

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL0921009</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R-C <b>03/11/2026</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THE HOPE CENTER FOR YOUTH AND FAMILY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>400 WEST RANSOM STREET FUQUAY VARINA, NC 27526</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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V 000	<p><b>INITIAL COMMENTS</b></p> <p>A complaint and follow up survey was completed on 3/11/26. The complaint was substantiated (intake #NC00236045). A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5000 Facility Based Crisis Service for Individuals of All Disability Groups.</p> <p>This facility is licensed for 16 and has a current census of 10. The survey sample consisted of audits of 4 current clients and 1 former client.</p>	V 000	<p style="text-align: center;"><b>RECEIVED</b> <b>MAR 30 2026</b> DHSR-MH Licensure Sect</p>	
V 318	<p><b>130 .0102 HCPR - 24 Hour Reporting</b></p> <p><b>10A NCAC 130 .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL</b> The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g).</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report an allegation of abuse to the Health Care Personnel Registry (HCPR) within 24</p>	V 318		<p><b>10A NCAC 130 .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL</b></p> <ul style="list-style-type: none"> <li>Both reporting forms- Rept 24hr and 5dFINAL were obtained and placed into a binder.</li> <li>In the event that an allegation occurs when management is not on site, QA will delegate to have the form completed and faxed to the Health Care Personnel Registry within 24 hrs.</li> <li>Staff will be provided information about the binder via email and one on one supervision.</li> <li>Compliance will be monitored on an ongoing basis by QA and Program Director immediately following each incident and tracked on a monthly basis.</li> <li>Completed 10/12/26</li> </ul>

Division of Health Service Regulation	LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	<i>Jimmy W. [Signature]</i>	Crisis Program Director	3-25-26

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER  <b>THE HOPE CENTER FOR YOUTH AND FAMILY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>400 WEST RANSOM STREET FUQUAY VARINA, NC 27526</b>
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V 318	<p>Continued From page 2</p> <ul style="list-style-type: none"> <li>- She was responsible to ensure that the HCPR was notified of any allegations of abuse</li> <li>- She called the HCPR on 1/26/26 and the HCPR representative told her to complete an IRIS report</li> <li>- It "gets hairy (confusing)" because she received different instructions on how to notify the HCPR within 24 hours of the abuse allegation</li> <li>- She would call the HCPR to determine the necessary abuse allegation steps moving forward so that "this citation does not happen again"</li> </ul> <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 318		



NC DEPARTMENT OF  
**HEALTH AND  
HUMAN SERVICES**

JOSH STEIN • Governor

DEVDUTTA SANGVAI • Secretary

MARK PAYNE • Director, Division of Health Service Regulation

March 24, 2026

Ms. Tammy Margeson, Crisis Program Director  
Kidspace National Center for Youth and Family Crisis  
400 West Ransom Street  
Fuquay Varina, NC 27526

Re: Complaint and Follow-Up Survey completed 3/11/26  
The Hope Center for Youth and Family Crisis, 400 West Ransom St, Fuquay Varina, NC 27526  
MHL # 092-1009  
E-mail Address: tammy.margeson@kidspace.org  
Intake #NC00236045

Dear Ms. Margeson:

Thank you for the cooperation and courtesy extended during the complaint and follow-up survey completed 3/11/26. The complaint was substantiated.

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

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

**Type of Deficiencies Found**

- A re-cited standard level deficiency.

**Time Frames for Compliance**

- A re-cited standard level deficiency must be **corrected** within 30 days from the exit of the survey, which is April 10, 2026.

**What to include in the Plan of Correction**

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

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

MENTAL HEALTH LICENSURE & CERTIFICATION SECTION

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

LOCATION: 1915 Health Services Way, Raleigh, NC 27607  
MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718  
www.ncdhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

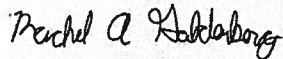
March 24, 2026  
The Hope Center for Youth and Family Crisis  
Kidspeace National Centers of North America, Inc

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

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

A follow-up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Shawn Page at 910-990-3708.

Sincerely,



Rachel Goldenberg  
Facility Compliance Consultant I  
Mental Health Licensure & Certification Section

Cc: DHSR@Alliancebhc.org  
Antonia Pedroza, Director, Wake County DSS  
Michael Blake, Administrative Supervisor