STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-993	A. BUILDING: _____ B. WING _____	R-C 05/01/2026

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DESIGN DESTINATION YOUTH AND FAMILY NI	924 CHESTER CIRCLE FAYETTEVILLE, NC 28303

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on May 1, 2026. The complaint was unsubstantiated (intake #NC00236883). 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 3 and has a current census of 2. The survey sample consisted of 2 current clients and 1 former client.	V 000		
V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable. This Rule is not met as evidenced by: Based on records reviews and interview, the facility failed to obtain drug regimen reviews every six months for 2 of 2 current clients (#1 and #2)	V 121		

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V 121	Continued From page 1 and 1 of 1 audited former clients (FC) (#3) who received psychotropic drugs. The findings are: Review on 4/30/26 of client #1's record revealed: -Date of admission: 11/26/24. -Diagnoses: Posttraumatic Stress Disorder (PTSD), Generalized Anxiety Disorder (GAD), Major Depressive Disorder (MDD), and Attention Deficit Hyperactivity Disorder (ADHD). -There was no documented evidence of a signed 6 month drug regimen review. Review on 4/30/26 of client #1's current drug regimen revealed: -Guanfacine 2 milligrams (mg) (ADHD) - Take twice daily. -Hydroxyzine 10mg (anxiety) - Take once daily. -Sertraline 100mg (anti-depressant) - Take once daily. Review on 4/30/26 of client #2's record revealed: -Date of admission: 4/7/25 -Diagnoses: Disruptive Mood Dysregulation Disorder (DMDD), Anxiety, and ADHD. -There was no documented evidence of a signed 6 month drug regimen review. Review on 4/30/26 of client #2's current drug regimen revealed: -Methylphenidate 72mg (ADHD) - Take once daily. -Trazodone 50mg (anti-depressant) - Take once at bedtime -Sertraline 100mg (anti-depressant) - Take once daily. Review on 4/30/26 of FC #3's record revealed: -Date of admission: 9/5/24. -Date of discharge: 4/14/26. -Diagnoses: ADHD, PTSD, and DMDD.	V 121		

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V 121	Continued From page 2 -There was no documented evidence of a signed 6 month drug regimen review. Review on 4/30/26 of FC #3's drug regimen through 4/14/26 revealed: -Atomoxetine 80mg (ADHD) - Take once daily. -Clonidine 0.1mg (ADHD) - Take once daily. -Guanfacine 1mg (ADHD) - Take once daily. -Sertraline 100mg (anti-depressant) - Take once daily. -Quetiapine 150mg (anti-psychotic) - Take once daily. -Quetiapine 25mg (anti-psychotic) - Take twice daily. Interview on 4/30/26 the Owner/Qualified Professional (QP)stated: -She was aware the drug regimen review was required every six months for clients who received psychotropic drugs. -She had the medications for client #1, client #2, and FC #3 reviewed, but the pharmacist had not signed off on the reviews or made any notations. -Moving forward, the facility would ensure the drug regimen reviews were completed and signed. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 121		
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:	V 366		

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(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
(D) transferring the copy to an internal review team;
(2) convening a meeting of an internal

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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 Rule .0604;
(B) the LME where the client resides, if different;

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V 366	Continued From page 5 (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 review and interview, the facility failed to implement policies governing their response to level II incidents as required. The findings are: Review on 4/30/26 of the North Carolina Incident Response Improvement System (IRIS) revealed: -One incident had been reported in IRIS dated 4/15/26 and was for former client (FC) #3. Interview on 4/30/26 the Owner/Qualified Professional (QP) stated: -Former Client (FC) #3 had two documented contacts with local law enforcement. -The incident on 4/15/26 was documented in IRIS. -A second incident occurred on 3/27/26. -FC #3 had walked out of the facility on 3/27/26 and she had contacted local local enforcement who met her at the end of the street with FC #3. -FC #3 was compliant and got in the vehicle with her and police presence was no longer required. -She had not completed a level II incident report for police contact on 3/27/26, as FC #3 became	V 366		

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V 366	Continued From page 6 compliant and their presence was no longer needed once they arrived. -Moving forward, she would ensure level II incident reports were completed in IRIS for all contact with law enforcement. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 366		