

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL013-226	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/08/2026
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NAME OF PROVIDER OR SUPPLIER UNION POINT	STREET ADDRESS, CITY, STATE, ZIP CODE 519 UNION STREET SOUTH CONCORD, NC 28025
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V 000	<p>INITIAL COMMENTS</p> <p>A complaint and follow up survey was completed on 5/8/26. The complaints were unsubstantiated (intake #NC00237183, #NC00236951, #NC00236732, #00236212). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.</p> <p>This facility is licensed for 6 and has a current census of 4. The survey sample consisted of audits of 4 current clients and 4 former clients.</p>	V 000		
V 112	<p>27G .0205 (C-D) Assessment/Treatment/Habilitation Plan</p> <p>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN</p> <p>(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.</p> <p>(d) The plan shall include:</p> <p>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;</p> <p>(2) strategies;</p> <p>(3) staff responsible;</p> <p>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;</p> <p>(5) basis for evaluation or assessment of outcome achievement; and</p> <p>(6) written consent or agreement by the client or responsible party, or a written statement by the</p>	V 112		

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

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V 112	<p>Continued From page 1</p> <p>provider stating why such consent could not be obtained.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to develop and implement goals and strategies in the treatment/habilitation or service plans based on the needs of the clients for 3 of 4 Former Clients (FC #1, FC #2 and FC #8) and 2 of 4 audited current clients (#5 and #6). The findings are:</p> <p>Review on 4/27/26 of FC #1's record revealed: -An admission date of 2/11/26. -Diagnoses of Post Traumatic Stress Disorder (PTSD) and Oppositional Defiant Disorder (ODD). -Age 16. -A discharge date of 3/18/26. -A treatment plan dated 2/20/26 did not include goals and strategies to address elopement tendencies.</p> <p>Review on 4/27/26 of FC #2's record revealed: -An admission date of 1/29/26. -Diagnoses of ODD, Attention Deficit Hyperactivity Disorder (ADHD), Combined Presentation. -Age 15. -A discharge date of 3/5/26. -A treatment plan dated 1/27/26 did not include</p>	V 112		

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V 112	<p>Continued From page 2</p> <p>goals and strategies to address elopement tendencies.</p> <p>Review on 4/28/26 of FC #8 revealed: -An admission date of 2/20/26. -Diagnoses of Disruptive Mood Dysregulation Disorder (DMDD), Major Depressive Disorder (MDD) and PTSD. -Age 17. -A discharge date of 4/17/26. -A treatment plan dated 1/27/26 did not include goals and strategies to address Self-Injurious Behaviors (SIBs).</p> <p>Review on 4/27/26 of client #5's record revealed: -An admission dated of 3/9/26. -Diagnoses of ADHD, PTSD, and ODD. -Age 16. -A treatment plan dated 2/20/26 did not include goals and strategies to address SIBs.</p> <p>Review on 4/28/26 of client #6's record revealed: -An admission date of 1/30/26 and 11/10/25. -Diagnoses of ODD, and ADHD, Combined Type. -Age 17. -An updated Comprehensive Clinical Assessment Addendum dated 11/12/25 noted " ...ongoing marijuana use ..." -A treatment plan dated 6/2/25 did not include any goals or strategies to address substance use.</p> <p>Finding #1 Review on 4/27/26 of the North Carolina Incident Response Improvement System (IRIS) revealed: -3/10/26 elopement incident where FC #1 walked out the front door (of the facility) at 7:53pm and returned at 9:30pm. -2/26/26 elopement incident where FC #1 was discovered missing from the facility during bedroom checks and the police returned FC #1 at</p>	V 112		

