Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0261001	A. BUILDING: ______ B. WING ______	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODYSSEY YOUTH	301 BANDERA DRIVE FAYETTEVILLE, NC 28303

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on April 10, 2026. The complaint was unsubstantiated (Intake #NC00236749). Deficiencies were cited. This facility is licensed for the following service 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for 6 and has a current census of 0. The survey sample consisted of audits of 2 former 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 treatment goals and strategies based on assessment of 1 of 2 audited former clients (Former Client (FC) #1). The findings are:

Review on 4/9/26 of FC #1's record revealed:
-16 year-old female.
-Admission date of 11/15/25.
-Diagnoses of Bipolar Disorder and Physiologic Insomnia.
-Person Centered Profile (PCP) completed on 11/17/25 and updated on 12/17/25, 1/14/26, 2/11/26, and 3/11/26 did not include goals or strategies to address elopement.

Review on 4/9/26 of FC #1's Application for Services dated 11/12/25 revelaed:
-Current Behaviors/Presenting Problems and Reason for Referral: "Not following Rules/Running away/Suicidal Atemps/thoughts."
-History of Running: Box checked for "Runs away from home or placements."
-FC #1 had run away once in the past year.
-The average "duration of run" for FC #1 was identified as greater than 24 hours.
-FC #1 has been returned home by police.

Review on 4/9/26 of FC #1's External

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V 112	Continued From page 2 Assessment Information dated 11/12/25 revelaed: -Presenting Problem: "The client is being referred to [facility] following her most recent inpatient psychiatric hospitalization. This was her fourth stay in a PRTF (Psychiatric Residential Treatment Facility). Her intensive in-home therapist recommends services to support the client and her family due to the severity of her mental health needs and the complexity of her psychosocial environment and history of running away." -Individual and Family Risk Factors: "The client has a history of running away." -Summary of initial treatment goals and interventions: "Based on the client's recent discharge from a PRTF following her fourth suicide attempt, ongoing suicidal risk, and continued patterns of running away from home, a Level 3 Residential Treatment placement is recommended." Interview on 4/10/24 the Qualified Professional stated: -She had been responsible for completing treatment plan for FC #1. -Upon intial assessment, it was determined that FC #1 had only run away once to a friend's house and that her actions had not developed into a pattern on elopement behaviors. -FC #1 had not displayed any elopement behaviors in her time at the facility. -She would review FC #1's treatment plan to address any changes that were required.	V 112		
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	V 114		

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V 114	Continued From page 3	V 114		

Continued From page 3

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

Review on 4/9/26 of the facility's documented disaster drills for 7/1/25 - 3/30/26 revealed:
- First quarter (1/1/26 - 3/31/26); no disaster drills documented.
- Third quarter (7/1/25 - 9/30/25); no disaster drills documented.
- Third quarter (10/1/25 - 12/31/25); no disaster drills documented.

Interview on 4/10/26 staff #1 stated:
- He had been employed with the facility since October, 2025.
- He had participated in fire drills as scheduled by management.
- He had not completed any disaster drills.

Interview on 4/10/26 the Qualified Professional

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V 114	Continued From page 4 stated: - Fire and disaster drills were completed monthly and covered all shifts. Interview on 4/9/26 - 4/10/26 the Chief Executive Officer (CEO)/Licensed Professional (LP) stated: - Fire and disaster drills were completed each month and all shifts were covered. - There were three shifts. - Monday - Friday during school year (2pm - 8pm, 8pm - 8am) - Monday - Friday during summer months (8am - 8pm, 8pm - 8am) - Saturday and Sunday (8am - 8pm and 8pm - 8am). - She would ensure disaster drills were completed.	V 114		
V 521	27E .0104(e9) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (9) Whenever a restrictive intervention is utilized, documentation shall be made in the client record to include, at a minimum: (A) notation of the client's physical and psychological well-being; (B) notation of the frequency, intensity and duration of the behavior which led to the intervention, and any precipitating circumstance contributing to the onset of the behavior; (C) the rationale for the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less	V 521		

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V 521	Continued From page 5	V 521		

restrictive intervention techniques that were used;
(D) a description of the intervention and the date, time and duration of its use;
(E) a description of accompanying positive methods of intervention;
(F) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate or reduce the probability of the future use of restrictive interventions;
(G) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if determined to be clinically necessary; and
(H) signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure the necessary documentation was in the client record when restrictive intervention was utilized affecting 1 of 2 audited former clients (FC (FC #2)). The findings are:

Review on 4/9/26 of FC #2's record revealed:
-13 year-old female.
-Admission date of 7/3/25.
-Diagnoses of Posttraumatic Stress Disorder (PTSD) and Reactive Attachment Disorder (RAD).
-No documentation of a description of the debriefing and planning with the client and the legally responsible person to reduce the probability of the future use of restrictive

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V 521		V 521		

Continued From page 6

interventions.
-No documentation of the duration of the intervention.

