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ANDERSON HEALTH SERVICES-WALFUS	1915-A HASTY ROAD MARSHVILLE, NC 28103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and complaint survey was completed on 4/9/26. The complaints were substantiated (intake #NC00235244 and NC00235563). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents. This facility is licensed for 12 and has a current census of 10. The survey sample consisted of audits of 3 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 responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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V 112	Continued From page 1	V 112		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to develop and implement goals and strategies to address the needs of three of three audited clients and failed to have written consent or agreement by the client or responsible party affecting one of three audited clients (#2). The findings are:

Review on 4/2/26 and 4/9/26 of client #1's file revealed:
-Age 16 years.
-Admission 3/31/25.
-Comprehensive Clinical Assessment (CCA) dated 1/8/25 with history of defiant and non-compliant behaviors...struggles to express his feelings...which can lead to emotional dysregulation, defiant behaviors, and potential conflicts with others...Persistent pattern of defiant, argumentative, and non-compliant behavior toward authority figures, as evidenced by frequent refusal to follow directions, talking back, and having a strained relationship with caregivers due to negative behaviors...Chronic irritability and mood swings, as well as difficulty regulating emotions, contributing to verbal and physical aggression...Frequent anger outbursts and an inability to consistently engage in positive behaviors.
-Treatment plan dated 12/31/25 with the following

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V 112	Continued From page 2 goals: ...develop and maintain appropriate personal hygiene and room cleanliness...actively participate in the daily program structure...demonstrate medication compliance...attend weekly therapy sessions...to identify personal emotional triggers and learn coping skills to manage emotions effectively. Client will work on applying at least one identified coping skill in real-life situations. -Diagnoses: Oppositional Defiant Disorder; Disruptive Mood Dysregulation Disorder. -No documentation of goals and strategies to address mood, emotional dysregulation, negative behaviors and defiance. Review on 4/2/26 and 4/9/26 of client #2's file revealed: -Age 17 years. -Admission 8/11/25. -CCAs dated 7/4/25 and 8/5/25 with history of trauma, placement disruptions due to rebellion, noncompliance with rules and making accusations of mistreatment; family conflicts and stress related to life transitions. -Treatment plan dated 3/24/26 with the following goals:...will develop and maintain appropriate personal hygiene and room cleanliness...will actively participate in the daily program structure...demonstrate medication compliance...attend weekly therapy sessions...to identify personal emotional triggers and learn coping skills to manage emotions effectively. Client will work on applying at least one identified coping skill in real-life situations...attend school consistently. -Diagnoses: Conduct Disorder, Childhood Onset Type; Attention Deficit-Hyperactivity Disorder (ADHD); Reactive Attachment Disorder. -No documentation of goals and strategies to address trauma history, noncompliance, decision	V 112		

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V 112	Continued From page 3 making related to 18th birthday, graduation, and transition to adulthood to include independent living skills and employment. Review on 4/2/26 and 4/9/26 of client #3's file revealed: -Age 15 years. -Admission 7/29/25. -CCA dated 5/4/16 with history of defiance, verbal and physical aggression, poor school performance with suspensions, altercations, vaping, theft, and hospitalizations. -Treatment Plan dated 2/24/26 with the following goals...will develop and maintain appropriate personal hygiene and room cleanliness...will actively participate in the daily program structure...demonstrate medication compliance...attend weekly therapy sessions...to identify personal emotional triggers and learn coping skills to manage emotions effectively. Client will work on applying at least one identified coping skill in real-life situations...attend school consistently. -Diagnoses: ADHD, Predominately Inattentive Type. -No documentation of goals and strategies to address defiance, aggressive behaviors, altercations, poor school performance and suspensions, safety related to injuries, elopement, substance use and vaping. Review on 4/1/26 of Child Family Team (CFT) meeting note for client #2 dated 3/24/26 revealed: -3/24/26, "One recent peer-related incident during sports activity on campus...Youth reports missing/unfinished assignments and lack of materials impacting grades...Guardian reports receiving frequent absence notifications and concern regarding impact of absences on graduation...Therapy focus includes: Emotional	V 112		

