and engagement in school. Clinical Recommendations: 1. Due to ongoing behavioral concerns and substance use, the client is no longer appropriate for a traditional public-school environment. Placement in a day treatment program is recommended to provide structured academics, therapeutic services, and increased supervision. 2. Remain in a Level 3 group home for residential placement.	V 112		

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V 112	Continued From page 42 3. Individual therapy addressing behavior management and emotional regulation. 4. Substance use counseling and psychoeducation. 5. Family and team collaboration through Child and Family Team (CFT) meetings to discuss day treatment referral, substance use concerns, and updated treatment goals and progress. Clinical Impression: The client continues to exhibit persistent high-risk behaviors including substance use, defiance toward authority figures, and limited accountability for actions with limited response to current interventions. While medication compliance is noted, emotional regulation remains impaired, with low frustration tolerance and poor impulse control. A higher level of structured care such as Day Treatment with integrated substance abuse counseling is strongly recommended to address these concerns and reduce risk. If behaviors continue to persist, a PRTF (Psychiatric Residential Treatment Facility) residential facility may need to be explored to ensure continuity of care." Review on 1/28/26 of client #2's file revealed: -Age 16 years old. -Admitted on 10/4/25. -Diagnoses: Adjustment Disorder; Post Traumatic Stress Disorder, unspecified; Major Depressive Disorder, moderate; Generalized Anxiety Disorder Oppositional Defiant Disorder; Attention-Deficit/Hyperactivity Disorder, predominately Inattentive Presentation; Parental-Child Relational Problem -CCA dated 10/15/25 with history of emotional dysregulation, trauma and strained familial relationships...anger, distrust of adults, and a lack of emotional safety...expresses a desire for stability, autonomy and inclusion...multiple placements, depressive symptoms, suicidal	V 112		

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V 112	Continued From page 43 ideation (SI) and attempts, and challenges with maintaining peer relationships...history of multiple placements, including higher-level locked facilities, reflects a pattern of emotional and behavioral dysregulation requiring intensive support...low energy, poor appetite, excessive sleep...mood fluctuations, irritability, and episodes of intense emotional overwhelm...relationship with her mother is a significant emotional trigger, contributing to SI and past attempts...hospitalization in June 2025...desire for emancipation and identifies her mother's controlling behavior and lack of emotional support as detrimental to her mental health; SI via cutting wrists and overdose (once), use of nicotine and marijuana via a vape; maternal abuse and long term sexual abuse by family while in father's care; last suicide attempt 6/27/25. -Treatment Plan dated 12/10/25, will develop positive coping skills -Treatment Plan had no effective date. was not signed by the mother/Legal Guardian (LG), and was signed by client #2 as the mother/LG. -No goals and strategies to address history of SI via cutting wrists and overdose, substance use, elopement, seeking employment, self-sufficiency, and plan for emancipation. Review on 2/3/26 of client #2's Treatment plan dated 1/27/26 provided by the Licensee/Director/CEO revealed: -Effective date 1/28/26, with the following goals: will develop positive coping skills; will obtain a job; will learn emotional regulation and reduce emotional outburst. -Was not signed by mother/LG and was signed by client #2 as the mother/LG and dated 2/3/26. -Did not have goals and strategies to address history of SI via cutting wrists and overdose, substance use, elopement, strategies for seeking	V 112		

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V 112	Continued From page 44 employment, self-sufficiency, and plan for emancipation. Review on 1/28/26 of the facility's internal incident reports revealed: -1/7/26, 3:15am, client #2 elopement "...During routine overnight room checks, staff (FS #12) discovered that the resident, [client #2], was not present in her bedroom. Upon entering the room (client #2 bedroom), staff (FS #12) observed the bed arranged in a manner that appeared occupied, with the bedroom window open and curtains closed. Staff (FS #12) paused briefly to assess and then conducted an immediate check of the residence. Shortly thereafter, staff (FS #12) heard movement downstairs and observed [client #2] inside the home (facility) with personal belongings. [Client #2] re-entered the residence (facility) and proceed upstairs to her bedroom. She appeared tired and did not exhibit signs of distress or injury at that time. Staff (FS #12) informed her that the situation would be discussed later; however, follow-up did not occur due to the time and circumstances. [Client #2] was accounted for, and no further elopement occurred..." Review on 2/13/26 of the Incident Response Improvement System from 12/20/25 to 2/13/26 revealed: -1/3/26, submitted 1/30/26, "The consumer (client #2) left the residence and was absent for approximately one to three hours. The consumer returned voluntarily. No injuries or medical concerns were observed upon return." -1/29/26, submitted 1/30/26, "Consumer (client #1) consumed an edible while at school. Due to periods of altered consciousness, school staff contacted emergency medical services. consumer was transported to the hospital for	V 112		

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V 112	Continued From page 45 evaluation and testing." -2/13/26, submitted 2/15/26, "[Client #1] came in (facility) from school in a bad mood because she was holding a grudge against a peer (client #2). [Client #1] immediately began antagonizing her peer with profanity, insults and threats. [Client #1] eventually provoked an argument with her peer and assaulted her (client #2) with a closed fist. [Client #1] chased after her peer when her peer ran outside. [Client #1] incited a second altercation (with client #2) outside. [Client #1] incurred bruising over her right eyebrow and superficial abrasions to the back of her right shoulder. [Client #1] was transported to [local hospital] to be evaluated. [Client #1] did not any broken bones. [Client #1] was administered 400mg of Ibuprofen (pain reliever) for pain while at the hospital (no further medication prescribed.) [Client #1] was evaluated, diagnosed, treated and discharged for scrapes (skin abrasions)." -2/13/26, submitted 2/15/26, "[Client #2] engaged in a verbal altercation with a peer (client #1) that escalated. Both individuals became verbally aggressive, and the peer physically assaulted [Client #2] by striking and kicking her. Staff (unknown) and [Client #2]'s mother (mother/LG) directed her to exit the facility to de-escalate the situation. While outside, [Client #2] verbally challenged the peer, resulting in a second brief altercation. Staff (unknown) immediately intervened and implemented a brief therapeutic hold lasting approximately five (5) minutes for safety and de-escalation. [Client #2] complied with staff direction, regained behavioral control, and left the area by entering her mother's vehicle." Interview on 2/17/26 with Department of Social Services Social Worker/LG (DSS SW/LG) for client #1 revealed:	V 112		

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V 112	Continued From page 46 -Director of DSS for the county and she was client #1's DSS SW/LG due to staff changes in the agency. -Had recently started working as client #1's DSS SW/LG in December 2025 or January 2026. -Participated in the January 2026 Child Family Team (CFT) meeting on 1/29/26 and addressed "education goals, behavior goals in the home (facility) and at school, sixteenth birthday and what would be happening; discussed that she (client #1) was doing well, de-escalating when approaching certain situations and things like that." -Had discussed reunification with plan for guardianship with client #1's grandparent. -Had discussed reunification in prior CFT meetings and no timeline was put in place for reunification because DSS had to review the home study of client #1's grandparent. -A week after the CFT meeting on 1/29/26, "after an incident occurred (1/28/26 edible), discussed that we (team) may want to look at day treatment because of some things that were going on with [client #1] at school." -"We (team) talked about an incident that occurred, domestic violence with [client #1] and an individual at school; an alleged boyfriend, a guy she was liking, talking to. This (domestic violence) was bought out in a prior CFT meeting, probably around October/November (2025)." -DSS SW/LG inquired in the October/November 2025 CFT meeting whether anything had been done with the report of domestic violence and was told by the facility that "it was in law enforcement hands." -January 2026 CFT, the facility reported client #1's "grades improving, doing well, based on what the house manager (Associate Professional (AP)/HM) and QP (Qualified Professional) were saying, that's why we (DSS) were looking at	V 112		

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V 112	Continued From page 47	V 112		

possible placement of grandparent."
-In the January 2026 CFT meeting "it was discussed that she (client #1) got into THC (marijuana), an edible, and went to hospital. We (DSS) received that information in a phone call. It was the weekend of the 30th or 31st of January (2026). This call came in on the after-hours line to the on call SW."
-Received an updated treatment plan after the January 2026 CFT meeting, "I got the PCP (treatment plan) or treatment plan the first week of February (2/2/26-2/6/26) and I signed it electronically."

Interview on 2/17/26 with the mother/LG for client #2 revealed:
-Was sent the treatment plan signature page without the entire treatment plan until she requested to see the entire treatment plan document.
-The facility tried to get her to sign the January 2026 treatment plan, "since 2/15/26 and I asked for a PDF (portable document format) copy. I asked [AP/HM] while [client #2] was packing and she (AP/MH) said, sure if you can sign before you leave. I told her I have to read it (treatment plan) first and asked her to print it. When it was time to leave, I was looking to collect a hard copy (treatment plan) and [Licensee/Director/CEO] called [AP/HM] and told [AP/HM] to have me sign (treatment plan) and not give me a copy."
-Had not singed the January 2026 PCP (treatment plan) because "there were things I didn't agree with."
-Did not agree with client #2 signing the treatment plan as the legally responsible person.
-Was sent a blank signature page for the December 2025 treatment plan.
-"I already had problems with the PCP (treatment plan), no staff...no signatures in December

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V 112	Continued From page 48 (2025)" on the signature page. "How you (facility) want me to sign (treatment plan) and your own folks (staff) hadn't signed? So you can go fill in? -"It (treatment plan signature page) said a signature constitutes agreement. No I did not sign PCP (treatment plan) because I didn't agree. There was only one goal, to obtain a job, that wasn't all of her (client #2) goals, and they didn't want her to look for job." -"I couldn't name all the goals missing, but I wasn't in agreement. The goals are not being met and not even worked on." Interview 2/13/26 with anonymous staff (AS) #31 revealed: -Was responsible for updating treatment plan, along with the Licensee/Director/CEO. -Had updated the treatment plan for client #2 after the 1/27/26 CFT meeting. -Had not known client #2 well enough to update the treatment plan. -Sent out request for mother/LG's signature and she did not sign the treatment plan for 1/27/26. -"I think the goals can look good on paper, but it (goal) is not being done." -"Everything on the treatment plan seemed like long term goals and no goals or short term goals about outburst and de-escalation and what we as staff can do (interventions)." Interview on 1/30/26 with the AS #32 revealed: -The facility had not been able to get signatures on treatment plans because the Licensee/Director/CEO "didn't pay the [cloud storage and sharing tool] people." -"I didn't assist with intake and should have because some clients aren't level three and she (Licensee/Director/CEO) will level them (clients) down and let them come (be admitted) because she gets enhanced rate and is always looking for	V 112		

