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V 000	INITIAL COMMENTS An annual and complaint survey was completed on May 4, 2026. The complaint was substantiated (NC#00236372). Deficiencies were cited. This facility is licensed for the following service categories: 10A NCAC 27G.1100 Partial Hospitalization for Individuals Who are Acutely Mentally Ill, 10A NCAC 27G .3700 Day Treatment Facilities for Individuals with Substance Abuse Disorders, 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program and 10A NCAC 27G .4500 Substance Abuse Comprehensive Outpatient Treatment Program. This facility has a current census of 29. The .1100 Partial Hospitalization Program (PHP) has a current census of 3, the .3700 Day Treatment Facilities for Individuals with Substance Abuse Disorders has a current census of 0, the .4400 Substance Abuse Intensive Outpatient Program (SAIOP) has a current census of 21, and the .4500 Substance Abuse Comprehensive Outpatient Program (SACOT) has a current census of 5. The survey sample consisted of audits of 1 current PHP client, 1 current SAIOP client, 1 current SACOT client, 1 deceased SAIOP client, and 1 deceased former SACOT client.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services;	V 105		

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V 105	Continued From page 1 (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant	V 105		

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treatment/habilitation privileges:
(G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death;
(H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to develop and implement their admission policies to the Substance Abuse Intensive Outpatient Program (SAIOP). The findings are:

Attempted review on 4/22/26 of the facility's SAIOP admission policies requested by email from the Division of Health Service Regulation (DHSR) on 4/22/26 to the Executive Director (ED) and Director of Operations (DO) at 9:42AM revealed:
-Policies were not provided on this date as requested.

Attempted review on 4/24/26 of the facility's

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SAIOP admission policies requested by email from DHSR on 4/24/26 to the Chief Executive Officer at 11:19AM revealed:
-Policies were not provided on this date as requested.

Review on 4/27/26 of the facility's SAIOP admission policies emailed at 12:37AM on 4/27/26 from the Chief Executive Officer to DHSR revealed:
-"Admissions Policy & Procedure...(SAIOP)
-Effective Date: 4/22/26.
-4. Admission Criteria...Adult (18+) with a primary substance use disorder or co-occurring diagnosis...
-5. Exclusion Criteria...Client needs are greater than SAIOP can meet (refer to SACOT (Substance Abuse Comprehensive Treatment), PHP (Partial Hospitalization Program), or higher level of care...
-6. Pre-Admission Screening...Otter House Wellness uses ASAM (American Society of Addiction Medicine) Criteria and LOCUS (Level of Care Utilization System) to determine the appropriate level of care..."

Review on 4/27/26 of "All Staff Communication-Admissions Protocol-Effective Immediately-April 27, 2026, emailed at 3:02PM to DHSR from the ED revealed:
"-...MEDICAL TEAM AUTHORITY - FINAL AND NON-NEGOTIABLE When the Otter House Wellness medical provider determines that a client is not medically suitable for a recommended level of care, that determination is final. The medical team's judgment on client safety and appropriate placement cannot be overridden, reversed, or circumvented by any staff member, department leader, or individual within the organization - including ownership and

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V 105	Continued From page 4 executive leadership. No admission shall proceed contrary to the recommendation of the medical provider. Any staff member who attempts to override, pressure, or work around a medical provider's determination is in direct violation of this policy. Such actions will be treated as serious patient safety and regulatory compliance matter and will be addressed accordingly." Review on 4/23/26 of Deceased Client #4's (DC #4) record revealed: -Date of Admission: 2/2/26. -Diagnoses: Major Depressive Disorder, Recurrent Episode, Severe; and Post Traumatic Stress Disorder. -Program: Virtual SAIOP also known as Virtual Intensive Outpatient Program (VIOP). -Date of death: 2/12/26. -Discharge Date: 2/16/26. -Pre-Admission Assessment Form 2/2/26, "Intention of Treatment: -MH (mental health) Primary Anxiety/Depression with occasional Adderall and Xanax use." "Client is seeking IOP virtual for MH, substance use is very minimal and not a current issue for abuse..." -History of psychiatric hospitalizations noted in 2021 and 2022. -History of multiple IOP/PHP (Partial Hospitalization Program) treatment programs. -Medical History and Psychiatric Assessment dated 2/2/26, completed by the Nurse Practitioner (NP) revealed: "Chief Complaint(s): I've been really depressed. -Treatment Plan: Risk Assessment: -The patient presents with acute and chronic risk factors for suicide... -Current risk factors include severe depression Montgomery-Asberg Rating Scale (MADRS) score 37, active suicidal ideation, history of	V 105		

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multiple suicide attempts, polysubstance use disorder with recent sobriety (1.5 months), recent significant psychosocial stressors...She has an active prescription for lorazepam from her outpatient psychiatrist and no UDS (urine drug screen) has been obtained to assess for ongoing alcohol or illicit substance use.

-Assessment and Plan: This patient presents with severe, treatment-resistant depression, Post Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, and polysubstance use disorder. She demonstrates acute and chronic suicide risk with current passive suicidal ideation, severe depressive symptoms, history of multiple suicide attempts, and access to lethal means (lorazepam prescription). She also exhibits concerning features, including paranoid ideation and anger dysregulation, that suggest possible emerging psychotic features or severe mood disorder with psychotic features requiring further evaluation.

Level of Care Recommendation: This patient is NOT appropriate for virtual IOP level of care due to acute and chronic risk for suicide, severity of depression (MADRS 37), recent significant psychosocial stressors, limited protective factors, and concerning cognitive symptoms requiring close monitoring and more intensive intervention.

-Recommended level of care is Partial Hospitalization Program (PHP) or residential treatment to provide daily monitoring, medication management, intensive therapeutic intervention, and crisis stabilization. This case was discussed with the Operations Director, (who is now the Executive Director) and it was recommended that the patient be referred to a higher level of care (PHP or residential), given the acute and chronic suicide risk and severity of presentation. The Operations Director stated that they were going to continue with admission to virtual IOP despite my

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recommendation that the patient be referred to a higher level of care."
-Virtual Bio-psychosocial Assessment dated 2/3/26, "My depression is making my addiction worse."
-DC #4 was hard of hearing and needed to put captions on during the virtual assessment.
-Admission level of care utlization system (LOCUS) dated 2/3/26, completed and reviewed by Therapist #4 revealed:
"Guidance:
-MHOP (mental health outpatient program): Composite Score of 14-16
-MHIOP (mental health intensive outpatient program): Composite Score of 17-19
-MHPHP (mental health partial hospitalization program): Composite Score of 20-22
-Clinically Recommended Level of Care Based on Above Assessment: Client scored 24...Writer recommends transition to higher level of care, such as PHP or Residential Treatment to adequately address client's mental health needs."

Interview on 4/22/26 and 4/24/26 with the Admissions/Former Director of Operations (A/FDO) revealed:
-Did not hold a clinical license.
-Started in Admissions role, "about a month ago...and prior to that was in Director of Operations role (DO)."
-"[Vice President (VP) of Business Development and Admissions] was on that call (DC #4)'s admission."
-DC #4 was admitted to the VIOP program.
-"Contacted [DC #4]'s emergency contact on Sunday (2/15/26)...her mother reported that she (DC #4) had killed herself..."
-Denied on 4/24/26 that he made the decision to admit DC #4 to the VIOP program despite the Nurse Practitioner's (NP)/medical provider's

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recommendation for a higher level of care.
-Denied having a conversation with the NP about DC #4's admission, "I would never try and make a call like that or override something like that."
-Since DC#4's death, the facility was "trying to look deeper at (admission) criteria for someone that can actually do virtual programming...trying to stay away from primary mental health diagnoses for virtual."

Interview on 4/22/26 with Therapist #4 revealed:
-Was assigned therapist for DC #4.
-Completed DC #4's LOCUS assessment at admission and wrote that the client needs to be in person...she was primary mental health and not substance. "But she was in IOP."
-DC #4 needed a higher level of care.
-DC #4 was a client that "needed to be in person...me and the [NP] said she needs to be in person."
-"[DC #4] was supposed to have a session on 2/12/26. She wasn't present. I reached out and reported she didn't show up and then was told she had deceased."
-Was told on 2/16/26 that she had passed away by the ED and was directed to complete a discharge summary.
-"When mental health is the biggest concern, we cannot provide the level of service here (at the facility)...most of the treatment is going to be SUD (substance use) heavy."
-Information about what happened with DC #4, "was not relayed to me to understand the situation and felt like it (her death) was swept under the rug."

Interview on 4/24/26 with the NP revealed:
-Screened DC #4 and consulted with Therapist #4 about her treatment and level of care.
-Then it (screening/admission decision) went to

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the Director of Operations (DO).
-"It was [ED] at the time as the DO and prior to that it was [A/FDO]."
-DC #4 was not appropriate for VIOP.
-DC #4 had mental health issues and needed a higher level of care.
-Wanted to get DC #4 at least "in person" (for services) or inpatient mental health treatment.
-The DO at the time, who was the ED did not agree with her recommendation of a higher level of care.
-The DO told her that they needed to move forward with VIOP for DC #4.

Interview on 5/4/26 with the VP of Business Development and Admissions revealed:
-Had been in this role for a month since January 1, 2026.
-Did not hold a clinical license.
-Was the "gatherer of information" for admission screening and then sent it on to a clinician.
-The admissions policies were "just updated by us (facility). There was now an admission policy for SAIOP, SACOT (Substance Abuse Comprehensive Outpatient Treatment), and overall, that was expanded to make sure it was up to standards with joint commission and scope."
-The previous admissions policy was "bare bones."
-Regarding DC #4's admission, "We wanted her to step up in care, but she wouldn't do it...we didn't want to leave her with nothing."
-Denied that DC #4's admission was brought up to management.
-The decision to admit DC #4, "On my side, I didn't want to leave her with nothing...Once I pass her off to people I don't know."

Interview on 4/24/26 with the Chief Executive

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Officer (CEO) revealed:
-His understanding of what happened with DC #4 was that she stopped showing up to group and committed suicide.
-"Initially she (DC #4) was engaged (with VIOP) and was finally agreeing to do something rather than nothing."
-The ED was involved with her groups and had contact with the family.
-"Didn't understand why the NP didn't call him (about disagreement with DC #4's admission to VIOP)."

Interview on 4/27/26 with the ED revealed:
-Completed DC #4's pre-assessment to admission.
-Led evening VIOP groups that DC #4 participated in.
-Denied that he made the decision to override the NP's recommendation for a higher level of care for DC #4 despite being named in an interview.
-"There's a difference between sharing that I have concerns versus we are taking her anyway...I can't override medical."
-Reported it was multi-team decision to admit DC #4 to VIOP.
-Spoke with DC #4 about going to a higher level of care.
-Reported that moving forward the assessment piece of the admissions process was very important to make sure clients are in an appropriate level of care.
-"If medical makes a decision, we are going with that."

This deficiency is cross referenced into 10A NCAC 27G .4401 Scope (V266) for a Type A1 rule violation and must be corrected within 23 days.

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V 107	27G .0202 (A-E) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (a) All facilities shall have a written job description for the director and each staff position which: (1) specifies the minimum level of education, competency, work experience and other qualifications for the position; (2) specifies the duties and responsibilities of the position; (3) is signed by the staff member and the supervisor; and (4) is retained in the staff member's file. (b) All facilities shall ensure that the director, each staff member or any other person who provides care or services to clients on behalf of the facility: (1) is at least 18 years of age; (2) is able to read, write, understand and follow directions; (3) meets the minimum level of education, competency, work experience, skills and other qualifications for the position; and (4) has no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry. (c) All facilities or services shall require that all applicants for employment disclose any criminal conviction. The impact of this information on a decision regarding employment shall be based upon the offense in relationship to the job for which the applicant is applying. (d) Staff of a facility or a service shall be currently licensed, registered or certified in accordance with applicable state laws for the services provided. (e) A file shall be maintained for each individual	V 107		

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employed indicating the training, experience and other qualifications for the position, including verification of licensure, registration or certification.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure a file was maintained for 4 of 4 audited staff (Therapist #1, Admissions/Former Director of Operations (A/FDO), Clinical Director/Clinical Consultant (CD/CC), and Executive Director (ED)). The findings are:

Review on 4/22/26 of the Facility Staff List provided by the ED revealed:
-Date of Hire:
- -Therapist #1: 2/4/26.
- -CD/CC: 3/31/26.
- -ED: 2/5/25.
- -A/FDO: not provided.