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V 112	Continued From page 4 processing; Independent living skills; Healthy relationships; Decision-making regarding romantic/sexual behavior; Understanding consequences of aggression in adulthood...Concern regarding adjustment to adulthood and transition; Need to coordinate and clarify visitation plan with potential transition placement (biological mom)...next CFT 4/23 (2026)." Review on 4/2/26 of CFT meeting notes provided by Quality Director for client #3 from 10/1/25 to 2/1/26 revealed: -2/10/26, "...continues to demonstrate patterns of noncompliance overall, particularly related to treatment engagement and expectations. He has been described as doing what he wants at times and not consistently adhering to rules or expectations...currently struggling academically. He has several missing assignments, which are contributing significantly to his failing grades in multiple subjects...Ongoing noncompliance is observed across multiple areas (therapy engagement, behavioral expectations, injury care)...initially had a cast placed for his broken wrist. He removed the cast himself...wrist is still in the healing process and may take longer to heal due to noncompliance...Despite repeated conversations about health, medications, and decision-making, [client #3] remains largely noncompliant...Team will reconvene on February 24 (2026) at 11:30 AM to review updates, including potential placement feedback." -No documentation provided for the CFT dated 2/24/26. -3/19/26, "...Continuing to work on refraining from verbal exchanges with peers. Currently home from school due to a peer-related incident on the bus...has some missing assignments and zeros due to suspensions...substance use remains a	V 112		

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V 112	Continued From page 5 concern...Recent nosebleeds: three at school, one at residential; significant in volume, treated with ice and pressure. History uncertain; may occur 1-2 times per month..." Review on 4/7/26 of emails correspondence between client #2's Legal Guardian/mother (LG/mother) to the Care Coordinator (CC) dated 12/2/25 and 12/3/25 revealed: -12/2/25 from the CC at 10:52am, "I hope this email finds you well. I am reaching out to share [client #2]'s updated PCP (person centered plan (treatment plan)) and crisis. Could you possibly sign his PCP and get it back to us by the end of the day? Let me know if you have any questions or concerns..." -12/3/25 from client #2's LG/mother at 6:03pm, "...If this is a new and updated PCP, it has already been electronically signed by someone else besides me..." Interview on 4/7/26 with client #2's LG/mother revealed: -"I got an email (December 2026) communication from the facility with a PCP attached, it was auto signed by not by me. My signature was on it but I didn't sign it and I replied back in an email (letting the facility know that the treatment plan had been auto signed with her signature)." Interview on 4/8/26 with the CC revealed: -Managed CFT meetings. -Managed interactions with schools. -She emailed client's treatment plans to LGs for signature. -The November treatment plan for client #2 was signed by his LG/mother. -Client #1 was working with another CC, "she who would know more about him." -Client #2 was "working on accountability,	V 112		

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V 112	Continued From page 6 transparency...appropriate relationship skills, transitioning with independent living skills; he (client #2) had a job and wasn't communicating honestly about the times he was working." -Client #3 "has changed for the better, there was a period when he was not doing so good and there was a time he wasn't complying with the program." -"[Client #3] is working on substance use, complying with treatment...following staff directives. He can get in a space when he is doing well and one thing will happen and he will start crashing out. He is not doing great in school, missing assignments." Interview on 4/8/26 and 4/9/26 with the Chief Agency Director revealed: -Treatments plans were sent to LGs for signature by the facility's CC. -Was not aware that there was not a LG's signature on client #2's November treatment plan. -"The care coordinators are responsible for getting the signatures. The clinicians do the treatment plans and sign the treatment plan. The goals are in collaboration between the clinicians, the client and the legal guardians." -Staff therapist informed that the November treatment plan for client #2 had not been signed by the LG/mother. -"The goals (clients) being "cookie cutter" is the reason we (management) moved on (terminated) from the clinician (clinical supervisor) we had. It (treatment plan) was addressed with the clinician and she left in March (2026) because she became upset when it was addressed that the plans (treatment) needed to reflect individualized treatment."	V 112		

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V 131	Continued From page 7	V 131		
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 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 reviews and interview, the facility failed to access the Health Care Personnel Registry (HCPR) prior to the date of hire for 2 of 4 audited staff (Staff #1, #3) The findings are: Review on 4/1/26 of Staff #1's personnel record revealed: -Hire date of 9/23/24. -HCPR was accessed on 12/10/24. Review on 3/31/26 of Staff #3's personnel record revealed: -Hire date of 2/10/24. -HCPR was accessed on 12/10/24. Interview on 4/9/26 with the Chief Agency Director revealed: -Human Resources was responsible for accessing HCPR prior to hire -He was responsible for oversight of the facility's functions. -He was aware HCPR checks were to be	V 131		