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V 112	Continued From page 49 IDD (Intellectual and Developmental Disability) girls (clients)." -Client #1 should have been working on reunification but the Licensee/Director/CEO had not addressed the goal. -In the December 2025 CFT meeting, "I was blindsided and [AP/HM) just started and she said [client #1] was getting beat up at school and I said that is something that the school needs to know." Interview on 2/5/26 with the Licensee/Director/CEO revealed: .-"...the one (treatment plan) we (facility) have has goals. Typically we don't have an emergency CFT to address that (treatment plan goals), it (elopement) happened in January (2026); but, we do address it (treatment plan goals) in the monthly CFT, definitely." -"It (goal for client #2) was on the PCP (treatment plan), if you look at the top she (client #2) makes up her own goals. It says she wants to get a job and prepare for independent living, it's on there." -"It's (goal) on the one (1/27/26 treatment plan) I just sent you." -"The elopements (clients #2, #3) didn't happen until January (2026), both of them happened in January (2026) so it wouldn't be in the December (2025) PCP (treatment plan)." -"No substance use based on who? Because we (facility staff) weren't seeing that (substance use) when she (client #2) came to us(facility)." -"The client comes up with the goals and tells us (facility staff) what the goals are and we work on those goals." -"The treatment plans all had goals and strategies." -The QP was responsible for writing and updating the treatment plans. This deficiency constitutes a recited deficiency	V 112		

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V 112	Continued From page 50 and must be corrected within 30 days. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for an Imposed B rule violation and must be corrected within 45 days.	V 112		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders	V 113		

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V 113	Continued From page 51 diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain complete client records affecting one of three clients (#2). The findings are: Review on 1/28/26 of client #2's file revealed: -Age 16 years old. -Admitted on 10/4/25. -Diagnoses: Adjustment Disorder; Post Traumatic Stress Disorder, unspecified; Major Depressive Disorder, moderate; Generalized Anxiety Disorder Oppositional Defiant Disorder; Attention-Deficit/Hyperactivity Disorder, predominately Inattentive Presentation; Parental-Child Relational Problem -Comprehensive Clinical Assessment (CCA) dated 10/15/25 with history of emotional dysregulation, trauma and strained familial relationships...anger, distrust of adults, and a lack of emotional safety...expresses a desire for stability, autonomy and inclusion...multiple placements, depressive symptoms, suicidal	V 113		

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V 113	Continued From page 52 ideation (SI) and attempts, and challenges with maintaining peer relationships...history of multiple placements, including higher-level locked facilities, reflects a pattern of emotional and behavioral dysregulation requiring intensive support...low energy, poor appetite, excessive sleep...mood fluctuations, irritability, and episodes of intense emotional overwhelm...relationship with her mother is a significant emotional trigger, contributing to SI and past attempts...hospitalization in June 2025...desire for emancipation and identifies her mother's controlling behavior and lack of emotional support as detrimental to her mental health; SI via cutting wrists and overdose (once), use of nicotine and marijuana via a vape; maternal abuse and long term sexual abuse by family while in father's care; last suicide attempt 6/27/25. -No documentation of therapy services that were provided. -No documentation of client's progress toward outcomes. Review on 2/12/26 of therapy notes provided by the Licensee/Director/Chief Executive Officer (CEO) revealed: -Client #2 had no documented individual and group therapy services. Interview on 2/4/26 with client #2 revealed: -Had not had therapy since the former therapist (Former Licensed Professional (FLP)) left and was waiting to meet with the new therapist who had not been able to meet because of the weather. -"My mom (mother/legal guardian (LG)) got me a referral for substance abuse therapy." Interview on 2/10/26 with the mother/LG revealed: -Was told by the Licensee/Director/CEO that	V 113		

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V 113	Continued From page 53 therapy was being provided. -Client #2 requested "an outside counselor rather than sharing a counselor with everyone in the house and they (facility) were supposed to set up family counseling. I had been asking for this from the beginning (October 2025)." -"I asked her (client #2) about if she was getting counseling and she was like, what counseling?, and when I talked with [Licensee/Director/CEO] she was saying, yes she (client #2) was getting counseling." -Client #2 stated she was not getting therapy. Interview on 2/2/26 and 2/3/26 with the FLP revealed: -Gave her notice the end of November and left employment on 1/16/26. -"[Licensee/Director/CEO] would tell me [client #2] doesn't want me as a therapist." -Resigned due to concerns with the facility's practices and because she was asked by the Licensee/Director/Chief Executive Officer (CEO) to discontinue provision of individual therapy. -"I made that decision because it's (individual therapy) needed and it goes along with all the recommendations for the girls (clients)." -The Licensee/Director/CEO "said it's (cost of therapy) just too much and they (facility) wanted to move forward with just group services, and I said you can't do that. I told her I don't feel comfortable and she wasn't having that. I told her I would give her to February 1st (2026) to transition." Interview on 2/16/26 with the Licensee/Director/CEO revealed: -Clients had never been without therapy. -It was not necessary to have individual and group therapy, "as long as they (clients) the four hours a week."	V 113		

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V 113	Continued From page 54 -"I told her (FLP) to discontinue individual therapy in November (2025). They (clients) are getting therapy currently." -There was only one week in November (2025) that client were only getting group therapy. -Had no response for the absence of documentation of therapy notes for client #2.	V 113		
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	V 118		

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V 118	Continued From page 55 with a physician. This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to administer medications on the written order of a physician for 3 of 3 clients (#1, #2 and #3), failed to ensure 1 of 2 clients (#2) self-administer on the written order of a physician, failed to keep MARs current for 2 of 2 clients (#1 and #2), and failed to ensure medications were administered by staff trained in medication administration 1 of 4 audited staff (Staff #5). The findings are: Cross Reference: 10A NCAC 27G .0209 Medication Requirements (V119). Based on observation and interview, the facility failed to dispose of all prescription medication in a manner that guards against diversion or accidental ingestion for one of three clients (#1). Cross Reference: 10A NCAC 27G .0209 Medication Requirements (V120). Based on observation and interviews, the facility failed to ensure that all medications were stored in a secure manner for one of three clients (#2). Finding #1 Review on 1/28/26 of client #1's file revealed: -Age 16 years old; -Admitted on 12/2/24. -Diagnoses: Borderline Personality Disorder; Attention Deficit Hyperactivity Disorder; Post Traumatic Stress Disorder; Major Depressive	V 118		

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V 118	Continued From page 56 Disorder, Recurrent, Moderate; Generalized Anxiety Disorder; Oppositional Defiant Disorder. -Physician Orders for: -10/12/25 for Metadate/Methylphenidate (ADHD) 50mg (milligram), take one capsule by mouth once a day (morning); -11/13/25 for Metadate/Aptensio/Methylphenidate (ADHD) 40mg, take one pill in the morning after breakfast; -11/4/25 for Clonidine (sleep) 0.1mg, take one pill at night; Cyproheptadine (allergy) 4mg, take one pill in the morning and evening; Abilify (mood) 15mg, take one pill in the morning; Lamotrigine (mood) 150mg, take 1 tablet by mouth daily with breakfast; Sertraline (PTSD) 25mg, take one pill at night. -No PO for Norethindrone (contraceptive) .35mg, take 1 tablet by mouth daily. -No PO for Hydroxyzine (anxiety) 10mg PRN (as needed), take one tablet by mouth every 8 hours as needed for anxiety. -No discontinue order for change in Metadate/Methylphenidate dosage from 50mg to 40mg. -No discontinue order for Clonidine 0.1mg and Cyproheptadine 4mg. Review on 1/30/26 of client #1's MARs from 12/20/25 to 1/29/26 revealed: December 2025 MAR: -Abilify 15mg, initialed as administered in the evening on 12/20/25-12/31/25 (12 days). -Sertraline 25mg, initialed as administered in the morning on 12/20/25-12/31/25 (12 days). January 2026 MAR: The following medications were initialed as being administered by Staff #5 who was not trained to administer medications: -Metadate/Methylphenidate 50mg, 1/6/26 (1 day). -Metadate/Aptensio/Methylphenidate 40mg,	V 118		

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V 118	Continued From page 57 1/7/26-1/14/26 (8 days); 1/18/26-1/24/26 (7 days); 1/26/26 and 1/28/26 (2 days). Total of 17 days. -Abilify 15mg, 1/6/26-1/14/26 (9 days); 1/18/26-1/24/26 (7 days); 1/26/26 and 1/28/26 (2 days). Total of 18 days. -Lamotrigine 150mg, 1/6/26-1/14/26 (9 days); 1/18/26-1/24/26 (7 days); 1/26/26 and 1/28/26 (2 days). Total of 18 days. -Sertraline 25mg, 1/6/26, 1/9/26, 1/13/26, 1/16/26, 1/27/26. Total of 5 days. -Norethindrone .35mg, 1/6/26-1/14/26 (9 days); 1/18/26-1/24/26 (7 days); 1/26/26 and 1/28/26 (2 days). Total of 18 days. -Hydroxyzine 10mg PRN, 1/10/26, twice at 6:18pm and 6:26pm and 1/18/26, twice at 4:03pm and 4:04pm. Total of 2 days. Finding #2 Review on 1/28/26 of client #2's file revealed: -Age 16 years old. -Admitted on 10/4/25. -Diagnoses: Adjustment Disorder; Post Traumatic Stress Disorder, unspecified; Major Depressive Disorder, moderate; Generalized Anxiety Disorder Oppositional Defiant Disorder; Attention-Deficit/Hyperactivity Disorder, predominately Inattentive Presentation; Parental-Child Relational Problem. -Physician Orders for: -11/16/25 for Lexapro (depression) 20mg, take 1 tablet by mouth daily. -12/6/25 for Trazodone (depression) 50mg, take 1 tablet mouth once a day, at bedtime with food. -1/12/26 for Epinephrine (EpiPen, allergy) 0.3mg injection, inject into the muscle once as needed; Albuterol Sulfate (inhaler), inhale two puffs into the lungs every 4 hours as needed for wheezing. -No discontinue order for Trazodone 50mg. -No documentation of a self-administration order for Epinephrine (EpiPen) injection and Albuterol	V 118		

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V 118	Continued From page 58	V 118		

inhaler.
-No documentation of antibacterial medication administered 14 days.