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V 112	<p>Continued From page 3</p> <p>1:30am.</p> <p>Attempted interview on 4/28/26 with FC #1 was unsuccessful as she had eloped from her current placement.</p> <p>Interview on 5/7/26 with staff #2 revealed: -The Qualified Professional (QP) was responsible for writing the clients' treatment plans.</p> <p>Interview on 5/8/26 with staff #3 revealed: -"There were elopement issues with [FC #1] and she did it one time. [FC #1] ran away and the police came (out to the facility) ..." -"I'm pretty sure the new guy (QP) writes the treatment plans."</p> <p>Interview on 5/7/26 with staff #4 revealed: -"We have had several AWOL (Absent Without Leave) clients, all former clients. [FC #1] and [FC #2] attempted to leave the facility. They went out the door and walked up the street and tried to go AWOL. They did it without permission. I feel like the police were involved this particular time ..."</p> <p>Interview on 5/7/26 with the QP revealed: -Was responsible for writing FC #1's treatment plan. -Acknowledged FC #1 had an incident of elopement from the facility -"It (elopement tendencies) has to be in their history to directly be addressed in the treatment plan."</p> <p>Interview on 5/7/26 with the Program Manager revealed: -" ...[FC #1] was running out of the house several times, would leave for an hour and then come back. We'd call the police. [FC #1] will return before dark. It's only twice this has happened ..."</p>	V 112		

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V 112	<p>Continued From page 4</p> <p>Interview on 5/7/26 with the Licensed Professional/Director (LP/D) revealed: -In FC #1's previous placement at the facility, she had elopement tendencies." -Currently FC #1 ran "maybe once or twice" and was "influenced by her peers." -Thought the elopement tendencies were addressed in FC #1's treatment plan.</p> <p>Finding #2 Review on 4/27/26 of North Carolina IRIS revealed: -3/10/26 elopement incident where FC #2 walked out the front door (of the facility) at 7:53pm and returned at 9:30pm -2/26/26 FC #2 ran from the facility, the police were called and she returned on her own. Interview on 4/29/26 with FC #2 revealed: -"The day I was leaving (3/10/26), I went AWOL and was gone for about an hour. This was the second time I went AWOL." -"I don't think I had time to do anything with goals (elopement tendencies) ..." -Both instances of AWOL were with FC #1.</p> <p>Interview on 5/7/26 with staff #2 revealed: -The Qualified Professional (QP) was responsible for writing the clients' treatment plans.</p> <p>Interview on 5/7/26 with staff #4 revealed: -"We have had several AWOL (Absent Without Leave) clients, all former clients. [FC #1] and [FC #2] attempted to leave the facility. They went out the door and walked up the street and tried to go AWOL. They did it without permission. I feel like the police were involved this particular time ..."</p> <p>Interview on 5/7/26 with the QP revealed:</p>	V 112		

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V 112	<p>Continued From page 5</p> <p>-Did not complete FC #2's treatment plan. -Acknowledged FC #2 had elopement tendencies. -"It (elopement tendencies) has to be in their history to directly be addressed in the treatment plan."</p> <p>Interview on 5/7/26 with the Program Manager (PM) revealed: -"[FC #2] influenced [FC #1] to go AWOL." -The QP was responsible for treatment plans.</p> <p>Interview on 5/7/26 with the Licensed Professional/Director (LP/D) revealed: -"I believe every time [FC #2] ran, it was with [FC #1] ..." -Thought elopement tendencies were addressed in FC #2's treatment plan. -The QP was responsible for treatment plans.</p> <p>Finding #3 Review on 4/27/26 of the North Carolina IRIS revealed: -On 4/14/26, client #5 cut her arm with a pencil and was taken to the hospital for an evaluation.</p> <p>Interview on 5/7/26 with staff #5 revealed: -"I have not seen any injuries to a client, but I have heard one client did that (self harming) and was taken to behavioral health ..."</p> <p>Interview on 5/7/26 with the QP revealed: -Acknowledged he wrote client #5's treatment plan. -Client #5 had a history of SIBs and has had one incident of self-harming at the facility.</p> <p>Interview on 5/7/26 with the PM revealed: -The QP was responsible for the clients'</p>	V 112		