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V 131	Continued From page 8 completed prior to hire. -Was not aware HCPR had been accessed after staff #1 and #2's hire date. -Thought the facility had previously been cited for these employees and would provide documentation. No documentation of a previous cite was provided prior to survey exit.	V 131		
V 179	27G .1301 Residential Tx - Scope 10A NCAC 27G .1301 SCOPE (a) The rules of this Section apply only to a residential treatment facility that provides residential treatment, level II, program type service. (b) A residential treatment facility providing residential treatment, level III service, shall be licensed as set forth in 10A NCAC 27G .1700. (c) A residential treatment facility for children and adolescents is a free-standing residential facility which provides a structured living environment within a system of care approach for children or adolescents who have a primary diagnosis of mental illness or emotional disturbance and who may also have other disabilities. (d) Services shall be designed to address the functioning level of the child or adolescent and include training in self-control, communication skills, social skills, and recreational skills. Children or adolescents may receive services in a day treatment facility, have a job placement, or attend school. (e) Services shall be designed to support the child or adolescent in gaining the skills necessary to return to the natural, or therapeutic home setting. (f) The residential treatment facility shall	V 179		

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V 179	Continued From page 9 coordinate with other individuals and agencies within the client's system of care.	V 179		

This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to coordinate with other individuals and agencies within the client's system of care affecting two of three clients (#2, #3). The findings are:

Review on 4/2/26 and 4/9/26 of client #2's file revealed:
-Age 17 years.
-Admission 8/11/25.
-Comprehensive Clinical Assessments (CCA) dated 7/4/25 and 8/5/25 with history of trauma, placement disruptions due to rebellion, noncompliance with rules and making accusations of mistreatment; family conflicts and stress related to life transitions.
-Diagnoses: Conduct Disorder, Childhood Onset Type; Attention Deficit-Hyperactivity Disorder (ADHD); Reactive Attachment Disorder.

Review on 4/2/26 and 4/9/26 of client #3's file revealed:
-Age 15 years.
-Admission 7/29/25.
-CCA dated 5/4/16 with history of defiance, verbal and physical aggression, poor school performance with suspensions, altercations, vaping, theft, and hospitalizations.

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V 179	Continued From page 10 -Diagnoses: ADHD, Predominately Inattentive Type. Review on 4/7/26 of emails correspondence between client #2's Legal Guardian/mother (LG/mother) to the Care Coordinator (CC) dated 12/3/25 revealed: -"...One correction on the PCP under the medication section-we (parents) did not "give permission" for him to stop ADHD meds (medication). I was notified that they (facility) can not get [medication] anymore. When [client #2] met with his medication management doctor, the two of them (client #2 and doctor) decided that [client #2] should stop the ADHD medication, and I was notified about it (discontinued medication) after the fact. We (parents) were never part of that decision..." Review on 4/2/26 of client #3's hospital after visit summaries revealed: 8/2/25, Eye pain, periorbital hematoma of left eye, "...we would expect the bruising and swelling to go down over the next one to two weeks..." 9/8/25, hand injury, facial injury; contusion of right hand Review on 4/8/26 of Quality Staff's cell phone history revealed: -9/5/25 Outgoing call at 10:15pm, 15 minutes -8/1/25 Outgoing calls at 11:13pm, 11 minutes; 8:27pm, 4 minutes face time call; and 8:22pm 5 minutes; 8:10pm 2 minute face time call. Interview on 4/2/26 and 4/7/26 with client #3 revealed: -"My first week here (facility), went to [theme park], [former client] told me to steal shoes and got mad because he started to pick up the shoes to hide, got caught and he blamed me, when we	V 179		

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V 179	Continued From page 11 got back (facility) he (former client #1) was caught with a vape. He hit me and popped blood vessel in left eye. I went to the ER (emergency room). Second time (black eye), I got in fight with [former client #2], not here no more. I hurt my hand from the middle finger down to the pinky (finger), it was cut. We started fighting and he fell and when I went to hit him, I missed and I hit the concrete." -"Was bullied when I first arrived (admitted) by [former client #1] and client #7, but no one was threatening me." -"When I got my black eye that was intentional, the first time [former client #1] hit me. I didn't know that was going to happen. The second time (black eye), I was fighting with [former client #2] and he is no longer here, he is in a different placement. My other injuries were not intentional, just from playing sports." Interview on 4/8/26 with client #2's Legal Guardian/mother revealed: -There was communication from the facility about client #2's status "sometimes." -"I think there is information that has happened that I haven't gotten right away. He (client #2) has been in physical altercations and they (facility staff) bought it up in CFT (Child Family Team meeting)." -Client #2 wanted to be taken off his ADHD medication "and med (medication) management began taking him off and I found out a week or two later. It was bought up in CFT meeting after it was already done. It was bought up as an afterthought." -Received an email in 12/2/25 with the treatment plan attached and it had been signed electronically, "not by me. My signature was on it but I didn't sign it. -She sent a return email that addressed her	V 179		

