

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-222	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/01/2026
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NAME OF PROVIDER OR SUPPLIER REVIVE HOUSING, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 523 NORTH LONG STREET SALISBURY, NC 28144
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V 000	<p>INITIAL COMMENTS</p> <p>An annual, complaint and follow up survey was completed on 4/1/26. The complaints were unsubstantiated (intake # NC00236357 and intake # NC00236594). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.</p> <p>The facility is licensed for 4 and has a current census of 4. The survey sample consisted of audits of 4 current clients.</p>	V 000		
V 366	<p>27G .0603 Incident Response Requirements</p> <p>10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS</p> <p>(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:</p> <p>(1) attending to the health and safety needs of individuals involved in the incident;</p> <p>(2) determining the cause of the incident;</p> <p>(3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;</p> <p>(4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;</p> <p>(5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;</p> <p>(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</p>	V 366		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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V 366	<p>Continued From page 1</p> <p>(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.</p> <p>(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.</p> <p>(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:</p> <p>(1) immediately securing the client record by:</p> <p>(A) obtaining the client record;</p> <p>(B) making a photocopy;</p> <p>(C) certifying the copy's completeness; and</p> <p>(D) transferring the copy to an internal review team;</p> <p>(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:</p> <p>(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;</p> <p>(B) gather other information needed;</p> <p>(C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the</p>	V 366		

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V 366	<p>Continued From page 2</p> <p>LME in whose catchment area the provider is located and to the LME where the client resides, if different; and</p> <p>(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</p> <p>(3) immediately notifying the following:</p> <p>(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;</p> <p>(B) the LME where the client resides, if different;</p> <p>(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;</p> <p>(D) the Department;</p> <p>(E) the client's legal guardian, as applicable; and</p> <p>(F) any other authorities required by law.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility</p>	V 366		
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V 366	<p>Continued From page 3</p> <p>failed to implement written policies governing their response to level II incidents as required affecting clients (#1, #2 and #3). The findings are:</p> <p>Finding #1:</p> <p>Review on 3/27/26 of client #1's record revealed:</p> <ul style="list-style-type: none"> - An admission date of 5/26/25 - Diagnoses of Disruptive Mood Dysregulation Disorder (D/O), Combined Presentation and Unspecified Trauma and Stressor Related D/O <p>Interview on 3/26/26 with client #1 revealed:</p> <ul style="list-style-type: none"> - Denied any staff having harmed him - He felt safe at the facility - If anyone ever harmed him, he would tell the Qualified Professional (QP) or the Director <p>Review on 3/27/26 of client #2's record revealed:</p> <ul style="list-style-type: none"> - An admission date of 1/15/26 - Diagnoses: Conduct D/O; Adjustment D/O with Anxiety; Trauma Related Stress D/O; Attention Deficit Hyperactivity D/O, Combined Type; Sibling Relational Challenges and Problems Related to Upbringing <p>Interview on 3/26/26 with client #2 revealed:</p> <ul style="list-style-type: none"> - When asked about whether or not he had concerns about the safety of himself or his peers at the facility, client #2 reported he believed the Qualified Professional (QP) had "choked" client #1 - Although, he did not see the QP "choke" client #1, he believed the incident had occurred because he "heard some stuff" coming from client #1's bedroom - Client #2 could provide no additional information regarding the alleged incident to include when the incident occurred 	V 366		

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V 366	<p>Continued From page 4</p> <ul style="list-style-type: none"> - When asked if he liked the QP, he stated, "I like snacks." <p>Finding #2:</p> <p>Review on 3/27/26 of client #3's record revealed:</p> <ul style="list-style-type: none"> - An admission date of 1/28/26 - A diagnosis of Disruptive Mood Dysregulation D/O <p>Interview on 3/27/26 with client #3 revealed:</p> <ul style="list-style-type: none"> - No one at the facility (staff or other clients) had provided him with marijuana - Had never told his mother that staff had provided him with marijuana <p>Review on 3/31/26 of the QP's record revealed:</p> <ul style="list-style-type: none"> - A hire date of 3/13/23 <p>Interview on 3/27/26 with the Qualified Professional (QP) revealed:</p> <ul style="list-style-type: none"> - In February 2026 (exact date not provided), client #2 alleged the QP "choked" client #1 while at the facility - The Department of Social Services (DSS) initiated an investigation into the allegation, and he was instructed by the Director to leave the facility on the same day (no dates provided) - On 3/26/26, the Director was notified by DSS personnel that the allegation was unsubstantiated - He returned to work at the facility on 3/26/26 - The QP denied choking client #1 and stated that client #2 fabricated the allegation because he wanted a snack, adding that client #2 "will say and do anything for snacks." - Was aware of client #3's mother's allegation that client #3 had reported to her that staff had provided him with marijuana; however, she never named any staff, the date or the time the alleged incident occurred 	V 366		