Review on 4/27/26 of a Former and Current Staff List since October 1, 2025, to present (4/25/26) for the facility, emailed by the Chief Executive Officer (CEO) on 4/27/26 at 1:13AM revealed:
-Date of Hire:
- -Therapist #1: 1/24/26.
- -CD/CC: 12/10/25.
- -ED: 2/1/25.
- -A/FDO: 7/7/23.

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Review on 4/22/26 of the Therapist #1's personnel record revealed:
-Date of Hire: 1/20/26.
-No documentation of:
-written job description.
-the minimum level of education, competency, work experience, other qualifications for the position and determination if Therapist #1 met these criteria.
-the duties and responsibilities of the position.

Review on 4/22/26 of the CD/CC's personnel record revealed:
-No documentation of:
-written job description.
-the minimum level of education, competency, work experience, other qualifications for the position and determination if CD/CC met these criteria.
-the duties and responsibilities of the position.

Review on 4/27/26 of the CD/CC's personnel record revealed:
-"Independent Contractor Agreement" signed on 4/24/26.
-"Contractor will provide clinical director services, including clinical oversight..."

Review on 4/22/26 of the ED's personnel record revealed:
-Date of Hire: 12/1/23.
-No documentation of:
-written job description.
-the minimum level of education, competency, work experience, other qualifications for the position and determination if the ED met these criteria.
-the duties and responsibilities of the position.

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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
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Review on 4/27/26 of the A/FDO's personnel record revealed:
-Date of Hire: 12/1/23.
-No documentation of:
-written job description.
-the minimum level of education, competency, work experience, other qualifications for the position and determination if the A/FDO met these criteria.
-the duties and responsibilities of the position.

Interview on 4/22/26 with the A/FDO revealed:
-Had transitioned from Director of Operations (DO) role to Admissions "about a month ago."
-"I was doing onboarding for new employees (Human Resource (HR) duties)."
-Had been in that role since "September 2025 to March 2026."
-"Kind of like with [DO] being new, looking at her taking that over (HR duties)."
-Everyone should have a job description.

Interview on 4/22/26 with the DO revealed:
-Had only been in the role for "about a month and a week."
-"My job is to make sure the system is working and I am overseeing the system as a whole."

Interviews on 4/22/26 and 5/4/26 with the ED revealed:
-"A couple of people have three different job descriptions."
-The facility did not have a HR department or role.
-The A/FDO was responsible for personnel requirements.
-The Executive Assistant would be taking over the responsibility of personnel files.

Interview on 4/24/26 with the CEO revealed:

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V 107	Continued From page 14 -Was responsible for "everything." -"As of today [Executive Assistant] (will be in the HR role). She has been with me for 60 days...no one specific person (was in that role prior)."	V 107		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients.	V 108		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure 4 of 4 audited staff (Therapist #1, Admissions/Former Director of Operations (A/FDO), Clinical Director/ Clinical Consultant (CD/CC), and Executive Director (ED)) received training to meet the mental health/developmental disabilities/substance abuse (MH/DD/SA) needs of the clients. The findings are:

Review on 4/22/26 of the Facility Staff List provided by the ED revealed:
-Date of Hire:
-Therapist #1: 2/4/26.
-CD/CC: 3/31/26.
-ED: 2/5/25.
-A/FDO: not provided.

Review on 4/27/26 of a Former and Current Staff List since October 1, 2025, to present (4/25/26) for the facility, emailed by the Chief Executive Officer (CEO) on 4/27/26 at 1:13AM revealed:
-Date of Hire:
-Therapist #1: 1/24/26.
-CD/CC: 12/10/25.
-ED: 2/1/25.
-A/FDO: 7/7/23.

Review on 4/22/26 of the Therapist #1's personnel record revealed:
-No documentation of:
-training to meet the mh/dd/sa needs of the clients.

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Continued From page 16

Review on 4/22/26 of the CD/C's personnel record revealed:
-No documentation of:
-training to meet the mh/dd/sa needs of the clients.

Review on 4/22/26 of the ED's personnel record revealed:
-No documentation of:
-training to meet the mh/dd/sa needs of the clients.

Review on 4/27/26 of the A/FDO's personnel record revealed:
-No documentation of:
-training to meet the mh/dd/sa needs of the clients.

Interview on 4/22/26 and with the Director of Operations (DO) revealed:
-Had only been in the role for about a month.
-Was going to be responsible for the "...day to day operations...overseeing the system as a whole..."

Interviews on 4/22/26 and 5/4/26 with the ED revealed:
-The facility did not have a Human Resources (HR) department or role.
-The A/FDO was responsible for personnel requirements.
-The Executive Assistant would now be responsible for tracking and ensuring staff have all required trainings.

Interview on 4/24/26 with the CEO revealed:
-Was responsible for "everything."
-"As of today [Executive Assistant] (will be in the HR role). She has been with me for 60 days...no

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one specific person (was in that role prior)."

V 131 — **V 131**

G.S. 131E-256 (D2) HCPR - Prior Employment Verification

G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY
(d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure the Health Care Personnel Registry (HCPR) was accessed prior to hire for 2 of 4 audited staff (Admissions/Former Director of Operations (A/FDO) and Clinical Director/Clinical Consultant (CD/CC)). The findings are:

Review on 4/22/26 of the facility staff list provided by the Executive Director (ED) revealed:
-Date of Hire:
-CD/CC: 3/31/26.
-A/FDO: not provided.

Review on 4/27/26 of a Former and Current Staff List since October 1, 2025, to present (4/25/26) for the facility, emailed by the Chief Executive Officer (CEO) on 4/27/26 at 1:13AM revealed:
-Date of Hire:
-CD/CC: 12/10/25.

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-A/FDO: 7/7/23.

Review on 4/22/26 of the CD/CC's personnel record revealed:
-No hire date documented.
-Licensure: North Carolina Licensed Clinical Social Worker (LCSW) issued 3/30/26, expiration 3/30/28.
-No documentation that the HCPR was accessed.

Review on 4/27/26 of the CC/CC's personnel record revealed:
-HCPR was accessed on 4/24/26.
-Independent Contractor Agreement signed on 4/26/26.

Review on 4/27/26 of the A/FDO's personnel record revealed:
-Date of Hire: 12/1/23.
-No documentation that the HCPR was accessed.

Interview on 4/22/26 with the A/FDO revealed:
-Had transitioned from Director of Operations (DO) role to Admissions "about a month ago."
-"I was doing onboarding for new employees (Human Resource (HR) duties)."
-Had been in that role since "September 2025 to March 2026."
-"Kind of like with [DO] being new, looking at her taking that over (HR duties)."
-Was responsible for background and licensure checks when he was the DO.

Interview on 4/22/26 with the DO revealed:
-Had only been in the role for "about a month and a week."
-Was going to be responsible for the "...day to day operations...overseeing the system as a whole..."

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V 131	Continued From page 19 Interviews on 4/21/26 with the ED revealed: -The facility did not have an HR department or role. -The A/FDO was responsible for personnel requirements. Interview on 4/24/26 with the CEO revealed: -The CD/CC started employment back in November or December of 2025. -Referred to the CD/CC as "...Clinical Consultant is the technical term." -As CEO he was responsible for "everything." -"As of today [Executive Assistant] (will be in the HR role). She has been with me for 60 days...no one specific person (was in that role prior)."	V 131		
V 133	G.S. 122C-80 Criminal History Record Check G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT. (a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter. (b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If	V 133		

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V 133	Continued From page 20 the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State	V 133		

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criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency.
(c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant:
(1) The level and seriousness of the crime.
(2) The date of the crime.
(3) The age of the person at the time of the conviction.
(4) The circumstances surrounding the commission of the crime, if known.
(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.
(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed.
(7) The subsequent commission by the person of a relevant offense.
The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the

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V 133	Continued From page 22 applicant. (d) Limited Immunity. - A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for: (1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual. (2) Failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section. (e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and	V 133		

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V 133	Continued From page 23 Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5. (f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor. (g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met: (1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10. (2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.)	V 133		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure a national criminal history record check was requested within five business days of making the conditional offer of employment affecting 1 of 4 audited staff (Clinical Director/Clinical Consultant (CD/CC)). The findings are:

Review on 4/22/26 of the facility staff list provided by the Executive Director (ED) revealed:
-Date of Hire:
-CD/CC: 3/31/26.

Review on 4/27/26 of a Former and Current Staff List since October 1, 2025, to present (4/25/26) for the facility, emailed by the Chief Executive Officer (CEO) on 4/27/26 at 1:13AM revealed:
-Date of Hire:
-CD/CC: 12/10/25.

Review on 4/22/26 of the CD/CC's personnel record revealed:
-No hire date documented.
-Licensure: North Carolina (NC) Licensed Clinical Social Worker (LCSW) issued 3/30/26, expiration 3/30/28.
-No documentation of a national criminal history record check was requested within five business days of making the conditional offer of employment.

Review on 4/27/26 of the CD/CC's personnel record revealed:
-National criminal history record check completed

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on 4/21/26.
-Independent Contractor Agreement signed on 4/26/26.

Interview with on 4/22/26 with Therapist #4 revealed:
-The CD/CC lived in another state and was recently licensed in NC.

Interview on 4/21/26 with the CD/CC revealed:
-Lived in another state and worked remotely.
-Had only been in this role "not even 30 days" but would not clarify how long he had worked for the facility.

Interview on 4/22/26 with the Admissions/Former Director of Operations A/FDO) revealed:
-Had transitioned from Director of Operations (DO) role to Admissions "about a month ago."
-"I was doing onboarding for new employees (Human Resource (HR) duties)."
-Had been in that role since "September 2025 to March 2026."
-"Kind of like with [DO] being new, looking at her taking that over (HR duties)."
-Was responsible for background and licensure checks when he was the DO.

Interview on 4/22/26 with the DO revealed:
-Had only been in the role for "about a month and a week."
-Was going to be responsible for the "...day to day operations...overseeing the system as a whole..."

Interviews on 4/21/26 with the ED revealed:
-The facility did not have a HR department or role.
-"It may not have happened (background checks)."

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V 133	Continued From page 26 -The A/FDO was responsible for personnel requirements. Interview on 4/24/26 with the CEO revealed: -Was responsible for "everything." -The CD/CC started employment back in "November or December (of 2025)". -Referred to the CD/CC as "...Clinical Consultant is the technical term." -"As of today [Executive Assistant] (will be in the HR role). She has been with me for 60 days...no one specific person (was in that role prior)."	V 133		
V 171	27G .1101 Partial Hospitalization - Scope 10A NCAC 27G .1101 SCOPE A partial hospitalization facility is a day/night facility which provides a broad range of intensive and therapeutic approaches which may include group, individual, occupational, activity and recreational therapies, training in community living and specific coping skills, and medical services as needed primarily for acutely mentally ill individuals. This facility provides services to: (1) prevent hospitalization; or (2) to serve as an interim step for those leaving an inpatient hospital. This facility provides a medical component in a less restrictive setting than a hospital or a residential treatment or rehabilitation facility. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide a broad range of intensive and therapeutic approaches for primarily acutely	V 171		

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mentally ill individuals separately from other provided services affecting 1 of 1 audited client (#3). The findings are:

Cross Reference: 10A NCAC 27G .1102 Staff (V172). Based on record reviews and interviews, the facility failed to identify at least one qualified mental health professional for the program affecting 1 of 1 audited client (#3).

Review on 4/21/26 of the facility license from North Carolina Division of Health Service Regulation (DHSR) revealed:
-Licensed for the following service categories: Partial Hospitalization for Individuals who are acutely Mentally Ill (PHP), Day Treatment Facilities for Individuals with Substance Abuse Disorders, Substance Abuse Intensive Outpatient Program (SAIOP), and Substance Abuse Comprehensive Outpatient Program (SACOT).

Interview on 4/21/26 with the Executive Director (ED) revealed:
-Census:
-PHP - 3.
-Day Treatment - 0.
-SAIOP - 21.
-SACOT -5.