Review on 1/30/26 of client #2's MAR from 12/20/25 to 1/29/26 revealed:
December 2025 MAR:
-Lexapro 20mg, initialed as administered in the morning on 12/20/25-12/23/25 (4 days) and in the evening on 12/24/25-12/31/25 (8 days). Total of 12 days.
-Trazodone 50mg, initialed as administered on 12/14/25 (1 day).
January 2026 MAR:
-Lexapro 20mg, initialed as administered on 1/1/26-1/28/26 (28 days) in the evening.
-Lexapro 20mg, initialed as administered on 1/9/26, 1/13/26, and 1/16/26 Staff #5 who was not trained to administer medications.
-Epinephrine 0.3mg injection and Albuterol Sulfate (inhaler) not listed on MAR.

Finding #3
Review on 2/17/26 of Staff #5's personnel file revealed:
-Hired 1/4/26.
-Job Title as Direct Support Professional.
-Completed virtual medication administration training on 1/4/26.

Interview on 2/4/26 with client #1 revealed:
-She was taking her medications daily as administered by staff.

Interview on 2/4/26 and 2/10/26 with client #2 revealed:
-Was prescribed an antibacterial medication in January 2025 and the facility had administered the medication for 14 days.
-Was prescribed and administered Trazodone in

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V 118	Continued From page 59	V 118		

December 2025 without her mother/legal guardian (LG)'s knowledge.
-Her mother/LG didn't want client #2 to take Trazodone and was upset when she learned it was administered to client #2.
-"My mom (mother/LG) said she didn't want me to take Trazodone. She doesn't like Trazodone. She wasn't aware that they (facility)were changing medications and I didn't like the way they did that, because I called my mom the second night I was taking it (Trazodone) and she said she didn't approve it."
-Her albuterol was kept in her book bag and the EpiPen was on the bookshelf in her bedroom.

Interview on 2/11/26 with client #3 revealed:
-The AP/HM "was giving me and [client #2] Melatonin (sleep aid), she would sneak us in the bathroom and say, you gotta eat it (Melatonin) in here, in the staff office away from the cameras. [AP/HM] was giving me Melatonin, when [Licensee/Director/CEO] told her not to."

Interview on 2/5/26 and 2/10/26 with client #2 mother/LG revealed:
-The facility had not informed mother/LG of changes to client #2's medications prior to Trazodone being administered on 12/14/25.
-Was informed by text from the Licensee/Director/Chief Executive Officer (CEO) on 12/16/25 at 6:24pm that Trazodone had been administered to client #2.
-Requested Trazodone be discontinued in December 2025.
-Client #2 was prescribed an antibacterial medication on 1/16/26 after appointment with the gynecologist.
-"...one of the staff (unknown) took her (client #2) to the appointment (gynecologist)...the name of it (antibacterial) was metronidazole 500mg, one pill

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V 118	Continued From page 60 by mouth, prescribed 1/19 (2026); sent to [local pharmacy], it was for (to be taken) 14 days." Interview on 2/18/26 with the facility's Prescriber revealed: -Had been the prescriber for the facility since October 2025. -Was not aware of requirements for the physician orders. -Had provided the facility with physician orders in a form that listed the medications and she signed. -Had created a printable MAR to provide to the facility that did not meet the requirements of the physician orders. -"All my physician orders are e-scripts (electronic prescriptions). I will have to figure out how to do copies of those." -Was not aware over-the-counter (OTC) medications were being administered to clients. -"I was not aware of the Melatonin being given to clients (#2 and #3) without a prescription. But, that was my newest request, for [client #3] to get Melatonin and I denied because I wanted to see her first." -"[Licensee/Director/CEO] reserves the right to determine if medication is given." -The facility sent a new "over the counter form" on 2/16/26 or 2/17/26 that the prescriber had not seen before, "I hope she (Licensee/Director/CEO) doesn't think that I was giving her permission to the medication without a script. -The only OTC currently being prescribed was Ibuprofen for client #2. Interview on 2/18/26 with the facility's Registered Nurse (RN) revealed: -Provided the medication administration training for the facility. -Most of the time the training was instructed in person, "I don't do a lot of [virtual platform]	V 118		

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V 118	Continued From page 61 training." -When virtual trainings were done, a mock medication pass was also done. -"When I do trainings I do whatever the provider is needing. I do whatever the provider asks me to do." -If instructing a full medication administration training, "look at 6 rights, how to administer, refusals, act out scenarios, every step in the process, from looking at name of medications to administration, dose, charting and proper ways to chart." -If staff previously had medication administration training, the RN "wanted to ensure they know what to do." -She would do a review on line and make sure a demonstration was done virtually. -Had done a few online medication administration trainings "because the provider (Licensee/Director/CEO) wanted me to go over some things." -"If it's (training) done on [virtual platform], it's a review" for the staff that the Licensee/Director/CEO had identified as having prior training or experience in medication administration. -Kept an attendance log, but did not keep a separate log to differentiate staff that had previous experience and staff that needed the full medication administration training that included the assessment and the observed med pass -When the training was virtual, "we (staff) still go over looking at meds (medication) and do a mock med pass. Anything I did on [virtual platform] was a refresher and I still do the mock presentation." Did not receive the RNs attendance log for medication administration training prior to survey exit.	V 118		

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V 118	Continued From page 62 Interview on 2/2/26 with AS #21 revealed: -Had the medication administration training by the registered nurse on a virtual platform online. Interview on 2/11/26 with AS #24 revealed: -Medication administration training had been done by "some questionnaire in a [online application]. It was not done in person by a nurse like it was supposed to be. I asked [Associate Professional/House Manager (AP/HM)] and she just brushed it off. I know it was supposed to be done by a nurse because that's how it was done at the group home I used to work at." -The facility administered OTC medications to clients without a physician order. -Had seen the AP/HM give hydroxyzine to client #1 nightly, "but it is not supposed to given every night. I've seen her give it to her." Interview on 2/16/26 with the AP/HM revealed: -"Not aware an antibacterial medication being administered, for what? No I don't recall that." Interview on 1/29/26 with Licensee/Director/CEO revealed: -Had no explanations for the changes in client #2's Lexapro dosage in December 2025. -Client #1's medications had changed and "when orders change we (facility) have to change it on our end. I will have to check what we have. I know her (client #1) meds (medications) changed, that's when she got her review (December 2025). -Provided no explanation for why the Hydroxyzine was administered twice on 1/14/26 and 1/18/26. -Initially stated that client #2's mother/LG was informed by telephone that client #2 had been prescribed Trazodone for administration. -"No, she (mother/LG) wasn't aware (Trazodone), but when she signed permission for her (client	V 118		

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V 118	Continued From page 63 #2) to be in the program, she agreed. I feel like it was a communication issue with her (mother/LG) because she was asked if she wanted to be part of those meetings (medication)...if she was in those meetings, she would know what 's going on. Once she found out, we corrected it and took her (client #2) off (Trazodone)." -"I think it was one day that she (client #2) received (was administered) the Trazodone, we (facility) initialed one day." -Medication administration training was taught by an RN. -Wasn't sure if there was an attendance log for the medication administration training. -Staff had been given medication administration training by the RN on a virtual platform online. -Was not aware that the medication administration training should be taught in person by the RN and include an observed medication pass. Review on 2/19/26 of the Plan of Protection signed by the Licensee/Director/CEO and dated 2/19/26 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? -Upon identification of the deficiencies related to medication administration, storage, and disposal, the Director (Licensee/Director/CEO) immediately implemented corrective actions to ensure consumer safety. -Immediate actions include: -The Director conducted an immediate review of all medications stored within the facility to verify proper labeling, storage conditions, and security. -All medications were secured in locked storage areas accessible only to authorized, trained staff. -Expired, discontinued, or unused medications were identified and removed from active medication storage areas during the active	V 118		

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V 118	Continued From page 64 survey. -Medication Administration Records (MARs) were reviewed to ensure accurate documentation and verification of physician orders. -The Director verified that only trained and authorized staff administer medications in accordance with facility policy and regulatory requirements. -The facility confirmed that no consumers were placed at risk as a result of the identified deficiencies. Describe your plans to make sure the above happens. -Beginning February 20, 2026, the Director will ensure ongoing compliance through the following corrective measures: V118-10A NCAC 27G .0209 Medication Administration -The Director will ensure that medications are administered only by staff who have completed required medication administration training and competency verification. -Medication orders will be verified prior to administration, and documentation will be completed on the MAR immediately after administration by the director. -Monthly MAR audits will be conducted to ensure accuracy, completeness, and compliance by the director. V119-10A NCAC 27G .0209 Medication Disposal -The Director will ensure that expired, discontinued, or unused medications are removed from active storage immediately upon identification. -Medication disposal will be conducted according to facility policy and documented appropriately, including verification by the director. -Routine monthly medication cabinet inspections will be conducted to identify and remove	V 118		

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V 118	Continued From page 65 medications requiring disposal by the director. V120-10A NCAC 27G .0209 Medication Storage -The Director will ensure that all medications are stored in locked cabinets or storage areas inaccessible to consumers and unauthorized individuals. -Medications requiring refrigeration will be stored in locked containers within temperature-controlled refrigerators by the AP(AP/HM). -Separate storage will be maintained for internal, external, and controlled medications in accordance with regulatory standards, the director will ensure this. -Weekly medication storage checks will be conducted by designated staff. Monitoring Plan -The Director will ensure ongoing compliance by: -Conducting weekly medication storage inspections -Performing monthly MAR audits -Verifying staff medication training and competency documentation -Monitoring adherence to medication administration policies." Review on 2/19/26 of the amended Plan of Protection signed by the Licensee/Director/CEO and dated 2/19/26 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? -Immediate actions include: -The Director (Licensee/Director/CEO) conducted an immediate review of all medications on 02/12/2026 stored within the facility to verify proper labeling, storage conditions, and security. -All medications were secured in locked storage areas accessible only to authorized, trained staff as of 02/19/2026. -Expired, discontinued, or unused medications were identified and removed from active	V 118		