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V 112	<p>Continued From page 6</p> <p>treatment plans.</p> <p>Interview on 5/7/26 with the LP/D revealed: -"[Client #5] has SIBs and suicidal ideation when she is triggered ...She was scratching herself and it is addressed in her treatment plan ..."</p> <p>Finding #4 Review on 4/27/26 of the North Carolina IRIS revealed: -On 4/17/26, FC #8 "rolled up her legging to her thigh and showed where she had scratched herself." -As FC #8 continued to escalate, she was observed banging her head on the wall which resulted in a restraint and ultimately hospitalization.</p> <p>Interview on 4/29/26 with FC #8 revealed: -Her goal was to attend public school but did not reach the goal "because I was there a short period of time." -Self harmed on one occasion and went to the hospital.</p> <p>Interview on 5/7/26 with the QP revealed: -Wrote FC #8's treatment plan. -Did not include SIB in the treatment plan. -"It (problematic behaviors) has to be in their history to be addressed in their treatment plan."</p> <p>Interview on 5/7/26 with the LP/D revealed: -FC #8 had a history of SIBs -"I want to say around the last time she was with us (previous admission), she used a bottle cap to scrape her leg ...we addressed it in her treatment plan ..." -The QP was responsible for writing the clients' treatment plans.</p>	V 112		

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V 112	<p>Continued From page 7</p> <p>Finding #5 Interview on 5/8/26 with client #6 revealed: -Had tested positive for marijuana. -Had smoked marijuana at school. -He did not have any goals or strategies to address his marijuana use.</p> <p>Interview on 5/7/26 with the PM revealed: -"[Client #6] likes to overeat and there was a suspicion he was using marijuana at school. He was drug tested and it was positive. DSS (Department of Social Services) will reach out to enroll him in substance abuse classes ..."</p> <p>Interview on 5/7/26 with the QP revealed: -Had updated client #6's treatment plan, -When a client is admitted, "if it isn't in their history, we don't address it."</p> <p>Interview on 5/7/26 with the LP/D revealed: -Client #6 tested positive for marijuana on 3/30/26. -The QP was responsible for writing the clients' treatment plans. -"I would hope the QP has updated his treatment plan."</p>	V 112		
V 132	<p>G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection</p> <p>G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes:</p>	V 132		

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V 132	<p>Continued From page 8</p> <p>a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.</p> <p>b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.</p> <p>c. Misappropriation of the property of a healthcare facility.</p> <p>d. Diversion of drugs belonging to a health care facility or to a patient or client.</p> <p>e. Fraud against a health care facility or against a patient or client for whom the employee is providing services).</p> <p>Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report an allegation of abuse, neglect or exploitation to the Health Care Personnel Registry (HCPR) and failed to protect clients during the investigation. The findings are:</p> <p>Review on 4/27/26 of the North Carolina Incident Response Improvement System (IRIS) from 2/14/26 to 4/27/26 revealed: -There was no report related to the 4/1/26 allegation of abuse. -3/17/26 "[FC# 1] requested to call her sister. Staff allowed the call per protocol, with the expectation that all calls remain on speakerphone</p>	V 132		

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V 132	<p>Continued From page 9</p> <p>as required by D SS (Department of Social Services). During the call, staff observed [FC #1] engaging in an inappropriate conversation involving marijuana. Staff provided a verbal redirection, reminding [FC #1] of phone call expectations and that such topics are not permitted. [FC #1] became visibly upset, removed the phone from speaker, and began to escalate verbally, calling staff inappropriate names. Staff calmly reiterated expectations and informed [FC #1] that the call could only continue if it remained on speakerphone. [FC #1] then hung up the phone, went to her room, and barricaded the door.</p> <p>Escalation & Unsafe Behaviors: Staff entered the room to ensure safety after the barricade was placed. [FC# 1] began yelling, using profanity, and demanded staff leave the room. Staff honored her request and provided space to allow for de-escalation.</p> <p>Shortly after exiting, staff heard loud banging noises. Upon re-entering, [FC #1] was observed throwing items around the room and attempting to break the window. Staff intervened verbally and physically blocked further damage to the window to maintain safety. [FC #1] continued escalating behaviors, including verbal aggression and property destruction. Due to imminent safety concerns, [FC #1] was placed in a therapeutic restraint in accordance with protocol. While in restraint, [FC #1] verbalized feelings of not being cared about, stating that 'nobody gives a f*** about her' and that she intended to make staff 'do their job.'</p> <p>Therapeutic Interventions: Throughout the incident, staff made multiple attempts to provide therapeutic support and de-escalation, including: Verbal redirection and reinforcement of expectations Offering emotional support and reassurance Validating feelings ('staff do care</p>	V 132		

