Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-333	A. BUILDING: ______ B. WING ______	R 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME BUIL	**703 WEST 3RD AVENUE (BUILDING B) RED SPRINGS, NC 28377**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and follow up survey was completed on February 20, 2026. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1800 Intensive Residential Treatment for Children and Adolescents. This facility is licensed for 12 and has a current census of 5. The survey sample consisted of audits of 4 current clients.	V 000	RECEIVED MAR 18 2026 DHSR-MH Licensure Sect	
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes. (b) The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate the facility's response to fire emergencies. (d) Each facility shall have a first aid kit accessible for use. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure the disaster drills were held at least quarterly and repeated on each shift.	V 114	V114 Facility will ensure that fire and disaster drills are held quarterly per shift. Executive Director will ensure that fire and disaster drills are held quarterly per shift. Executive Director will monitor monthly to ensure that drills are performed as indicated and documentation is present to support all drills.	4/21/2026

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laura Jacobs, QP / Executive Director
TITLE
(X6) DATE: 3/13/2026

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V 114	Continued From page 1 The findings are: Review on 2/20/26 of the facility's disaster drills for the third quarter of 2025 revealed: -October 2025-December 2025 -No first shift 7am-3pm disaster drills documented. -No third shift 11pm-7am disaster drills documented. Interview on 2/19/26 client #1 stated: -He resided at the facility for 5 months. -He had participated in one disaster drill while at the facility. Interview on 2/19/26 client #3 stated: -He remembered completing fire drills but has never completed disaster drill. Interview on 2/19/26 client #4 stated: -He did fire and disaster drills twice weekly. -Clients got into the hallway with hands on their heads for tornado drills. Interview on 2/19/26 the Qualified Professional stated: -Shifts are first shift 7am-3pm, second shift 3pm-11pm, third shift 11pm-7am seven days a week. -She would ensure fire and disaster drills were completed and documented.	V 114		
V 519	27E .0104(e3-7) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions	V 519		

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V 519	Continued From page 2 may be used, the policy and procedures shall be in accordance with the following provisions: (3) the process for identifying, training, assessing competence of facility employees who may authorize and implement restrictive interventions; (4) the duties and responsibilities of responsible professionals regarding the use of restrictive interventions; (5) the person responsible for documentation when restrictive interventions are used; (6) the person responsible for the notification of others when restrictive interventions are used; and (7) the person responsible for checking the client's physical and psychological well-being and assessing the possible consequences of the use of a restrictive intervention and, in such cases there shall be procedures regarding: (A) documentation if a client has a physical disability or has had surgery that would make affected nerves and bones sensitive to injury; and (B) the identification and documentation of alternative emergency procedures, if needed; This Rule is not met as evidenced by: Based on record reviews and interview the facility failed to develop and implement policy and procedures for restrictive interventions as required. The findings are: Review on 02/20/26 of the facility policy for restrictive interventions effective 1/15/26 revealed the following requirements were not included: -The process for identifying, training, assessing competence of facility employees who may authorize and implement restrictive interventions. -The duties and responsibilities of responsible professionals regarding the use of restrictive	V 519	V519 Facility will ensure that the policy and procedures for restrictive interventions address all the identified components to include: process for identifying, training, and assessing competence of facility employees who may authorize and implement restrictive interventions; the duties and responsibilities of responsible professionals regarding the use of restrictive interventions; the person responsible for documentation when restrictive interventions were used; and the person responsible for the notification of others when restrictive interventions are used. The facility policy will be revised to include all necessary components. Executive Director will monitor monthly.	3/22/2026

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V 519	Continued From page 3 interventions. -The person responsible for documentation when restrictive were used. -The person responsible for the notification of others when restrictive interventions are used. Interview 02/20/26 the Director/Qualified Professional stated: -The restrictive intervention policy was revised in 2018. -The current policy would be reviewed to ensure it reflected the required language for restrictive interventions.	V 519		
V 525	27E .0104(e17) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (17) The facility shall conduct reviews and reports on any and all use of restrictive interventions, including: (A) a regular review by a designee of the governing body, and review by the Client Rights Committee, in compliance with confidentiality rules as specified in 10A NCAC 28A; (B) an investigation of any unusual or possibly unwarranted patterns of utilization; and (C) documentation of the following shall be maintained on a log: (i) name of the client; (ii) name of the responsible professional; (iii) date of each intervention; (iv) time of each intervention; (v) type of intervention;	V 525		