Review on 4/22/26 of Client #3's record revealed:
-Date of Admission: 3/13/26.
-Diagnoses: Amphetamine-type Substance Use Disorder, Severe; Opioid Use Disorder (OUD), Severe; Alcohol Use Disorder (AUD), Severe; Unspecified Schizophrenia Spectrum and other Psychotic Disorder; Unspecified Mood Disorder; and Anxiety Disorder.
-Preadmission screening not dated: current status dual diagnosis.
-Enrolled in PHP.

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-Authorization for 6 days per week.
-Bio-psychosocial assessment dated 3/13/26: "Integrated Clinical Summary:...presenting for treatment related to substance use that has negatively impacted his mental health...He is seeking services to address his substance use and its impact on his mental health..."
-Medical History and Physical/Psychiatric Assessment dated 3/16/26: "Patient appropriate for PHP level of care at this time given need for structured treatment environment, medication initiation and monitoring, and diagnostic clarification. Will require close monitoring for safety given psychotic symptoms with poor insight, history of bringing firearms to mother's home, and passive suicidal ideation. Collateral information suggests jail recommended inpatient psychiatric hospitalization at [local psychiatric hospital]; will monitor closely for need for higher level of care if symptoms worsen or safety concerns emerge."

Review on 4/22/26 of the Facility's weekly example schedule for the PHP, SAIOP, and SACOT programs revealed:
-Groups were identical for all three programs as follows:
    -Monday, Tuesday, Thursday 9:00-10:30am Topic Group
    -Wednesday 9:00-10:30am Gender Group
    -Friday 9:00-10:30am Community Group
    -Monday - Friday 10:45am-12:15 pm Process Group
-Afternoon Groups from 12:45-2:15pm were identified as PHP Afternoon Group and SACOT afternoon group.

Interview on 4/21/26 with Client #3 revealed:
-The first groups of the day "work on addiction stuff."

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-Groups amongst all service categories would be "intermingled."
-Goals were to "work through mental health and addiction stuff. I forget the particulars of it."

Interview on 4/21/26 with Therapist #1 revealed:
-Groups across service categories had been run together.
-"The groups, I don't know how it's set up at the moment..."
-"...they (groups) were combined and they are separate now...I am not sure (length of separation of groups)."

Interview on 4/22/26 with Therapist #3 revealed:
-"PHP is kind of sprinkled through (groups with other services)."

Interview on 4/22/26 with Therapist #4 revealed:
-Back in September of 2025 "...got a call. Our PHP will be closed and all transferred to IOP...since then programming has been, throw a dart at the bullseye and see what happens."
-Mental health clients are mixed into the substance groups..."we try to cultivate the groups to address mental health but it is mostly SA (substance abuse) heavy."

Interview on 4/22/26 with the Director of Operations (DO) revealed:
-Group sessions were all together across all service categories "...at the moment but won't be in two weeks. We have new staff coming in two weeks..."

Interview on 4/22/26 with the ED revealed:
-Everyone attended the same groups.
-There was no differentiation between groups.

Interview on 4/24/26 with the Nurse Practitioner

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(NP)revealed:
-Client #3 had a primary diagnosis of a substance use disorder.

Interview on 4/27/26 with the ED revealed:
-"PHP is the same hours (as SAIOP and SACOT), every day, 6 days a week."
-"...we were doing PHP. We had more clients."
-"We would split sometimes...(based on service provided)...We didn't want two people in a group. It was easier to provide services together."
-"PHP are all in the same groups."
-"We didn't have many mental health IOP."

Review on 4/30/26 of the Plan of Protection (POP) written and signed by the ED on 4/30/26 revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care?
1. Effective immediately, [Therapist #4], LCMHC,(Licensed Clinical Mental Health Counselor) has been assigned to provide direct clinical oversight and care coordination for all current PHP clients. [Therapist #4] will review each active client record, monitor treatment needs, coordinate services with assigned staff, and ensure that any clinically indicated referral, step-down, or treatment plan update is documented on an individualized basis. This immediate action identifies who is responsible, what will occur, why the action is necessary to protect consumers, and how continuity of care will be maintained while the staffing deficiency is corrected.
2. Effective immediately, the Executive Director and Clinical Director will review all PHP staffing assignments, credentials, supervision responsibilities, and daily coverage expectations to ensure that staff roles are clearly identified and documented for PHP service delivery. This

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immediate action addresses the cited staffing deficiency by establishing documented accountability and active leadership oversight without relying on postponement or cancellation language.
3. Effective immediately, the facility will maintain a daily PHP staffing and census review process to confirm that the staff assigned to PHP are matched to the number of clients being served and that supervision responsibilities are clearly designated. This action protects consumers by ensuring that service delivery is organized, monitored, and documented in alignment with staffing expectations.

Describe your plans to make sure the above happens.
Finding 1: 10A NCAC 27G .1102 Staff (V172)
Who: The Governing Body, Executive Director, Clinical Director, Human Resources, [Therapist #4] (assigned clinical lead), and all staff assigned to PHP services.
What: The facility will strengthen and document PHP staffing by confirming required roles, verifying credentials, assigning supervision responsibilities, maintaining coverage schedules, and establishing backup staffing procedures for PHP operations.
Why: The cited staffing deficiency indicates that PHP operations must demonstrate clear, documented compliance with staff qualification and coverage requirements to protect consumer safety and maintain regulatory compliance.
How: Human Resources will complete a staffing analysis identifying each required PHP staff role, the staff member assigned to that role, credential status, orientation status, and supervision structure. The Clinical Director will maintain a weekly PHP staffing grid showing program hours, assigned clinical and support staff, census

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V 171	Continued From page 32 expectations, and backup coverage. The Executive Director will review the grid weekly for 90 days and monthly thereafter to ensure ongoing compliance, and any staffing or documentation gap will be corrected through reassignment, credential verification, supervisory clarification, or additional staffing support. Finding 2: Consumer oversight and continuity of care Who: [Therapist #4], LCMHC; the Clinical Director; assigned counselors; and admissions/utilization review staff. What: The facility will ensure that each PHP client remains under active clinical review and that treatment plans, attendance, progress, and any referrals are individualized and documented. Why: Consumer protection requires that staffing corrections do not interrupt individualized clinical oversight or create gaps in treatment planning, documentation, or service coordination. How: [Therapist #4] will review all active PHP charts using a standardized audit tool to confirm diagnosis, level of care, treatment plan, service frequency, assigned clinician, and current progress documentation. Any needed updates will be completed by the assigned clinical staff and reviewed by the Clinical Director. A client tracking log will be maintained to confirm that all follow-up actions are completed and sustained. Sustained compliance measures -All PHP personnel files will include credential verification, job descriptions, orientation records, training records, and supervision assignments. -A weekly staffing review will be completed by the Clinical Director and retained with supporting schedules for audit purposes. -The Governing Body will review PHP staffing compliance monthly and document follow-up actions taken to maintain continued compliance. -Quarterly personnel and chart audits will be	V 171		

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V 171	Continued From page 33 completed to verify that staffing, supervision, and service documentation remain aligned with PHP requirements." Review on 5/1/26 of the amended POP written and signed by the ED on 5/1/26 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? 1. Effective immediately, [Therapist #4], LCMHC, has been assigned to provide direct clinical oversight and care coordination for all current PHP clients. [Therapist #4] will review each active client record, monitor treatment needs, coordinate services with assigned staff, and ensure that any clinically indicated referral, step-down, treatment plan update, or consultation with the NP or psychiatrist is documented on an individualized basis. 2. Effective immediately, the Executive Director and designated licensed clinical leadership will review all PHP staffing assignments, credentials, supervision responsibilities, and daily coverage expectations to ensure that staff roles are clearly identified and documented for PHP service delivery. The facility will also ensure that PHP services are staffed, scheduled, and documented separately from SACOT, SAIOP, VIOP, and other program services where applicable. 3. Effective immediately, the facility will maintain a daily PHP staffing and census review process to confirm that staff assigned to PHP are matched to the number of clients being served, that supervision responsibilities are clearly designated, and that consultation with the NP or psychiatrist occurs when clinically indicated. The facility will maintain continuity of care for PHP clients during implementation of this Plan of Correction through active clinical review, treatment planning updates, appropriate staffing coverage, and compliant service delivery while	V 171		

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V 171	Continued From page 34 corrective actions are being completed. Describe your plans to make sure the above happens. Finding 1: 10A NCAC 27G .1102 Staff (V172) Who: The Governing Body, Executive Director, Human Resources, designated licensed clinical leadership, [Therapist #4] as assigned clinical lead, and all staff assigned to PHP services. What: The facility will strengthen and document PHP staffing by confirming required roles, verifying credentials, assigning supervision responsibilities, maintaining coverage schedules, establishing backup staffing procedures, and ensuring that PHP operates as a distinct program service with separate staffing and documentation from SACOT, SAIOP, VIOP, and other services as applicable. Why: The cited staffing deficiency indicates that PHP operations must demonstrate clear, documented compliance with staff qualification and coverage requirements in order to protect consumer safety, maintain continuity of care, and ensure that PHP services are provided and monitored as a distinct level of care. How: Human Resources will complete a staffing analysis identifying each required PHP staff role, the staff member assigned to that role, credential status, orientation status, supervision structure, and effective date of assignment. A weekly PHP staffing grid will be maintained showing PHP program hours, assigned clinical and support staff, census expectations, backup coverage, and the responsible reviewer. Leadership will review the PHP staffing grid weekly for 90 days and monthly thereafter to ensure ongoing compliance, and any staffing or documentation gap will be corrected through reassignment, credential verification, supervisory clarification, consultation with licensed clinical leadership, or additional staffing support as needed.	V 171		

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V 171	Continued From page 35 Finding 2: Consumer oversight and continuity of care Who: [Therapist #4], LCMHC, designated licensed clinical leadership, assigned counselors, admissions staff, utilization review staff, and the NP or psychiatrist when clinically indicated. What: The facility will ensure that each PHP client remains under active clinical review and that treatment plans, attendance, progress, referrals, step-down recommendations, and consultations are individualized and documented in the client record. Why: Consumer protection requires that staffing corrections do not interrupt individualized clinical oversight or create gaps in treatment planning, service coordination, documentation, or access to clinical and medical consultation when indicated. How: [Therapist #4] will review all active PHP charts using a standardized audit tool to confirm diagnosis, level of care, treatment plan, service frequency, assigned clinician, current progress documentation, and whether NP or psychiatrist consultation is indicated based on client presentation. Any needed updates will be completed by the assigned clinical staff and reviewed by designated licensed clinical leadership. A client tracking log will be maintained to confirm that all follow-up actions, referrals, consultations, and documentation updates are completed and sustained. Sustained compliance measures -All PHP personnel files will include credential verification, job descriptions, orientation records, training records, supervision assignments, and documentation of role responsibilities for PHP services. -A weekly PHP staffing review will be completed by leadership and retained with supporting schedules, census documentation, and any corrective follow-up taken. -The Governing Body will review PHP staffing	V 171		

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compliance monthly and document follow-up actions taken to maintain continued compliance.
-Quarterly personnel and chart audits will be completed to verify that PHP staffing, supervision, service documentation, and clinical consultation pathways remain aligned with PHP requirements."

This facility provides services for acutely mentally ill individuals with dual diagnoses including but not limited to Amphetamine-type Substance Use Disorder, Severe; Opioid Use Disorder (OUD), Severe; Alcohol Use Disorder (AUD), Severe; Unspecified Schizophrenia Spectrum and other Psychotic Disorder; Unspecified Mood Disorder; and Anxiety Disorder. The facility enrolled clients in the PHP program that were dually diagnosed with a primary substance use diagnosis. The facility did not provide intensive services separately for the PHP clients to address their mental health needs. They were comingled with clients primarily recieving both SAIOP and SACOT services. The services provided for the PHP clients were primarily substance use focused. The facility did not have an identified qualified mental health professional providing oversight for the PHP program. Staff could not identify who provided oversight for the PHP program while the management provided inconsistent information regarding who was responsible for the PHP program.

This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients and must be corrected within 45 days.

