STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL013-212	A. BUILDING: _____ B. WING _____	R 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADRIENNE'S HOUSE	120 TODD DRIVE NW CONCORD, NC 28025

(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 A follow-up survey was completed on 04/30/2026. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G 1700 Residential Treatment Staff Secure for Children and Adolescents. This facility is licensed for 4 and currently has a census of 4. The survey sample consisted of audits of 2 current clients.	{V 000}		
{V 295}	27G .1703 Residential Tx. Child/Adol - Req. for A P 10A NCAC 27G .1703 REQUIREMENTS FOR ASSOCIATE PROFESSIONALS (a) In addition to the qualified professional specified in Rule .1702 of this Section, each facility shall have at least one full-time direct care staff who meets or exceeds the requirements of an associate professional as set forth in 10A NCAC 27G .0104(1). (b) The governing body responsible for each facility shall develop and implement written policies that specify the responsibilities of its associate professional(s). At a minimum these policies shall address the following: (1) management of the day to day day-to-day operations of the facility; (2) supervision of paraprofessionals regarding responsibilities related to the implementation of each child or adolescent's treatment plan; and (3) participation in service planning meetings.	{V 295}		

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{V 295}	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to employ an Associate Professional (AP) who provided services to the facility on a full-time basis. The findings are: Review on 04/24/2026 of the AP's personnel record revealed: -Date of Hire: 12/09/2025. -There was an AP Job description signed and dated 12/09/2025. Interview on 04/24/2026 with the AP revealed: -She started as the AP in February or March 2026. -"I work 24 hours per week on the weekends; 12 hours on Saturday and Sunday." -She worked part-time and did not work throughout the weekday at the facility due to other full-time employment obligations. Interview on 04/27/2026 with the Qualified Professional/Licensee revealed: -"She (AP) only works part-time, and we have not been able to find another person who meets the requirements of an AP." Interview on 04/30/2026 with the Executive Director revealed: -"We will look for a full time AP (to hire)." This deficiency constitutes a recited deficiency.	{V 295}		
{V 296}	27G .1704 Residential Tx. Child/Adol - Min. Staffing 10A NCAC 27G .1704 MINIMUM STAFFING	{V 296}		

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{V 296}	Continued From page 2 REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and	{V 296}		

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{V 296}	Continued From page 3 needs as specified in the treatment plan. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure the minimum staffing ratio of 2 staff for up to 4 adolescents while they were awake. The findings are: Review 04/24/2026 of the facility's incident reports from 03/01/2026 - 04/23/2026 revealed: -03/29/2026; Client #1's self-harm (shoelace around neck) and hospitalization incident. Interview on 04/29/2026 with Client #1 revealed: -There were always two or more facility staff on duty. Interview on 04/29/2026 with Client #2 revealed: -There were two facility staff on duty at each shift. Interview on 04/29/2026 with Client #3 revealed: -"Staff have left to go on break and only one staff remain here." -She did not know when or what facility staff left the facility. Interview on 04/29/2026 with Client #4 revealed: - "There have been times when staff would leave. They would step out to go outside or to get some food." Interview on 04/29/2026 with Staff #1 revealed:	{V 296}		

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{V 296}	Continued From page 4 -She left Staff #2 at facility alone with four clients on 03/29/2026. - "My break was an hour because I was working a 24-hour shift. But most of the time nobody (facility staff) takes a break." Interview on 04/30/2026 with Staff #2 revealed: -Staff #1 left her alone with four clients on 03/29/2026 for one hour. -"When I got [Client #1] out of the bathtub, she (Staff #1) came back. She was gone between 5 and 6 pm (on 03/29/2026)." -"Staff will take 2 kids and leave 2 kids with the other staff (if facility staff need to leave the facility)." Interview on 04/30/2026 with the Qualified Professional/Licensee revealed: -"I didn't know she (Staff #1) left (the facility on 03/29/2026) and [Staff #2] did not mention it. -"I will send communication out staff letting them know that management must be notified before they leave (the facility)." Interview on 04/30/2026 with the Executive Director revealed: -"We are going to maintain ratio. We will communicate with staff that they are not to leave the premises without notifying anyone (management)." This deficiency constitutes a recited deficiency.	{V 296}		
{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	{V 366}		

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{V 366}	Continued From page 5 implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in 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	{V 366}		

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{V 366}	Continued From page 6 (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the 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	{V 366}		

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{V 366}	Continued From page 7 Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement written policies governing their response to Level I and II incidents. The findings are: Review 04/24/2026 of the facility's incident reports from 03/01/2026 - 04/23/2026 revealed: -03/24/2026; Client #2's medication unavailable for administration incident. -03/28/2026; Client #1's self-harm (cutting) incident. -03/29/2026; Client #1's self-harm (shoelace around neck) and hospitalization incident. -04/20/2026; Client #3's Absent without leave (AWOL), Police, and Emergency Medical Services (EMS) involvement incident. Review on 04/24/2026 of the facility's records revealed: There was no Risk Cause Analysis (RCA) documentation for the above incidents from	{V 366}		

