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	MHL036-434	A. BUILDING: _____ B. WING _____	R 02/26/2026

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RENEWED BEGINNINGS HOME INC.	2600 CLUB DRIVE GASTONIA, NC 28054

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on February 26, 2026. Two complaints were substantiated (intake #NC00235371 and #NC00235510) and one complaint was unsubstantiated (#NC00235587). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children and Adolescents. This facility is licensed for 6 and has a current census of 6. The survey sample consisted of audits of 5 current clients.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or	V 112		

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V 112	Continued From page 1 responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to develop and implement goals and strategies to meet the individual needs of the clients affecting 4 of 5 audited clients (#1, #2, #4 and #5) and failed to have written consent or agreement by the client or responsible party affecting 1 of 5 audited clients (#5). The findings are: Review on 2/9/26 of Client #1's record revealed: -Admission date not documented. -17 years old. -Diagnoses of Type 2 Diabetes, Post Traumatic Stress Disorder (PTSD), Oppositional Defiant Disorder, Conduct Disorder, Intellectual Developmental Disorder, Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder. -Comprehensive Clinical Assessment (CCA) completed 10/28/25: "history of physical aggression, disrupting others, aggressive behavior in school and violence toward others." -"[Client #1] was recently discharged from [mental health hospital] after a one year stay. During that admission, the client (#1) required over 200 restrictive interventions to maintain safety for herself and others."	V 112		

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V 112	Continued From page 2 -Treatment plan dated 11/19/25 goals: "[Client #1] will complete the program and transition to independent living. [Client #1] will use appropriate coping skills, and [Client #1] will learn appropriate social interactions and learn appropriate boundaries with others." -No goals and strategies for violent and aggressive behaviors, and sexual touching. Review on 2/12/26 of an email sent by the Licensee/Director/Chief Executive Officer (CEO) on 2/12/26 revealed: -Client #1's admission date was 11/5/25. Review on 2/23/26 of the facility's internal shift notes from 1/1/26 to 2/23/26 revealed: -On 1/20/26, Client #1 had a physical altercation with another client over the use of a laptop. -On 1/22/26, Client #1 had an anger outburst where she threatened staff and other clients. -On, 2/10/26, Clients #4 and #5 reported to Staff #6 that while Staff #1 was sleeping on 2/9/26, Client #1 entered Client #4 and #5's bedroom and tried to touch them in a sexual manner. -On 2/21/26, Client #1 had an anger outburst when "she punched Client #2 with a closed fist and threatened staff." -Interview and observation on 2/9/26 at 3:47pm with Client #1 was unsuccessful due to Client #1 answering "I don't know" to questions and shrugged her shoulders. Interview on 2/13/26 with Anonymous Staff #3 revealed: -"[Client #1] needed a higher level of care." -Client #1 was "violent and aggressive." Interview on 2/23/26 with Anonymous Staff #5 revealed :	V 112		

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V 112	Continued From page 3 -Client #1 "constantly displayed violence and aggression toward staff and clients." -Client #1 pushed and hit her with an open hand (date unknown). -Client #1 has had physical altercations with the other clients. -"We (staff) don't know what else to do for her (Client #1), nothing is working." -"She (Client #1) has an anger outburst almost daily. She threatens and hit others when she is upset." -There were no goals and strategies for Client #1's violent and aggressive behavior. Interview on 2/25/26 with the Licensee/Director/CEO revealed: -The Former Qualified Professional (QP) was responsible for treatment plans. -New QP started on 2/9/26. -Would ensure Client #1 had goals and strategies to address her violent and aggressive behavior, and sexual touching. Review on 2/9/26 of Client #2's record reveal: -Admission date not documented. -12 years old. -Diagnoses of Oppositional Defiant Disorder, Disruptive Mood Dysregulation Disorder, Unspecified Depressive Disorder, and Trauma and Stressor related disorder -Admission assessment dated 11/17/25 completed by Former QP: she had a history of suicidal ideation, self-harm, verbal and physical aggression. -No goals and strategies on treatment plan dated to address suicidal ideation and self-harm. Review on 2/12/26 of an email sent by the Licensee/Director/CEO on 2/12/26 revealed: -Client #2's admission date was 11/25/25.	V 112		