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V 179	Continued From page 12 concerns that the treatment plan had already been signed when she received it, she "didn't know or agree with medication change", and "that the crisis plan looked like a training form and not an actual crisis plan. Come to think of it, I never got the crisis plan." -"My husband and I are getting calls at least one to two times a week that he (client #2) is missing school but the facility is saying he is attending. I don't know if he is not going or that he is skipping." -Thought that some of client #2's behavior "may have been the result of him not getting his medication (ADHD). "[Client #2] has never been aggressive but since he was off his medication he initiated fights, about 4-5 months, or about once a month...they (prescriber) just took him off...there was no alternative offered and there was no taper. I have never talked with the prescriber. His behavior has leveled out. I think it (behaviors) was that initial jolt after not having his medication." Interview on 4/8/26 with client #3's LG/mom revealed: -"I wish they would communicate a lot more when he gets sent out to the hospital, I usually hear about it two to three days later or they will cover everything in the CFT." -She was not getting updates from the facility about client #3's school attendance. -"The night he (client #3) went to the hospital for his groin, he called me from the facility to say he was on his way to the hospital. The nurse asked who he was talking to on the phone and the nurse told him she would call me back later and told him to get off the phone. I don't know the name of the nurse." -"If he is suspended from school we get emails with referral from the school but I feel like I should	V 179		

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V 179	Continued From page 13	V 179		

get a call from the facility."
-Knew about the black eye in August 2025 and was not aware of an eye or facial injury in September 2025.

Interview on 4/2/26 with the Managed Care Organization (MCO) Care Manager for client #3 revealed:
-Received information from the facility and the legal guardian of client #3's injury from January 2026.
-Had not received a medical report of the injury.
-Was informed that client #3 went to the hospital for his groin and was told by the hospital that his wrist was broken.
-Would reach out to the MCO Nurse "to see if we can get additional medical information."
-Client #3's LG/mom lived out of the area and did not get to the hospital when there were injuries.
-"He (client #3) called her (LG/mom) when he was on his way (to hospital). There had been other instances when he went to the hospital and no one (facility staff) told her (LG/mom). She never gave me specific dates. Some of that (information) I have to take what she is saying."

Interview on 4/8/26 with the Quality staff revealed:
-Guardians had been contacted within 24 hours of an incident.
-She had several conversations with client #3's LG/mom.
-Had notified client #3's LG/mom about client #3's black eye in August 2025 and wrist injury in January 2026.
-Called client #3's LG/mom in August 2025 "on face time to let her see his face."
-In September 2025, client #3 was in an altercation with former client #2 and client #3 injured his right hand. "Her (LG/mom) husband was in the back ground. She (LG/mom) asked

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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
V 179	Continued From page 14 me if it (altercation) was about a vape because she knows her son and I told her they (client #3 and former client #2) were fighting over a vape. The fight was over a vape from school." -Client #3 "has never had two black eyes." -Was not aware of an eye or facial injury from the altercation with a peer in September 2025. Interview on 4/8/26 with the Therapist for client #2 revealed: -Client #2's LG/mother "called [CC] and said she wouldn't sign until the PCP (treatment plan) was changed." -Client #2's treatment plan was changed on 11/18/25. -The ADHD medication was discontinued without the permission of client #2's LG/mother. -"She (LG/mother) signed the monthly updated PCP. [Client #2] went directly to nursing and advocated to be off medication (ADHD). He was refusing to take that medication anymore, they would discontinue, and the nurse (Registered Nurse, RN) updated that he would stop taking ADHD medication." -"She (LG/mother) signed it (November PCP) on 11/25 (2025), that's when I scanned it to her, she signed on 12/2 (2025); she signed both of them, the November and December's PCP." -"The problem was he (client #2) was refusing to take it (ADHD medication), went to nursing and said he didn't need it anymore, had review and discontinued due to non-compliance. Initially she (LG/mother) was upset when it was shared in the CFT meeting and said she knew he wanted to get off his ADHD medication. It was discontinued due to non-compliance. It wasn't changed. -The electronic signature could not be "a copy and paste, there is a notification that it was signed by the guardian (LG/mother)."	V 179		