V 172	27G .1102 Partial Hospitalization - Staff	V 172		

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V 172	Continued From page 37 10A NCAC 27G .1102 STAFF (a) Staff shall include at least one qualified mental health professional. (b) Each facility serving minors shall have: (1) a program director who has a minimum of two years experience in child or adolescent services and who has educational preparation in administration, education, social work, nursing, psychology or a related field; and (2) one staff member present if only one client is in the program, and two staff members present when two or more clients are in the program. (c) Each facility shall have a minimum ratio of one staff member present for every six clients at all times. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to identify at least one qualified mental health professional for the program affecting 1 of 1 audited client (#3). The findings are: Interview on 4/21/26 with the Executive Director (ED) revealed: -Could not identify a qualified mental health professional designated for the Partial Hospitalization Program (PHP) program. -Was not fully aware of staffing and oversight requirements. Interview on 4/21/26 with Therapist #1 revealed: -Had 2 PHP clients on his caseload currently. -Was Certified Alcohol and Drug Counselor (CADC) licensed.	V 172		

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-His supervisor was the ED since the Clinical Director/Clinical Consultant (CD/CC) was not in the building.
-Would staff his cases with Therapist #3 and Therapist #4. "If I have a client issue, I will go to her (Therapist #3) and I think she is gearing up to take over the clinical role."

Interview on 4/22/26 with Therapist #2 revealed:
-Was fully licensed as a Licensed Clinical Addiction Specialist (LCAS) and Certified Clinical Supervisor (CCS).
-"I am just doing some contract groups...just filling in and helping out."
-"I don't think we really have one (someone in charge of the program) yet. I thought that was still in the works."
-"We have a person I only know online, [CD/CC]."

Interview on 4/22/26 with Therapist #3 revealed:
-Was licensed as a Licensed Clinical Addiction Specialist - Associate (LCAS-A).
-Was hired as "clinical lead. I am still trying to get used to what I do. We have a clinical director..."
-The CD/CC was her supervisor.
-She and Therapist #4 were "splitting things...We are both kind of like team leads..."

Interview on 4/22/26 with Therapist #4 revealed:
-Was licensed as an LCAS-A and Licensed Clinical Mental Health Counselor (LCMHC).
-Current position was Therapist.
-PHP had a census of 6 as of 4/21/26.
-"I guess [CD/CC] is my boss..."
-"We had a clinical director that was licensed and he was let go. We had a fully licensed LCSW (Licensed Clinical Social Worker). He took on clinical director until that September (2025) and then he was let go and we were in the air without anyone..."

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-The CD/CC was based out of a different state.
-"We have a handful of admissions that is not appropriate. Mental health is the primary concern. We cannot provide the services they need. I have had clients that have no substance abuse history."
-"We do also have 2 client primarily mental health..."
-Mental health clients were mixed in the substance abuse groups. "We try to cultivate groups to address mental health, but it is mostly substance abuse heavy."

Interview on 4/29/26 with Former Therapist (FT) #5 revealed:
-Was licensed as a CADC.
-"We (Licensee) had [CD/CC]. He was our clinical director. He was there remotely."
-"I left because I felt that I didn't have the support I needed."

Interview on 4/22/26 with the Admissions/Former Director of Operations (A/FDO) revealed:
-Unlicensed.
-"Clinically, [CD/CC] (in charge of PHP, IOP, and SACOT)."
-The CD/CC did not work on site.

Interview on 4/22/26 with the Director of Operations (DO) revealed:
-"Right now [CD/CC] is in charge of all programs..."
-"[CD/CC] is legally responsible because he is the one signing off (on chart reviews)."
-"We are definitely low staff but getting back to the standard."

Interviews on 4/21/26 and 5/4/26 with the CD/CC revealed:
-His role was "pretty much chart reviewer, sign

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charts, clinical meetings, more of like a compliance guy."
-Had only been in this role "not even 30 days" but would not clarify how long he had worked for the facility.
-Did not provide any supervision.
-"I am out of state...strictly remote."
-"I'm not in there (the facility) at all."
-"Two people are in charge (of PHP) [Therapist #3 and Therapist #4]. They handle all of the onsite stuff."
-"I am doing strictly client notes. Making sure things are correct and make sure they are reviewed before billing..."

Interview on 4/24/26 with the Nurse Practitioner revealed:
-"I think he (Clinical Director) is in another state."

Interviews on 4/21/26, 4/22/26 and 4/27/26 with the ED revealed:
-Was CADC licensed.
-The CD/CC was responsible for PHP.
-Was not aware of the NC Mental Health Licensure of the service categories the facility was licensed for, "...familiar but not like that (mainly regarding program oversight)."
-"Part of the clinical team meetings in the morning is to make sure everything is covered."
-"[CD/CC] has helped out (providing clinical oversight) now since he is licensed."

Interview on 4/24/26 with the CEO revealed:
-Therapist #4 was overseeing the PHP program.

This deficiency is cross referenced into 10A NCAC 27G .1101 Scope (V172) for a Type B rule violation and must be corrected within 45 days.

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V 266	27G .4401 Sub. Abuse Intensive Outpt - Scope	V 266		

10A NCAC 27G .4401 SCOPE
(a) A substance abuse intensive outpatient program (SAIOP) is one that provides structured individual and group addiction treatment and services that are provided in an outpatient setting designed to assist adults or adolescents with a primary substance-related diagnosis to begin recovery and learn skills for recovery maintenance.
(b) Treatment support activities may be adapted or specifically designed for persons with physical disabilities, co-occurring disorders including mental illness or developmental disabilities, pregnant women, chronic relapse and other homogenous groups.
(c) Each SAIOP shall have a structured program, which includes the following services:
(1) individual counseling;
(2) group counseling;
(3) family counseling;
(4) strategies for relapse prevention, which incorporate community and social supports;
(5) life skills;
(6) crisis contingency planning;
(7) disease management;
(8) service coordination activities; and
(9) biochemical assays to identify recent drug use (e.g. urine drug screens).

This Rule is not met as evidenced by:
Based on record reviews and interviews, the

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facility failed to provide services within the scope of Substance Abuse Intensive Outpatient Program (SAIOP) program affecting 1 of 1 audited current client, (# 2) and 1 of 1 deceased client (DC #4). The findings are:

Cross Reference: 10A NCAC 27G .0201 Governing Body Policies (V105) Based on record review and interview, the facility failed to develop and implement their admission policies to the Substance Abuse Intensive Outpatient Program (SAIOP).

Cross Reference: 10A NCAC 27G .4402 Staffing (V267) Based on record review and interview, the facility failed to ensure SAIOP was under the direction of a Licensed Clinical Addictions Specialist (LCAS) or Certified Clinical Supervisor (CCS) affecting 1 of 1 audited current client, (# 2) and 1 of 1 deceased client (DC #4).

Review on 4/23/26 of Client #2's chart revealed:
-Date of Admission: 1/21/26.
-SAIOP program: 3/10/26.
-Diagnoses: Cocaine Use Disorder, Severe; Cannabis Use Disorder, Moderate; Tobacco Use Disorder Severe; Post Traumatic Stress Disoreder (PTSD); and Hypertension.

Finding #1: The Facility provided Virtual Intensive Outpatient Program (VIOP) services to clients without a waiver.

The following is an example:

Review on 4/21/26 of the Division of Health Service Regulation (DHSR)'s facility records revealed:
-There was no waiver applied for or approved for telehealth services with the .4400 Substance

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Abuse Intensive Outpatient Program.

Interview on 4/21/26 with the Executive Director (ED) revealed:
-Census:
-PHP (Partial Hospitalization Program) - 3.
-Day Treatment - 0.
-SAIOP - 21.
-SACOT (Substance Abuse Comprehensive Outpatient Treatment) -5.

Interview on 4/21/26 with Admissions/Former Director of Operations (A/FDO) revealed:
-The facility had provided VIOP services, "since end of June/early July 2025"
-Facilitators, including the ED, and the Clinical Director/Clinical Consultant (CD/CC) were over the VIOP clinically.
-The CD/CC was not on site and worked remotely.
-As part of VIOP, drug screens were done virtually as well. "They (clients) do an oral swab... (its) shipped to their house prepackaged, and then the client would call [Operations Director] or [Non-Audited Staff #14] and they watch the client do it, seal it, and it gets mailed directly to [lab name]."
-VIOP was a decision made by the Chief Executive Officer (CEO), "it was his idea."
-Sometimes they would have the virtual clients come in person to the facility during VIOP treatment, but mostly, "the whole process was virtual."

Interview on 4/21/26 with Therapist # 1 revealed:
-Worked at the facility as a counselor since February 3, 2026.
-Provided group and individual sessions for SAIOP and other program clients.
-Had four SAIOP clients he saw individually.

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-Some of his SAIOP clients attended VIOP (group) at night.

Interview on 4/21/26 with Therapist #2 revealed:
-There were SAIOP clients that did hybrid VIOP (virtual and in person) during the day.

Interview on 4/23/26 with Therapist #3 revealed:
-Hired as clinical lead on 2/25/26.
-Still trying to learn the programming at this facility and licensure rules.
-Did not understand how VIOP worked at this facility.
-VIOP was not allowed at a facility she worked at previously and that's how she understood it.
-"When I heard about it here (VIOP), I wondered why it was allowed here."

Interview on 4/22/26 with Therapist # 4 revealed:
-There were 6 clients in virtual daytime (VIOP), 12 in-person IOP clients and 5 in the virtual evening (VIOP).
-DC #4 was an evening virtual VIOP client.
-Clients were allowed to go between VIOP and in-person SAIOP services.
-There used to be a facilitator for the VIOP program, but unknown who was assigned currently.

Interview on 4/22/26 with the Director of Operations (DO) revealed:
-"Virtual SAIOP is an option for everyone that comes in (for admission)...The whole program is under [CD/CC]."
-The virtual clinicians that run the groups are not on site at the facility.
-The CD/CC was not on site and worked out of state.

Interview on 4/22/26 and 4/27/26 with the ED

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revealed:
-The facility had six VIOP clients.
-The CEO made the decision to do VIOP.
-There was also hybrid VIOP during the day separate from evening VIOP clients.

Interview on 4/21/26 and 5/4/26 with the CD/CC revealed:
-Was a chart reviewer.
-Did not supervise staff or do individual/group treatment with the clients.
-Reviewed client notes before billing.

Interview on 4/24/26 with the CEO revealed:
-The facility had been providing VIOP services since June/July 2025.
-Denied that he was sole decision maker to start VIOP services, "it was a collective team (made the decision)."
-In response to asking if the facility had a waiver, "I had never heard of a waiver until y'all (DHSR surveyors) came in..."

Finding #2: The facility merged all licensed substance programs together for group treatment.

Review on 4/22/26 of the facility weekly example schedule for the PHP, SAIOP, and SACOT programs revealed:
-Groups were identical for all three programs as follows:
  -Monday, Tuesday, Thursday 9:00-10:30am Topic Group
  -Wednesday 9:00-10:30am Gender Group
  -Friday 9:00-10:30am Community Group
  -Monday - Friday 10:45am-12:15 pm Process Group
-Afternoon Groups from 12:45-2:15pm were identified as PHP Afternoon Group and SACOT

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afternoon group.

Interview on 4/21/26 with Client #2 revealed:
-"Coming to IOP...Come here 5 days a week."
-"I come mainly for the PHP people and let them know how recovery works."
-Attended groups together with other programs during the day.

Interview on 4/21/26 with Therapist #1 revealed:
-All the groups are "really all together right now."
-Prior to today (4/21/26), "all the groups were together and (clinicians) were working with 2 levels of care"
-In response to when was the first day the groups were separated, "Today (4/21/26)."

Interview on 4/22/26 with Therapist # 4 revealed:
-There were major program changes in September of 2025 and all PHP clients were shifted to IOP. "All staff that aren't clinicians are being let go due to billing."
-"Since then, programming has been like throwing a dart at a bullseye and seeing what sticks."