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V 112	Continued From page 4 Interview on 2/9/26 with Client #2 revealed: -Denied expressing any recent suicidal ideation since admission. -Did not feel safe around Client #1 because "she (Client #1) is always violent and tries to fight me." Review on 2/9/26 of Client #4's record revealed: -Admission date not documented. -11 years old. -Diagnoses of PTSD, Reactive Attachment Disorder, Anxiety and Depression. -Admission assessment dated 11/14/25 completed by Former QP: had a history of aggressive behaviors, self-harm/suicidal thoughts in the last six months, and conflicts with peers. -Treatment plan completed by the Forner QP and dated 11/24/25 included Client #1's name in front of Client #4's name. -No goals and strategies on treatment plan to address suicidal ideation and self-harm. Review on 2/12/26 of an email sent by the Licensee/Director/CEO on 2/12/26 revealed: -Client #4's admission date was 11/19/25. Interview on 2/9/26 with Client #4 revealed: -"We have therapy but the lady has not been here (facility) in a while." -Denied expressing any recent suicidal ideation since admission. -Did not feel safe around Client #1. Review on 2/9/26 of Client #5's record revealed: -Admission date not documented. -13 years old. -Diagnoses of PTSD, Reactive Attachment Disorder, Anxiety and Depression. -CCA dated 10/23/25: history of "aggressive behaviors, self-harm/suicidal thoughts, and	V 112		

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V 112	Continued From page 5	V 112		

conflicts with peers."
-Treatment plan dated 11/17/25 had no signatures on signature page an no goals and strategies on treatment plan dated to address suicidal ideation, self-harm or aggressive behavior.

Review on 2/12/26 of an email sent by the Licensee/Director/CEO on 2/12/26 revealed:
-Client #5's admission date was 10/22/25.

Interview on 2/9/26 with Client #5 revealed:
-Denied expressing any suicidal ideation since admission.
-"We just started having groups on Saturdays."

Interview with Anonymous Staff #8 revealed:
-There had not been any suicidal ideation or self-harming incidents with Clients #2, #4 or #5 in the "last month".
-Clients #2, #4 and #5 have had "some anger outburst but they were easily deescalated."

Interview with Anonymous Staff #5 revealed:
-Clients #2, #4 and #5 had not had any incidents with suicidal ideation or self-harm but "had some crisis that could have triggered their suicidal ideation if not quickly deescalated."

Interview on 2/25/26 with the Licensee/Director/CEO revealed:
-The Former QP was responsible for treatment plans.
-QP "started on 2/9/26."
-Would ensure the new QP "would include goals and strategies for [Clients #2, #4 and #5's] suicidal ideation and self-harm."

This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a continued

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V 112	Continued From page 6 Type A1 rule violation and must be corrected within 23 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 diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and	V 113		

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V 113	Continued From page 7 (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 review and interview, the facility failed to maintain complete client records affecting 4 of 5 audited Clients (Clients #1, #2, #4 and #5). The findings are: Review on 2/9/26 of Client #1's record revealed:, -Admission date not documented. -17 years old. -Diagnoses of Type 2 Diabetes, Post Traumatic Stress Disorder (PTSD), Oppositional Defiance Disorder, Conduct Disorder, Intellectual Developmental Disorder, Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder. -Comprehensive Clinical Assessment (CCA) completed 10/28/25: history of physical aggression and required over 200 restraints to maintain safety for herself and others, disrupting others, aggressive behavior and school and violence toward others. -No therapy notes. Review on 2/9/26 of Client #2's record reveal: -Admission date not documented. -12 years old. -Diagnoses of Oppositional Defiant Disorder, Disruptive Mood Dysregulation Disorder,	V 113		

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V 113	Continued From page 8 Unspecified Depressive disorder, and Trauma and Stressor related disorder -Admission assessment dated 11/17/25 completed by former Qualified Professional (QP): history of suicidal ideation, verbal and physical aggression. -No therapy notes Review on 2/9/26 of Client #4's record revealed: -Admission date not documented. -11 years old. -Diagnoses of PTSD, Reactive Attachment Disorder, Anxiety and Depression. - Admission assessment date 11/14/25 completed by the previous QP: history of aggressive behaviors, self-harm/suicidal thoughts, and conflicts with peers. -No therapy notes. Review on 2/9/26 of Client #5's record revealed: -Admission date not documented. -13 years old. -Diagnoses of PTSD, Reactive Attachment Disorder, Anxiety and Depression. -CCA dated 10/23/25: history of aggressive behaviors, self-harm/suicidal thoughts, and conflicts with peers. -No therapy notes. Review on 2/12/26 of an email sent by the Licensee/Director/Chief Executive Officer (CEO) on 2/12/26 revealed: -Client #1's admission date was 11/5/25. -Client #2's admission date was 11/25/25. -Client #4's admission date was 11/19/25. -Client #5's admission date was 10/22/25. Interview on 2/25/26 with the Licensee/Director/Chief Executive Officer (CEO) revealed:	V 113		

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V 113	Continued From page 9 -The Forner Qualified Professional (QP) was responsible for maintaining client files. -Recently hired a new QP on 2/9/26. -Would ensure the new QP would maintain client files.	V 113		
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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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 2/10/26 of the facility's internal incident reports from 1/1/26- 2/23/26 revealed:
-On 1/20/26, Client #3 reported that Staff #6 had a gun in the facility and slapped her in the face in December of 2025.
-An internal investigation was conducted on 1/22/26.