Review on 4/10/26 of North Carolina Incident Response Improvement System (IRIS) reports for FC #2 revealed restrictive interventions had been implemented on the following dates:
(3/13/26)
-Date of Incident: 3/13/26.
-Time of Incident: 6:30pm.
-Provider Comments: "[FC#2] then returned to her room, where she removed clothing from a hanger, broke the hanger, and made a gesture consistent with attempting to harm herself by placing it near her throat. Staff immediately intervened and implemented a therapeutic hold to safely remove the object and prevent self-harm. Following this intervention, [FC#2] continued to escalate and made verbal threats toward staff and other residents, stating that she was going to kill individuals in the home...she was transported to the hospital for further assessment."

(3/7/26)
-Date of Incident: 3/7/26.
-Time of Incident: 12:00pm.
-Provider Comments: "[FC#2] reported experiencing impulsive thoughts to elope from the facility. Staff immediately implemented safety measures and attempted verbal de-escalation to assist [FC#2] in regulating her emotions. During this process, [FC#2] became physically aggressive and lunged toward staff. As a result, staff implemented a one-person therapeutic hold to maintain safety. Staff continued to provide verbal de-escalation throughout the intervention, and [FC#2] was eventually able to calm down."

(11/28/25)

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V 521	Continued From page 7 -Date of Incident: 11/28/25. -Time of Incident: 8:30am. -Provider Comments: "[FC#2] became upset with staff while consequences for negative behaviors were being discussed. She escalated quickly and became verbally aggressive, attempting to scratch and bite staff. Due to her continued aggression and attempts to move toward the exit, she was placed in a therapeutic hold to prevent elopement and ensure safety. During the incident, "[FC#2] also reported experiencing thoughts of wanting to harm herself but denied having a plan or intent." (7/19/25) -Date of Incident: 7/19/25. -Time of Incident: 6:45am. -Provider Comments: Staff "implemented a therapeutic hold to ensure the safety of both [FC#2] and staff. Once [FC#2] was released from the hold, she returned to her bedroom, where she threw clothing and damaged property for approximately two minutes. [FC#2] then sat on her bed and became visibly emotional, expressing remorse for her behavior. She tearfully stated that she felt like a bad person for her actions and was apologetic to staff." Interview on 4/10/26 staff #1 stated: -He had not used restrictive interventions. -He had seen other staff use restrictive interventions. -He was not aware if debriefing was completed after the use of restrictive interventions. Interview on 4/10/26 the Chief Executive Officer stated: -The guardian was notified when restrictive interventions were used. -She had a therapeutic hold risk assessment	V 521		

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V 521	Continued From page 8 screening tool that had not been implement yet. -The risk assessment tool included a debriefing section. -She would ensure the therapeutic hold risk assessment screening tool was completed with all required information.	V 521		
V 525	27E .0104(e17) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (17) The facility shall conduct reviews and reports on any and all use of restrictive interventions, including: (A) a regular review by a designee of the governing body, and review by the Client Rights Committee, in compliance with confidentiality rules as specified in 10A NCAC 28A; (B) an investigation of any unusual or possibly unwarranted patterns of utilization; and (C) documentation of the following shall be maintained on a log: (i) name of the client; (ii) name of the responsible professional; (iii) date of each intervention; (iv) time of each intervention; (v) type of intervention; (vi) duration of each intervention; (vii) reason for use of the intervention; (viii) positive and less restrictive alternatives that were used or that were considered but not used and why those alternatives were not used; (ix) debriefing and planning conducted with the client, legally responsible person, if applicable,	V 525		

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V 525	Continued From page 9	V 525		

and staff, as specified in Parts (e)(9)(F) and (G) of this Rule, to eliminate or reduce the probability of the future use of restrictive interventions; and
(x) negative effects of the restrictive intervention, if any, on the physical and psychological well-being of the client.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to maintain a log of restrictive interventions performed at the facility and conduct regular reviews of restrictive interventions as required, affecting 1 of 2 audited former clients (FC (FC #2)). The findings are:

Review on 4/9/26 of FC #2's record revealed:
-Admission date of 7/3/25.
-Discharge date of 3/13/26.
-Diagnoses of Posttraumatic Stress Disorder (PTSD) and Reactive Attachment Disorder (RAD).
-No documentation of restrictive intervention log to reflect the restrictive interventions between the dates of 7/3/25-4/10/26.

Interview on 4/10/26 the Chief Executive Officer stated:
-The facility was initially licensed on 3/14/25.
-She was not aware of a current restraint log.
-A restraint log should be maintained for restrictive interventions.