Review on 4/30/26 of the Plan of Protection written and signed by the ED on 4/30/26 revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care?
1. [Therapist #2], a current qualified staff member, has been assigned to serve as acting Clinical Director for the SAIOP program and will maintain an on-site schedule on Monday, Wednesday, and Friday for a minimum of 7.5 hours weekly to provide clinical oversight for 50% of the 15 hours of SAIOP programming. This immediate action identifies who is responsible for oversight, what supervision will occur, why the

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action is necessary to address the staffing deficiency, and how the facility will ensure oversight is present during ongoing program operations.
2. [Non Audited Staff #13 (NAS #13)] and [NAS #14] have been assigned as Qualified Professionals for SAIOP
services to maintain the required staff-to-client ratio during programming hours. This immediate action corrects the staffing deficiency by ensuring qualified staff are identified and scheduled for coverage, and daily staffing assignments will be reviewed against the program census before each service day begins.
3. [Therapist #3] who is trained in withdrawal symptoms and secondary complications related to substance use, has been assigned to be present during all SAIOP programming hours. This immediate action addresses consumer safety by ensuring a trained staff member is available to observe, identify, report, and document signs that require clinical follow-up or higher-level intervention.
4. The facility has initiated an immediate review of all governing body policies related to SAIOP operations, including admissions, screenings, assessments, staffing, supervision, service structure, documentation, and discharge planning. This action is necessary because the cited policy deficiency indicates the need to align written policies with applicable North Carolina requirements and actual program operations.
5. SAIOP and SACOT services have been operationally separated through distinct staffing assignments, schedules, and program rosters. This immediate action addresses the concern that service lines must operate according to their own staffing and scope requirements and ensures that SAIOP is delivered as a stand-alone service.

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V 266	Continued From page 48 6. All currently enrolled SAIOP clients are being clinically reviewed by the Clinical Director and assigned staff to ensure each individual is receiving services in the appropriate program structure and that treatment plans, service frequency, and modality are accurately documented. This immediate action supports consumer safety and continuity of care while ensuring that service delivery reflects the licensed and approved structure of the program. Describe your plans to make sure the above happens. Finding 1: 10A NCAC 27G .4402 Staff (V267) Who: The Governing Body, Executive Director, acting Clinical Director, Human Resources, and assigned Qualified Professionals. What: The facility will maintain appropriate clinical oversight and staffing for SAIOP by assigning a qualified acting Clinical Director, scheduling Qualified Professionals to meet the staff-to-client ratio, and documenting staff assignments for each service day. Why: The staffing citation requires the facility to demonstrate that SAIOP services are overseen and staffed by qualified personnel in a manner consistent with program requirements and consumer safety. How: A weekly staffing matrix will be created and maintained showing the SAIOP schedule, assigned Clinical Director coverage, Qualified Professional assignments, anticipated census, and backup coverage. Human Resources will verify and maintain credentials, job descriptions, and role assignments in staff files. The Executive Director and Clinical Director will review the staffing matrix weekly for 90 days and document any corrective staffing adjustments needed to maintain sustained compliance.	V 266		

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V 266	Continued From page 49 Finding 2: Withdrawal and Secondary Complications Coverage Who: The Clinical Director, Training Coordinator, [PT #3], and all direct care staff assigned to SAIOP. What: The facility will ensure that a staff member trained in withdrawal symptoms and secondary complications is present during all SAIOP service hours and that all direct care staff are trained to recognize, report, and respond to these clinical issues. Why: Clients participating in substance use disorder treatment may present with symptoms that require immediate recognition, documentation, clinical review, or referral for a higher level of care. How: The facility will maintain a daily assignment schedule identifying the trained staff member present for each program day. Training certificates, competency checklists, and refresher training dates will be stored in personnel files and tracked centrally. The Clinical Director will review this tracking log monthly and immediately address any gap in required competency documentation. Finding 3: Continuing Education and Staff Competency Who: The Clinical Director, Human Resources, and all SAIOP direct care staff. What: The facility will implement a formal continuing education process for SAIOP staff that includes required topics, approved training sources, due dates, completion verification, and annual renewal tracking. Why: Ongoing training is necessary to ensure staff competency, support safe service delivery, and demonstrate that the facility is sustaining compliance rather than responding only once to the citation.	V 266		

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How: A centralized training tracker will list each employee, required trainings, date completed, expiration date if applicable, and renewal deadline. Staff will submit all certificates of completion to Human Resources, and the Clinical Director will review training compliance monthly during supervision and quarterly through personnel file audits. Any missing training will be assigned a completion deadline and followed through to resolution with written documentation.

Finding 4: 10A NCAC 27G .0201 Governing Body Policies (V105)
Who: The Governing Body, Executive Director, Compliance Lead, and Clinical Director.
What: The facility will revise, approve, and implement governing body policies that accurately reflect SAIOP requirements and current operational practice, including admissions criteria, screening procedures, assessments, staffing, supervision, program delivery, documentation, and discharge planning.
Why: The policy citation indicates that written policy did not fully align with the applicable rule requirements, creating risk for inconsistent practice and regulatory noncompliance.
How: The Governing Body will conduct a line-by-line review of all policies affecting SAIOP operations. Revised policies will be approved with effective dates and maintained in the policy manual. Staff will be trained on all updated policies, sign acknowledgements of receipt and understanding, and be monitored through quarterly audits of charts, schedules, and operational practices to verify that actual service delivery matches written policy.
Finding 5: Service Structure and Program Separation
Who: The Clinical Director, Program Supervisors, scheduler, and admissions staff.

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What: The facility will maintain SAIOP as a separate service line from SACOT through distinct schedules, staffing assignments, service rosters, and documentation practices.
Why: Separate program structure is necessary to ensure each level of care operates within its own scope, staffing model, and documentation requirements.
How: Separate calendars, attendance rosters, group notes, and staff schedules will be used for SAIOP and SACOT. The Clinical Director will review these records weekly, and monthly chart audits will confirm that documentation reflects the correct service line, staffing structure, and treatment model for each enrolled client.

Finding 6: Client Review and Service Alignment
Who: The Clinical Director, assigned counselor, admissions staff, and utilization review staff.
The facility will review each current SAIOP client record to ensure the client's treatment plan, level of care, attendance pattern, and modality of service are clinically appropriate, documented, and consistent with the facility's approved program structure.
Why: Individual review is necessary to ensure each consumer remains appropriately served and that service delivery aligns with licensure, policy, and clinical documentation expectations.
How: Each chart will be reviewed using a standardized audit tool. Needed updates to treatment plans, progress notes, modality documentation, and referrals will be completed and signed by the appropriate clinical staff. The Clinical Director will maintain a client review log and verify completion of all follow-up items to support sustained compliance."

Review on 5/1/26 of the Amended Plan of Protection written and signed by the ED on 5/1/26

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V 266	Continued From page 52 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? 1. [Therapist #2], a current qualified staff member, has been assigned to serve as acting Clinical Director for the SAIOP program and will maintain an on-site schedule on Monday, Wednesday, and Friday for a minimum of 7.5 hours weekly to provide clinical oversight for 50% of the 15 hours of SAIOP programming. 2. Daily staffing assignments will be reviewed against the program census before each service day begins, and any coverage adjustment will be documented the same day it occurs. 3. A staff member trained in withdrawal symptoms...staff member will observe, identify, report, and document signs that require clinical follow-up, referral, or higher-level intervention. 4. The facility has initiated an immediate review of all governing body policies related to SAIOP operations, including...virtual service limitations, waiver requirements, and in-person service delivery, to ensure that written policies align with applicable North Carolina requirements and actual program operations. 5. SAIOP services have been operationally separated from SACOT, PHP, VIOP, and other programming through distinct staffing assignments, schedules, program rosters, and documentation practices. This action ensures that SAIOP is delivered and monitored as a separate service line. 6. All currently enrolled SAIOP clients are being clinically reviewed by licensed clinical leadership and assigned staff... 7. All clients previously receiving or referred for virtual SAIOP services are being reviewed by the clinical and medical team to determine appropriate next steps while the facility works toward compliance with applicable requirements.	V 266		

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Virtual SAIOP services are not being continued unless and until a waiver is granted. During this period, the facility will maintain continuity of care through clinical review, updated level-of-care determinations, referral to appropriate providers or levels of care when indicated, transfer or discharge planning as clinically appropriate, and placement into compliant in-person services when available.

Describe your plans to make sure the above happens
Finding 1: 10A NCAC 27G .4402 Staff (V267)
What:...and maintaining SAIOP as a separate service line from SACOT, PHP, VIOP, and other programming.
How:...and the responsible reviewer.

Finding 2: Withdrawal and Secondary Complications Coverage
Who: The acting Clinical Director, licensed clinical leadership, the staff member assigned to withdrawal monitoring coverage, and all direct care staff assigned to SAIOP.
Why:...and referral for a higher level of care when indicated.
How: Licensed clinical leadership will review this tracking log...

Finding 3: Continuing Education and Staff Competency
What:...and role-specific competency expectations.
How:...and follow-up status for any incomplete requirement. Staff will submit all certificates of completion to...licensed clinical leadership...

Finding 4: 10A NCAC 27G .0201 Governing Body Policies (V105)
Who:...and licensed clinical leadership.

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V 266	Continued From page 54 What:...virtual service limitations, waiver requirements, and in-person services. Finding 5: Service Structure and Program Separation: Who: Licensed clinical leadership....and utilization review staff. What:...maintain SAIOP as a separate service...from SACOT, PHP, VIOP, and other programming...The facility will maintain separate operational oversight for in-person SAIOP and any virtual service requests, and virtual SAIOP services will not be delivered unless and until any required waiver is granted. Why...and service modality operates within its own scope, staffing model, documentation requirements, and clinical review process. How:...and documentation workflows will be used for SAIOP and other services. In-person SAIOP services and any virtual service review activity will be tracked separately for scheduling, staffing, review, and audit purposes. Licensed clinical leadership will review these records weekly...and that virtual services are not being provided without required approval. Finding 6: Client Review and Service Alignment Who: Licensed Clinical Leadership...and the clinical and medical team as indicated. Why:...and the client's current clinical needs. How:...level-of-care recommendations, discharge planning, or transfer planning will be completed and signed by the appropriate clinical staff. Clients previously receiving or considered for virtual SAIOP will be specifically reviewed to determine whether they should be referred to another provider or level of care, transitioned to compliant in-person services when available, or discharged with appropriate planning based on clinical indication. Licensed clinical leadership will	V 266		

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maintain a client review log and verify completion of all follow-up items within established timeframes. No virtual SAIOP services will be continued unless and until a waiver is granted.

Sustained compliance measures
-Weekly SAIOP staffing reviews will be completed by leadership and retained with schedules, census documentation, and backup coverage records.
-Personnel files will contain credential verification, training records, supervision assignments, competency documentation, and evidence of required education for SAIOP staff.
-Quarterly chart and program audits will be completed to verify that SAIOP staffing, supervision, service delivery, documentation, virtual service review, and in-person service structure remain aligned with SAIOP requirements.
-The Governing Body will review SAIOP staffing and policy compliance monthly and document follow-up actions taken to maintain continued compliance."