Attempted interview with Client #3 was unsuccessful since she was discharged on 2/4/26 and client#3's Mother/Legal Guardian did not return phone calls left on 2/9/26, 2/14/26 and 2/23/26 prior to survey exit.

Interview on 2/10/26 with Staff #6 revealed:
-On 1/22/26 she was notified by a local Department of Social Service (DSS) Social Worker of the allegations against her made by Client #3 on 1/20/26.
-The Licensee/Director/Chief Executive Officer (CEO) started an internal investigation on 1/20/26.
-DSS and the Licensee unsubstantiated the allegation.
-Was not suspended pending the investigation.

Interview on 2/25/26 with the Licensee/Director/CEO revealed:
-Began the internal investigation on 1/22/26 when she found out about the allegation Client #3 made against Staff #6 from DSS.
-No explanation to why Staff #6 was "not

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V 132	Continued From page 11 suspended" pending the internal investigation. -No staff would be working with clients pending investigation going forward. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 132		
V 133	G.S. 122C-80 Criminal History Record Check G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT. (a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter. (b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider	V 133		

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V 133	Continued From page 12 shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting	V 133		

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criminal history record checks utilizing public records obtained from a State agency.
(c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant:
(1) The level and seriousness of the crime.
(2) The date of the crime.
(3) The age of the person at the time of the conviction.
(4) The circumstances surrounding the commission of the crime, if known.
(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.
(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed.
(7) The subsequent commission by the person of a relevant offense.
The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.
(d) Limited Immunity. - A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for:
(1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual.
(2) Failure to check an employee's history of

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criminal offenses if the employee's criminal history record check is requested and received in compliance with this section.
(e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or

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V 133	Continued From page 15 sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5. (f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor. (g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met: (1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10. (2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.) This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a valid national criminal history record check was requested within five business days of making the conditional offer of	V 133		

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V 133	Continued From page 16 employment affecting 5 of 5 audited staff (#1, #2, #3, #4 and #5). The findings are: Review on 2/9/26 of Staff #1's record revealed: -No hire date. -A document titled, "Been Verified" dated 1/3/26, page 1 reads "Please remember, you are restricted from using this information for employment screening. You may not use this information for evaluating a person for employment, reassignment, promotion, or retention.... Using this information in these ways violates both our Terms & Conditions and the law, and can lead to possible criminal penalties. We take this very seriously, and reserve the right to terminate user accounts and/or report violators to law enforcement as appropriate." Review on 2/9/26 of Staff #2's record revealed: -No hire date. -A document titled, "Been Verified" dated 2/4/26, page 1 reads "Please remember, you are restricted from using this information for employment screening. You may not use this information for evaluating a person for employment, reassignment, promotion, or retention.... Using this information in these ways violates both our Terms & Conditions and the law, and can lead to possible criminal penalties. We take this very seriously, and reserve the right to terminate user accounts and/or report violators to law enforcement as appropriate." Review on 2/9/26 of the Associate Professional's (AP) record revealed: -According to the Licensee, hire date of 1/16/26 and start date of 1/16/26. -A document titled, "Been Verified" dated 1/13/26, page 1 reads "Please remember, you are restricted from using this information for	V 133		

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V 133	Continued From page 17 employment screening. You may not use this information for evaluating a person for employment, reassignment, promotion, or retention.... Using this information in these ways violates both our Terms & Conditions and the law, and can lead to possible criminal penalties. We take this very seriously, and reserve the right to terminate user accounts and/or report violators to law enforcement as appropriate." Review on 2/9/26 of the Qualified Professional's (QP) record revealed: -According to the Licensee, hire date of 1/24/26 and start date of 2/9/26. -A document titled, "Been Verified" dated 1/24/26, page 1 reads "Please remember, you are restricted from using this information for employment screening. You may not use this information for evaluating a person for employment, reassignment, promotion, or retention.... Using this information in these ways violates both our Terms & Conditions and the law, and can lead to possible criminal penalties. We take this very seriously, and reserve the right to terminate user accounts and/or report violators to law enforcement as appropriate." Review on 2/10/26 of the Life Coach's record revealed: -According to the Licensee, hire date of 2/9/26 and start date of 2/11/26. -A document titled, "Been Verified" dated 2/9/26, page 1 reads "Please remember, you are restricted from using this information for employment screening. You may not use this information for evaluating a person for employment, reassignment, promotion, or retention.... Using this information in these ways violates both our Terms & Conditions and the law, and can lead to possible criminal penalties. We	V 133		