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V 132	<p>Continued From page 10</p> <p>about you and want to help you') Encouraging [FC #1] to communicate her emotions appropriately Providing space when requested to allow self-regulation Attempting to process underlying feelings contributing to behavior Despite these efforts, [FC #1] remained dysregulated and continued to escalate. AWOL Attempt: After being released, [FC #1] resumed unsafe behaviors, including tampering with the window, which triggered the alarm system. Staff redirected [FC #1] and temporarily silenced the alarm to reduce further stimulation. [FC #1] then attempted to elope through the front door. Staff intervened and placed [FC #1] in another therapeutic restraint due to safety risk. During the restraint, [FC #1] broke free and physically assaulted staff by punching one staff member in the face. [FC #1] then exited to her room, climbed out of the bedroom window, and fled outside. Staff followed and located [FC #1] on the side of the house. During this time, [FC #1] continued to display aggressive behavior, including pulling staff's hair and striking another staff member."</p> <p>Review on 4/27/26 of the facility's Grievance/Investigation Form dated 4/1/26 revealed: -"On 04/01/2026, Turning Point Union House Group Home was made aware of an ongoing allegation of abuse investigation involving client (FC#1) related to an incident that reportedly occurred on 03/17/2026. Awareness of the allegation occurred when DSS worker arrived onsite to conduct interviews with both staff and clients regarding the matter. [DSS worker] did not identify any specific staff member as the accused party but requested to review video footage of the incident and requested information regarding all</p>	V 132		

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V 132	<p>Continued From page 11</p> <p>staff present during the shift in question." -Upon internal review of the available video footage, Turning Point leadership did not determine that the incident constituted abuse based on observable interactions and staff response during the event."</p> <p>Review on 4/29/26 at 1:33pm, of the facility's camera footage dated 3/17/26 from 4:43pm to 4:45pm revealed: -The camera was inside the facility. -The camera angle was at the middle of the hallway and faced the front door. -Former Staff #1 (FS #1) tried to stop Former Client #1 (FC #1) from going out the front door. FS #1 came out of a side entrance as FC #1 was headed towards the front door of the facility. FC #1 had a doo rag on her head. Staff #2 came down the hall towards the front door. Then the Program Manager (PM) came down the hall headed towards the front door. All three staff used their bodies to deny FC #1 access to leave the facility by the front door. Staff was heard stating 'you have to go out the back door' at 4:43:53. The PM and FS #1 had their arm kind of around FC #1's waist and they are to the right of the door. Staff #2 is to the left of the front door and appeared to have a cell phone in her hand. FC #1 appeared to be sandwiched between the PM and FS #1. At 4:44:03 staff stated, "Don't get my hair." FC #1 was pulled away from the front door while holding onto it. Staff #2 arrives at 4:43:50. FS #1 had her arms around FC #1. At 4:43:54, staff #2 was standing to the side of the hallway with her cell phone. FS #1 had her left arm inside the coat area and it was undetermined where the other hand was due to the dimness of the video and window light only. Both staff continued to block the client at the door. At 4:43:57, The PM arrived after coming up the hall</p>	V 132		