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V 179	Continued From page 15 Interview on 4/2/26 with facility Registered Nursing Staff revealed: -"...There were two black eyes, one on 8/2 (2025) around the time he (client #3) was admitted, he was admitted in July and one on 9/8 (2025) from an altercation (with client #2)." -"It was an injury to his (client #3) left eye and he went to the hospital the next day (8/2/25) because it was getting worse and he had more complaints, that was in the Linden Cottage chart. The altercation was on 8/1 (2025) at 8pm, it was unprovoked with [former client #1]...He (client #3) was moved that night to Ashford Cottage temporarily for his safety and then moved permanently to Walfus in his age group. He was brought up to the nurse station on 8/1 (2025) because he had a medication management appointment that weekend (8/2/25) with [Facility Doctor] who saw him and wanted him to be evaluated to make sure nothing else was going on. He reported he was jumped and punched in the eye by [former client #1] and would be sent to the Urgent Care, that was in [Facility Doctor]'s note; there was no fracture (eye)." Interview on 4/8/26 and 4/9/26 with the Chief Agency Director revealed: -Client #2's LG/mother was aware of a plan to discontinue client #2's medications prior to discharge when he turned eighteen years old. -Client #2's LG/mother was aware that client #2 wanted to discontinue his ADHD medication but was not informed prior to the decision to discontinue the medication. -Client #2's ADHD medication was discontinue due to non-compliance with taking the medication, but the facility was responsible for informing the LG/mother prior to a decision to discontinue the medication. -LGs are "contacted in real time, we have	V 179		

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V 179	Continued From page 16 twenty-four hours to notify." -Clients may call their LGs before the facility gets a chance to call LGs. "[Client #3] called his mother (LG/mom) while he was at the hospital (1/8/26). He got through to her before we did. That happened twice. I have documentation that the guardian (LG/mom) was contacted, but we did not get her on the phone. -Client #3 never had two black eyes, "I think the black eye from August (2025) was not healed when he (client #3) had an altercation in September 2025. The nurse might have noted that he still had the black eye because it was healing. It may have been a new nurse." -Was not aware of a second facial or eye injury in September 2025.	V 179		
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	V 366		

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V 366	Continued From page 17 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; (B) gather other information needed;	V 366		

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V 366	Continued From page 18 (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 19 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 findings are: Review on 4/2/26 and 4/9/26 of client #3's file revealed: -Age 15 years. -Admission 7/29/25. -CCA dated 5/4/16 with history of defiance, verbal and physical aggression, poor school performance with suspensions, altercations, vaping, theft, and hospitalizations. -Treatment Plan dated 2/24/26 with the following goals...will develop and maintain appropriate personal hygiene and room cleanliness...will actively participate in the daily program structure...demonstrate medication compliance...attend weekly therapy sessions...to identify personal emotional triggers and learn coping skills to manage emotions effectively. Client will work on applying at least one identified coping skill in real-life situations...attend school consistently... -Diagnoses: ADHD, Predominately Inattentive Type. Review on 3/31/26 of client #3's hospital after visit summaries from September 2025 to March 2026 revealed: -9/8/25, reason for visit hand injury, facial injury, contusion of right hand, initial encounter. -10/4/25, reason for visit altered mental state; diagnoses ingestion of foreign substance, initial encounter, cannabis intoxication with complication. -1/8/26, reason for visit groin injury, wrist injury;	V 366		

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V 366	Continued From page 20 diagnoses closed fracture of distal end of left radius, unspecified fracture morphology, initial encounter, spermatocele, left inguinal pain. -1/14/26, consult for closed fracture of distal end of left radius, right distal radius fracture, short arm cast for 3-4 weeks. -3/26//26, reason for visit testicle pain; diagnosis pain in right testicle. Review on 3/31/26 and 4/7/26 of the Incident Response Improvement System (IRIS) from 9/1/25 to 4/7/26 revealed: -No level II incident report of client #3's eye injury on 9/8/25. -No level II incident report of client #3's "cannabis intoxication with complication" on 10/4/25. Interview on 4/2//26 with the Quality Director revealed: -Was made aware of client #3's multiple injuries. -Was not aware of an eye injury on 9/8/26. -Quality Staff was responsible for making sure incident reports were completed. -Was responsible for ensuring investigations were initiated and completed. -There was no investigation "because it was always peer altercation led, so I didn't do an investigation." -Failed to attend to the health and safety needs of the client involved in the incident. -Failed to determine the cause of the incident. -Failed to develop and implement corrective measures. -Failed to develop and implement measures to prevent similar incidents from occurring. -Failed to assign person(s) to be responsible for implementation of the corrections and preventive measures.	V 366		

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V 367	Continued From page 21	V 367		
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 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	V 367		

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V 367	Continued From page 22 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 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	V 367		

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V 367	Continued From page 23 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 observation, 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 required time frames. The findings are: Review on 3/31/26 of the facility's incident reports for client #3 from August 2025 to March 2026 revealed: -8/2/25, altercation between client #3 and a former client, "staff intervened and separated" client #3 and a former client, client #3 sustained right eye injury. -10/9/25, client #3 smoked a marijuana vape, was taken to the hospital and diagnosed with altered mental status related to cannabis intoxication with complications. -1/9/26, during game client #3 fell and landed on his arm and testicular region, transported to the hospital and diagnosed with fractured wrist and testicular trauma. -3/4/26, client #3 was sent to Urgent Care for body aches, low grade temp, and diarrhea. Diagnosed with Viral URI (upper respiratory infection).	V 367		