This facility serves clients with primary substance abuse diagnoses including Opioid Use Disorder, Alcoholism, Amphetamine Type Use D/O; with mental health disorders in an outpatient setting. SAIOP services were being provided virtually and in person at the facility without licensed clinical oversight and a waiver to allow virtual service delivery. The facility has not had a fully licensed on site clinical director for at least 6 months. DC #4 was admitted to the virtual IOP program despite a medical provider and mental health clinician's recommendation for a higher level of care. DC #4's chart noted suicidal ideation/attempts, mental health history, prior treatment programs, and need for services

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V 266	Continued From page 56 greater than facility's SAIOP program. The facility did not develop and implement their admission policies when admitting DC #4 as she had primary mental health diagnoses. She was recommended for a higher level of care based on risk of harm and her mental health needs were not being met while enrolled in the VIOP. DC #4 committed suicide while SAIOP had no delinated staff responsible for clinical oversight. Facility staff denied responsibility in their role with DC #4's admission to the program contradictory to a medical provider's recommendation. Facility staff did not know who was in charge of the SAIOP program and reported that their clinical director was out of state. The CEO identified the clinical director as a consultant only. Additionally, SAIOP program groups were blended together with other licensed programs including Partial Hospitalization (PHP) and Substance Abuse Comprehensive Treatment (SACOT). This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 266		
V 267	27G .4402 Sub. Abuse Intensive Outpt- Staff 10A NCAC 27G .4402 STAFF (a) Each SAIOP shall be under the direction of a Licensed Clinical Addictions Specialist or a Certified Clinical Supervisor who is on site a minimum of 50% of the hours the program is in operation. (b) When a SAIOP serves adult clients there shall be at least one direct care staff who meets the requirements of a Qualified Professional as set forth in 10A NCAC 27G .0104 (18) for every 12 or fewer adult clients. (c) When a SAIOP serves adolescent clients	V 267		

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V 267	Continued From page 57 there shall be at least one direct care staff who meets the requirements of a Qualified Professional as set forth in 10A NCAC 27G .0104 (18) for every 6 or fewer adolescent clients. (d) Each SAIOP shall have at least one direct care staff present in the program who is trained in the following areas: (1) alcohol and other drug withdrawal symptoms; and (2) symptoms of secondary complications due to alcoholism and drug addiction. (e) Each direct care staff shall receive continuing education that includes the following: (1) understanding of the nature of addiction; (2) the withdrawal syndrome; (3) group therapy; (4) family therapy; (5) relapse prevention; and (6) other treatment methodologies. (f) When a SAIOP serves adolescent clients each direct care staff shall receive training that includes the following: (1) adolescent development; and (2) therapeutic techniques for adolescents. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure Substance Abuse Intensive Outpatient Program (SAIOP) was under the direction of a Licensed Clinical Addictions Specialist (LCAS) or Certified Clinical Supervisor	V 267		

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V 267	Continued From page 58 (CCS) affecting 1 of 1 audited current client, (# 2) and 1 of 1 deceased client (DC #4). The findings are: Review on 4/28/26 of Therapist #1's personnel record revealed: -Date of hire: 2/4/26. -Licensure: Certified Alcohol and Drug Counselor (CADC). Review on 4/28/26 of Therapist #2's personnel record revealed: -Date of hire: 2/23/26. -Licensure: LCAS/CCS. Review on 4/28/26 of Therapist #3's personnel record revealed: -Date of Hire: 2/24/26. -Licensure: Licensed Clinical Addictions Specialist-Associate (LCAS-A). Review on 4/28/26 of Therapist #4's personnel record revealed: -Date of Hire:12/12/24. -Licensure: Licensed Clinical Mental Health Counselor (LCMHC) and LCAS-A. Review on 4/22/26 of the Clinical Director/Clinical Consultant (CD/CC)'s personnel record revealed: -No hire date documented. -Licensure: North Carolina Licensed Clinical Social Worker (LCSW) issued 3/30/26, expiration 3/30/28. Review on 4/27/26 of the CD/CC's personnel record revealed: -"Independent Contractor Agreement" signed on 4/24/26. -"Contractor will provide clinical director services, including clinical oversight..."	V 267		

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Review on 4/28/26 of the Executive Director's (ED) personnel file revealed:
-Date of Hire: 2/5/25.
-Licensure: CADC.

Interview on 4/21/26 with Therapist #1 revealed:
-Worked at the facility as a counselor since 2/3/26.
-Credentialed as a CADC.
-Provided group and individual sessions for SAIOP clients.
-The ED was his supervisor at the facility.
-Did not know was in charge of the SAIOP program, "I don't know that we really have that."
-"[Therapist #3] had taken over as the lead (of SAIOP) since she was hired."
-"Our Clinical Director (CD/CC) lives in [another state]; he isn't in the building and doesn't know our clients."

Interview on 4/22/26 with Therapist #2 revealed:
-Started working at the facility part time in February 2026, "Just helping out."
-Fully licensed LCAS and LCSW.
-Did some contract groups and had one client on her caseload.
-Was not sure who was in charge of the SAIOP program, "I don't think we really have one yet. I thought it was still in the works."
-Knew that there was a clinical staff, (CD/CC) that she received chart audits from.
-Had never met this person or spoken with him.

Interview on 4/23/26 with Therapist #3 revealed:
-Was hired as a clinical lead on 2/25/26.
-Some of her responsibilities included leading group, auditing charts, meeting with clients individually, and moving clients up and down in treatment programs.

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-Credentialed as an LCAS-A.
-Herself and Therapist #4, "kind of split things as team lead (with facility programs SAIOP/SACOT(Substance Abuse Comprehensive Treatment))."
-Had a Clinical Director (CD/CC) over the SAIOP program who was not on site and lived in another state.

Interview on 4/22/26 with Therapist #4 revealed:
-Credentialed as a LCMHC and LCAS-A.
-Led groups and saw clients for individual sessions.
-The CD/CC completed chart audits and worked remotely.
-Was not sure about the current CD/CC's licensure.
-She did not ask the CD/CC for assistance if she had questions or concerns.
-"We need somebody (that's in charge)."

Interview on 4/29/26 with Former Therapist #5 revealed:
- "I don't know what you mean (who provided clinical program oversight) of substance programs."

Interview on 4/21/26 with the ED revealed:
-Therapists provided group and individual sessions for SAIOP.
-Therapist #3 supervised SAIOP.
-Therapist #3 was licensed as LCAS-A and was the clinical lead.
-"[CD/CC] is the Clinical Director."
-The CD/CC was licensed as LCSW.
-"[Therapist #2] was PRN (as needed), she had her own private practice."
-Therapist #4 was the clinical supervisor and she had her LCMHC.
-Did not have delineated staff for SAIOP on site

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that was licensed as an LCAS/CCS.

Interview on 4/24/26 with the Chief Executive Officer (CEO) revealed:
-Responsible for "everything."
-Unlicensed.
-Had a "clinical consultant" documented by the facility at survey entrance as the Clinical Director.
-"He is not our clinical director, he's a consultant."
-The clinical director/clinical consultant (CD/CC) worked remotely and did not supervise staff.
-Believed that the CD/CC was fully licensed as an LCAS in North Carolina.
-The CD/CC was responsible for chart compliance.
-The CD/CC had been in this role since November/December 2025.
-The Non-Audited Former Co-Clinical Director left in September 2025.
-Therapist #3 was running SAIOP. "I thought she had her LCAS when she came on."
-When advised that this was not the case, "I guess this is where I get confused..." (Didn't have a fully licensed LCAS providing oversight).

Review on 4/28/26 of a Former Staff List since 10/1/25 to 4/25/26 for the facility, emailed by the CEO on 4/27/27 at 1:13AM revealed:
-There was not a fully licensed LCAS/CCS listed in a Clinical Director role from 10/1/25 to 4/25/26 which was a period over 6 months.

Interview on 4/27/25 with the ED revealed:
-Licensed as a CADC.
-Had multiple roles and responsibilities at the facility.
-"[CD/CC] has helped out now since he is licensed in North Carolina...since 3/31/26."
-Confirmed the CD/CC was out of state and worked remotely.

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V 267	Continued From page 62 -Therapist # 2 was going to take over SAIOP and would be signing a contract today (4/27/26). -"We are very aware that things need to happen (changes made)." This deficiency is cross referenced into 10A NCAC 27G .4401 Scope (V266) for a Type A1 rule violation and must be corrected within 23 days.	V 267		
V 280	27G .4501 Sub. Abuse Comp. Outpt. Tx.- Scope 10A NCAC 27G .4501 Scope (a) A substance abuse comprehensive outpatient treatment program (SACOT) is one that provides a multi-faceted approach to treatment in an outpatient setting for adults with a primary substance-related diagnosis who require structure and support to achieve and sustain recovery. (b) Treatment support activities may be adapted or specifically designed for persons with physical disabilities, co-occurring disorders including mental illness or developmental disabilities, pregnant women, chronic relapse, and other homogenous groups. (c) SACOT shall have a structured program, which includes the following services: (1) individual counseling; (2) group counseling; (3) family counseling; (4) strategies for relapse prevention to include community and social support systems in treatment; (5) life skills; (6) crisis contingency planning; (7) disease management; (8) service coordination activities; and (9) biochemical assays to identify recent	V 280		

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drug use (e.g. urine drug screens).
(d) The treatment activities specified in Paragraph (c) of this Rule shall emphasize the following:
(1) reduction in use and abuse of substances or continued abstinence;
(2) the understanding of addictive disease;
(3) development of social support network and necessary lifestyle changes;
(4) educational skills;
(5) vocational skills leading to work activity by reducing substance abuse as a barrier to employment;
(6) social and interpersonal skills;
(7) improved family functioning;
(8) the negative consequences of substance abuse; and
(9) continued commitment to recovery and maintenance program.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure it operated within the scope of a substance abuse comprehensive outpatient treatment (SACOT) program affecting 1 of 1 audited current client (#1) and 1 of 1 deceased client (DC #5). The findings are:

CROSS REFERENCE: 10A NCAC 27G .4502 Staff (281). Based on record reviews and interviews, the facility failed to operate under the direction of an Licensed Clinical Addiction Specialist (LCAS) or Certified Clinical Supervisor (CCS) and identify at least one direct care staff who met the requirements of a Qualified Professional (QP), and failed to ensure 3 of 4 audited (Therapist #1, Admissions/Former Director of Operations, and the Executive Director

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(ED)) staff received continuing education affecting 1 of 1 audited current client (#1) and 1 of 1 deceased client (DC #5).

Review on 4/21/26 of the facility license from North Carolina Division of Health Service Regulation (DHSR) revealed:
-Licensed for the following service categories: Partial Hospitalization for Individuals who are acutely Mentally Ill (PHP), Day Treatment Facilities for Individuals with Substance Abuse Disorders, Substance Abuse Intensive Outpatient Program (SAIOP), and Substance Abuse Comprehensive Outpatient Program (SACOT).

Interview on 4/21/26 with the ED revealed:
-Census:
-PHP - 3.
-Day Treatment - 0.
-SAIOP - 21.
-SACOT -5.

Review on 4/21/26 of Client #1's record revealed:
-Date of Admission: 4/9/26.
-Diagnoses: Schizophrenia; Cannabis Use Disorder; Other Unspecified Stimulant Use Disorder; and Opioid Use Disorder (OUD), Severe.
-Enrolled in SACOT.

Review on 4/22/26 of the Facility's weekly example schedule for the PHP, SAIOP, and SACOT programs revealed:
-Groups were identical for all three programs as follows:
-Monday, Tuesday, Thursday 9:00-10:30am Topic Group
-Wednesday 9:00-10:30am Gender Group
-Friday 9:00-10:30am Community Group
-Monday - Friday 10:45am-12:15 pm Process

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Group
-Afternoon Groups from 12:45-2:15pm were identified as PHP Afternoon Group and SACOT afternoon group.

Interview on 4/21/26 with Cient #1 revealed:
-Had not been assigned a therapist yet.
-Attended groups with everyone that was served by the facility across all service categories.

Interview on 4/21/26 with Therapist #1 revealed:
-"The groups, I don't know how it's set up at the moment..."
-"...they (groups) were combined and they are separate now...I am not sure (length of separation of groups)."

Interview on 4/22/26 with Therapist #3 revealed:
-"IOP (SAIOP) and SACOT come to all 3 groups (3 groups sessions per day)."
-All group sessions are blended with all clients in all service categories.

Interview on 4/22/26 with Therapist #4 revealed:
-Back in September of 2025 "...got a call. Our PHP will be closed and all transferred to IOP...since then programming has been, throw a dart at the bullseye and see what happens."
-Mental health clients are mixed into the substance groups..."we try to cultivate the groups to address mental health, but it is mostly SA (substance abuse) heavy."

Interview on 4/22/26 with the Director of Operations (DO) revealed:
-Group sessions were all together across all service categories "...at the moment but won't be in two weeks. We have new staff coming in two weeks..."

