STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-150	A. BUILDING: _____ B. WING _____	R 03/17/2026

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HOPE HOUSE	3775 OLD LOWERY ROAD SHANNON, NC 28386

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on March 17, 2026. The complaint was substantiated (intake #NC00235715). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for 4 and currently has a census of 3. The survey sample consisted of audits of 1 current client and 2 former clients.	V 000		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes. (b) The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate the facility's response to fire emergencies. (d) Each facility shall have a first aid kit accessible for use. This Rule is not met as evidenced by: Based on record review and interviews the facility	V 114		

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V 114	Continued From page 1	V 114		

failed to ensure fire and disaster drills were held quarterly and repeated on each shift. The findings are:

Review on 3/12/26 of the facility's records of fire and disaster drills from January 2025 - December 2025 revealed:
First Quarter 2025 (January-March)
-No disaster drills documented on the first or fourth shift.
-No fire drill documented on the fourth shift.
Second Quarter 2025 (April-June)
-No fire or disaster drills documented on first or second shifts.
Third Quarter 2025 (July-September)
-No disaster drills documented on first or third shift.
-No fire drill documented on third shift.
Fourth Quarter 2025 (October-December)
-No disaster drill documented on the third shift.
-No fire drills documented on the second, third or fourth shifts.

Interview on 3/11/26 client #1 stated:
-"We do drills once a month."

Interview on 3/11/26 client #2 stated:
-"We do drills every week."

Interview on 3/13/26 former client (FC) #4 stated:
-"We did fire and disaster, I don't remember how often."

Interview on 3/16/26 FC #5 stated:
-"We did drills twice a month."

Interview on 3/11/26 staff #3 stated:
-Drills were completed "once or twice" a month.

Interview on 3/11/26 staff #9 stated:

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V 114	Continued From page 2 -Drills were completed twice a month. Interview on 3/17/26 the Director stated: -There were four shifts at the facility. The shifts were 2 pm-10 pm and 10 pm-8 am; Monday-Friday and 8am - 8pm and 8pm - 8am; Saturday-Sunday. -"We will make sure staff are completing drills once per shift per quarter." This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 114		
V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable. This Rule is not met as evidenced by: Based on records reviews and interview, the facility failed to obtain drug regimen reviews every six months for 1 of 1 audited current clients (#2)	V 121		

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V 121	Continued From page 3 and 2 of 2 former clients (FC) (#4, #5) who received psychotropic drugs. The findings are: Review on 3/11/26 of client #2's record revealed: -Date of admission: 5/7/25. -Diagnoses: Attention Deficit Hyperactivity Disorder (ADHD), Anxiety, Post Traumatic Stress Disorder (PTSD) and High Risk Sexual Behavior. -Physician's order dated 3/11/26: Methylphenidate 36 mg (milligram) (ADHD) - Take one every morning and Buspirone 15 mg (Anxiety) - Take one tablet twice daily. -There was no documented evidence of a current six-month drug regimen review. Reviews on 3/11/26 of client #2's MARs from 12/1/2025 - 03/10/2026 revealed: -Staff documented client #2 was administered the above medications from 12/01/2025 - 03/10/2026. Review on 3/11/26 of FC #4's record revealed: -Date of admission: 3/3/25. -Date of discharge: 2/16/26. -Diagnoses: Reactive Attachment Disorder, Oppositional Defiant Disorder, ADHD and Fetal Alcohol Syndrome. -Physician's order dated 12/10/25: Methylphenidate 54 mg (ADHD) - Take one daily, Trazodone 100 mg (ADHD) - Take one daily, Clonidine 0.2 mg (ADHD) - Take one daily. -There was no documented evidence of a current six-month drug regimen review. Reviews on 3/11/26 of FC #4's MARs from 12/1/2025 - 2/16/26 revealed: -Staff documented client #4 was administered the above medications from 12/1/2025 - 2/16/26. Review on 3/11/26 of FC #5's record revealed:	V 121		

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V 121	Continued From page 4 -Date of admission: 2/11/25. -Date of discharge: 3/2/26. -Diagnoses: PTSD, ADHD and Conduct Disorder. -Physician's order dated 2/11/26: Risperidone 1 mg (Conduct Disorder) - Take one by mouth in the morning and two at bedtime, Dextroamphetamine 30 mg (ADHD) - Take one every morning, Divalproex 500 mg (Conduct Disorder) - Take in the morning and two at bedtime and Guanfacine 1 mg (ADHD) - Take one at bedtime. -There was no documented evidence of a current six-month drug regimen review. Reviews on 3/11/26 of FC #5's MARs from 12/1/2025 - 3/2/26 revealed: -Staff documented client #4 was administered the above medications from 12/1/2025 - 3/2/26. Interview on 3/12/26 with the Director stated: -She was aware of the 6 month drug regimen review every six months for clients who received psychotropic drugs. -"We will start having the physician do 6 month med (medication) review when the clients go to the doctor every other month." This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 121		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care	V 131		

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V 131	Continued From page 5 Personnel Registry and shall note each incident of access in the appropriate business files. This Rule is not met as evidenced by: Based on record review and interview the facility failed to complete Health Care Personnel Registry (HCPR) check prior to hire for 1 of 5 audited staff (Former Staff (FS) #10). The findings are: Finding #1: Review 3/12/26 of FS #10 personnel record revealed: -Hire date: 1/13/26. -Date of separation: 2/2/26. -Position: Counselor I -HCPR accessed: 1/15/26. Interview on 3/17/26 with the Director stated: -She was responsible to access the HCPR prior to hire for all staff. -"I thought I had checked [FS #10] prior to him being hired." -"I will do better about making sure it (HCPR check) is done prior to hiring any staff."	V 131		
V 295	27G .1703 Residential Tx. Child/Adol - Req. for A P 10A NCAC 27G .1703 REQUIREMENTS FOR ASSOCIATE PROFESSIONALS (a) In addition to the qualified professional specified in Rule .1702 of this Section, each	V 295		