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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 132	<p>Continued From page 12</p> <p>to the front door. FS #1 reached around FC #1's waist area again. FC #1's back was facing away from the wall and the PM reached with her right arm across FC #1 as if to get her in a bear hug. At 4:44:00, the PM had the front of her body facing FC #1's back and staff #2 had the front of her body facing FC #1. At 4:44:44, staff yelled 'call the police. Call 911, call 911.' The PM reached over the top of FS #1's head and over her shoulder. The view of the camera is blocked by the PM's body. "Don't get my hair." was heard on the video and the PM was pulling FS #1 to get her away from FC #1 as she held onto FS #1's hair. FC #1 reached up and behind the door with her right hand trying to open the front door. The PM's body continued to block the camera's view. Staff #2 continued to stand off to the left side. 4:44:05 staff continued to attempt to pull FC #1 away from the door. 4:44:07 Staff #2 was now involved in the pulling of FC #1 away from the door. All three staff's bodies blocked the camera angle. 4:44:17 FC #1 was leaning forward and the camera angle still blocked the view. The PM was in front of FC #1 and FS #1 was in the front of the client. Staff #2 remained to the left side. FC #1 squatted down. Her arms continued to hold onto the front of the door which was cracked. The angle of the camera was blocked by four bodies. 4:44:19 FC #1 came down the hall, away from the front door. FS #1 reached in the general area of FC #1 and they backed up towards the front door. FS #1's back was to the camera. The PM reached towards FC #1 and then backed up. Were unable to determine where the hands of staff and client are clearly. There were no lights on in the hallway, but was lit by the front door and windows. 4:44:21. The PM had her left arm across the chest and around FC #1 as she stood to the side of FC #1. FC #1 continued to move towards the front door and staff put their body in</p>	V 132		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL013-226	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/08/2026
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V 132	Continued From page 13 front to prevent this from happening. At 4:44:21, FC #1 moved her right hand and struck PM on the left side of her face. 4:44:22, PM was facing FC #1 with her left hand over FC #1's shoulder. Staff #2 was to the right of PM and reached around and over the shoulder of FC #1. 4:44:23, FC #1 backed away from staff. Staff did not appear to be holding onto FC #1. Staff #2 was behind FC #1. FS #1 had moved up to the front of the door. Staff continued to block FC #1 from moving. Unable to see FC #1 and the staff's hands. The group was moving towards the right of the front door. There was no clear camera angle. 4:44:24 the staff are using their bodies to prevent FC #1 from moving towards the front door. Again there was no clear camera angle. It appeared FC #1's doo rag was being pulled on by staff. This occurred to the left of the hallway. The doo rag remained on FC #1's head during the movements. 4:44:36, FS #1 moved to the right of the doorway and PM and staff #2 remained to the left of the front door with FC #1. FC #1 was sitting on the floor. 4:44:37 the front door was shut closed. FC #1 remained on the floor and staff were standing around her. PM bent down at 4:44:40. FC #1 remained on the floor in a sitting position. The video in the hallway was dark. Staff #2 was standing over FC #1. FC #1 slid onto her back. 4:44:41 staff #2 continued to stand over FC #1. Then staff can be seen backing away from FC #1. There are no hands on FC #1. At 4:44:43 as FC #1 starts to move, staff #2 moves along with her towards the front door. 4:44:44 FC #1 was standing up. PM had her back to the front door. 4:44:46 FC #1 walked away from the door down the hallway. All three staff were at the front door with their backs to it. 4:44:48 FC #1 walked out of the camera's angle. 4:44:57 staff was heard saying 'call 911.'" Then there were two loud bangs. 4:45:02 FC #1 walked to the front door	V 132		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL013-226	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/08/2026
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V 132	<p>Continued From page 14</p> <p>and walked out the front door. The video ended.</p> <p>Interview on 4/29/26 with the DSS Social Worker revealed: -Was currently investigating the allegation by FC #1 of abuse against facility staff on 3/17/26. -Watched the video of the incident and did not see staff acting inappropriately. -"The restraints that the facility does are limited." -She had no concerns about the client's treatment at the facility.</p> <p>Attempted interview with FC#1 on 4/28/26 was unsuccessful due her being AWOL from her current placement.</p> <p>Interview on 3/28/26 with the Quality Improvement Specialist at FC #1's current placement revealed: -"There are no allegations that have been reported regarding her (FC #1's) previous placement. If there were allegations we would have it on an incident report."</p> <p>Interviews on 4/27/26 and 5/8/26 with the Licensed Professional/Director revealed: -Learned of the allegation of abuse on 4/1/26 when DSS arrived at the facility. -The DSS social worker did not indicate which staff were accused. -Investigated the allegation. -Staff #2, FS #1 and the PM were involved in a restraint of Client #1 on 3/17/26. -Did not suspend staff during the investigation. -Reviewed the video of the incident. -Determined that the staff involved were using improper restraint techniques. -Did not substantiate the allegation of abuse. -Did not report to the Health Care Personnel Registry.</p>	V 132		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL013-226	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/08/2026
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V 367	<p>27G .0604 Incident Reporting Requirements</p> <p>10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS</p> <p>(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:</p> <ol style="list-style-type: none"> (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. <p>(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:</p> <ol style="list-style-type: none"> (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. 	V 367		