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V 118	Continued From page 66 medication storage areas during the active survey on the date of 02/12/2026 by the director. -Medication Administration Records (MARs) were reviewed to ensure accurate documentation and verification of physician orders as of 02/19/2026 this was completed. -The Director verified that only trained and authorized staff administer medications in accordance with facility policy and regulatory requirements on 02/19/2026 by going through each employee files. Describe your plans to make sure the above happens. -Beginning February 20, 2026, the Director will ensure ongoing compliance through the following corrective measures: V118-10A NCAC 27G .0209 Medication Administration -Medication orders will be verified prior to administration by the staff giving medication, and documentation will be completed on the MAR immediately after administration by the staff on shift. The director will continue to mointoir the MARS weekly to ensure compliance. This will start 02/19/2026 -Monthly Medication Administration Record (MAR) audits will be conducted by the Director to ensure accuracy, completeness, and compliance. The Director will perform these audits by reviewing MAR documentation at the end of each month and printing the finalized monthly MAR reports for verification and recordkeeping. V119-10A NCAC 27G .0209 Medication Disposal -The Director will ensure that expired, discontinued, or unused medications are removed from active storage immediately upon identification. This will start 02/19/2026. The director will do quarterly checks. -Medication disposal will be conducted according	V 118		

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V 118	Continued From page 67 to facility policy and documented appropriately, including verification by the director starting 02/19/2026. -Routine quarterly medication cabinet inspections will be conducted to identify and remove medications requiring disposal by the director starting 02/19/2026 V120-10A NCAC 27G .0209 Medication Storage -The Director will ensure that all medications are stored in locked cabinets or storage areas inaccessible to consumers and unauthorized individuals starting 02/19/2026. -Separate storage will be maintained for internal, external, and controlled medications in accordance with regulatory standards, the director will ensure this starting 02/19/2026 -Weekly medication storage checks will be conducted by designated staff or director starting 02/19/2026 Monitoring Plan -Monitoring adherence to medication administration." The facility served adolescents age 15 to 16 years old with diagnoses that include Borderline Personality Disorder, Attention Deficit Hyperactivity Disorder, Post Traumatic Stress Disorder, Major Depressive Disorder, Generalized Anxiety disorder, Oppositional Defiant Disorder, Adjustment Disorder. The facility did not administer clients #1's Abilify (11 days) and Sertraline (11 days) according to a physician order in December 2025 and did not administer client #1's Hydroxyzine 2 days in January 2026 according to the physician's order. Client #1's Hydroxyzine had expired, had not been removed from client #1's medication lockbox and had not been disposed. The facility had administered an antibacterial to client #2 that was not placed on the January MAR. Client #2	V 118		

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V 118	Continued From page 68 had her Albuterol and EpiPen with her in the facility, but these medication were not on her MAR and were not kept in client #2's medication lockbox. Client #2 had administered her Albuterol without a self administer order. Client #2 was placed on Trazadone without client #2's mother/legal guardian's consent. Client #2 was taken off Trazadone without a discontinue order. The AP/HM had administered over the counter melatonin to client #3 without a physician order. The facility did not have physician orders for discontinued medications. The facility's Registered Nurse had provided online, virtual training for medication administration instruction without an assessment and an observed medication pass for competency. A staff with the virtual medication administration training and no observed medication pass for competency had administered medications to client #1 a total of 77 days and, in January 2026 staff administered medication to client #2 a total of 3 days. This deficiency constitutes a Continuing Type A1 rule violation and must be corrected within 23 days.	V 118		
V 119	27G .0209 (D) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for	V 119		

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V 119	Continued From page 69 destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction. (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to dispose of all prescription medication in a manner that guards against diversion or accidental ingestion for one of three clients (#1). The findings are: Observation on 1/29/26 at approximately 2:05pm of client #1's medication storage box revealed: -Two bubble packs of Hydroxyzine 10mg (milligram). -Bubble pack #2, Hydroxyzine 10mg, take one tablet by mouth every eight hours as needed for anxiety: -"2/3" handwritten with black ink on the top right	V 119		

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V 119	Continued From page 70 corner, bubble pack had one pill. -"Discard after: 12/12/25." Interview on 1/29/26 with the Licensee/Director/Chief Executive Officer revealed: -She did not know that one of client #1's Hydroxyzine 10mg bubble pack had expired on 12/12/25. -The expired Hydroxyzine had not been administered to client #1. -She was person responsible for medication disposal. This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a continuing A1 rule violation and must be corrected within 23 days.	V 119		
V 120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently	V 120		

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V 120	Continued From page 71 registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure that all medications were stored in a secure manner for one of three clients (#2). The findings are: Observation on 2/10/26 at approximately 3:04pm in the facility revealed: -Staff #6 and Staff #8 went upstairs together and client #2 was getting out of the shower. - Staff #6, "surely it (Albuterol and EpiPen) wouldn't be with her that would probably with her meds (medications)." -Staff #8 confirmed, "it's (EpiPen) in there (client #2's bedroom). -Client #2 asked why her medications were needed. -Staff #6 brought the Albuterol and EpiPen downstairs. -Box with Epinephrine Injection (EpiPen), 0.3mg (Single-Dose Auto-Injectors); Fill date 01/12/2026; inject 0.3 mls (milliliter) into the muscle once as needed for anaphylaxis for up to 1 dose. -Albuterol Sulfate, Inhalation Aerosol, 90mcg (microgram) per activation; Shake well before use; Silver canister pump wrapped in information tap within a green plastic inhaler with yellow cap covering area for mouthpiece; counter window on opposite side of mouthpiece revealed 200. Interview on 2/10/26 and 2/17/26 with client #2	V 120		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWED BEGINNINGS HOME INC	13113 LAKEMORE DRIVE CHARLOTTE, NC 28278

(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 120	Continued From page 72 revealed: -Had an inhaler at admission that had expired and got a refill of the Albuterol on 1/12/26. -The Albuterol and EpiPen were not in her lockbox at the facility because they were as needed medications. -The Albuterol was kept in her book bag and the EpiPen was on the bookshelf in her bedroom at the facility. -Had used the Albuterol but not the EpiPen. -"The facility (Associate Professional/House Manager (AP/HM)] and Licensee/Director/Chief Executive Officer (CEO)) knew I had them (Albuterol and EpiPen) because I told them the day I got them (January 2026). I talk to [AP/HM] and called [Licensee/Director/CEO] to tell her and she said okay." Interview on 2/10/26 with client #2's mother/legal guardian (LG) revealed: -The AP/HM and Licensee/Director/CEO were aware client #2 was taken to a medical appointment on 1/12/26. -"I gave them all the paperwork with the summary and prescription (1/12/26)." -The prescription for the Albuterol and the EpiPen was to be filled by the facility but the medications were not filled. -She picked up the Albuterol and the EpiPen at the pharmacy, gave the medications to client #2, client #2 gave the medications to the facility and she followed up with the AP/HM in January 2026 by telephone to confirmed. -"I called [AP/HM] to confirm that they (facility) had gotten it (medication) and she said she received it...It wasn't like she (client #2) snuck medication in there (facility)." Interview on 2/11/26 and 2/20/26 with Staff 6 revealed:	V 120		

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V 120	Continued From page 73 -Client #2's Albuterol and EpiPen were not in client #2's lockbox with the rest of her medications. -Was not sure why the Albuterol and EpiPen were not kept in client #2's lockbox in the facility. -Assisted with retrieving the Albuterol that was in client #2's book bag and the EpiPen which was on a bookshelf in client #2's bedroom. Interview on 2/10/26 and 2/11/26 with Staff #8 revealed: -Was aware client #2 kept her EpiPen in her bedroom at the facility. --"I don't know, not sure why EpiPen and albuterol were not in med box." Interview on 2/16/26 with the AP/HM revealed: -"Not aware of EpiPen and Albuterol in [client #2]'s possession." Interview on 2/16/26 with the Licensee/Director/CEO revealed: -"EpiPen and Albuterol, that sounds like something she may have gotten from her mom (mother/LG) because we didn't pick those up. She probably got those from her mom." -"I don't know anything about that (Albuterol and EpiPen), this is all new information you are giving me. Don't know where this information is coming from." -There was not an order for client #2 to self-administer any medications. -Was aware of the 1/12/26 appointment with the gynecologist but was not sure if the facility had taken client #2 to that appointment. "I will have to check." No additional information was provided by the Licensee/Director/CEO about the 1/12/26 appointment for client #2 prior to survey exit.	V 120		

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V 120	Continued From page 74 This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a continuing A1 rule violation and must be corrected within 23 days.	V 120		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the	V 132		

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V 132	Continued From page 75 Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to protect the clients during an investigation. The findings are: Review on 1/28/26 of client #1's file revealed: -Age 16 years old; -Admitted on 12/2/24. -Diagnoses: Borderline Personality Disorder; Attention Deficit Hyperactivity Disorder; Post Traumatic Stress Disorder; Major Depressive Disorder, Recurrent, Moderate; Generalized Anxiety Disorder; Oppositional Defiant Disorder. Review on 1/28/26 of client #2's file revealed: -Age 16 years old. -Admitted on 10/4/25. -Diagnoses: Adjustment Disorder; Post Traumatic Stress Disorder, unspecified; Major Depressive Disorder, moderate; Generalized Anxiety Disorder Oppositional Defiant Disorder; Attention-Deficit/Hyperactivity Disorder, predominately Inattentive Presentation; Parental-Child Relational Problem Review on 1/28/26 of client #3's file revealed: -Age 15 years old. -Admitted on 10/15/25. -Diagnoses: Adjustment Disorder with mixed anxiety and depressed mood. Review on 2/3/26 of FS #12's personnel file revealed: -Hired 10/22/25. -Date of termination unknown. -Job Title Direct Support Professional (DSP).	V 132		

