Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	MHL055-132		12/18/2025

NAME OF PROVIDER OR SUPPLIER: RESTORED BRIDGES, LLC (KAMALA HOUSE)

STREET ADDRESS, CITY, STATE, ZIP CODE: 718 MADISON STREET, LINCOLNTON, NC 28092

(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 survey was completed on December 18, 2025 . Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. The facility is licensed for 3 and has a current census of 1. The survey sample consisted of audits of 1 current client.	V 000	QP will update Policy and procedure manual in accordance to the governing body policies. QP will ensure to maintain a physical/electronic copy on the premises. V 000 V 105	
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and	V 105	RECEIVED JAN 16 2026 DHSR-MH Licensure Sect	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Director (X6) DATE: 01/12/2026

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V 105	Continued From page 2	V 105		
	This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to implement its written policies for the delegation of management authority. The findings are: Observation on 12/17/25 at 12:05pm of the facility revealed: -No staff or clients were present at the facility. Interviews on 12/17/25 and 12/18/25 the QP Revealed: -"Nobody (staff or clients) at home (facility) during the day." -Client #1 was at the day program. -Staff #1 was scheduled to work at the facility at 2:30pm. -He was unable to come to the facility on 12/17/25 due to being "in a meeting" for another job and having to pick his kids up from school. -Was in the process of hiring additional staff.		QP will update staff charts. Maintain physical/electronic staff files on the premises. QP will conduct semi aunnual internal audits to ensure compliance. V 107 V 108	
V 107	27G .0202 (A-E) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (a) All facilities shall have a written job description for the director and each staff position which: (1) specifies the minimum level of education, competency, work experience and other qualifications for the position; (2) specifies the duties and responsibilities of the position; (3) is signed by the staff member and the supervisor; and	V 107		

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V 107	Continued From page 3 (4) is retained in the staff member's file. (b) All facilities shall ensure that the director, each staff member or any other person who provides care or services to clients on behalf of the facility: (1) is at least 18 years of age; (2) is able to read, write, understand and follow directions; (3) meets the minimum level of education, competency, work experience, skills and other qualifications for the position; and (4) has no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry. (c) All facilities or services shall require that all applicants for employment disclose any criminal conviction. The impact of this information on a decision regarding employment shall be based upon the offense in relationship to the job for which the applicant is applying. (d) Staff of a facility or a service shall be currently licensed, registered or certified in accordance with applicable state laws for the services provided. (e) A file shall be maintained for each individual employed indicating the training, experience and other qualifications for the position, including verification of licensure, registration or certification. This Rule is not met as evidenced by: Based on record reviews and interviews the	V 107		

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V 107	Continued From page 4 facility failed to ensure a file was maintained for 3 of 3 staff (Staff #1, Staff #2 and the Qualified professional (QP)). The findings are: An attempted review on 12/17/25 of Staff #1, Staff #2 and the QP's personnel record revealed: -No personnel records that contained the following: -A written job description with the following: (1) Specified the minimum level of education, competency, work experience and other qualifications for the position. (2) Specified the duties and responsibilities of the position. (3) Was signed by the staff member and the supervisor. (4) Was retained in the staff member's file. -Documentation that each staff member: (1) Met the minimum level of education, competency, work experience, skills and other qualifications for the position. (2) Had no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry. -Documentation that: (1) The facility required that all applicants for employment disclose any criminal conviction. (2) A file was maintained for each individual employed indicating the training, experience and other qualifications for the position, including verification of licensure, registration or certification. Interviews on 12/17/25 and 12/18/25 the QP Revealed: -Was working on "compiling everything" (gathering staff records)..."have a lot of stuff (staff records), but not all together." -"First time doing a state review, still learning	V 107		

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V 107	Continued From page 5 everything we need to have." -"Now that we know what we need for the staff files we will have everything together moving forward."	V 107		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients.	V 108		

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V 108	Continued From page 6 This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure the minimum required training was met by 3 of 3 staff (Staff #1, Staff #2 and the Qualified professional (QP)). The findings are: An attempted review on 12/17/25 of Staff #1, Staff #2 and the QP's personnel record revealed: -No personnel records that contained the following: -Continuing education -Employee trainings programs were provided and, at a minimum, consisted of the following: (1) General organizational orientation. (2) Training on client rights and confidentiality. (3) Training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan. (4) Training in infectious diseases and bloodborne pathogens. (5) Basic first aid including seizure management. (6) Training to provide cardiopulmonary resuscitation (CPR). (7) Training in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. Interview on 12/17/25 with Staff #1 revealed: -"Did a lot of trainings on [online training vendor] but don't remember which ones."	V 108		

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V 108	Continued From page 7 Interviews on 12/17/25 and 12/18/25 the QP Revealed: -Was working on "compiling everything (gathering staff records)...have a lot of stuff (staff records), but not all together." -"First time doing a state review, still learning everything we need to have." -"Now that we know what we need for the staff files we will have everything together moving forward."	V 108		
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	QP will update and maintain accurate client chart including assessment, treatment plan, Physician orders, medication review. Client file will be accessible on premises electronic/physical copies. QP will conduct monthly internal audits to ensure compliance. V 112 V 113	