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V 367	Continued From page 24 -3/26/26, client #3 went to the emergency room (ER) due to right testicle pain Review on 3/31/26 of client #3's hospital after visit summaries from September 2025 to March 2026 revealed: -9/8/25, hand injury, facial injury, contusion of right hand, initial encounter -10/4/25, altered mental state; ingestion of foreign substance, initial encounter, cannabis intoxication with complication. -1/1/26, flu -1/8/26, groin and wrist injury -1/14/26, orthopedic for fractured wrist -3/26/26, pain in right testicle Review on 3/31/26 and 4/7/26 of the Incident Response Improvement System (IRIS) from 8/1/25 to 4/7/26 revealed: -9/5/25, submitted on 9/10/25, "On September 8, 2025, at approximately 6:09 p.m. Client [#3] was involved in a physical altercation with another client. During this incident, Client [#3] sustained injury to his right hand. The client was immediately assess by nursing staff, who determined that he required a higher level of medical care. No further incidents were reported following this event." -10/4/25, submitted on 10/9/25, client #3's hospitalization for altered mental status related to cannabis intoxication with complications.. -1/8/26, submitted on 1/9/26, client #3 injury, while playing football, fell and landed on arm and testicular region, staff transported to hospital, diagnosed with fractured wrist and testicular trauma that will resolve on its own. -3/36/26, client #3 went to the ER due to right testicle pain. He received an ultrasound with doppler, there were no testicular torsion or another acute emergency.	V 367		

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V 367	Continued From page 25 -No submission of a level II report of client #3's facial injury on 9/8/25. -No submission of a level II report of staff intervention and separation of client #3 and a former client during an altercation on 8/2/25, as described by the residential director when breaking up a physically aggressive altercation between clients. -No submission of a level II report of client #7's restraint on unknown date. Interview on 4/2/26 and 4/7/26 with client #3 revealed: -"My first week here (facility), went to [theme park], [former client] told me to steal shoes and got mad because he started to pick up the shoes to hide, got caught and he blamed me, when we got back (facility) he (former client #1) was caught with a vape. He hit me and popped blood vessel in left eye. I went to the ER. Second time (black eye), I got in fight with [former client #2], not here no more. I hurt my hand from the middle finger down to the pinky (finger), it was cut. We started fighting and he fell and when I went to hit him, I missed and I hit the concrete." -"Was bullied when I first arrived (admitted) by [former client #1] and client #7, but no one was threatening me." -"When I got my black eye that was intentional, the first time [former client #1] hit me. I didn't know that was going to happen. The second time (black eye), I was fighting with [former client #2] and he is no longer here, he is in a different placement. My other injuries were not intentional, just from playing sports." Interview on 4/8/26 with client #7 revealed: -Was admitted to the facility on 3/3/26. -"Seen a lot of people be restrained...I've been restrained (date unknown), when I chipped tooth	V 367		

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V 367	Continued From page 26 on food in cafeteria. I was yelling and they (unknown staff) restrained me, 4 people some were women, 2 women, 2 people behind me and 3 people in front of me, some people are more effective with restraints than others." -"They (staff) come and restrain you if you are doing something they don't like, you're getting punished every day, wake up to bulls**t and go to bed to bulls**t." Interview on 4/8/26 with the facility's residential director revealed: -Rarely had restraints. -"When there are fights (clients), staff are taught in [restrictive intervention (RI) training] to grab (client) by arms and separate them, and if not able (to separate) a restrictive intervention is applied. There has been a fight in the last week or two, not sure if there was a RI and not sure if boys were in the same cottage." -Had no documented hands-on restrictive interventions when clients were physically separated during physically aggressive altercations. Interview on with Quality Staff revealed: -She was responsible for IRIS report submissions. -The 9/5/25 incident was submitted late on 9/10/26 because she thought a supervisor had already submitted the report. -She was not aware of client #3's facial injury or injury to his eye on 9/8/25. -She submitted the information that was shared with her by staff who reported the incident. Interview on 4/2/26 with the Quality Director revealed: -Was not aware of client #3's facial injury or injury to his eye on 9/8/25.	V 367		