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V 133	Continued From page 18 take this very seriously, and reserve the right to terminate user accounts and/or report violators to law enforcement as appropriate." Interview on 2/25/26 with the Licensee/Director/Chief Executive Officer (CEO) revealed: -Staff #1's hire date was 1/3/26 and start date was 1/5/26. -Staff #2's hire date was 2/4/26 and start date was 2/5/26. -The AP's hire and start date was 1/16/26. -The QP's hire date was 1/24/26 and start date was 2/9/26. -The Life Coach's hire date was 2/9/26 and her start date was 2/11/26. -She had not noticed the statement prohibiting the "Been Verified" documents to be used for employment. -Would find a valid background check system for employment purposes. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 133		
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.	V 293		

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V 293	Continued From page 19 (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to a community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting. (e) Services shall be designed to: (1) include individualized supervision and structure of daily living; (2) minimize the occurrence of behaviors related to functional deficits; (3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting. (f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care.	V 293		

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This Rule is not met as evidenced by:
Based on record reviews and interviews the facility failed to 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 affecting 4 of 5 audited clients (#1, #2, #4 and #5). The findings are:

Cross Reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112). Based on record review and interviews, the facility failed to develop and implement goals and strategies to meet the individual needs of the clients affecting 4 of 5 audited clients (#1, #2, #4 and #5) and failed to have written consent or agreement by the client or responsible party affecting 1 of 5 audited clients (#5).

Cross Reference: 10A NCAC 27G .1704 Minimum Staffing Requirements (V296). Based on observation and interviews the facility failed to ensure the minimum staffing ratio required of three staff in the facility during client awake hours and two awake staff during sleep hours.

Cross Reference: 10A NCAC 27G .1705 Requirements of Licensed Professionals (V297). Based on record review and interview the facility failed to provide face to face consultation in the facility at least four hours per week by a Licensed Professional (LP)

Cross Reference: 10A NCAC 27G .0603 Incident Response Requirements (V366). Based on record reviews and interviews, the facility failed to

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V 293	Continued From page 21 implement written policies governing their response to Level II incidents. Cross Reference: 10A NCAC 27E .0104 Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices used for Behavioral Control (V521).Based on record review and interview the facility failed to ensure whenever a restrictive intervention was utilized, documentation was in the clients' records for 1 of 5 audited current Client's (#1) records. Review on 2/26/26 of the Plan of Protection dated 2/26/26 and signed by the Licensee/Director/Chief Executive Officer (CEO) revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? Immediate Action Taken to Ensure Consumer Safety: On 02/20/2026, the Director (Licensee/Director/CEO) conducted an immediate full review of all Person-Centered Plans (PCPs) in comparison with each consumer's most recent Comprehensive Clinical Assessment (CCA). Any discrepancies between documented behaviors, diagnoses, goals, or interventions were corrected during or immediately following the last Child and Family Team (CFT) meeting. Goals and behavioral interventions were updated to accurately reflect current needs. WHO: Director WHAT: Conducted line-by-line comparison of CCA and PCP Updated goals and behavioral interventions Ensured measurable and clinically appropriate objectives 1	V 293		

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V 293	Continued From page 22 Documented updates in consumer records Upon identification of the concern, the Director immediately 02/26/2026 scheduled a meeting with all staff including overnight staff regarding the prohibition of sleeping during scheduled shifts. WHO: Director QP (Qualified Professional) All Direct Support Professionals (DSPs) WHAT: Mandatory staff meeting to reinforce minimum staffing ratios and supervision standards Re-education on No Sleeping During Overnight Shift policy WHEN: Staff meeting scheduled for 03/01/2026 10A NCAC 27G .0603 Requirements of Licensed Professionals (V297) Immediate Action Taken to Ensure Consumer Safety: On 02/12/2026, during the survey process, the Director immediately corrected the deficiency by hiring a Licensed Professional (LP) to ensure clinical oversight and compliance with regulatory requirements. WHO: Director Licensed Professional WHAT: Secured contract/employment of Licensed Professional Verified licensure Established supervision schedule Documented clinical oversight plan 10A NCAC 27G .0204 / Incident Response Requirements (V366)	V 293		

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V 293	Continued From page 23 Immediate Action Taken to Ensure Consumer Safety: The Director and QP initiated immediate review of all Level II and Level III incident documentation procedures to ensure proper reporting timelines and compliance. WHO: The Director Qualified Professional WHAT: Enroll in formal training on Level II and Level III reporting requirements Review IRIS (Incident Response Improvement System) reporting timelines and documentation standards Implement internal incident reporting checklist Conduct quarterly audits of incident reports WHEN: Training scheduled for 03/03/2026 10A NCAC 27E .0104 Documentation Requirements for Seclusion, Physical Restraint, Isolation Time-Out and Protective Devices Used for Behavioral Control Immediately upon identification of the concern, the Director scheduled a meeting on 03/01/26 with staff to discuss recent restrictive intervention documentation to verify compliance with all required documentation elements under 27E .0104. 3 Staff will be instructed that: All restrictive interventions must be reported immediately to the Director or QP. Documentation must be completed in full prior to the end of the shift. The Director or QP will conduct a follow-up review within 24 hours to ensure completeness and accuracy. WHO: The Director	V 293		

