

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL096-294</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/06/2026</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HOPE 4 THE FUTURE LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 BRYANWOOD DRIVE GOLDSBORO, NC 27534</b>
------------------------------------------------------------------	---------------------------------------------------------------------------------------------

(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	<p><b>INITIAL COMMENTS</b></p> <p>An annual, complaint and follow up survey was completed on May 6, 2026. Two complaints were unsubstantiated (intake #NC00236265, NC00236739 and one complaint was substantiated NC00236843). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children and Adolescents.</p> <p>This facility is licensed for 4 and has a current census of 3. The survey sample consisted of audits of 3 current clients and 2 former clients.</p>	V 000		
V 118	<p><b>27G .0209 (C) Medication Requirements</b></p> <p><b>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</b></p> <p>(c) Medication administration:</p> <p>(1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs.</p> <p>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.</p> <p>(3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications.</p> <p>(4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following:</p> <p>(A) client's name;</p>	V 118		

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL096-294</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/06/2026</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HOPE 4 THE FUTURE LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 BRYANWOOD DRIVE</b> <b>GOLDSBORO, NC 27534</b>
------------------------------------------------------------------	---------------------------------------------------------------------------------------------------

(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 118	<p>Continued From page 1</p> <p>(B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to administer medications on the written order of a physician affecting 2 of 3 audited current clients (#1 and #3). The findings are:</p> <p>Finding #1: Review on 04/22/26 of client #1's record revealed: - Admission date of 03/14/26. - 15 year old male. - Diagnoses of Adjustment Disorder and Oppositional Defiant Disorder (ODD). - No medication orders from 03/14/26 thru 04/05/26.</p> <p>Review on 05/05/26 of client #1's medication orders dated 04/06/26 revealed: - Intuniv - (Guanfacine) (Attention Deficit Hyperactivity Disorder (ADHD)) 1 milligram (mg) - take once daily.</p> <p>Review on 04/23/26 of client #1's March 2026 and April 2026 MARs revealed:</p>	V 118		
-------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL096-294</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/06/2026</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HOPE 4 THE FUTURE LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 BRYANWOOD DRIVE GOLDSBORO, NC 27534</b>
------------------------------------------------------------------	---------------------------------------------------------------------------------------------

(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 118	<p>Continued From page 2</p> <p>March 2026 - Staff initials to indicate Guanfacine was administered daily from 03/15/26 thru 03/28/26. - Staff initials circled to indicated Guanfacine was not administered from 03/29/26 thru 03/31/26.</p> <p>April 2026 - Staff initials circled to indicated Guanfacine was not administered from 04/01/26 thru 04/06/26.</p> <p>Interview on 04/22/26 client #1 stated he received his medication daily.</p> <p>Finding #2: Review on 04/23/26 and 05/06/26 of client #3's record revealed: - Admission date 03/20/26. - 10 year old male. - Diagnoses of ADHD, ODD and Post-Traumatic Stress Disorder.</p> <p>Review on 05/06/26 of client #3's medication orders dated 02/06/26 revealed: - Escitalopram (antidepressant) 5mg - take 3 every day. - Levocetirizine (allergies) 5mg - take once daily.</p> <p>Review on 04/23/26 of client #3's March 2026 and April 2026 MARs revealed: March 2026 - Staff initials circled to indicate the Escitalopram was not administered from 03/29/26 thru 03/31/26.</p> <p>April 2026 - Staff initials circled to indicate the Escitalopram was not administered from 04/01/26 thru 04/07/26. - Staff initials circled to indicate the Levocetirizine was not administered from 04/04/26 thru</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL096-294</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/06/2026</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HOPE 4 THE FUTURE LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 BRYANWOOD DRIVE GOLDSBORO, NC 27534</b>
------------------------------------------------------------------	---------------------------------------------------------------------------------------------