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V 367	Continued From page 27 -Did not know whether physical escort of clients during behaviors had been documented. -Would share information with the Director for timely documentation. -Had no explanation for why incident reports were submitted late in IRIS. Interview on 4/7/26 with the Chief Agency Director revealed: -Was not aware of client #3's facial injury or injury to his eye on 9/8/25. -Was not aware that any hands-on, physical contact with clients during an altercation was a restrictive intervention. -Would to retrain staff in RI and documentation. -Was not aware of late incident reports and submission. -Facility incident reports are dated for the date they are submitted in the system.	V 367		
V 503	27D .0103 Client Rights - Search And Seizure Policy 10A NCAC 27D .0103 SEARCH AND SEIZURE POLICY (a) Each client shall be free from unwarranted invasion of privacy. (b) The governing body shall develop and implement policy that specifies the conditions under which searches of the client or his living area may occur, and if permitted, the procedures for seizure of the client's belongings, or property in the possession of the client. (c) Every search or seizure shall be documented. Documentation shall include: (1) scope of search; (2) reason for search; (3) procedures followed in the search; (4) a description of any property seized;	V 503		

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V 503	Continued From page 28 and (5) an account of the disposition of seized property. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 audited clients (#3) was free from unwarranted invasion of privacy and failed to ensure every search or seizure was documented as required. The findings are: Review on 4/2/26 and 4/9/26 of client #1's file revealed: -Age 16 years. -Admission 3/31/25. -Diagnoses: Oppositional Defiant Disorder; Disruptive Mood Dysregulation Disorder. Review on 4/2/26 and 4/9/26 of client #2's file revealed: -Age 17 years. -Admission 8/11/25. -Diagnoses: Conduct Disorder, Childhood Onset Type; Attention Deficit-Hyperactivity Disorder (ADHD); Reactive Attachment Disorder. Review on 4/2/26 and 4/9/26 of client #3's file revealed: -Age 15 years. -Admission 7/29/25. -Diagnoses: ADHD, Predominately Inattentive Type. Review on 4/6/26 of the facility's records revealed: -No documentation of the facility's daily searches of clients (#1, #2, #3, #5, #6, #8, #9, and #10) coming from school or from home visits. -3/27/26 incident of search with client #3, "While	V 503		

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V 503	Continued From page 29 in the cottage the fire alarm went of (off) and shortly after [client #3] ran out of the cottage. While all the clients are out of the cottage staff conduced a search of the room to ensure nothing was in the room that might have triggered the fire alarm. [Client #3] was anxious to go back into the cottage and staff suspected that he might be in possession of a contraband item. Staff took [client #3] to nursing to conduct search of client where they (nursing) located a vape on [client #3]. [Client #3] became aggressive towards staff yelling, cursing and making threats to harm staff. [Client #3] eventually handed over the vape to staff." Attempted interview on 4/2/26, 4/7/26, and 4/8/26 with client #1 unable due to not in the facility, off campus for family visit and unable to contact by telephone. Interview on 4/8/26 with client #2 revealed: -He had been searched when he came home from school and when he came back from a home visit. -"Now they (staff) are doing pat downs. I don't like that. I don't really like being touched, it's too extra. When they pat, they go from head to toe. Sometimes they pull your pant legs up. -Had never been searched at nurses station and asked to change clothing. -Had heard that client #3 and client #6 were searched in basketball shorts in the nursing office. "I heard sometimes they take off all their clothes, a lot of kids (clients) here (facility) said that...It's been awhile since [client #7]'s search and I don't know about [client #3] because I don't talk to him like that anymore." -There had been an incident with client #3 at the theater. "I think he (client #3) stole something...I heard he was in the bathroom (theater) vaping). I	V 503		

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V 503	Continued From page 30 didn't hear who (staff) found him. He was searched and he said, "they searched the s**t out of me. He said a couple of times that he was grabbed in the crouch (by staff)...I have seen staff grab [client #3], [client #9], and client #8]." Interview on 4/2/26 with client #3 revealed: -"...got caught with a vape about 2 weeks ago (exact date unknown). I hid the vape in my pants and [former staff] grabbed my crouch, this was about three to four months ago. He (former staff) was attempting to find the vape. I caused a scene and he no longer works here (facility). -He told a supervisor about the incident and "he (residential supervisor) said he would handle it" because the former staff had "not searched anyone else like that. Other clients had it (vape) in their crouch also, but they (staff) didn't grab them (clients), they grabbed me." -He was caught with a vape again "a month ago." -"I was strip searched the other day (date unknown)...they (staff) made me take off my underwear, put on shorts and take my shirt off. I gave up the vape and they proceeded to make me take off my underwear and put on shorts. They had never done that before, they usually let me keep on underwear, jump up and down, squat, and cough." Interview on 4/7/26 with client #3 revealed: -He was searched in the nurse's office by a residential supervisor, the residential director and a nurse about two weeks ago, exact date unknown. -He was asked by the nurse to remove his shirt. -He was asked by the residential supervisor and director to "take off my underwear and put on shorts, they both said it. I was in the nurses station about two weeks ago when this happened. I don't remember the nurse (name)."	V 503		