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V 295	Continued From page 6 facility shall have at least one full-time direct care staff who meets or exceeds the requirements of an associate professional as set forth in 10A NCAC 27G .0104(1). (b) The governing body responsible for each facility shall develop and implement written policies that specify the responsibilities of its associate professional(s). At a minimum these policies shall address the following: (1) management of the day to day day-to-day operations of the facility; (2) supervision of paraprofessionals regarding responsibilities related to the implementation of each child or adolescent's treatment plan; and (3) participation in service planning meetings. This Rule is not met as evidenced by: Based on record review and interview the facility failed to have at least one full-time direct care staff who meets or exceeds the requirements of an Associate Professional (AP). The findings are: Review on 3/11/26 of the client/staff census revealed no AP listed. Interview on 3/11/26 the Assistant Director stated: -The facility did not have a full time AP. -The facility was in the process of searching options to hire for a new AP. -The previous AP's last day was 9/24/25. Interview on 3/11/26 the Director stated: -The facility did not have a full time AP at the facility.	V 295		

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V 295	Continued From page 7 -The facility has had a difficult time in hiring a "qualified staff for the position." This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 295		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in	V 366		

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V 366	Continued From page 8 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; (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	V 366		

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V 366	Continued From page 9 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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement policies governing their response to level II incidents as required. The findings are: Review on 3/12/26 of the facility's records 1/1/26-3/12/26 revealed: -There were no incident reports for the allegation	V 366		

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of FC #5 had exposed himself to FC #4 or client #2 as reported to facility staff on January 15, 2026.
-There was no evidence that the Director attended to the health and safety needs of individuals involved in the incident, determined the cause of the incident, developed and implemented corrective measures and developed and implemented measures to prevent similar incidents for the level III incident.

Interview on 3/11/26 with client #2 stated:
-He reported an allegation (date unknown) that FC #5 had exposed himself to staff #9.
-The Director interview him about the allegation.

Interview on 3/13/26 with FC #4 stated:
-FC #5 had "exposed himself once or twice" to him while at the facility.
-He reported the allegation that FC #5 had exposed himself to staff #9.
-The Director interviewed (date unknown) him about the allegations.

Interview on 3/16/26 with FC #5 stated:
-He denied he exposed himself to any clients.
-The Director interviewed him about the allegation that he exposed himself to clients (date unknown).

Interview on 3/11/26 staff #9 stated:
-Client #2 and FC #4 reported an allegation that FC #4 had "exposed himself" to them on 1/15/26.
-She reported the allegation to the Program Director on 1/15/26.

Interview on 3/12/26 the Director stated:
-She was responsible for attending to the health and safety needs of individuals involved in the incident, determining the cause of the incident,

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V 366	Continued From page 11 developing and implementing corrective measures and developing and implementing measures to prevent similar incidents. -"I interviewed the clients and staff involved but I did not document the investigation."	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 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	V 367		

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V 367	Continued From page 12	V 367		

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 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

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V 367	Continued From page 13 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 review and interview, the facility failed to report a level II incident to the Local Management Entity/Managed Care Organization (LME/MCO) as required. The findings are: Review on 3/11/26 of the North Carolina Incident Response Improvement System (IRIS) revealed: -No IRIS report had been submitted for the allegation of FC #5 had exposed himself to FC #4 or client #2 that was reported to staff #9 on January 15, 2026. Interview on 3/11/26 with client #2 stated: -He reported an allegation that FC #5 had exposed himself to staff #9. -He did not remember when he reported the allegation to staff #9. -The Director interviewed (date unknown) him about the allegation. Interview on 3/13/26 with FC #4 stated: -FC #5 had "exposed himself once or twice" (date	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-150	A. BUILDING: _____ B. WING _____	R 03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE HOUSE	3775 OLD LOWERY ROAD SHANNON, NC 28386

(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 14 unknown) to him while at the facility. -He reported the allegation (date unknown) that FC #5 had exposed himself to staff #9. -The Director interviewed him about the allegations. Interview on 3/16/26 with FC #5 stated: -He denied he exposed himself to any clients. -The Director interviewed him about the allegation (date unknown) that he exposed himself to clients. Interview on 3/11/26 staff #9 stated: -Client #2 and FC #4 reported an allegation that FC #4 had "exposed himself" to them. -She reported the allegation to the Director on 1/15/26. Interview on 3/12/26 the Director stated: -She was responsible for the submission of all IRIS reports for the facility. -"I will do a separate IRIS report for the allegation of [FC #5] exposing himself to [client #2] and [FC #4]."	V 367		
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 odor. This Rule is not met as evidenced by: Based on observation and interview the facility was not maintained in a clean, attractive and orderly manner. The findings are:	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-150	A. BUILDING: _____ B. WING _____	R 03/17/2026

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V 736	Continued From page 15 Observation on 3/11/26 at approximately 10:30 am during the tour of the facility revealed: -The area rug in the den was frayed around 3 corners of the rug. -The desk at the entrance of the facility at the top of the desk the material was missing approximately 10 inches long and 5 inches wide. -The 4 wooden chairs were faded black paint. -The outlet on the left entry side of hallway was loose and hung from the wall at the top on and the right side. -Client #1's bedroom dresser was missing a knob. -Client #3's bedroom had an outlet which hung down loose away from the wall at the bottom half near the bed. Interview on 3/17/26 the Director stated: -"With the type of clients we have there will always be some issues with the home (facility)." -"We have made some updates in the home (facility)." -She would follow up on the areas of concerns. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		