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V 525	Continued From page 4 (vi) duration of each intervention; (vii) reason for use of the intervention; (viii) positive and less restrictive alternatives that were used or that were considered but not used and why those alternatives were not used; (ix) debriefing and planning conducted with the client, legally responsible person, if applicable, and staff, as specified in Parts (e)(9)(F) and (G) of this Rule, to eliminate or reduce the probability of the future use of restrictive interventions; and (x) negative effects of the restrictive intervention, if any, on the physical and psychological well-being of the client. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to maintain a restrictive intervention log with debriefing and planning conducted with staff. The findings are: Review on 02/19/26 of client #1's record revealed: -13 year old male. -Admission date of 10/13/25. -Diagnoses of Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder and Mild Intellectual Developmental Disability. Review on 02/19/26 and 02/20/26 of the restrictive intervention log for client #1 revealed: 12/26/25 at 3:40pm -5 minute standing restraint. -No documentation of debriefing with staff. 12/08/25 at 10:45am -1 minute standing restraint. -No documentation of debriefing with staff. 11/22/25 at 2:45pm	V 525	V525 Facility will ensure that when restrictive interventions are utilized that the policy/procedure shall include a review/report of all restrictive interventions to include: regular review by a Client Rights Committee; investigation of any unusual or unwarranted patterns of utilization and documentation of the following maintained on a log: name of client, name of responsible professional, date of intervention, time of intervention, duration of intervention, reason for use of intervention, positive and less restrictive alternatives that were used or considered but not used and why those alternatives were not used, debriefing and planning conducted with the client, legally responsible person and staff to eliminate or reduce the probability of the future use of	3/22/2026

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V 525	Continued From page 5 -1 minute standing restraint. -No documentation of debriefing with staff. Interview on 02/19/26 and 02/20/26 the Executive Director stated: -She served as the Qualified Professional for the facility. -She completed the documentation when restraints were used at the facility. -Staff were debriefed after every restraint. -She was not able to locate the staff debriefing for client #1's restrictive interventions on 12/26/25, 12/08/25 and 11/22/25.	V 525	restrictive interventions, and negative effects of the restrictive intervention if any, on the physical and psychological well-being of the client. Restrictive Intervention Log will be revised to ensure that debriefing and planning is conducted with client and staff. Executive Director will monitor as each incident occurs and/or at least weekly to ensure all documentation is completed as indicated.	
V 526	27E .0104(e18-19) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (18) The facility shall collect and analyze data on the use of seclusion and physical restraint. The data collected and analyzed shall reflect for each incident: (A) the type of procedure used and the length of time employed; (B) alternatives considered or employed; and (C) the effectiveness of the procedure or alternative employed. The facility shall analyze the data on at least a quarterly basis to monitor effectiveness, determine trends and take corrective action where necessary. The facility shall make the data available to the Secretary upon request. (19) Nothing in this Rule shall be interpreted to	V 526		

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V 526	Continued From page 6 prohibit the use of voluntary restrictive interventions at the client's request; however, the procedures in this Rule shall apply with the exception of Subparagraph (f)(3) of this Rule. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to collect and analyze data as required for the use of seclusion and physical restraints on a quarterly basis to monitor effectiveness, determine trends and take corrective action where necessary. The findings are: Review on 2/19/26 of facility records from 11/1/25-2/19/26 revealed: -No quarterly collection or analysis on the use of physical restraints at the facility to monitor effectiveness, determine trends and take corrective action where necessary . Interview on 2/19/26 the Executive Director stated: -Staff had meetings weekly to discuss all seclusion and physical restraints that were used during the previous week. -There was no documentation of the collection and analysis of seclusion and physical restraints at the facility to monitor effectiveness, determine trends and take corrective action where necessary. -"I will form a committee to ensure we collect and analyze the data for restraints at least quarterly."	V 526	V526 The facility will ensure that the policy/procedure include the collection and analyzing of data on the use of seclusion/physical restraint to include type of procedure use and length of time employed, alternative considered or employed and effectiveness of the procedure/alternative employed at least quarterly to monitor effectiveness, determine trends and take corrective action when necessary. The facility shall form a committee to review and analyze data as identified to determine effectiveness, trends and any corrective action necessary. Executive Director will monitor quarterly to ensure that all data is analyze by the Committee.	3/22/2026
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE	V 536		

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V 536	Continued From page 7 INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities;	V 536	V536 The facility will ensure that the policy/procedure addresses the use of alternatives to restrictive interventions and that all staff will receive this training prior to providing services and annually thereafter. All staff will have current training documented in each personnel file. Executive Director will monitor training monthly to ensure that all staff have current training.	4/21/2026

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V 536	Continued From page 8 (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by	V 536		

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V 536	Continued From page 9 observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer.	V 536		