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V 366	<p>Continued From page 5</p> <ul style="list-style-type: none"> - Client #3 had been removed from his mother's care because she had allowed him to smoke marijuana and drink alcohol - When this was addressed with client #3, he denied ever having reported to his mother that staff had provided him with marijuana - Client #3's mother had a history of substance use and he believed she was attempting to disrupt client #3's placement <p>Interview conducted on 3/26/26 with a DSS social worker revealed the following:</p> <ul style="list-style-type: none"> - On 2/25/26, her agency received a report which alleged "sometime in early February (2026), the facility's QP had "choked" client #1 - A DSS investigation was initiated and she made a visit to the facility on or about 2/25/26 - Upon her visit to the facility, the facility's Director agreed to suspend the QP from all duties at the facility until the completion of the DSS investigation - In March 2026, a second report was received by her Department that staff had allegedly provided client #3 with marijuana <p>Review on 3/26/26 and on 3/27/26 of the Incident Response Improvement System (IRIS) revealed:</p> <ul style="list-style-type: none"> - The last level II incident report submitted to IRIS by the facility was dated 11/25/25 - No evidence that a level II incident report had been submitted to IRIS regarding DSS visiting the facility to investigate client #2's allegation that the QP had "choked" client #1 sometime in February 2026 or a second visit to the facility by a DSS social worker in March 2026 to investigate an allegation that staff had provided client #3 with marijuana - As no level II incident reports had been submitted, there was no documentation that would indicate the facility had initiated internal 	V 366		

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V 366	Continued From page 6 investigations to determine if there were any validity to the allegations; documentation of how the facility had attended to the health and safety needs of the individuals involved in the alleged incidents; had determined the cause of the allegations; if the facility had developed and implemented any corrective measures; if any measures had been developed to prevent similar incidents and had the facility assigned person(s) to be responsible for implementation of any corrective/preventative measures which are all to be addressed when completing a level II incident report Interview on 4/1/26 with the Director revealed: - He had failed to ensure level II incident reports had been completed and submitted to IRIS as required	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:	V 367		

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V 367	<p>Continued From page 7</p> <p>(1) reporting provider contact and identification information;</p> <p>(2) client identification information;</p> <p>(3) type of incident;</p> <p>(4) description of incident;</p> <p>(5) status of the effort to determine the cause of the incident; and</p> <p>(6) other individuals or authorities notified or responding.</p> <p>(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:</p> <p>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or</p> <p>(2) the provider obtains information required on the incident form that was previously unavailable.</p> <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <p>(1) hospital records including confidential information;</p> <p>(2) reports by other authorities; and</p> <p>(3) the provider's response to the incident.</p> <p>(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</p>	V 367		

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V 367	<p>Continued From page 8</p> <p>.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:</p> <ol style="list-style-type: none"> (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. <p>This Rule is not met as evidenced by: Based on record review and interview, 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 are provided within the 72 hours of becoming aware of the incident affecting 3 of 3 audited clients (clients #1, #2 and #3). The findings are:</p>	V 367		