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OTTER HOUSE WELLNESS	**40 NORTH FRENCH BROAD AVENUE ASHEVILLE, NC 28801**

(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 280	Continued From page 66 Interviews on 4/22/26 and 4/27/26 with the ED revealed: -Was not aware of the NC Mental Health Licensure of the service categories the facility was licensed for, "...familiar but not like that (mainly regarding program oversight)." -"PHP is the same hours (as SAIOP and SACOT), every day, 6 days a week." -"We would split sometimes...(based on service provided)...We didn't want two people in a group. It was easier to provide services together." -All clients attended the same group sessions together. -There was no differentiation between groups. Review on 4/30/26 of the Plan of Protection (POP) written and signed by the ED on 4/30/26 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? 1.The facility has initiated immediate assignment and finalization of qualified SACOT clinical oversight through an LCAS (Licensed Clinical Addiction Specialist) or CCS (Certified Clinical Supervisor), and leadership is actively documenting recruitment, credential review, and supervisory responsibilities to ensure ongoing SACOT operations are supported by clearly identified clinical oversight. This action identifies who is responsible, what is being corrected, why the correction is necessary, and how the facility will document sustained compliance with the staffing requirement. 2. The facility will maintain the required 1:10 ratio at all times during SACOT treatment hours with a qualified or licensed professional physically assigned to the program. Daily staffing assignments and census will be reviewed before services begin, and coverage adjustments will be made through reassignment of qualified staff or	V 280		

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V 280	Continued From page 67 backup staffing support to ensure ratio compliance is maintained throughout the day. 3. [Therapist #3] will be present during SACOT treatment hours to assess and identify alcohol and drug withdrawal symptoms and symptoms of secondary complications related to addiction. This action protects consumers by ensuring that a trained staff member is available to observe symptoms, notify supervisory staff, and document intervention steps when concerns arise. 4. The facility has implemented a structured continuing education process for all direct care staff assigned to SACOT using the training resources already identified by the program. This action addresses the deficiency by moving from informal exploration of training resources to a documented training and competency process designed to support safe and compliant service delivery. Describe your plans to make sure the above happens. Finding 1: 10A NCAC 27G .4502 Staff (V281) Who: The Governing Body, Executive Director, Clinical Director, Human Resources, SACOT Program Supervisor, and staff assigned to SACOT services. What: The facility will ensure that SACOT services are supported by qualified clinical oversight, appropriate direct care staffing, documented ratio compliance, and clear supervisory accountability. Why: The cited staffing deficiency requires the facility to demonstrate that SACOT services are staffed and supervised in a manner consistent with consumer safety, program intensity, and regulatory expectations. How: Human Resources will maintain documentation of the LCAS or CCS recruitment, appointment, credential verification, and assigned supervisory duties. The Clinical Director or	V 280		

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V 280	Continued From page 68 designated supervisor will maintain a weekly staffing grid showing SACOT service hours, assigned qualified staff, census expectations, and backup staffing coverage. Leadership will review the grid weekly for 90 days and monthly thereafter to verify sustained compliance and document any staffing correction made during that period. Finding 2: Staff-to-client ratio Who: The SACOT Program Supervisor, scheduler, qualified professionals, licensed professionals, and direct care staff assigned to SACOT. What: The facility will maintain a 1:10 staff-to-client ratio during all SACOT treatment hours with qualified or licensed staff assigned to the program. Why: Maintaining ratio compliance is necessary to ensure adequate monitoring, therapeutic engagement, and timely response to consumer needs in a high-intensity substance use disorder service. How: A daily staffing and census form will be completed before programming begins and updated as attendance changes. The Program Supervisor will verify ratio compliance each day and retain documentation for audit review. When staffing or attendance changes occur, qualified backup staff will be assigned and documented to maintain compliance within the existing service structure. Finding 3: Withdrawal symptoms and secondary complications Who: [Therapist #3], the Clinical Director, Training Coordinator, and all direct care staff assigned to SACOT. What: The facility will ensure that SACOT staff are trained and able to identify withdrawal symptoms and secondary complications related to substance use and that there is always a	V 280		

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V 280	Continued From page 69 trained staff member present during treatment hours. Why: Consumers in SACOT may present with elevated clinical risk, and prompt recognition and response are necessary to protect health and safety. How: The facility will maintain training certificates, competency checklists, and refresher dates in personnel files and in a centralized compliance tracker. Written protocols will identify how symptoms are escalated, documented, and referred for additional clinical review or medical intervention when needed. The Clinical Director will complete quarterly audits of competency records for one year to verify ongoing compliance. Finding 4: Continuing education and competency development Who: The Clinical Director, Human Resources, Training Coordinator, and all SACOT direct care staff. What: The facility will implement a formal continuing education and competency development system for SACOT staff that includes required training topics, approved resources, completion deadlines, and annual renewal tracking. Why: The original plan referenced possible training vendors but did not establish a formal process to ensure training is assigned, completed, documented, and sustained over time. How: A training matrix will be maintained for each staff member showing required orientation, annual updates, specialty competencies, completion dates, and renewal deadlines. Approved training sources will include the resources already identified by the facility, and certificates will be stored in personnel files. Supervisors will review the matrix monthly,	V 280		

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V 280	Continued From page 70 address any missing items through written completion plans, and document follow-up until all training requirements are met. Sustained compliance measures · Weekly staffing reviews will be completed by leadership and retained with schedules and census documentation. · Personnel files will contain credential verification, training records, supervision assignments, and competency documentation for SACOT staff. · Quarterly chart and program audits will be completed to verify that staffing, supervision, and service delivery remain aligned with SACOT requirements. The Governing Body will review staffing and training compliance monthly and document any follow-up action taken to maintain continued compliance." Review on 5/1/26 of the amended POP written and signed by the ED on 5/1/26 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? 1. The facility has initiated the immediate assignment and finalization of qualified SACOT clinical oversight through an LCAS or CCS, and leadership is documenting recruitment, credential review, supervisory responsibilities, and implementation dates to ensure ongoing SACOT operations are supported by clearly identified clinical oversight. 2. The facility will maintain the required 1:10 staff-to-client ratio at all times during SACOT treatment hours, with qualified or licensed staff physically assigned to SACOT and daily documentation identifying census, assigned coverage, and the staff member responsible for meeting the qualified professional function for that service period.	V 280		

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V 280	Continued From page 71 3. The facility will ensure that a trained staff member is physically present during SACOT treatment hours to assess and identify alcohol and drug withdrawal symptoms and symptoms of secondary complications related to addiction, notify supervisory or licensed clinical staff as indicated, and document all intervention steps taken in response to consumer presentation. 4. The facility has implemented a structured continuing education and competency process for all direct care staff assigned to SACOT using approved training resources already identified by the program, with completion tracking, competency verification, and follow-up for any missing requirements. 5. The facility has separated SACOT services from PHP, SAIOP, VIOP (Virtual Intensive Outpatient Program), and other programming in scheduling, staffing assignments, service delivery, and program documentation so that SACOT is implemented and monitored as a distinct level of care. The facility will maintain continuity of care for SACOT clients during implementation of this Plan of Correction through active clinical review, treatment planning updates, appropriate staffing coverage, and compliant service delivery while corrective actions are being completed. Describe your plans to make sure the above happens. Finding 1: 10A NCAC 27G .4502 Staff (V281) Who: The Governing Body, Executive Director, Human Resources, SACOT Program Supervisor, LCAS or CCS clinical oversight, and staff assigned to SACOT services. What: The facility will ensure that SACOT services are supported by qualified clinical oversight, appropriate direct care staffing, documented ratio compliance, separate SACOT scheduling and staffing assignments, and clear	V 280		

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supervisory accountability.
Why: The cited staffing deficiency requires the facility to demonstrate that SACOT services are staffed, supervised, and documented in a manner consistent with consumer safety, program intensity, and regulatory expectations, and that SACOT operates as a distinct service rather than being blended with other program tracks.
How: Human Resources will maintain documentation of LCAS or CCS recruitment, appointment, credential verification, supervisory assignment, and effective date of coverage. A weekly staffing grid will be maintained for SACOT only and will show SACOT service hours, assigned qualified or licensed staff, census expectations, backup staffing coverage, and the responsible supervisory reviewer. Leadership will review the SACOT grid weekly for 90 days and monthly thereafter, documenting any staffing correction, coverage change, or follow-up action taken to maintain compliance.
Finding 2: Staff-to-client ratio
Who: The SACOT Program Supervisor, scheduler, qualified professionals, licensed professionals, and direct care staff assigned to SACOT.
What: The facility will maintain a 1:10 staff-to-client ratio during all SACOT treatment hours, with qualified or licensed staff assigned specifically to SACOT and with daily documentation showing the staff assigned to fulfill the QP or licensed coverage requirement for that shift or service period.
Why: Maintaining ratio compliance is necessary to ensure adequate monitoring, therapeutic engagement, timely response to consumer needs, and program integrity within a high-intensity substance use disorder service.
How: A daily staffing and census form will be completed before programming begins and

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V 280	Continued From page 73 updated as attendance changes throughout the day. The SACOT Program Supervisor or designee will verify ratio compliance each day and retain documentation for audit review. When staffing or attendance changes occur, qualified backup staff assigned to SACOT will be documented and deployed to maintain compliance without combining SACOT staffing coverage with PHP, SAIOP, VIOP, or other services. Finding 3: Withdrawal symptoms and secondary complications Who: The SACOT Program Supervisor, licensed clinical leadership, qualified staff assigned to SACOT, and all direct care staff assigned to SACOT services. What: The facility will ensure that SACOT staff are trained and able to identify withdrawal symptoms and secondary complications related to substance use and that a trained staff member is physically present during SACOT treatment hours to monitor consumers and escalate concerns appropriately. Why: Consumers in SACOT may present with elevated clinical risk, and prompt recognition, escalation, and response are necessary to protect consumer health and safety. How: The facility will maintain training certificates, competency checklists, refresher dates, and supervision records in personnel files and in a centralized compliance tracker. Written protocols will identify how symptoms are observed, escalated to supervisory staff and licensed clinical leadership, documented in the record, and referred for additional clinical review or medical intervention when indicated. Competency records for SACOT staff will be audited quarterly for one year to verify ongoing compliance and identify corrective follow-up needs. Finding 4: Continuing education and competency	V 280		

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development
Who: Human Resources, the SACOT Program Supervisor, licensed clinical leadership, and all SACOT direct care staff.
What: The facility will implement and maintain a formal continuing education and competency development system for SACOT staff that includes required orientation topics, annual updates, role-specific competencies, completion deadlines, renewal tracking, and documentation expectations specific to SACOT roles.
Why: The original plan referenced possible training resources but did not establish a formal process to ensure training is assigned, completed, reviewed, documented, and sustained over time.
How: A training matrix will be maintained for each SACOT staff member showing required orientation, annual updates, role-specific competencies, completion dates, renewal deadlines, and follow-up for any deficiencies. Approved training sources will include the resources already identified by the facility, and certificates and competency documentation will be stored in personnel files. Supervisory review of the training matrix will occur monthly, and any missing items will be addressed through written completion plans and documented follow-up until requirements are met.
Sustained compliance measures
-Weekly SACOT staffing reviews will be completed by leadership and retained with SACOT schedules, census documentation, and backup coverage records.
-Personnel files will contain credential verification, training records, supervision assignments, competency documentation, and evidence of required education for SACOT staff.
-Quarterly chart and program audits will be completed to verify that SACOT staffing,

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supervision, service delivery, and documentation remain aligned with SACOT requirements as a separate program service.
-The Governing Body will review SACOT staffing and training compliance monthly and document follow-up actions taken to maintain continued compliance.

Review on 5/1/26 of the third amended POP written and signed by the ED on 5/1/26 revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care?
1. The facility has initiated the immediate assignment and finalization of qualified SACOT clinical oversight through an LCAS or CCS, and leadership is documenting recruitment, credential review, supervisory responsibilities, and implementation dates to ensure ongoing SACOT operations are supported by clearly identified clinical oversight.
within two weeks..."

The facility served clients with diagnoses including but not limited to Schizophrenia, Cannabis Use Disorder, Other Unspecified Stimulant Use Disorder, OUD, AUD, PTSD, and Anxiety Disorder. The facility enrolled clients in their SACOT program.

Clients across the PHP, SAIOP, and SACOT service categories recieved the same clinical programming with no regard to their specific needs. DC #5 had been enrolled in the SACOT programming and been stepped down to the SAIOP level of care without clinical oversight recommendations. Within days of transitioning between SACOT and SAIOP, DC #5 overdosed and died. The facility did not have an identified licensed staff to provide program oversight for the SACOT program nor did the facility have

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identified Qualified Professional staff. There had not been an on-site qualified clinical director since prior to October 2025. There was confusion amongst staff as to who filled what roles and what their responsibilities were. Staff in the facility were unaware of the program rules including clinical oversight requirements as well as continuing education requirements. There was nobody responsible for oversight to ensure program requirements were being met and followed.

This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.