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V 132	Continued From page 76 Review on 1/28/26 of the Associate Professional/House Manager (AP/HM)'s personnel file revealed: -Hired 11/17/25. -Job Title AP. Review on 1/28/26 of the facility's records revealed: - An incident report dated 1/7/26 for client #2's elopement that occurred on 1/2/26 and involved assistance from FS #12 to return to the facility. -An incident report dated 1/13/26 for "Staff Policy Violation" related to FS #12 allowing client #2 the use of an "unauthorized cellular phone...engaged in inappropriate communication with the consumer (client #2) and instructed or coached the consumer on what to say to staff upon returning to the facility following an unauthorized absence (elopement)." -No documented evidence of an investigation by the facility for the allegation that the AP/HM grabbed client #3's arm on an unknown date. -No documentation of an allegation that the AP/HM grabbed client #3's arm on an unknown date. Review on 2/5/26 of the facility's records revealed: -"Investigation Report and Findings: Facility: Renewed Beginnings Group Homes; Incident Type: Elopement / Failure to Report / Unauthorized Cell Phone; Client: [#2]; Staff Member Involved: [FS #12]; Date of Incident: January 4, 2026; Date Investigation Concluded: January 13, 2026. -Investigation Summary: The investigation began on January 4, 2026, the date of the elopement. During the investigation, it was determined that staff member [FS #12] failed to report the elopement in accordance with facility policy. [FS	V 132		

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V 132	Continued From page 77 #12] was immediately removed from the facility pending the outcome of the investigation. During the investigation, [client #2] ' s mother contacted the facility and reported that she was in possession of a cell phone belonging to [client #2]. This information prompted a formal interview with [FS #12]. During the interview, [FS #12] admitted to giving the phone to [client #2], which was unauthorized and violated facility policy. -Findings: Failure to report a critical incident (elopement); Provision of unauthorized contraband (cell phone) to a client. -Outcome: Based on the findings, [FS #12] was terminated from employment due to policy violations. Additional staff reminders and reinforcement of reporting and supervision requirements were conducted to prevent future occurrences. -Investigation Status: Closed on January 13, 2026." -1/11/26 Department of Social Services (DSS) Child Protective Services Protection (CPS) Plan after investigation of allegation that the AP/HM grabbed client #3's arm on an unknown date. -No documented evidence of an investigation by the facility for the allegation that the AP/HM grabbed client #3's on an unknown date. Review on 2/5/26 and 2/6/26 of the facility's records provided by the Licensee/Director/CEO revealed: -Reporter Notification Letter, undated, of a report made to Department of Social Services on 1/14/26 for FS #12 providing client #2 "with an unauthorized cell phone and failed to report her (client #2) absence from the facility." -Letter dated 1/22/26 regarding FS #12 from the Health Care Personnel Registry (HCPR) Section of a report made to HCPR, "on or about 1/3/26."	V 132		

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V 132	Continued From page 78 Review on 2/12/26 of facility records provided by Licensee/Director/Chief Executive Officer (CEO) revealed: -A partial email was missing the email heading details. -The date of the email, the name of the sender and sender email address, the name of the email recipient and the recipient's email address were missing. -Message in the body of the email read: "Dear [FS #12], This letter serves as formal notice that you employment with the Renewed Beginnings Group Homes is terminated effective Immediately. This decision is based on a violation of company policy related to dishonesty and providing false information to leadership. Integrity and honesty are essential requirements of you position, and your actions have resulted in a loss of trust necessary to continue your employment...We wish you the best in your future endeavors. Sincerely [Licensee/Director/CEO]. -No documented date of termination for FS #12. Review on 2/13/26 of the Incident Response Improvement System from 12/20/25 to 2/13/26 revealed: -1/3/26, submitted 1/30/26, "The consumer (client #2) left the residence and was absent for approximately one to three hours. The consumer returned voluntarily. No injuries or medical concerns were observed upon return." -Allegation that the Associate Professional/House Manager (AP/HM) grabbed client #3's arm on an unknown date was added to the IRIS submission of client #3's elopement on 1/9/26, submitted 1/12/26, with HCPR report added on 1/12/26 "DSS (Department of Social Services) determine it was a false report after interviewing the consumer (client #3)." HCPR Facility Allegation was incomplete: "Your Supervisor must complete	V 132		

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V 132	Continued From page 79 the HCPR Facility Allegation section of this Incident Report." Interview on 2/4/26 with client #2 revealed: -FS #12 gave client #2 a cell phone on an unknown date. -Texted FS #12 during and after the elopement on 1/2/26 through 1/3/26. -FS#12 assisted with the elopement by pretending to check on client #2 during the night of 1/2/26 and early morning of 1/3/26. -Texted FS #12 when she was ready to return to the facility. Interview on 2/11/26 with client #3 revealed: -"The first time she (AP/HM) grabbed my arm was a couple of weeks after my worker (DSS) came, when I first got suspended from school, in November (2025)." -"She (AP/HM) grabbed my arm at the wrist (November 2025), and [FS #15] pulled me away from her (AP/HM) because [AP/HM] was trying to get the phone. [FS #15] took the phone, then [AP/HM] snatched it from [FS #15]." -In December 2025, "I was trying to fill balloons in the bathroom. [AP/HM] came in the bathroom and turned off the water. I went back to the bathroom and she (AP/HM) pushed me into the wall and kept pushing." Interview on 2/10/26 with client #2's mother/Legal Guardian revealed: -The facility knew that FS #12 had given client #2 a cell phone, "I honestly believe they knew about the phone before I knew, [AP/HM] said the kids (clients) were saying she (client #2) had the phone. They (facility) did a check when she (client #2) was gone with me (home visit) that Saturday the 3rd (1/3/26)." -"Instead of firing her (FS #12), they (facility)	V 132		

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V 132	Continued From page 80	V 132		

moved [FS #12] to the other house (sister facility) and that is when I started getting on their (facility) behind. I demanded her (FS #12) resignation. Don't understand why you would have a person who would encourage a child to jump out a window working for you."
-Sent screen shots to the AP/HM on 1/14/26 from the cell phone provided to client #2 by FS #12 along with her concerns about FS #12's continued employment.
-Licensee/Director/CEO responded to the mother/LG's concern by text that "she understood my concern and this is new information (cell phone given to client #2 by FS #12); liar, she knew and said she had just received the information (cell phone) in the last 24 hours, that was on Wednesday, January 14th (2026)."

Interview on 2/2/26 with FS #12 revealed:
-Gave client #2 a cell phone and exchanged texts with client #2 during and after client #2's elopement on 1/2/26.
-Was moved to the sister facility on 1/3/26 to continue working.
-"I got moved to [sister facility], so maybe I left (ended employment) January 15th (2026) because it was right after New Years. I was never removed from the working schedule."

Interview on 2/12/26 with anonymous staff #25 revealed:
-FS #12 "told me they (facility) took her (FS #12) off the schedule because one of the girls (client #2) jumped out the window (eloped) and she (FS #12) got blamed. They (facility) put her at the [sister facility] on third shift, she worked a couple of nights."

Interview on 2/3/26 with the AP/HM revealed:
-Denied the allegation that she grabbed client

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V 132	Continued From page 81 #3's arm. -Denied she had performed any restraints. -Did not discontinue working because the allegation that she grabbed client #3's arm was false and was unsubstantiated by DSS on 1/11/26. Interview on 2/5/26 and 2/26/26 with the Licensee/Director/CEO revealed: -Hadn't heard about the allegation that the AP/HM grabbed client #3's arm until CPS came to investigate the allegation in January 2026. -She had investigated both (phone and elopement) the allegation for FS #12's involvement in client #2's elopement on 1/13/26. -CPS completed the investigation of the allegation that the AP/HM grabbed client #3 on 1/11/26. -The investigation of FS #12's involvement in client #2's started on 1/4/26 and ended on 1/13/26 because the facility found out about the phone 2 weeks after the start of the investigation. -AP/HM worked during the DSS investigation and FS #12 also worked while client #2's elopement was investigated by facility. -Provided no documentation of a facility investigation once she learned of the allegation that the AP/HM grabbed client #3's arm on an unknown date. -The documentation of an investigation for the allegation that the AP/HM grabbed client #3's arm was completed by DSS on 1/11/26. -Provided no date of termination of employment for FS #12. -Denied that FS #12 was sent to the sister facility on 1/3/26 to work during the investigation. -FS #12 was terminated immediately.	V 132		

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V 293	Continued From page 82	V 293		
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 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	V 293		

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V 293	Continued From page 83 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 reviews and interviews the facility failed to minimize the occurrence of behaviors related to functional deficits, support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting and failed to coordinate with other individuals or agencies within the child or adolescent's system of care affecting three of three clients (#1, #2 and #3). The findings are: Cross Reference: 10A NCAC 27G .0203 Competencies of Qualified Professional and Associate Professional (V109). Based on record review, observations, and interviews, one of one Associate Professional (AP/House Manager (AP/HM)) failed to demonstrate the knowledge, skills and abilities required for the population served. Cross Reference: 10A NCAC 27G .0205: Assessment and Treatment/Habilitation/Service Plan (V112). Based on record reviews and	V 293		

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V 293	Continued From page 84 interviews, the facility failed to develop and implement with treatment strategies to address clients' needs in partnership with the legally responsible person for two of three clients (#1 and #2). Cross Reference: 10A NCAC 27G .0603: Incident Response Requirements (V366). Based on records review and interviews, the facility failed to implement written policies governing their response to Level I and II incidents. Cross Reference: 10A NCAC 27G .0604: Incident Reporting Requirements (V367). Based on records review and interviews, the facility failed to implement written policies governing their response to Level I and II incidents. Review on 1/28/26 of client #3's file revealed: -Age 15 years old. -Admitted on 10/15/25. -Diagnoses: Adjustment Disorder with mixed anxiety and depressed mood. Interview on 2/17/26 with client #1's Department of Social Services Social Worker/Legal Guardian (DSS SW/LG) revealed: -Facility discussed that client #1 "got into THC (Tetrahydrocannabinol), an edible." Interview on with client #2's mother/LG revealed: -Facility did not inform her of changes in clients medications prior to administration. -The Licensee/Director/CEO had made herself the primary school contact for client #2. -Was not getting client #2's school report cards and facility had not provided. -Was not getting school notifications of when client #2 was skipping school and facility had not provided.	V 293		