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V 367	<p>Continued From page 9</p> <p>Finding #1:</p> <p>Review on 3/27/26 of client #1's record revealed:</p> <ul style="list-style-type: none"> - An admission date of 5/26/25 - Diagnoses of Disruptive Mood Dysregulation Disorder (D/O), Combined Presentation and Unspecified Trauma and Stressor Related D/O <p>Interview on 3/26/26 with client #1 revealed:</p> <ul style="list-style-type: none"> - No staff have ever harmed him - He felt safe at the facility - If anyone ever harmed him, he would tell the Qualified Professional (QP) or the Director <p>Review on 3/27/26 of client #2's record revealed:</p> <ul style="list-style-type: none"> - An admission date of 1/15/26 - Diagnoses: Conduct D/O; Adjustment D/O with Anxiety; Trauma Related Stress D/O; Attention Deficit Hyperactivity D/O, Combined Type; Sibling Relational Challenges and Problems Related to Upbringing <p>Interview on 3/26/26 with client #2 revealed:</p> <ul style="list-style-type: none"> - When asked about whether or not he had concerns about the safety of himself or his peers at the facility, client #2 reported he believed the Qualified Professional (QP) had "choked" client #1 - Although, he did not see the QP "choke" client #1, he believed the incident had occurred because he "heard some stuff" coming from client #1's bedroom - Client #2 could provide no additional information regarding the alleged incident to include when the incident occurred - When asked if he liked the QP, he stated, "I like snacks." <p>Finding #2:</p>	V 367		

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V 367	<p>Continued From page 10</p> <p>Review on 3/27/26 of client #3's record revealed:</p> <ul style="list-style-type: none"> - An admission date of 1/28/26 - A diagnosis of Disruptive Mood Dysregulation D/O <p>Interview on 3/27/26 with client #3 revealed:</p> <ul style="list-style-type: none"> - No one at the facility (staff or other clients) had provided him with marijuana - Had never told his mother that staff had provided him with marijuana <p>Review on 3/31/26 of the QP's record revealed:</p> <ul style="list-style-type: none"> - A hire date of 3/13/23 <p>Interview on 3/27/26 with the Qualified Professional (QP) revealed:</p> <ul style="list-style-type: none"> - In February 2026 (exact date not provided), client #2 alleged the QP "choked" client #1 while at the facility - The Department of Social Services (DSS) initiated an investigation into the allegation, and he was instructed by the Director to leave the facility on the same day (no dates provided) - On 3/26/26, the Director was notified by DSS personnel that the allegation was unsubstantiated - He returned to work at the facility on 3/26/26 - The QP denied choking client #1 and stated that client #2 fabricated the allegation because he wanted a snack, adding that client #2 "will say and do anything for snacks." - Was aware of client #3's mother's allegation that client #3 had reported to her that staff had provided him with marijuana; however, she never named any staff, the date or the time the alleged incident occurred - Client #3 had been removed from his mother's care because she had allowed him to smoke marijuana and drink alcohol - When this was addressed with client #3, he 	V 367		

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V 367	<p>Continued From page 11</p> <p>denied ever having reported to his mother that staff had provided him with marijuana</p> <ul style="list-style-type: none"> - Client #3's mother had a history of substance use and he believed she was attempting to disrupt client #3's placement <p>Interview conducted on 3/26/26 with a DSS social worker revealed the following:</p> <ul style="list-style-type: none"> - On 2/25/26, her agency received a report which alleged "sometime in early February (2026), the facility's QP had "choked" client #1 - A DSS investigation was initiated and she made a visit to the facility on or about 2/25/26 - Upon her visit to the facility, the facility's Director agreed to suspend the QP from all duties at the facility until the completion of the DSS investigation - She was also aware of an allegation that had been made regarding staff providing client #3 with marijuana and on 3/12/26, another DSS social worker visited the facility to check on the health and safety of the clients at the facility <p>Review on 3/26/26 and on 3/27/26 of the Incident Response Improvement System (IRIS) revealed:</p> <ul style="list-style-type: none"> - The last level II incident reported submitted to IRIS was dated 11/2/25 - No evidence that a level II incident report had been submitted to IRIS regarding client #2's allegation that the QP had "choked" client #1 "sometime" in February 2026 or that staff had provided client #3 with marijuana in March 2026 <p>Interview on 4/1/26 with the Director revealed:</p> <ul style="list-style-type: none"> - He had failed to ensure level II incident reports had been completed and submitted to IRIS as required 	V 367		