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V 293	Continued From page 24 Qualified Professional (QP) WHAT will be discussed: Restraint documentation to verify inclusion of: Physical and psychological well-being assessment Behavioral frequency, intensity, duration Precipitating factors Less restrictive interventions attempted Full intervention description (date, time, duration) Positive supports used Debriefing documentation Required signatures and authorization Established mandatory reporting requirement: DSP must notify Director or QP immediately following any restrictive intervention. Director/QP will review documentation within 24 hours. Implemented documentation checklist aligned exactly to subsections (A)-(H) of 27E .0104. WHEN: Mandatory staff meeting scheduled for 03/01/2026 Describe your plans to make sure the above happens. Director Responsible for All Items: [Licensee/Director/CEO] The Director will be responsible for implementing, monitoring, and ensuring compliance with all corrective actions outlined in the above deficiencies. The following plan details WHO will do it, WHAT will be done, and WHEN it will occur. . 10A NCAC 27G .0205 Assessment and PCP Alignment (V112) WHO: The Director WHAT WILL BE DONE: The Director has already reviewed all PCPs in conjunction with the CCAs on 02/20/2026.	V 293		

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V 293	Continued From page 25 The Director will continue to compare each consumerfs CCA to the PCP to ensure behaviors, goals, and interventions are accurately reflected with new consumers. Any updates identified during CFT meetings will be revised immediately in the PCP. WHEN: Initial correction completed 02/20/2026 . 10A NCAC 27G .1704 & .1705 Minimum Staffing / Overnight Supervision (V296) WHO: The Director WHAT WILL BE DONE: The Director (Licensee/Director/CEO) will conduct a mandatory staff meeting to address overnight supervision expectations and reinforce that sleeping on shift is prohibited. The Director (Licensee/Director/CEO) will review staffing schedules to ensure minimum staffing ratios are maintained at all times. The house manager [Staff #6] will conduct periodic unannounced overnight checks to ensure compliance. WHEN: Staff meeting on 03/01/2026 Weekly staffing schedule review ongoing . 10A NCAC 27G .0603 Licensed Professional Requirement (V297) WHO: The Director (Licensee/Director/CEO) WHAT WILL BE DONE: The Director corrected this deficiency on 02/12/2026 by hiring a Licensed Professional. The Director will maintain verification of licensure in personnel files. The Director will ensure the Licensed Professional provides ongoing clinical oversight. The Director will review LP involvement in treatment planning and documentation. WHEN:	V 293		

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V 293	Continued From page 26 Corrected 02/12/2026 Ongoing oversight reviewed monthly beginning 03/31/2026 Incident Response Requirements (V366) WHO: The Director (Licensee/Director/CEO) WHAT WILL BE DONE: The Director will attend formal training on Level II and Level III incident reporting requirements. The Director will review all incidents to ensure they are reported within required timelines. The Director will implement an internal checklist to verify reporting compliance. The Director will monitor IRIS submissions for completeness. WHEN: Training scheduled 03/03/2026 Checklist implemented by 03/05/2026 Monthly review of incidents beginning 03/31/2026 . 10A NCAC 27E .0104 & 27G .1701 Scope Restrictive Intervention Oversight (V521 & V293) WHO: The Director WHAT WILL BE DONE: The Director has reviewed all restrictive intervention documentation to ensure compliance with required elements (A-H). The Director will require staff to notify her immediately following any restrictive intervention. The Director will review documentation within 24 hours to ensure required elements are included: Physical and psychological well-being Behavior frequency, intensity, duration Rationale and less restrictive interventions attempted Date, time, duration 8 Positive interventions used Debriefing documentation Required signatures	V 293		

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V 293	Continued From page 27 The Director will conduct monthly audits of restraint documentation. The Director will reinforce that restrictive interventions are last-resort measures and must align with PCP and state regulations. WHEN: Documentation review completed 02/25/2026 Staff meeting reinforcement on 03/01/2026 24-hour review process effective immediately Staff Meeting . 03/01/2026 On 03/01/2026, the Director will: Review PCP documentation requirements Review staffing and supervision requirements Reinforce no sleeping during overnight shifts Review incident reporting requirements Review restraint documentation requirements under 27E .0104 Require staff acknowledgment of understanding." Review on 2/26/26 of the amended Plan of Protection dated 2/26/26 and signed by the Director revealed: -"The director will immediately ensure the ratio as of today 2/26/26 will be maintained. 3 staff in the day, and 2 staff at night awake. -Immediate actions to minimize violent behaviors is to speak with prescriber about medication increase, and stepping down will be talked about in CFT (Child Family Team) meetings. The house manager will ensure clients receive weekly therapy as of 2/26/26. The director will speak with house manager about ensuring staff ratio is ensured and no one is sleeping at night as of 2/26/26. The director will speak with house manager about our plan to help with consumer behaviors on	V 293		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWED BEGINNINGS HOME INC.	2600 CLUB DRIVE GASTONIA, NC 28054