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V 293	Continued From page 85 Interview on with the Assistant Principal for clients #1 and #3 revealed: -The school had difficulty with communicating with and getting responses from the facility and the Licensee/Director/CEO. -"They (facility staff) will not provide us (school office) with a a real number, and only give us [internet based] numbers." -"They (facility staff) don't notify (school) if they take students out and the student just doesn't come back (school)." -The facility had not provided notification when client #1 and client #3 were transferred from the school to the day treatment program and had not provided the school. -Requested that the Licensee/Director/CEO provide the Day Treatment Program with the school information so a request be made for clients #1 and #3's school records. -The Licensee/Director/CEO did not provide the name of the Day Treatment Program to the school. -"There are multiple emails with them when we (school) requested for her (Licensee/Director/CEO) to come to student/parent teacher meetings." -A virtual meeting was scheduled with the facility and "they were 45 minutes late for a [virtual platform] meeting (date unknown)." . Interview on 2/11/26 with the Day Treatment Program Director revealed: -"We (Day Treatment Program staff) collaborate with the group home and social worker to get information (client)." -"[Client #1] must be new because [client #3] has been here for a while. [Client #1] came on 2/4/26." -The facility did not provide client #1 and #3's	V 293		

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V 293	Continued From page 86 school information at intake. Interview on 1/29/26 with anonymous former staff #15 revealed: -"I don't have any dates but the school (clients') keeps a record and they (school) have threatened a couple of times to call DSS (Department of Social Services). They (school) have requested to have meetings with [Licensee/Director/CEO] and she never shows up." -"The girls (clients) attend [high school]; they (school) request meetings and [Licensee/Director/CEO] gets around them." -"[Licensee/Director/CEO] got her own program (way of doing things) when she do what she want to do." -"She (Licensee/Director/CEO) told us (staff) not to tell the school that [client #3] was at a behavior school before she came to us (facility), so she (client #3) could go to a regular school and when I was there [client #3] was getting in trouble every day (at school)." -"[Licensee/Director/CEO] would lie on their paperwork (school). [Client #3] supposed to be in a behavior school and you (Licensee/Director/CEO) got her in a regular school." -"It (program issues) was just a lot, that's why I left and that's what other people (staff) who left said. There was too much going on that they (staff) didn't like and didn't agree with." Interview on 2/5/26 with the Licensee/Director/CEO revealed: -She coordinated treatment services with agencies, LGs and school. -Communicated with school and LGs by phone and email. Review on 2/19/26 of the Plan of Protection	V 293		

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V 293	Continued From page 87 signed by the Licensee/Director/CEO and dated 2/19/26 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? -The Director (Licensee/Director/CEO) conducted a review of all Qualified Professional (QP) and Associate Professional (AP (AP/HM)) personnel records to verify competency documentation and supervision qualifications. -The Director reviewed all active Individualized Service Plans (ISPs) to ensure that each consumer has a current, person-centered treatment plan addressing their needs and safety risks. -The Director confirmed that staff understand and follow incident response procedures, including immediate protection of consumers during behavioral, medical, or safety incidents. -All staff were immediately reminded of requirements for timely incident reporting, documentation, and notification procedures to ensure consumer safety. -The Director verified that staffing coverage, clinical oversight, and service delivery continue without interruption, and no consumers were placed at risk as a result of the identified deficiencies. Describe your plans to make sure the above happens. Beginning February 20, 2026, the Director (Licensee/Director/CEO) will ensure ongoing compliance through the following corrective measures: V109-10A NCAC 27G .0203 Competencies of QP/AP -The Director will ensure all Qualified Professionals and Associate Professionals maintain documented competency verification in personnel files.	V 293		

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V 293	Continued From page 88 -Competency will include verification of technical knowledge, clinical skills, communication skills, analytical ability, decision-making, cultural awareness, and interpersonal skills. -Annual competency reviews and supervision documentation will be maintained and monitored monthly. V112-10A NCAC 27G .0205 Assessment and Treatment/Service Planning -The Director will ensure that all consumers have current assessments and individualized service plans completed, reviewed, and updated within required timeframes. -Treatment plans will reflect measurable goals, interventions, and clinical oversight appropriate to the consumer's needs. -Monthly record reviews will be conducted to verify compliance and accuracy. V293-10A NCAC 27G .1701 Scope -The Director will ensure that services provided are consistent with the facility's licensed scope of service and population served. -Staff roles and service delivery practices will be reviewed to confirm alignment with regulatory requirements. -Ongoing oversight will ensure that consumers receive appropriate levels of supervision and treatment services. V366-10A NCAC 27G .0603 Incident Response Requirements -The Director will ensure staff respond immediately to incidents to protect consumer safety, including securing the environment, providing supervision, and obtaining medical or clinical assistance when necessary. -Staff will receive reinforcement training on incident response procedures to ensure proper intervention and safety measures. V367-10A NCAC 27G .0604 Incident Reporting Requirements	V 293		

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V 293	Continued From page 89 -The Director will ensure that all reportable incidents are documented and reported within required timeframes. -Incident reports will be reviewed promptly to ensure accuracy, follow-up actions, and appropriate notifications. -Monthly incident report audits will be conducted to verify compliance." Review on 2/19/26 of the amended Plan of Protection signed by the Licensee/Director/CEO and dated 2/19/26 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? -The Director (Licensee/Director/CEO) conducted a review of all Qualified Professional (QP) and Associate Professional (AP(AP/HM)) personnel records to verify competency documentation and supervision qualifications on 2/19/2026 -The Director reviewed all active Individualized Service Plans (ISPs) when 2/18/2025 to ensure that each consumer has a current, person-centered treatment plan addressing their needs and safety risks. The way we address the needs were ensuring the goals align with PCP (Person Centered Plan) and consumer goals. Corrections were made as needed. -The Director confirmed on 02/19/2026 that staff understand and follow incident response procedures, including immediate protection of consumers during behavioral, medical, or safety incidents by having individual meetings with staff and asked them questions to know that they understand. -All staff were immediately reminded by the director on 02/19/2026 over our group chat of requirements for timely incident reporting, documentation, and notification procedures to ensure consumer safety. -The Director on 02/19/2026 verified that staffing	V 293		

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V 293	Continued From page 90 coverage, clinical oversight, and service delivery continue without interruption, and no consumers were placed at risk as a result of the identified deficiencies. Describe your plans to make sure the above happens. Beginning February 20, 2026, the Director will ensure ongoing compliance in a timely manner through immediate review, scheduled oversight activities, and continuous monitoring as outlined below. V109-10A NCAC 27G .0203 Competencies of QP/AP -To address this requirement promptly, the Director will conduct an immediate review of all Qualified Professional (QP) and Associate Professional (AP) personnel files to verify competency documentation. Beginning February 23, 2026, the Director will: -Ensure all QP/AP staff maintain documented competency verification in their personnel files. -Verify competencies including technical knowledge, clinical skills, communication, analytical ability, decision-making, cultural awareness, and interpersonal skills. -Conduct monthly monitoring of supervision documentation and annual competency reviews to ensure ongoing compliance. V112-10A NCAC 27G .0205 Assessment and Treatment/Service Planning -To address this requirement in a timely manner, the Director will complete an immediate review of all active consumer records. Beginning February 23, 2026, the Director will: -Ensure all consumers have current assessments and individualized service plans completed, reviewed, and updated within required timeframes. -Verify that treatment plans reflect measurable	V 293		

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goals, appropriate interventions, and clinical oversight.
-Conduct monthly record audits to ensure accuracy, timeliness, and compliance.
V293-10A NCAC 27G .1701 Scope (Coordination of Care)
-To ensure timely correction, the Director will immediately review service delivery practices to confirm alignment with the facility's licensed scope of services.
Ongoing actions include:
-Monitoring staff roles and service delivery to ensure services remain consistent with regulatory requirements and the population served.
-Providing continuous oversight to ensure consumers receive appropriate supervision, treatment services, and coordination of care.
-Conducting routine supervisory reviews to maintain compliance.
V366-10A NCAC 27G .0603 Incident Response Requirements
-To address this requirement promptly, the Director will immediately reinforce staff responsibilities related to incident response.
On February 23, 2026, the Director will conduct a staff training meeting to:
-Review procedures for immediate incident response, including securing the environment, providing supervision, and obtaining medical or clinical assistance when necessary.
-Reinforce staff expectations for protecting consumer safety during incidents.
-Ongoing monitoring will ensure staff continue to follow proper response procedures.
V367-10A NCAC 27G .0604 Incident Reporting Requirements
-To ensure timely compliance, the Director will immediately implement oversight procedures for incident reporting.
Beginning February 20, 2026, the Director will:

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V 293	Continued From page 92 -Monitor incidents as they occur to ensure staff report them promptly to appropriate parties. -Review all incident reports to verify accuracy, documentation completeness, follow-up actions, and required notifications. -Conduct monthly incident report audits to ensure continued compliance with reporting requirements." The facility serves adolescents ages 15-16 years with diagnoses including Borderline Personality Disorder, Attention Deficit Hyperactivity Disorder, Post Traumatic Stress Disorder, Major Depressive Disorder, Generalized Anxiety Disorder, Oppositional Defiant Disorder, and Adjustment Disorder. The facility's Associate Professional/House Manager (AP/HM) spoke to clients in an aggressive tone and allowed facility rules to be undermined by providing clients with laptops when other staff were instructed not to allow the use of laptops. The AP/HM vaped inside the facility. The AP/HM's interactions with clients were reported to trigger negative client behaviors. Treatment planning for clients #1 and #2 was not based on clients' needs. Treatment plans did not have goals and strategies to address behaviors such as escalating defiant behaviors, aggression, school fights, suspensions, mood swings, substance use, domestic violence, suicidal ideation (including cutting wrists and overdose), elopement, and plans related to employment, self-sufficiency, and possible emancipation. There were not effective dates on client #1 and #2 treatment plans and treatment plans for client #1 and client #2 were not signed by the clients' legal guardians. The facility did not respond to incidents as required and did not report all level I and level II incidents. The facility did not coordinate with other individuals and agencies	V 293		