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V 367	<p>Continued From page 16</p> <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <ol style="list-style-type: none"> (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. <p>(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).</p> <p>(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:</p> <ol style="list-style-type: none"> (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs 	V 367		

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V 367	<p>Continued From page 17</p> <p>(a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to submit a level III incident report within 72 hours of becoming aware of the incident. The findings are:</p> <p>Review on 4/7/26 of FC #1's record revealed: -Admission date of 2/11/26. -Diagnoses of Post Traumatic Stress Disorder and Oppositional Defiant Disorder. -Age 16. -Discharge date of 3/18/26.</p> <p>Review on 4/27/26 of the North Carolina Incident Response Improvement System (IRIS) from 2/14/26 to 4/27/26 revealed: -There was no report related to the 4/1/26 allegation of abuse by FC #1. -3/17/26 In attempt to prevent FC #1 from going out the facility's front door, Former Staff (FS #1) Staff #2, and the Program Manager (PM) used their bodies to block FC #1. The staff did not utilize Crisis Prevention Institute (CPI) approved techniques.</p> <p>Review on 4/27/26 of the facility's Grievance/Investigation Form dated 4/1/26 revealed: -"On 04/01/2026, Turning Point Union House Group Home was made aware of an ongoing</p>	V 367		

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V 367	<p>Continued From page 18</p> <p>allegation of abuse investigation involving client [FC#1] related to an incident that reportedly occurred on 03/17/2026. Awareness of the allegation occurred when DSS (Department of Social Services) worker arrived onsite to conduct interviews with both staff and clients regarding the matter. [DSS worker] did not identify any specific staff member as the accused party but requested to review video footage of the incident and requested information regarding all staff present during the shift in question.</p> <p>-Upon internal review of the available video footage, Turning Point leadership did not determine that the incident constituted abuse based on observable interactions and staff response during the event."</p> <p>Review on 4/29/26 at 1:33pm, of the facility's camera footage dated 3/17/26 from 4:43pm to 4:45pm revealed:</p> <p>-The camera was inside the facility.</p> <p>-The camera angle was at the middle of the hallway and faced the front door.</p> <p>-Former Staff #1 (FS #1) tried to stop Former Client #1 (FC #1) from going out the front door. FS #1 came out of a side entrance as FC #1 was headed towards the front door of the facility. FC #1 had a doo rag on her head. Staff #2 came down the hall towards the front door. Then the Program Manager (PM) came down the hall headed towards the front door. All three staff used their bodies to deny FC #1 access to leave the facility by the front door. Staff was heard stating 'you have to go out the back door' at 4:43:53. The PM and FS #1 had their arm kind of around FC #1's waist and they are to the right of the door. Staff #2 is to the left of the front door and appeared to have a cell phone in her hand. FC #1 appeared to be sandwiched between the PM and FS #1. At 4:44:03 staff stated, "Don't get</p>	V 367		

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V 367	Continued From page 19 my hair." FC #1 was pulled away from the front door while holding onto it. Staff #2 arrives at 4:43:50. FS #1 had her arms around FC #1. At 4:43:54, staff #2 was standing to the side of the hallway with her cell phone. FS #1 had her left arm inside the coat area and it was undetermined where the other hand was due to the dimness of the video and window light only. Both staff continued to block the client at the door. At 4:43:57, The PM arrived after coming up the hall to the front door. FS #1 reached around FC #1's waist area again. FC #1's back was facing away from the wall and the PM reached with her right arm across FC #1 as if to get her in a bear hug. At 4:44:00, the PM had the front of her body facing FC #1's back and staff #2 had the front of her body facing FC #1. At 4:44:44, staff yelled 'call the police. Call 911, call 911.' The PM reached over the top of FS #1's head and over her shoulder. The view of the camera is blocked by the PM's body. "Don't get my hair." was heard on the video and the PM was pulling FS #1 to get her away from FC #1 as she held onto FS #1's hair. FC #1 reached up and behind the door with her right hand trying to open the front door. The PM's body continued to block the camera's view. Staff #2 continued to stand off to the left side. 4:44:05 staff continued to attempt to pull FC #1 away from the door. 4:44:07 Staff #2 was now involved in the pulling of FC #1 away from the door. All three staff's bodies blocked the camera angle. 4:44:17 FC #1 was leaning forward and the camera angle still blocked the view. The PM was in front of FC #1 and FS #1 was in the front of the client. Staff #2 remained to the left side. FC #1 squatted down. Her arms continued to hold onto the front of the door which was cracked. The angle of the camera was blocked by four bodies. 4:44:19 FC #1 came down the hall, away from the front door. FS #1 reached in the general area of	V 367		