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V 293	Continued From page 28 3/1/26 through med management and speak with team about stepping down in out CFT meetings. A meeting will be scheduled on 3/1/26 with LP (Licensed professional) and manager about scheduling therapy sessions for the month with LP. Immediate action as of 2/26/26, the director will ensure anyone hired as a LP will be license through the license website. Ensuring this happens, the director will have the vice president double check the license at the website ncswb.igovsolutions.net." The facility serves adolescents ages 11-17 with diagnoses including Conduct Disorder, Attention Deficit Hyperactivity Disorder, Post-Traumatic Stress Disorder, Generalized Anxiety Disorder, Major Depressive Disorder, and Oppositional Defiant Disorder. Treatment planning for Clients #1, #2, #4, and #5 was not based on the individual needs of the clients. Clients #1, #2, #4, and #5 had histories of violent and aggressive behaviors, sexual touching, suicidal ideation, and/or self-harm; however, their treatment plans did not include goals or strategies to address their histories of these identified needs and behaviors. On 1/20/26, Client #1 had a physical altercation with another client; On 1/22/26 Client #1 had an anger outburst and threatened staff and others. On 2/10/26, Client #4 and #5 reported that Client #1 entered their bedroom and tried to touch them in a sexual manner while Staff #1 was sleeping. On 2/21/26, Client #1 had an anger outburst and punched client #2 with a closed fist and threatened staff. Client #1's treatment plan did not have an effective date. The treatment plan for Client #4 contained Client #1's name in front of Client #4's name. Client #5's treatment plan did not have an effective date and did not contain required signatures. The facility failed to maintain	V 293		

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V 293	Continued From page 29 the required staffing levels of three direct care staff when clients were present and awake and two awake direct care staff during sleep hours. The facility failed to provide at least four hours per week of face-to-face clinical consultation in the facility with a licensed professional. The facility did not respond to incidents as required for Level II incidents on 2/9/26 and 2/21/26. On 2/21/26, Client #1 was placed in a restraint; however, there was no documentation of the restraint in Client #1's record. The facility lacked adequate systems in place to minimize behaviors, assist with adaptive functioning, and support clients in gaining the skills necessary to transition to a less intensive level of care. This deficiency constitutes a Continuing Type A1 rule violation and must be corrected within 23 days.	V 293		
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for	V 296		

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V 296	Continued From page 30 nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan. This Rule is not met as evidenced by: Based on observation and interviews the facility failed to ensure the minimum staffing ratio required of three staff in the facility during client awake hours and two awake staff during sleep	V 296		

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V 296	Continued From page 31	V 296		

hours. The findings are:

Observation on 2/9/26 between 3:00pm and 4:11pm at the facility revealed:
-Staff #2, Staff #6 and the Qualified Professional (QP) were present, with clients #1, #2, #4, #5 and #6.
-The QP was in the office area reviewing files, Staff #6 was cooking and Staff #2 was in Client #2's bedroom with Client #2.
-Staff #2 left the facility and could be heard saying she was going to the local pharmacy to pick up medication for the clients, leaving Staff #6 and the QP with 4 clients.
-Staff #2 returned to the facility at approximately and left the facility again at approximately 3:46 pm.
-Staff #2 returned to the facility.

Interview on 2/10/26 with Client #2 revealed:
-"It's mostly two staff (at the facility), sometimes three."
-"The lady (Staff #1) sleeps on an air mattress or something at night."

Interview on 2/10/26 with Client #4 revealed:
-There were two or three staff during the day.
-"At night it's one or two, and they (staff #1 and Associate Professional (AP)) be asleep."

Interview on 2/9/26 with Client #5 revealed:
-"It's usually three staff during the day, and two staff at night."
-Staff #1 and the AP "slept at night."

Attempted interview with Staff #1 was unsuccessful due to Staff #1 not responding to voice messages left on 2/9/26, 2/13/26 and 2/14/26. Requested assistance from the Licensee/Director/Chief Executive Officer (CEO)

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V 296	Continued From page 32 but Staff #2 did not make herself available for an interview before the exit date. Interview on 2/13/26 with Staff #2 revealed: -She had been employed for a week. -Worked second shift. -There was always three staff on her shifts. -Did not know how many staff worked at night. -Never witnessed any staff sleeping. Interview on 2/13/26 with the AP revealed: -Worked 3rd shift full time. -It was two staff at night (her and Staff #1). -Denied she or Staff #1 slept during their shifts. Interview on 2/25/26 with the Licensee/Director/CEO revealed: -There were always three staff during the day and two at night. -Third shift staff never slept. -Denied having any knowledge of staff sleeping. -Would monitor cameras in the facility to make sure no staff was sleeping or left the facility without approval. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a continued Type A1 rule violation and must be corrected within 23 days.	V 296		
V 297	27G .1705 Residential Tx. Child/Adol - Req. for L P 10A NCAC 27G .1705 REQUIREMENTS OF LICENSED PROFESSIONALS (a) Face to face clinical consultation shall be provided in each facility at least four hours a week by a licensed professional. For purposes of this Rule, licensed professional means an	V 297		