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V 293	Continued From page 93 within each clients' system of care which included, clinicians, legal guardians and school officials. The facility did not have systems in place to minimize behaviors, assist adaptive functioning and support clients in gaining skills needed to step down to a less intensive setting. This deficiency constitutes an Imposed B rule violation and must be corrected within 24 days.	V 293		
V 318	13O .0102 HCPR - 24 Hour Reporting 10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g). This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report an allegation of neglect to the Health Care Personnel Registry (HCPR) within 24 hours of becoming aware of the allegation(s) and failed to notify HCPR of the	V 318		

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V 318	Continued From page 94 results of all investigations within five working days of the initial notification to HCPR affecting clients #2 and #3. The findings are: Review on 1/28/26 of client #2's file revealed: -Age 16 years old. -Admitted on 10/4/25. -Diagnoses: Adjustment Disorder; Post Traumatic Stress Disorder, unspecified; Major Depressive Disorder, moderate; Generalized Anxiety Disorder Oppositional Defiant Disorder; Attention-Deficit/Hyperactivity Disorder, predominately Inattentive Presentation; Parental-Child Relational Problem Review on 1/28/26 of client #3's file revealed: -Age 15 years old. -Admitted on 10/15/25. -Diagnosis: Adjustment Disorder with mixed anxiety and depressed mood. Review on 2/3/26 of FS #12's personnel file revealed: -Hired 10/22/25. -Date of termination unknown. -Job Title Direct Support Professional (DSP). Review on 1/28/26 of the Associate Professional/House Manager (AP/HM)'s personnel file revealed: -Hired 11/17/25. -Job Title AP. Review on 2/5/26/of the Incident Response Improvement System (IRIS) from 12/20/25 to 2/5/26 revealed: -1/3/26, submitted 1/30/26, "The consumer (client #2) left the residence and was absent for approximately one to three hours. The consumer returned voluntarily. No injuries or medical	V 318		

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concerns were observed upon return."
-Allegation that the Associate Professional/House Manager (AP/HM) grabbed client #3's arm on an unknown date was added to the IRIS submission of client #3's elopement on 1/9/26, submitted 1/12/26, with HCPR report added on 1/12/26 "DSS (Department of Social Services) determine it was a false report after interviewing the consumer (client #3)." HCPR Facility Allegation was incomplete: "Your Supervisor must complete the HCPR Facility Allegation section of this Incident Report."

Review on 1/28/26 of the facility's records revealed:
- An incident report dated 1/7/26 for client #2's elopement that occurred on 1/2/26 and involved assistance from FS #12 to return to the facility.
-An incident report dated 1/13/26 for "Staff Policy Violation" related to FS #12 allowing client #2 the use of an "unauthorized cellular phone...engaged in inappropriate communication with the consumer (client #2) and instructed or coached the consumer on what to say to staff upon returning to the facility following an unauthorized absence (elopement)."
-No documented evidence of an investigation by the facility for the allegation that the AP/HM grabbed client #3's arm on unknown date.
-No documentation of an allegation that the AP/HM grabbed client #3's arm on an unknown date.

Review on 2/5/26 of the facility's records revealed:
-"Investigation Report and Findings: Facility: Renewed Beginnings Group Homes; Incident Type: Elopement / Failure to Report / Unauthorized Cell Phone; Client: [#2]; Staff Member Involved: [FS #12]; Date of Incident:

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V 318	Continued From page 96 January 4, 2026; Date Investigation Concluded: January 13, 2026. -Purpose of Investigation: The purpose of this investigation was to determine the circumstances surrounding the elopement of client [#2] on January 4, 2026, assess staff compliance with reporting requirements, and identify policy violations or corrective actions required to ensure client safety. -Investigation Summary: The investigation began on January 4, 2026, the date of the elopement. During the investigation, it was determined that staff member [FS #12] failed to report the elopement in accordance with facility policy. [FS #12] was immediately removed from the facility pending the outcome of the investigation. During the investigation, [client #2] ' s mother contacted the facility and reported that she was in possession of a cell phone belonging to [client #2]. This information prompted a formal interview with [FS #12]. During the interview, [FS #12] admitted to giving the phone to [client #2]., which was unauthorized and violated facility policy. -Findings: Failure to report a critical incident (elopement); Provision of unauthorized contraband (cell phone) to a client. -Outcome: Based on the findings, [FS #12] was terminated from employment due to policy violations. Additional staff reminders and reinforcement of reporting and supervision requirements were conducted to prevent future occurrences. -Investigation Status: Closed on January 13, 2026." -No documented evidence of an investigation by the facility for the allegation that the AP/HM grabbed client #3's on an unknown date. Review on 2/5/26 and 2/6/26 of the facility's records provided by the Licensee/Director/CEO	V 318		

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V 318	Continued From page 97 revealed: -Reporter Notification Letter, undated, of a report made to Department of Social Services on 1/14/26 for FS #12 providing client #2 "with an unauthorized cell phone and failed to report her (client #2) absence from the facility." -Letter dated 1/22/26 regarding FS #12 from the Health Care Personnel Registry (HCPR) Section of a report made to HCPR, "on or about 1/3/26." Interview on 2/4/26 with client #2 revealed: -FS #12 gave client #2 a cell phone on an unknown date. -Texted FS #12 during and after the elopement on 1/2/26 through 1/3/26. -FS#12 assisted with the elopement by pretending to check on client #2 during the night of 1/2/26 and early morning of 1/3/26. -Texted FS #12 when she was ready to return to the facility. Interview on 2/11/26 with client #3 revealed: -"The first time she (AP/HM) grabbed my arm was a couple of weeks after my worker (DSS) came, when I first got suspended from school, in November (2025)." -"She (AP/HM) grabbed my arm at the wrist (November 2025), and [FS #15] pulled me away from her (AP/HM) because [AP/HM] was trying to get the phone. [FS #15] took the phone, then [AP/HM] snatched it from [FS #15]." -In December 2025, "I was trying to fill balloons in the bathroom. [AP/HM] came in the bathroom and turned off the water. I went back to the bathroom and she (AP/HM) pushed me into the wall and kept pushing." Interview on 2/2/26 with FS #12 revealed: -Gave client #2 a cell phone. -Client #2 texted FS #12 when she was ready to	V 318		

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V 318	Continued From page 98	V 318		

return to the facility on 1/3/26.
-The facility camera caught client #2's return and FS #12 assisted to get client #2 back into the facility at 4am on 1/3/26.
-The facility camera time stamped client #2's return to the facility.
-Was moved to the sister facility on 1/3/26 to continue working.
-"I got moved to [sister facility], so maybe I left (ended employment) January 15th (2026) because it was right after New Years. I was never removed from the working schedule."

Interview on 2/3/26 with the AP/HM revealed:
-Denied the allegation that she grabbed client #3's arm.
-Denied she had performed any restraints.
-Did not discontinue working because it was a false allegation.
-The allegation that she grabbed client #3's arm on an unknown date was unsubstantiated by DSS on 1/11/26.
-The Licensee/Director/Chief Executive Officer (CEO) was responsible for making reports to IRIS and HCPR.

Interview on 2/5/26 and 2/26/26 with the Licensee/Director/CEO revealed:
-Hadn't heard about the allegation that the AP/HM grabbed client #3's arm until CPS came to investigate the allegation in January 2026.
-Had investigated both (phone and elopement) the allegation for client #2's elopement on 1/13/26 and CPS had investigated the allegation that the AP/HM grabbed client #3 on 1/11/26.
-Did not notify HCPR within 24 hours of learning of FS#12's providing a cell phone and coaching client #2 during 1/2/26 elopement.
-Did not notify HCPR within 24 hours of learning of the allegation that the AP/HM grabbed client

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V 318	Continued From page 99 #3's arm. -Did not notify HCPR of the results of all investigations within five working days of the initial notification to HCPR.	V 318		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall	V 366		

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V 366	Continued From page 100 develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues	V 366		

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V 366	Continued From page 101 identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to implement written policies governing their response to Level I and II incidents. The findings are: Review on 2/12/26 of client #1's Clinical Assessment Addendum dated 2/1/26 provided by the Licensee/Director/Chief Executive Office (CEO) revealed: -Dated 2/1/26 and signed by the Licensed	V 366		

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V 366	Continued From page 102 Professional. -"This addendum supplements the prior comprehensive clinical assessment (4/29/24) due to escalating defiant behaviors, substance use, and a change in educational placement. The juvenile (client #1) has demonstrated increased oppositional behaviors and confirmed marijuana use, resulting in impaired academic and behavioral functioning. As a result, the juvenile is being referred to a therapeutic day treatment program in lieu of traditional public-school attendance. Within the last week the client had to be taken to the emergency room twice following the client ingesting cannabis-infused substances, as well as smoking marijuana and utilizing vaporizing devices (vapes) indicating ongoing substance use concerns. Clinical Impression: The client continues to exhibit persistent high-risk behaviors including substance use, defiance toward authority figures, and limited accountability for actions with limited response to current interventions. While medication compliance is noted, emotional regulation remains impaired, with low frustration tolerance and poor impulse control. A higher level of structured care such as Day Treatment with integrated substance abuse counseling is strongly recommended to address these concerns and reduce risk. If behaviors continue to persist, a PRTF (Psychiatric Residential Treatment Facility) residential facility may need to be explored to ensure continuity of care." Review on 1/28/26 of the facility's internal incident reports revealed: -No evidence of documentation of level I incident reports of client #1's "escalating defiant behaviors, ...smoking marijuana and utilizing vaping devices (vapes)...ongoing substance	V 366		