(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 118	<p>Continued From page 3</p> <p>04/07/26.</p> <p>Interview on 04/22/26 client #3 stated he received his medications daily.</p> <p>Interview on 05/06/26 staff #8/Owner stated: - It was difficult to get new clients seen by a local physician.</p> <p>Interview on 04/23/26 and 05/06/26 staff #9/Owner stated: - When staff initials were circled the medication was not available for administration. - Client #3's medications were brought with him. - Client #3's medication ran out before refills could be secured. - It was difficult to get new clients in to see local primary care providers.</p> <p>Interview on 05/06/26 the Qualified Professional stated: - It was difficult to get new clients seen by a local physician for medication refills. - She requested direction on how to get clients seen at local providers quicker for medication refills.</p>	V 118		
V 296	<p>27G .1704 Residential Tx. Child/Adol - Min. Staffing</p> <p>10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS</p> <p>(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.</p> <p>(b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows:</p>	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL096-294</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/06/2026</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HOPE 4 THE FUTURE LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 BRYANWOOD DRIVE GOLDSBORO, NC 27534</b>
------------------------------------------------------------------	---------------------------------------------------------------------------------------------

(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 296	<p>Continued From page 4</p> <p>(1) two direct care staff shall be present for one, two, three or four children or adolescents;</p> <p>(2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and</p> <p>(3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents.</p> <p>(c) The minimum number of direct care staff during child or adolescent sleep hours is as follows:</p> <p>(1) two direct care staff shall be present and one shall be awake for one through four children or adolescents;</p> <p>(2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and</p> <p>(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.</p> <p>(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.</p> <p>(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 needs as specified in the treatment plan.</p>	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL096-294</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/06/2026</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HOPE 4 THE FUTURE LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 BRYANWOOD DRIVE</b> <b>GOLDSBORO, NC 27534</b>
------------------------------------------------------------------	---------------------------------------------------------------------------------------------------

(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 296	<p>Continued From page 5</p> <p>This Rule is not met as evidenced by: Based on record review, observation and interviews the facility failed to provide the minimum number of staff for ensuring supervision when they are away from the facility affecting 1 of 3 audited current clients (#1). The findings are:</p> <p>Review on 04/22/26 of client #1's record revealed:</p> <ul style="list-style-type: none"> <li>- Admission date of 03/14/26.</li> <li>- 15 year old male.</li> <li>- Diagnoses of Adjustment Disorder and Oppositional Defiant Disorder.</li> <li>- Habilitation/Treatment plan dated 03/11/26.</li> <li>- No strategies for supervision by one staff while out in the community.</li> </ul> <p>Observation on 04/22/26 at approximately 2:50pm revealed:</p> <ul style="list-style-type: none"> <li>- Staff #8/Owner arrived at the facility with client #1 in a vehicle.</li> <li>- Staff #8/Owner was the only staff to provide supervision for client #1 in the community.</li> </ul> <p>Interview on 05/06/26 staff #8/Owner stated he was not aware 2 staff had to provide supervision in the community unless a client's treatment plan indicated one staff was capable of supervision.</p> <p>Interview on 05/06/26 staff #9/Owner stated she was not aware 2 staff had to accompany a client in the community unless specified in the treatment plan.</p> <p>Interview on 05/06/26 the Qualified Professional stated:</p> <ul style="list-style-type: none"> <li>- She was not aware 2 staff had to accompany a client in the community unless specified in the</li> </ul>	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL096-294</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/06/2026</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HOPE 4 THE FUTURE LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 BRYANWOOD DRIVE GOLDSBORO, NC 27534</b>
------------------------------------------------------------------	---------------------------------------------------------------------------------------------

(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 296	Continued From page 6  treatment plan. - One staff took clients to appointments.	V 296		
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 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	V 521		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL096-294</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/06/2026</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HOPE 4 THE FUTURE LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 BRYANWOOD DRIVE GOLDSBORO, NC 27534</b>
------------------------------------------------------------------	---------------------------------------------------------------------------------------------