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V 503	Continued From page 31 -"I had a vape on me but I have never been searched like that before." -"[Former staff] grabbed my crouch, that was about a month or so ago. I had a vape hid in my crouch. When [former staff] searched my crouch, I reported it to [residential supervisor] because I caused a scene. We (staff and clients) were at the movie theater." -"[Client #9] got searched before and they (staff) just patted him, down they made him pull down his pants, they made me go without underwear just shorts and made me jump up and down." Interview on 4/8/26 with client #4 revealed: -Had been searched twice since being at the facility. -He was taken to the nursing station "and they (staff) patted me down." Interview on 4/2/26 with client #5 revealed: -Had been searched and patted down. -Had been caught with vapes twice. Interview on 4/8/26 with client #6 revealed: -"I get searched, we (clients) all get searched when we come home from school. I put up my hands and spread my legs and the staff pats me down, from head to toe. -Had never been searched at nurses station and asked to change clothing. "Never seen that take place, but when they (clients) go inside the nursing station, they told me they have taken off their shorts and you (client) are in your underwear, and they (nurse) see if there is contraband and take their finger with the gloves on and grab it." -"...a lot of people (clients) said they had been strip searched and I never experienced that, so I don't know if that's true." -Had heard client #3 was strip searched, and	V 503		

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V 503	Continued From page 32	V 503		

client #9, "I know he (client #9) been strip searched coming home from school.
-Client #3 was vaping in the bathroom at the theater, he was caught and searched by staff.
-"[Client #3] is going around telling everybody that [former staff] grabbed his crouch, that never happened. I saw it, I was right there."

Interview on 4/8/26 with client #7 revealed:
-"They (staff) tried to search me yesterday (4/7/26) because I was out of line of site for like three minutes, in baseball fields, and staff thought we (clients) were over there smoking. They (staff) made it sound like they were going to search me but they didn't."
-"They (staff) search the rooms (client bedrooms). You (client) can't be present. They won't let me be in my room when they go clean the bathroom."
-"I know for a fact they (staff) be gripping your (client) balls (scrotum), pretty sure [client #3], they grabbed his balls. I know who the staff is, but I don't care to be involved, don't want to name staff."

Interview on 4/2/26 with client #8 revealed:
-He was searched daily when he came home from school "to make sure nothing comes in like weed, vapes, stuff like that."

Attempted interview on 4/8/26 with client #9 unable due to off campus on family visit.

Attempted interview on 4/8/26 with client #10 unable due to off campus on family visit.

Interview on 4/8/26 with the Residential Director revealed:
-The latest contraband seized was from client #6 and client #3.

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V 503	Continued From page 33 -Search and seizures performed "depends on the situation." -Clients were escorted to nursing station, given basketball shorts, and asked to change into the basketball shorts. -Staff would then "search the clothes they (clients) changed out of and search the bathroom (where they changed clothes)." -"In the past they (clients) hid it (vapes) in their scrotum." -Underclothes were removed and clients were asked to "take their thumb and roll around waistband area (of shorts). They (clients)are absolutely not asked to jump up and down. Most recently it was done with [client #3] about a week ago, probably last week (exact date unknown)." -"They (clients) can refuse anything they want, (staff) can't make them do anything; can't make them do searches, so if they refuse we (staff) document (refusal) and move on." Interview on 4/2/26 with the Chief Agency Director revealed: -Searches of clients were performed daily when clients came home from school. -"Those are routine checks and are separate from search and seizures; I don't believe they (daily searches) are documented." -"Book bags are left in the staff area and there is a quick observation to see if contraband was bought in from school and book bags are searched." -"Searches are not stripped (searches) and staff has been instructed to not go under clothing or touching body parts. Searches are never done by one staff alone and it is usually initiated when staff has smelled something or see something and is documented on a search and seizure form."	V 503		

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V 503	Continued From page 34 Interview on 4/7/26 and 4/8/26 with the Chief Agency Director revealed: -Staff did not physically tough clients during searches. -Staff could do property search with cause and permission was granted by guardians at admission. -"They (staff) may see that as a sweeping permission to search, their person and their belongings." -A search and seizure form is completed by staff only if contraband is found. -Was not aware that documentation of every search or seizure was required. -"[Client #7] is not in school and does not go on outings with clients, so he is not involved in the searches. He is not part of that process. So it is not possible for him to be aware of what happens in searching."	V 503		