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V 366	Continued From page 103 use...increased oppositional behaviors...Behavioral dysregulation, and poor response to authority as reported by the Licensed Professional in client #1's updated Comprehensive Clinical Assessment Addendum dated 2/1/26." Review on 1/28/26 and 2/5/26 of the facility's records revealed: -There was no documentation of the facility's response to the cause of the incident 1/2/26 of client #2's elopement with the details that client #2 was provided a cell phone by FS #12, had communication by text with FS #12 during and after the elopement 1/3/26; developed and implemented corrective measures according to the provider specified timeframes not to exceed 45 days; no measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days and assigned person(s) to be responsible for implementation of the corrections and preventive measures. -There was no documentation of the facility's response to the cause of the incident on 1/29/26 with details of client #1's overdose after she consumed an edible on 1/29/26; developed and implemented corrective measures according to the provider specified timeframes not to exceed 45 days; no measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days and assigned person(s) to be responsible for implementation of the corrections and preventive measures. Review on 2/13/26 of the Incident Response Improvement System from 12/20/25 to 2/13/26 revealed: -1/3/26, submitted on 1/30/26, The consumer (client #2) left the residence (facility) and was absent for approximately one to three hours. The	V 366		

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V 366	Continued From page 104 consumer returned voluntarily. No injuries or medical concerns were observed upon return. -Did not provide additional details of the 1/2/26 elopement of client #2 from the facility, that a cell phone was provided to client #2 by FS #12 on unknown date, and client #2's communication with FS #12 on 1/2/26 and 1/3/26 to assist client #2 with eloping, returning to the facility after the elopement and coaching to client #2 on what to tell the facility. -1/29/26, submitted 1/30/26, [Client #1] consumed an edible while at school. Due to periods of altered consciousness, school staff contacted emergency medical services. [Client #1] was transported to the hospital for evaluation and testing. -Did not provide additional details of the 1/29/26 report that client #1 consumed an edible of what type and the resulting overdose. Interview on 2/10/26 with the Assistant Principal from client #1's school revealed: -"If something happens (with clients) they (facility staff) are not responsive..." -When client #1 was sent to the hospital by the school on 1/29/26, the facility was notified to come to the school within an hour or the school would transport by emergency medical services (EMS). -"When we (school staff) send students to the hospital, their guardian has to be with them. We tell them (facility staff) they have an hour to get here (school). No one (from facility) comes within an hour." -They (facility staff) always deny transfer (EMS) if they can get here and they get mad if we transfer their student." -"Last week (1/29//26) the student (client #1) ODed (overdosed) on fentanyl, the report came from the hospital. It was an edible that was	V 366		

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V 366	Continued From page 105 fentanyl; got back from hospital at 2am and they (facility staff) sent her (client #1) to school the next day, and she was lethargic...we called and asked them why is she here today?" Interview on 1/16/26 with the Licensee/Director/CEO revealed: -Was the person responsible for the facility's response to incidents. -Had responded to client #2's elopement and FS #12's involvement with the elopement by terminating FS #12, termination date unknown. -The edible consumed by client #1 had been THC (Tetrahydrocannabinol). -"We (facility) responded to that (client #1's overdose)." -Had responded to client #1's overdose by going to the hospital to visit client #1 in the emergency room, took client #1 out of school, reported the incident to the guardian, and did a group with clients (#1, #2, and #3) about knowing who your friends are. This deficiency constitutes a recited deficiency and must be corrected within 30 days. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for an Imposed B rule violation and must be corrected within 45 days.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during	V 367		

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V 367	Continued From page 106 the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and	V 367		

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V 367	Continued From page 107 (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.	V 367		

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V 367	Continued From page 108 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report all level II incidents in the Incident Response Improvement System (IRIS) and failed to notify the Local Management Entity (LME)/Managed Care Organization (MCO) responsible for the catchment area where services were provided as required. The findings are: Review on 2/13/26 of the Incident Response Improvement System (IRIS) from 12/20/25 to 2/13/26 revealed: -1/3/26, submitted on 1/30/26, The consumer (client #2) left the residence (facility) and was absent for approximately one to three hours. The consumer returned voluntarily. No injuries or medical concerns were observed upon return. -Did not provide additional details of the 1/2/26 elopement of client #2 from the facility, that a cell phone was provided to client #2 by FS #12 on unknown date, and client #2's communication with FS #12 on 1/2/26 and 1/3/26 to assist client #2 with eloping, returning to the facility after the elopement and coaching to client #2 on what to tell the facility. -1/29/26, submitted 1/30/26, [Client #1] consumed an edible while at school. Due to periods of altered consciousness, school staff contacted emergency medical services. [Client #1] was transported to the hospital for evaluation and testing. -Did not provide additional details of the 1/29/26 report that client #1 consumed an edible of what type, the resulting overdose and the outcome of the hospital evaluation and testing.	V 367		

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V 367	Continued From page 109 Interview on 2/10/26 with the Assistant Principal from client #1's school revealed: -"Last week (1/29//26) the student (client #1) ODed (overdosed) on fentanyl, the report came from the hospital. It was an edible that was fentanyl; got back from hospital at 2am and they (facility staff) sent her (client #1) to school the next day, and she was lethargic...we called and asked them why is she here today?" Interview on with the anonymous staff (AS) #32 revealed: -Had not done an IRIS report before. -"[Former Qualified Professional (FQP/spouse of the Licensee/Director/Chief Executive Officer (CEO)] did the IRIS in the past as a QP, so he (FQP/Spouse of Licensee/Director/CEO) talked me through the IRIS while on the phone with him. He coached me through it (IRIS) because I didn't know what the IRIS report was..." -"I was told (by Licensee/Director/CEO and Associate Professional/House Manager (AP/HM)) she (client #1) took an edible and she was going in and out of consciousness and the school called the paramedics." -The Licensee/Director/CEO and AP/HM visited client #1 at the hospital on 1/29/26 and client #1 came home the same night. -[The Licensee/Director/CEO and AP/HM] told me that what she (client #1) took was interfering with her medication, but didn't tell me what she took, just said it was some kind of edible, but I know that an edible could be marijuana or something else...I was told to do the IRIS report for the incident (1/29/26)." Interview on 1/16/26 with the Licensee/Director/CEO revealed: -The QP was responsible for IRIS reports.	V 367		

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(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 367	Continued From page 110 -Had reported client #2's elopement in IRIS. -The edible consumed by client #1 had been THC (Tetrahydrocannabinol). -Had reported reported in IRIS that client #1 overdosed. This deficiency constitutes a recited deficiency and must be corrected within 30 days. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for an Imposed B rule violation and must be corrected within 45 days.	V 367		
V 503	27D .0103 Client Rights - Search And Seizure Policy 10A NCAC 27D .0103 SEARCH AND SEIZURE POLICY (a) Each client shall be free from unwarranted invasion of privacy. (b) The governing body shall develop and implement policy that specifies the conditions under which searches of the client or his living area may occur, and if permitted, the procedures for seizure of the client's belongings, or property in the possession of the client. (c) Every search or seizure shall be documented. Documentation shall include: (1) scope of search; (2) reason for search; (3) procedures followed in the search; (4) a description of any property seized; and (5) an account of the disposition of seized property.	V 503		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601608	A. BUILDING: _____ B. WING _____	R-C 02/20/2026

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V 503	Continued From page 111 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure every search or seizure was documented as required. The findings are: Review on 1/28/26 of client #2's file revealed: -Age 16 years old. -Admitted on 10/4/25. -Diagnoses: Adjustment Disorder; Post Traumatic Stress Disorder, unspecified; Major Depressive Disorder, moderate; Generalized Anxiety Disorder Oppositional Defiant Disorder; Attention-Deficit/Hyperactivity Disorder, predominately Inattentive Presentation; Parental-Child Relational Problem. Review on 2/12/26 of the facility's records revealed: -1/4/26, search of client #2's room for cell phone and laptop. -Client #2 was not present during the search on 1/4/26. -No documentation of a search of client #2's belongings in December 2025. -No documentation of a search of client #2's room on 11/6/25 Interview on 2/4/26 with client #2 revealed: -Admitted she used to smoke vapes, does not smoke and still has urges. -In December 2025, before Christmas, she found a vape that belonged to former staff #13 and she was trying to return it to AFS #13 away from the cameras in the facility when AFS #15 caught client #2 with the vape. -AFS #15 "accused me of smoking [AFS #13]'s vape when she (AFS #13) left it on the couch (in the facility)." Interview on 2/5/26 of client #2's mother/legal	V 503		

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V 503	Continued From page 112 guardian revealed: -There had been a search of client #2's room on 1/4/26 when the facility was searching for the cell phone client #2 had in her possession. -Client #2 got the cell phone from FS #12 and the mother/legal guardian found the phone in client #2's possession on 1/4/26. Interview on 2/16/26 with AFS #15 revealed: - A "weed pen (marijuana) and an cell phone" was found during a search of client #2's room on 11/6/25. -Client #2 had the cell phone and weed pen since 10/24/25-10/26/25. -She made client #2 write and sign a note of the items found in the 11/6/25 room search. -She wrote the report, entered the report in the electronic health system on 11/6/25 at 7:48pm, and informed the Licensee/Director/CEO that the weed pen and cell phone had been found during the room search on 11/6/25. Interview on 2/5/26 with anonymous staff #20 revealed: -In December 2025, there was vape found in the facility by client #2, "it was not Staff #13's, it was somebody else (unknown)" -Client #2's room had been searched in December 2025 after client #2 stole a vape from school and clients #1 and #2 told staff that client #2 had a vape. -Searches are done by probable cause and she had never had to do a search at the facility. Interview on 2/16/26 with the Associate Professional/House Manager (AP/HM) revealed: -Client #2's room had been searched in December 2025, after Christmas, for a phone and laptop. -There was a room search of client #2's room in	V 503		

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V 503	Continued From page 113 November 2025 before she was employed when a vape was found. -There was a report for the vape found in November 2025 and she had read the report. -Was not aware of other searches. Interview on 2/12/26 with the Licensee/Director/Chief Executive Officer revealed: -The facility had documented every search and seizure. -All documented searches had been provided. -There was no search and seizure log that documented every search and seizure.	V 503		