(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 521	<p>Continued From page 7</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure the necessary documentation was in the client record when restrictive interventions were utilized affecting 1 of 3 audited current clients (#2). The findings are:</p> <p>Review on 04/22/26 and 05/06/26 of client #2's record revealed:</p> <ul style="list-style-type: none"> <li>- Admission date: 10/02/25</li> <li>- 12 year old male.</li> <li>- Diagnoses of Unspecified Trauma, Stressor Disorder and Unspecified Neurodevelopmental Disorder.</li> <li>- Treatment plan dated 03/31/26.</li> <li>- Restrictive interventions could be used as a planned strategy.</li> <li>- 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 interventions. (03/12/26) (02/05/26)</li> <li>- No description of the duration of its use. (02/05/26)</li> </ul> <p>Review on 4/22/26 of the North Carolina Incident Response Improvement System (IRIS) revealed the following restrictive interventions had been implemented with client #2: 03/12/26 at 11:00am</p> <ul style="list-style-type: none"> <li>- "...[Client #2's initials] briefly returned to his room to calm down but later came back to the table where he began throwing items and</li> </ul>	V 521		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL096-294</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/06/2026</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HOPE 4 THE FUTURE LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 BRYANWOOD DRIVE GOLDSBORO, NC 27534</b>
------------------------------------------------------------------	---------------------------------------------------------------------------------------------

(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 521	<p>Continued From page 8</p> <p>attempting to bang his head against the table. Staff made multiple attempts to redirect [Client #2's initials] and asked him to stop hitting his head due to the risk of self-harm. [Client #2's initials] then became increasingly defiant and aggressive, spitting on the floor, standing up, urinating on himself, and continuing attempts to bang his head on the table. Due to the safety concerns, [Client #2's initials] was placed in a therapeutic wrap for approximately five minutes to assist with de-escalation. Once [Client #2's initials] calmed down, the hold was released. After regaining composure, [Client #2's initials] requested to take a shower to help calm himself, which staff permitted..."</p> <p>02/05/26 at 1:15pm - "[Client #2's initials] attempted to hit his head against the wall, while staff were actively redirecting, [Client #2's initials] turned toward staff and attempted to swing and punch staff, escalating the situation. [Client #2's initials] behavior presented imminent risk to himself and staff. Due to failed verbal redirection and de-escalation attempts staff implemented a therapeutic wrap to assist [Client #2's initials] in calming and to ensure the safety of all involved."</p> <p>Interview on 04/22/26 staff #9/Owner stated: - Client #2 had planned strategy for restrictive interventions. - She completed IRIS reports for restraints. - She understood restrictive interventions completed at the facility required 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 interventions. - The documentation needed to include the description of the restraint and the duration of its</p>	V 521		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL096-294</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/06/2026</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HOPE 4 THE FUTURE LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 BRYANWOOD DRIVE GOLDSBORO, NC 27534</b>
------------------------------------------------------------------	---------------------------------------------------------------------------------------------

(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 521	Continued From page 9  use.	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, 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	V 525		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL096-294</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/06/2026</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HOPE 4 THE FUTURE LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 BRYANWOOD DRIVE GOLDSBORO, NC 27534</b>
------------------------------------------------------------------	---------------------------------------------------------------------------------------------

(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 525	<p>Continued From page 10</p> <p>well-being of the client.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interview, 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 3 audited current clients (#2)). The findings are:</p> <p>Review on 04/22/26 and 05/06/26 of client #2's record revealed: - Admission date: 10/02/25 - 12 year old male. - Diagnoses of Unspecified Trauma, Stressor Disorder and Unspecified Neurodevelopmental Disorder. - No documentation of restrictive intervention log to reflect the restrictive interventions between the dates of 02/05/26 and 03/12/26.</p> <p>Review on 4/22/26 of the North Carolina Incident Response Improvement System (IRIS) revealed the following restrictive interventions had been implemented with client #2: 03/12/26 at 11:00am - "...[Client #2's initials] briefly returned to his room to calm down but later came back to the table where he began throwing items and attempting to bang his head against the table. Staff made multiple attempts to redirect [Client #2's initials] and asked him to stop hitting his head due to the risk of self-harm. [Client #2's initials] then became increasingly defiant and aggressive, spitting on the floor, standing up, urinating on himself, and continuing attempts to bang his head on the table. Due to the safety concerns, [Client #2's initials] was placed in a therapeutic wrap for approximately five minutes to</p>	V 525		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL096-294</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/06/2026</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HOPE 4 THE FUTURE LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 BRYANWOOD DRIVE GOLDSBORO, NC 27534</b>
------------------------------------------------------------------	---------------------------------------------------------------------------------------------