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{V 366}	Continued From page 8 03/01/2026 - 04/23/2026 to demonstrate how the facility: -Attended to the health and safety needs of the individuals involved in the incident. -Determined the cause of the incident. -Maintained documentation regarding Subparagraphs (a)(1) through (a)(2) of this Rule. Interview on 04/24/2026 with the Qualified Professional/Licensee revealed: -"I will update our form to ensure that all components (of the RCA) are met." Interview on 04/30/2026 with the Executive Director revealed: -"We will revise the incident report (form) to add how we are going to correct and prevent incidents from happening." This deficiency constitutes a recited deficiency.	{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	{V 367}		

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{V 367}	Continued From page 9	{V 367}		

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 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

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{V 367}	Continued From page 10 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 meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report all level II incidents in the Incident Response Improvement System (IRIS), failed to notify the Local Management Entity (LME)/Managed Care Organization (MCO) responsible for the catchment area where services were provided as required, and failed to	{V 367}		

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{V 367}	Continued From page 11 submit to the LME/MCO upon request other information regarding the incident. The findings are: Review 04/24/2026 of the facility's incident reports from 03/01/2026 - 04/23/2026 revealed: -03/28/2026; Client #1's self-harm (cutting) incident. -04/20/2026; Client #3's Absent without leave (AWOL) Police, and Emergency Medical Services (EMS) incident. Review on 04/24/2026 of IRIS revealed: -There was no report submitted in the IRIS system for Client #1's self-harm incident dated 03/28/2026 or Client #3's incident dated 04/20/2026. Review on 04/24/2026 an IRIS Report dated 03/29/2026 for Client #1 revealed: -The incident occurred on 03/29/2026. -The provider learned of the incident on 03/29/2026. -The report was submitted 04/01/2026. -LME/MCO Comments dated 04/07/2026: "Due to confidentiality and HIPAA (Health Insurance Portability and Accountability Act) requirements, incident reports CANNOT contain content or attachments with the full names of other consumers. Uploading an attachment containing the information of another consumer is a HIPPA violation. Please a) Notify your Quality Management (QM) Director and b) provide us with their contact information. Thank you! Emailed provider. " -There was no response to the LME/MCO request. Interviews on 04/24/2026 and 04/30/2026 with the Qualified Professional/Licensee revealed:	{V 367}		

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{V 367}	Continued From page 12 -"I did not complete an IRIS report (for Client #3's incident dated 04/20/2026)." -"I submit IRIS reports within 72 hours." -"When I submit IRIS reports, I will go back to check emails for updates as needed." Interview on 04/30/2026 with the Executive Director revealed: -"We will file IRIS reports for all incidents as required. It's going to be part of our routine to check for updates after the IRIS report is submitted." This deficiency constitutes a recited deficiency.	{V 367}		
V 513	27E .0101 Client Rights - Least Restrictive Alternative 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (a) Each facility shall provide services/supports that promote a safe and respectful environment. These include: (1) using the least restrictive and most appropriate settings and methods; (2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the clients served/supported; and (4) sharing of control over decisions with the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include: (1) using the intervention as a last resort; and	V 513		

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V 513	Continued From page 13 (2) employing the intervention by people trained in its use. This Rule is not met as evidenced by: Based on record review, observation, and interview, the facility failed to use the least restrictive environment for 2 of 4 Clients (#1 and #2). The findings are: Observation on 04/24/2026 at 12:15 pm of the facility revealed: -The bathroom door in Clients' #1 and 2 bedroom was locked. Interview on 04/30/2026 with Client #1 revealed: -"They (facility staff) locked the door (bathroom) completely because I had suicide attempts." Interview on 04/30/2026 with Client #2 revealed. -"They told me it (the bathroom door) would be like that (locked) when I got here (on 12/18/2025). They told me it would be unlocked at shower time." Interview on 04/30/2026 with Client #3 revealed: -"The other bathroom (in Clients' #1 and 2 bedroom) was locked." -She did not remember how long the bathroom door had been locked. Interview on 04/30/2026 with Client #4 revealed: -"The bathroom door in the other room was locked. A couple of days ago, they (facility staff) told clients (#1 and #2) that it (bathroom door) could be unlocked."	V 513		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL013-212	A. BUILDING: _____ B. WING _____	R 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADRIENNE'S HOUSE	120 TODD DRIVE NW CONCORD, NC 28025

(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 513	Continued From page 14 Interview on 04/30/2026 with the Qualified Professional/Licensee revealed: -"We communicated to staff that the door (bathroom) is to be unlocked at all times. We also communicated that it is their (Clients #1 and #2) right to have access (to the bathroom in their bedroom)." Interview on 04/30/2026 with the Executive Director revealed: -"We will keep the door (bathroom) unlocked."	V 513		