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V 536	Continued From page 10 (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (I) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure 3 of 15 audited staff (Medical Coordinator, Registered Nurse (RN)and Therapist) had annual refresher and initial training in alternatives to restrictive intervention. The findings are: Review on 02/20/26 of the Medical Coordinator's record revealed: -Hire date 07/19/23. -Non-Violent Crisis Intervention (NCI) training in alternatives to restrictive intervention expired 1/16/26. Review on 02/20/26 of the RN's record revealed: -Hire date 06/04/19. -No documentation of NCI training in alternatives to restrictive interventions. review on 02/20/26 of the Therapist'srecord revealed: -Hire date 09/11/23. -No attestation or documentation of NCI training	V 536		

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V 536	Continued From page 11 in alternatives to restrictive interventions. Interview on 02/20/26 the Executive Director stated: -Staff should have NCI training at the facility. -The RN had another type of alternative to restrictive intervention training from a seperate employer. -She would ensure training was completed for all staff.	V 536		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based,	V 537	V537 The facility will ensure that the policy/procedure for restrictive interventions are employed only by staff who have been trained and have demonstrated competency in the use of these interventions prior to services being provided and annually thereafter. All staff will have current training documented in each personnel file. Executive Director will monitor training monthly to ensure that all staff have current training.	3/22/2026

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V 537	Continued From page 12 include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include:	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME BUIL	**703 WEST 3RD AVENUE (BUILDING B) RED SPRINGS, NC 28377**

(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 537	Continued From page 13 (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 537	Continued From page 14 of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers.	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 537	Continued From page 15 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 3 of 15 audited staff (Medical Coordinator, Registered Nurse (RN) and Therapist) received annual or initial training in seclusion, physical restraint and isolation time out. The findings are: Review on 02/20/26 of the Medical Coordinator's record revealed: -Hire date 07/19/23. -Non-Violent Crisis Intervention (NCI) training in seclusion, physical restraint and isolation time out expired 1/16/26. Review on 02/20/26 of the RN's record revealed: -Hire date 06/04/19. -No documentation of NCI training in seclusion, physical restraint and isolation time out. review on 02/20/26 of the Therapist's record revealed: -Hire date 09/11/23. -No attestation or documentation of NCI training in seclusion, physical restraint and isolation time out. Interview on 02/20/26 the Executive Director stated: -Staff should have NCI training at the facility. -The RN had another type of restrictive intervention training from a separate employer. -She would ensure training was completed for all staff.	V 537		

March 13, 2026

Gloria Locklear
NC DHHS
DHSR
2718 Mail Service Center
Raleigh, NC 27699-2718

Ms. Locklear,

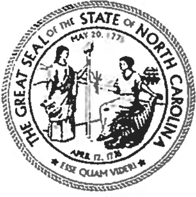
Please find enclosed the Plan of Correction for Renewing Grace Residential Home Building B located at 703B W. 3rd Ave. Red Springs, NC 28377. If you have questions or concerns, please feel free to contact me at 910-734-1824.

Sincerely,

Laura Jacobs, QP/ED

Laura Jacobs, QP/Executive Director

Renewing Grace Residential Home



NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

JOSH STEIN • Governor
DEVDUTTA SANGVAI • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

March 3, 2026

Melody Thomas, Program Director
Carter Clinic, P.A.
2151 Skibo Road Suite 200
Fayetteville, NC 28314

Re: Annual and Follow up Survey completed February 20, 2026
Renewing Grace Residential Home Building (B), 703 West 3rd Avenue (Building B), Red Springs, NC 28377
MHL # 078-333
E-mail Address: thomasmelody@rocketmail.com

Dear Ms. Thomas:

Thank you for the cooperation and courtesy extended during the Annual and Follow up survey completed February 20, 2026.

As a result of the follow up survey, it was determined that some of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- Re-cited standard level deficiencies.
- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- Re-cited standard level deficiencies must be ***corrected*** within 30 days from the exit of the survey, which is March 22, 2026.
- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is April 21, 2026.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

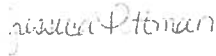
Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Gloria Locklear, Team Leader at 910-214-0350.

Sincerely,

Keith Hughes
Facility Compliance Consultant I
Mental Health Licensure & Certification Section



Jessica Pittman
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Latisha Grant
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Nikkie Lynch
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: networkEngagement@trilliumnc.org, CEO, Trillium Health Resources LME/MCO
Fonda Gonzales, Director of Quality Management, Trillium Health Resources LME/MCO
Velvet Nixon, Director, Robeson County DSS
Michael Blake, Administrative Supervisor