(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 525	<p>Continued From page 11</p> <p>assist with de-escalation. Once [Client #2's initials] calmed down, the hold was released. After regaining composure, [Client #2's initials] requested to take a shower to help calm himself, which staff permitted..."</p> <p>02/05/26 at 1:15pm - "[Client #2's initials] attempted to hit his head against the wall, while staff were actively redirecting, [Client #2's initials] turned toward staff and attempted to swing and punch staff, escalating the situation. [Client #2's initials] behavior presented imminent risk to himself and staff. Due to failed verbal redirection and de-escalation attempts staff implemented a therapeutic wrap to assist [Client #2's initials] in calming and to ensure the safety of all involved."</p> <p>Interview on 04/22/26 and 05/06/26 staff #9/Owner stated: - Client #2 had planned strategy for restrictive interventions. - She completed IRIS reports for restraints. - She did not have restrictive intervention policy. - There was not a restraint log.</p>	V 525		
V 526	<p>27E .0104(e18-19) Client Rights - Sec. Rest. &amp; ITO</p> <p>10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL</p> <p>(e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (18) The facility shall collect and analyze data on the use of seclusion and physical restraint. The data collected and analyzed shall reflect for each</p>	V 526		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL096-294</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/06/2026</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HOPE 4 THE FUTURE LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 BRYANWOOD DRIVE GOLDSBORO, NC 27534</b>
------------------------------------------------------------------	---------------------------------------------------------------------------------------------

(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 526	<p>Continued From page 12</p> <p>incident: (A) the type of procedure used and the length of time employed; (B) alternatives considered or employed; and (C) the effectiveness of the procedure or alternative employed. The facility shall analyze the data on at least a quarterly basis to monitor effectiveness, determine trends and take corrective action where necessary. The facility shall make the data available to the Secretary upon request. (19) Nothing in this Rule shall be interpreted to prohibit the use of voluntary restrictive interventions at the client's request; however, the procedures in this Rule shall apply with the exception of Subparagraph (f)(3) of this Rule.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to collect and analyze data as required for the use of seclusion and physical restraints. The findings are:</p> <p>Review on 04/22/26 and 05/06/26 of facility records revealed: - No quarterly collection or analysis on the use of physical restraints at the facility.</p> <p>Review on 4/22/26 of the North Carolina Incident Response Improvement System (IRIS) revealed the following restrictive interventions had been implemented with client #2: 03/12/26 at 11:00am - "...[Client #2's initials] briefly returned to his room to calm down but later came back to the table where he began throwing items and attempting to bang his head against the table. Staff made multiple attempts to redirect [Client #2's initials] and asked him to stop hitting his</p>	V 526		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL096-294</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/06/2026</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HOPE 4 THE FUTURE LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 BRYANWOOD DRIVE GOLDSBORO, NC 27534</b>
------------------------------------------------------------------	---------------------------------------------------------------------------------------------

(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 526	<p>Continued From page 13</p> <p>head due to the risk of self-harm. [Client #2's initials] then became increasingly defiant and aggressive, spitting on the floor, standing up, urinating on himself, and continuing attempts to bang his head on the table. Due to the safety concerns, [Client #2's initials] was placed in a therapeutic wrap for approximately five minutes to assist with de-escalation. Once [Client #2's initials] calmed down, the hold was released. After regaining composure, [Client #2's initials] requested to take a shower to help calm himself, which staff permitted..."</p> <p>02/05/26 at 1:15pm - "[Client #2's initials] attempted to hit his head against the wall, while staff were actively redirecting, [Client #2's initials] turned toward staff and attempted to swing and punch staff, escalating the situation. [Client #2's initials] behavior presented imminent risk to himself and staff. Due to failed verbal redirection and de-escalation attempts staff implemented a therapeutic wrap to assist [Client #2's initials] in calming and to ensure the safety of all involved."</p> <p>Interview on 04/22/26 and 05/06/26 staff #9/Owner stated: - Client #2 had planned strategy for restrictive interventions. - She completed IRIS reports for restraints. - She did not have restrictive intervention policy. - There was not a quarterly review of restraints.</p>	V 526		