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V 297	Continued From page 33 individual who holds a license or provisional license issued by the governing board regulating a human service profession in the State of North Carolina. For substance-related disorders this shall include a licensed Clinical Addiction Specialist or a certified Clinical Supervisor. (b) The consultation specified in Paragraph (a) of this Rule shall include: (1) clinical supervision of the qualified professional specified in Rule .1702 of this Section; (2) individual, group or family therapy services; or (3) involvement in child or adolescent specific treatment plans or overall program issues. This Rule is not met as evidenced by: Based on record review and interview the facility failed to provide face to face consultation in the facility at least four hours per week by a Licensed Professional (LP) . The findings are: Review on 2/10/26 of the Life Coach's record revealed: -Hired as the Licensed Professional on 2/9/26 according to offer letter. -Christian Life Coach certificate. -Job Description for LP signed 2/9/26. -Did not have the credentials or license as required for an LP. Interview on 2/13/26 with the Life Coach revealed: -"I am still under supervision and not fully licensed." -Did not have a provisional license.	V 297		

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V 297	Continued From page 34 -Had a degree from a local bible college. -"I don't have a license yet." Interview on 2/25/26 with the Licensee/Director/Chief Executive Officer revealed: -"She (Life Coach) gave me her certificate and education verification." -Did not verify the Life Coach's credentials or license before hire. -Did not know the Life Coach did not have a license. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a continued Type A1 rule violation and must be corrected within 23 days.	V 297		
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;	V 366		

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V 366	Continued From page 35 (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 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;	V 366		

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V 366	Continued From page 36 (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 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.	V 366		

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V 366	Continued From page 37 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement written policies governing their response to Level II incidents. The finding are: Review on 2/17/26 and 2/13/26 of the facility's records revealed: -No documentation of an incident on the night of 2/9/26 Client #1 went into Client #4 and #5's bedroom and attempted to touch them sexually. -No documentation of an incident on 2/21/26 Client #1 had a violent behavior where she physically attacked Client #2, threatened staff, and had to be restrained for the safety of others. -No documentation that the facility attended to the health and safety needs of individuals involved in the incidents on 2/9/26 and 2/21/26. -There was no documentation of a risk cause analysis to determine: The cause of the incident on 2/9/26 when Client #1 went into Client #4 and #5's bedroom and attempted to touch them sexually without their consent while staff was sleeping, and the incident on 2/21/26 when Client #1 physically attacked Client #2 and had to be restrained for the safety of others; -No documentation of the facility developed and implemented corrective measures according to the provider specified timeframes not to exceed 45 days for the incidents on 2/9/26 and 2/21/26; -No documented measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; -No documentation of assigning person(s) to be responsible for implementation of the corrections and preventive measures for the incidents on 2/9/26 and 2/21/26;	V 366		

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V 366	Continued From page 38 -No documentation adhering to confidentiality requirements and; -No maintained documentation of thr incident on 2/9/26 and 2/21/26. Review on 2/23/26 of the North Carolina Incident Response Improvement System (NC IRIS) from 1/10/26 to 2/23/26 revealed: -No incident reports for the incident on 2/9/26. -No incident report for the incident on 2/21/26. Interview on 2/23/26 with Client #2 revealed: -"On Saturday (2/21/26) [Client #1] started punching on me. I didn't do anything to her (Client #1)." -Staff #6 was able to stop the physical attack by getting in between her and Client #1, and holding Client #1 back. Interview on 2/10/26 with Client #4 revealed: -On 2/9/26 Client #1 came into her and Client #5's room while Staff #1 slept and was trying to touch them sexually. -Reported the incident to Staff #6. -"She (Client #1) had done it (touched her sexually) before and I don't feel safe around her." -Witnessed Client #1 punch Client #2 in the arm on 2/21/26. -"I don't know why she (Client #1) wanted to fight her (Client #2)." Interview on 2/10/26 with Client #5 revealed: -She did not feel safe around Client #1. -"She hit and punched [Client #2]." -"She was touched us (her and other clients)." -Reported the sexual touching to Staff #6. Interview on 2/23/26 with Staff #6 revealed: -All the clients told her Client #1 had touched them sexually.	V 366		