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V 112	Continued From page 8	V 112		
	This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement treatment strategies to address the needs of 1 of 1 current client (Client #1). The findings are: Review on 12/17/25 of Client #1's record revealed: -Date of admission: 9/12/25. -Diagnoses: Autism Spectrum Disorder, Mild Intellectual Disability, Persistent Depressive Disorder, and Conduct Disorder. -No documentation of allotted unsupervised time in the facility or out in the community. Interview on 12/17/25 with Client #1 revealed: -Worked at a local fast food restaurant in the evenings from 4pm-9pm. -"Staff drop me off at work and pick me up after." -Staff did not stay with him at work nor did he have a day worker with him, "no staff with me (while at work)." Interview on 12/17/25 with Client #1's guardian revealed: -Client #1 did not have an allotted amount of unsupervised time in the facility or out in the community documented. -Will work with facility staff to have Client #1's unsupervised time documented and approved. Interview on 12/17/25 with Staff #1 revealed:			

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V 112	Continued From page 9 -Took Client #1 to work and picked him up after his shift. -Was unsure if Client #1 had approved unsupervised time in the facility or while in the community. Interviews on 12/17/25 and 12/18/25 the QP Revealed: -Staff took Client #1 to work when scheduled and picked him up after his shift. -Will work with the guardian to ensure Client #1 has approved unsupervised time in the facility and out in the community.	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;	V 113		

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V 113	Continued From page 10 (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 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 the required documentation in the client's record affecting 1 of 1 current clients (#1). The findings are: Review on 12/17/25 of Client #1's record revealed: -Date of admission: 9/12/25. -Diagnoses: Autism Spectrum Disorder, Mild Intellectual Disability, Persistent Depressive Disorder, and Conduct Disorder. -No documentation of a face sheet to identify client's name, record number, date of birth, race, gender, marital status, and admission date.	V 113		

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V 113	Continued From page 11 Interview on 12/17/25 with Staff #1 revealed: -Client #1 had a binder of information in the facility. -Was not aware Client #1 needed a face sheet to identify Client #1's name, record number, date of birth, race, gender, marital status, and admission date. Interviews on 12/17/25 and 12/18/25 the QP Revealed: -Was not aware Client #1's binder in the facility did not have a face sheet. -"First time doing a state review, still learning everything we need to have." -"...we will have everything together moving forward."	V 113		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE 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.	V 536		

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V 536	Continued From page 12 (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; (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).	V 536	QP will conduct monthly internal audits to ensure compliance with state regualtions. Qp will maintain records on site that are demonstrative of following training compliance on alternative to restrictive interventions. V 536	

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V 536	Continued From page 13 (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 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,	V 536		

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V 536	Continued From page 14 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. (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. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interviews, the	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	MHL055-132		12/18/2025

NAME OF PROVIDER OR SUPPLIER: RESTORED BRIDGES, LLC (KAMALA HOUSE)

STREET ADDRESS, CITY, STATE, ZIP CODE: 718 MADISON STREET LINCOLNTON, NC 28092

(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 536	Continued From page 15 facility failed to ensure staff were trained in alternatives to restrictive interventions prior to providing services affecting 3 of 3 staff (Staff #1, Staff #2 and the Qualified professional (QP)). The findings are: An attempted review on 12/17/25 of Staff #1, Staff #2 and the QP's personnel record revealed: -No personnel records that contained the following: -Training in alternatives to restrictive interventions. Interview on 12/17/25 with Staff #1 revealed: -Did not remember completing a training in alternatives to restrictive interventions prior to working in the facility. Interviews on 12/17/25 and 12/18/25 the QP Revealed: -Could not provide a certificate of completion for training in alternatives to restrictive interventions for Staff #1, Staff #2 and himself. -Was working on "compiling everything (gathering staff records)...have a lot of stuff (staff records), but not all together." -"First time doing a state review, still learning everything we need to have." -"Now that we know what we need for the staff files we will have everything together moving forward."	V 536		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive	V 736		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	MHL055-132		12/18/2025

NAME OF PROVIDER OR SUPPLIER: RESTORED BRIDGES, LLC (KAMALA HOUSE)

STREET ADDRESS, CITY, STATE, ZIP CODE: 718 MADISON STREET, LINCOLNTON, NC 28092

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V 736	Continued From page 16 odor. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility and its grounds were not maintained in a safe manner. The findings are: Observation on 12/17/25 at 12:05pm of the exterior of the facility revealed: -Ramp leading up to the front door is cork board covered with a black rubber mat and sinks in when weight applied. -Front porch has 4 wooden slats that are warped and sink in when weight applied. -Back deck has 1 wooden slat that is the full length of the deck that sinks in when weight applied. Interviews on 12/17/25 and 12/18/25 the QP Revealed: -Was doing repairs on the facility prior to admitting clients and believed the ramp leading up to the front door, front porch and back deck issues were fixed. -Will make sure the ramp, front porch and back deck get fixed.	V 736	QP will ensure that repairs to damaged prpoerty are in compleiance with safe grounds protocol. QP will conduct monthly visual observations of any unsafe grounds conditions. V 736	

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

January 6, 2026

O'Neil Walker, Director
Restored Bridges, LLC
3126 Milton Rd.
Suite 217
Charlotte, NC 28215

Re: Annual Survey completed December 18, 2025
Restored Bridges, LLC (Kamala House), 718 Madison Street, Lincolnton, NC 28092
MHL # 055-132
E-mail Address: restoredbridges@gmail.com

Dear Mr. Walker:

Thank you for the cooperation and courtesy extended during the annual survey completed December 18, 2025.

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

- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- The standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is February, 16 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 Eileen Moreno at 336-247-0107.

Sincerely,

Jason Arenillas
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Maria Smith
Nurse Consultant I
Mental Health Licensure & Certification Section

Cc: QM@partnersbhm.org
Matthew Hillman, Director, Lincoln County DSS
Michael Blake, Administrative Supervisor