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V 367	<p>Continued From page 20</p> <p>FC #1 and they backed up towards the front door. FS #1's back was to the camera. The PM reached towards FC #1 and then backed up. Were unable to determine where the hands of staff and client are clearly. There were no lights on in the hallway, but was lit by the front door and windows. 4:44:21. The PM had her left arm across the chest and around FC #1 as she stood to the side of FC #1. FC #1 continued to move towards the front door and staff put their body in front to prevent this from happening. At 4:44:21, FC #1 moved her right hand and struck PM on the left side of her face. 4:44:22, PM was facing FC #1 with her left hand over FC #1's shoulder. Staff #2 was to the right of PM and reached around and over the shoulder of FC #1. 4:44:23, FC #1 backed away from staff. Staff did not appear to be holding onto FC #1. Staff #2 was behind FC #1. FS #1 had moved up to the front of the door. Staff continued to block FC #1 from moving. Unable to see FC #1 and the staff's hands. The group was moving towards the right of the front door. There was no clear camera angle. 4:44:24 the staff are using their bodies to prevent FC #1 from moving towards the front door. Again there was no clear camera angle. It appeared FC #1's doo rag was being pulled on by staff. This occurred to the left of the hallway. The doo rag remained on FC #1's head during the movements. 4:44:36, FS #1 moved to the right of the doorway and PM and staff #2 remained to the left of the front door with FC #1. FC #1 was sitting on the floor. 4:44:37 the front door was shut closed. FC #1 remained on the floor and staff were standing around her. PM bent down at 4:44:40. FC #1 remained on the floor in a sitting position. The video in the hallway was dark. Staff #2 was standing over FC #1. FC #1 slid onto her back. 4:44:41 staff #2 continued to stand over FC #1. Then staff can be seen backing away from</p>	V 367		

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V 367	<p>Continued From page 21</p> <p>FC #1. There are no hands on FC #1. At 4:44:43 as FC #1 starts to move, staff #2 moves along with her towards the front door. 4:44:44 FC #1 was standing up. PM had her back to the front door. 4:44:46 FC #1 walked away from the door down the hallway. All three staff were at the front door with their backs to it. 4:44:48 FC #1 walked out of the camera's angle. 4:44:57 staff was heard saying 'call 911.'" Then there were two loud bangs. 4:45:02 FC #1 walked to the front door and walked out the front door. The video ended. Interview on 4/29/26 with the DSS Social Worker revealed:</p> <ul style="list-style-type: none"> -Was currently investigating the allegation by FC #1 of abuse against facility staff on 3/17/26. -Watched the video of the incident and did not see staff acting inappropriately. -"The restraints that the facility does are limited." -She had no concerns about the client's treatment at the facility. <p>Attempted interview with FC#1 on 4/28/26 was unsuccessful due her being AWOL from her current placement.</p> <p>Interview on 3/28/26 with the Quality Improvement Specialist at FC #1's current placement revealed:</p> <ul style="list-style-type: none"> -"There are no allegations that have been reported regarding her (FC #1's) previous placement. If there were allegations, we would have it on an incident report." <p>Interviews on 4/27/26 and 5/8/26 with the Licensed Professional/Director revealed:</p> <ul style="list-style-type: none"> -Learned of the allegation of abuse on 4/1/26 when DSS arrived at the facility. -Staff #2, FS #1 and the PM were involved in a restraint of FC #1 on 3/17/26. -Reviewed the video of the incident. 	V 367		

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V 367	Continued From page 22 -Determined that the staff involved were using improper restraint techniques. -Did not substantiate the allegation of abuse. -Did not complete the IRIS report and did not report to the Local Management Entity/Managed Care Organization (LME/MCO).	V 367		