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V 366	Continued From page 39 -Client #2 was attacked by Client #1 on 2/21/26 and it took a long time for Client #1 to deescalate. -"I had to hold her (Client #1) back to get her to stop punching [Client #2]." -Completed internal incident reports. -Reported incidents to the Licensee/Director/Chief Executive Officer (CEO). Interview on 2/25/26 with the Licensee/Director/CEO revealed: -"Thought the 2 incidents were considered level I incidents." -Would complete a risk cause analysis and document the incident on 2/9/26 and 2/21/26. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a continued Type A1 rule violation and must be corrected within 23 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 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	V 367		

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V 367	Continued From page 40 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 (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	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-434	A. BUILDING: _____ B. WING _____	R 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWED BEGINNINGS HOME INC.	2600 CLUB DRIVE GASTONIA, NC 28054

(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 41 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. 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:	V 367		

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V 367	Continued From page 42 Review on 2/17/26 and 2/13/26 of the facility's records revealed: -On the night of 2/9/26 Client #1 went into Client #4 and #5's bedroom and attempted to touch them sexually without their consent while staff was sleeping. -On 2/21/26 Client #1 had a violent behavior where she physically attacked Client #2, threatened staff and had to be restrained for the safety of others. Review on 2/23/26 of the North Carolina Incident Response Improvement System (NC IRIS) from 1/10/2026 to 2/23/26 revealed: -No incident reports for the incident on 2/9/26. -No incident report for the incident on 2/21/26. Interview on 2/23/26 with Client #2 revealed: -"On Saturday (2/21/26) [Client #1] started punching on me. I didn't do anything to her (Client #1)." -Staff #6 was able to stop the physical attack by getting in between her and Client #1, and holding Client #1 back. Interview on 2/10/26 with Client #4 revealed: -On 2/9/26 Client #1 came into her and Client #5's room while Staff #1 slept and was trying to touch them sexually. -Reported the incident to Staff #6. -"She (Client #1) had done it (touched her sexually) before and I don't feel safe around her." -Witnessed Client #1 punch Client #2 in the arm on 2/21/26. -"I don't know why she (Client #1) wanted to fight her (Client #2)." Interview on 2/10/26 with Client #5 revealed: -She did not feel safe around Client #1.	V 367		

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V 367	Continued From page 43 -"She hit and punched [Client #2]." -"She was touched us (her and other clients)." -Reported the sexual touching to Staff #6. Interview on 2/23/26 with Staff #6 revealed: -All the clients have told her Client #1 had touched them sexually. -Client #2 was attacked by Client #1 on 2/21/26 and it took a long time for Client #1 to deescalate. -"I had to hold her (Client #1) back to get her to stop punching [Client #2]." -Completed internal incident reports. -Reported incidents to the Licensee/Director/Chief Executive Officer (CEO). Interview on 2/25/26 with the Licensee/Director/CEO revealed: -Thought the 2 incidents were considered level I incidents. -Would submit all level II incidents to NC IRIS.	V 367		
V 521	27E .0104(e9) 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: (9) Whenever a restrictive intervention is utilized, documentation shall be made in the client record to include, at a minimum: (A) notation of the client's physical and psychological well-being; (B) notation of the frequency, intensity and duration of the behavior which led to the intervention, and any precipitating circumstance contributing to the onset of the behavior;	V 521		

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V 521	Continued From page 44 (C) the rationale for the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used; (D) a description of the intervention and the date, time and duration of its use; (E) a description of accompanying positive methods of intervention; (F) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate or reduce the probability of the future use of restrictive interventions; (G) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if determined to be clinically necessary; and (H) signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure whenever a restrictive intervention was utilized, documentation was in the Client's record for 1 of 5 Client's (#1). The findings are: Review on 2/9/26 of Client #1's record revealed: -Admission date not documented. -17 years old. -Diagnoses of Type 2 diabetes, Post Traumatic Stress Disorder, Oppositional Defiance Disorder, Conduct Disorder, Intellectual Developmental Disability, Autism Spectrum Disorder and Attention Deficit Hyperactivity Disorder.	V 521		

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V 521	Continued From page 45 -Comprehensive Clinical Assessment dated 10/28/25: "history of physical aggression and required over 200 restraints to maintain safety for herself and others, disrupting others, aggressive behavior and school and violence toward others." -No documentation regarding Client #1 being restrained Staff #6 on 2/21/26. Review on 2/17/26 and 2/13/26 of the facility's records revealed: -On 2/21/26 Client #1 had a violent behavior where she physically attacked Client #2, threatened staff and had to be restrained by Staff #6 for the safety of others. Interview on 2/23/26 with Staff #6 revealed: -Documented the restraint in the restraint log. Interview on 2/25/26 with the Licensee revealed: -Was not aware a restraint was performed on 2/21/26. -The previous Qualified Professional was responsible for updating client files. -Would retrain staff on restraint documentation requirements. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a continued Type A1 rule violation and must be corrected within 23 days.	V 521		