V 281 — 27G .4502 Sub. Abuse Comp. Outpt. Tx. - Staff — V 281

10A NCAC 27G .4502 STAFF
(a) The SACOT shall be under the direction of a Licensed Clinical Addictions Specialist or a Certified Clinical Supervisor who is on site a minimum of 90% of the hours the program is in operation.
(b) For each SACOT there shall be at least one direct care staff who meets the requirements of a Qualified Professional as set forth in 10A NCAC 27G .0104 (18) for every 10 or fewer clients.
(c) Each SACOT shall have at least one direct care staff present in the program who is trained in the following areas:
(1) alcohol and other drug withdrawal symptoms; and
(2) symptoms of secondary complications due to alcoholism and drug addiction.
(d) Each direct care staff shall receive continuing education that includes the following:
(1) understanding of the nature of addiction;
(2) the withdrawal syndrome;

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(3) group therapy;
(4) family therapy;
(5) relapse prevention; and
(6) other treatment methodologies.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to operate under the direction of an Licensed Clinical Addiction Specialist (LCAS) or Certified Clinical Supervisor (CCS) and identify at least one direct care staff who met the requirements of a Qualified Professional (QP), and failed to ensure 3 of 4 audited (Therapist #1, Admissions/Former Director of Operations (A/FDO), and the Executive Director (ED)) staff received continuing education affecting 1 of 1 audited current client (#1) and 1 of 1 deceased client (DC #5). The findings are:

Finding #1: The facility did not have an LCAS or CCS to provide clinical oversight nor was there identified staff that met the requirements of a QP.

Interview on 4/21/26 with the ED revealed:
-Census: Substance Abuse Comprehensive Outpatient Treatment (SACOT) -5.
-Could not identify an LCAS or CCS who provided clinical supervision to the program.
-Was not fully aware of staffing and oversight requirements.

Review on 4/22/26 of Deceased Client (DC) #5's record revealed:
-Date of Admission: 1/7/26.

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-Date of Transfer to SAIOP: 2/6/26.
-Date of Death: 2/8/26.
-Diagnoses: Opioid Use Disorder, Severe; Alcohol Use Disorder (AUD), Severe; Post Traumatic Stress Disorder (PTSD); Anxiety Disorder; and Gastroesophageal Reflux Disease.
-Transfer Summary dated 2/6/26 completed by Former Therapist (FT) #5: "Transferred to Level of Care: IOP. Progress and Summary of Treatment...Client completed assigned therapeutic work and returned assignments for review and processing, reflecting increased insight into substance use patterns, relapse risk factors, and recovery needs. A significant area of progress was the client's re-engagement with the 12-step recovery community. He reconnected with a sponsor and began actively working the 12-step program, strengthening his recovery foundation and external support system. Treatment focused on relapse prevention, coping skill development, and establishing sustainable recovery routines. Client demonstrated improved commitment to sobriety, increased use of coping strategies, and growing accountability in his recovery process." Signed by FT #5, Certified Alcohol and Drug Counselor (CADC) with no supervisory review or signature.
-Discharge Summary dated 2/9/26: "Clinical Summary of Client's Response to Treatment: Client had recently stepped down to the Intensive Outpatient Program (IOP) level of care after demonstrating treatment progress and active engagement in services. At the time of step-down, client reported strong engagement with his 12-step sponsor and sober support network and was participating appropriately in treatment. Continued IOP engagement was planned with focus on strengthening relapse prevention skills, increasing insight into substance use patterns, and reinforcing

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recovery-oriented coping strategies and support systems." Signed by Former Therapist (FT) #5, CADC with no supervisory review or signature.

Review on 4/22/26 of the facility staff list provided by the ED revealed:
-Clinical Director/Clinical Consultant (CD/CC):
 -Date of Hire: 3/31/26.
 -Title: Clinical Director.
 -Licensure: LCSW

Review on 4/28/26 of a Former Staff List since 10/1/25 to 4/25/26 for the facility, emailed by the CEO on 4/27/27 at 1:13AM revealed:
-Non-Audited Staff Former Co-Clinical Director:
 -Date of Hire: 4/15/24.
 -Date of Separation: 10/6/25.
 -Title: Co-Clinical Director.
 -Licensure: Licensed Clinical Social Worker (LCSW).
-CD/CC:
 -Date of Hire: 12/10/25
 -Date of Separation: Active.
 -Title: Clinical Consultant.
 -Licensure: LCSW.
-Therapist #2:
 -Date of Hire: 2/20/26.
 -Date of Separation: Active.
 -Title: Therapist.
 -Licensure: LCAS, CCS
-After 10/6/25 no staff identified as Clinical Director.
-No staff identified as an LCAS or CCS to provide program oversight.
-No staff identified specifically as the QP.

Review on 4/28/26 of Therapist #1's personnel record revealed:
-Date of hire: 2/4/26.
-Licensure: CADC.

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V 281	Continued From page 80 Review on 4/28/26 of Therapist #2's personnel record revealed: -Date of hire: 2/23/26. -Licensure: LCAS/CCS. Review on 4/28/26 of Therapist #3's personnel record revealed: -Date of Hire: 2/24/26. -Licensure: Licensed Clinical Addictions Specialist-Associate (LCAS-A). Review on 4/28/26 of Therapist #4's personnel record revealed: -Date of Hire:12/12/24. -Licensure: Licensed Clinical Mental Health Counselor (LCMHC) and LCAS-A. Review on 4/22/26 of the CD/CC's personnel record revealed: -No hire date documented. -Licensure: North Carolina (NC) LCSW issued 3/30/26, expiration 3/30/28. Review on 4/27/26 of the CD/CC's personnel record revealed: -"Independent Contractor Agreement" signed on 4/24/26. -"Contractor will provide clinical director services, including clinical oversight..." Finding #2: The facility did not have identified QP staff nor did they ensure staff received continuing education requirements. Review on 4/22/26 of the Therapist #1's personnel record revealed: -Date of Hire: 1/20/26. -No documentation of continuing education that included the following:	V 281		

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-understanding the nature of addiction.
-the withdrawal syndrome.
-group therapy.
-family therapy.
-relapse prevention.
-other treatment methodologies.

Review on 4/27/26 of the A/FDO's personnel record revealed:
-Date of Hire: 12/1/23.
-No documentation of continuing education that included the following:
-understanding the nature of addiction.
-the withdrawal syndrome.
-group therapy.
-family therapy.
-relapse prevention.
-other treatment methodologies.

Review on 4/22/26 of the ED's personnel record revealed:
-Date of Hire: 12/1/23.
-No documentation of continuing education that included the following:
-understanding the nature of addiction.
-the withdrawal syndrome.
-group therapy.
-family therapy.
-relapse prevention.
-other treatment methodologies.

Interview on 4/21/26 with Therapist #1 revealed:
-"I don't know that we really have that (a person designated over each program)...Our Clinical Director (CD/CC) lives in [another state]. He isn't in the building and doesn't know our clients..."
-Had not had any continuing education training provided by the Licensee.

Interview on 4/22/26 with Therapist #2 revealed:

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-Was fully licensed as an LCAS and CCS.
-"I am just doing some contract groups...just filling in and helping out."
-Was supervising Therapist #3 and Therapist #1for their licensure, not as a part of the facility.
-"I don't think we really have one (someone in charge of the program) yet. I thought that was still in the works."
-"We have a person I only know online, [CD/CC]."
-Had not been asked to be Clinical Director.

Interview on 4/22/26 with Therapist #3 revealed:
-Was licensed as a LCAS-A.
-Was hired as "clinical lead. I am still trying to get used to what I do. We have a clinical director..."
-The CD/CC was her supervisor.
-"I didn't know that (North Carolina Mental Health Licensure rules for the SAIOP and SACOT for program oversight)."
-"What they would like is when I pass my exam, I become clinical director."
-She and Therapist #4 were "splitting things...we are both kind of like team leads..."

Interview on 4/22/26 with Therapist #4 revealed:
-Was licensed as a LCAS-A and Licensed Clinical Mental Health Counselor (LCMHC).
-Current position was Therapist.
-"I guess [CD/CC] is my boss..."
-"She (Therapist #2) is not providing supervision programmatically."
-"We had a clinical director that was licensed and he was let go. We had a fully licensed LCSW. He took on clinical director until that September (2025) and then he was let go and we were in the air without anyone..."
-The CD/CC was based out of a different state.
-"Do stuff (continuing education) for your licensure. I don't think they (Licensee) care about that (continuing education training)."

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Interview on 4/29/26 with FT #5 revealed:
-"I don't know what you mean (who provided clinical program oversight) of substance programs."
-"Made decision (for DC#5 to step down to SAIOP) in conjunction...I spoke with [Therapist #4]. We were not running a clinical treatment team because we were in transition..."
-"He (DC #5) was everything appropriate to step down. I communicated with my supervisor (clinical supervisor unrelated to facility)..."
-"I left because I felt that I didn't have the support I needed."

Interview on 4/22/26 with the A/FDO revealed:
-Unlicensed.
-"Clinically [CD/CC] (was in charge of all programs)."
-The CD/CC did not come to the facility on site.
-The CD/CC was licensed as a LCSW.

Interviews on 4/21/26 and 5/4/26 with the CD/CC revealed:
-Lived in another state and worked remotely.
-Had only been in this role "not even 30 days" but would not clarify how long he had worked for the facility.
-His role was "pretty much chart reviewer, sign charts, clinical meetings, more of like a compliance guy."
-Had only been in this role "not even 30 days" but would not clarify how long he had worked for the facility.
-Did not provide any staff supervision or training.
-"I am out of state...strictly remote."
-"I'm not in there (the facility) at all."
-"Two people are in charge (of PHP) [Therapist #3 and Therapist #4]. They handle all of the onsite stuff...Not sure how they divided it up."

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V 281	Continued From page 84 -"I am doing strictly client notes. Making sure things are correct and make sure they are reviewed before billing..." -"Don't understand why I would be called the Clinical Director." Interview on 4/24/26 with the Nurse Practitioner revealed: -"I think he (Clinical Director) is in another state." Interview on 4/22/26 with the Director of Operations (DO) revealed: -Had only been in the role for about a month. -"...right now, [CD/CC] is heading all the programs...[Therapist #3] is leading day to day, but [CD/CC] is legally responsible and signing off. -Was going to be responsible for the "...day to day operations...overseeing the system as a whole..." Interviews on 4/22/26, 4/27/26, and 5/4/26 with the ED revealed: -Was not aware of the NC Mental Health Licensure of the service categories the facility was licensed for, "...familiar but not like that (mainly regarding program oversight)." -"[CD/CC] has helped out (providing clinical oversight) now since he is licensed (since the end of March 2025)." -"I do know we did look into if it was legitimate (CD/CC providing oversight)." -No one was responsible for ensuring continuing education training had been completed. -The Executive Assistant would now be responsible for tracking and ensuring "everyone has the proper trainings." -Provided direct care by leading some groups. -Had a prospective employee "...guy coming in today, has LCAS for SACOT (program oversight) to look at the facility...we are looking at immediate	V 281		

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(hiring) but don't have a timeframe."

Interview on 4/24/26 with the CEO revealed:
-Identified Therapist #2 as the QP for the SAIOP program as well as co-leading the SACOT program with Therapist #3.
-Therapist #2 supervised the LCAS-A and CADC staff.
-Therapist #2 provided clinical oversight.
-"I hope so (if Therapist #2 was aware she provided clinical oversight)."
-Did not understand the confusion regarding Therapist #2 with her role.
-Referred to the CD/CC as "...Clinical Consultant is the technical term."
-"There is no way to show people with an LCAS-A have the experience or would be better (in program oversight)...There are not a lot of fully licensed people in general."

This deficiency is cross referenced into 10A NCAC 27G .4501 Scope (V280) for a Type A1 rule violation and must be corrected within 23 days.

V 366 — 27G .0603 Incident Response Requirements — V 366

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:
(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

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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 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

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V 366	Continued From page 87 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; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department;	V 366		

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(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 develop and implement policies regarding their response to Level III incidents.
The findings are:

Review on 4/23/26 of Deceased Client #4's (DC #4) record revealed:
-Date of Admission: 2/2/26.
-Program: Virtual Substance Abuse Intensive Outpatient Program (SAIOP), also known as Virtual Intensive Outpatient Program (VIOP).
-Diagnoses: Major Depressive Disorder, Recurrent Episode Severe; and Post Traumatic Stress Disorder (PTSD).
-Date of death: 2/12/26.
-Discharge Date: 2/16/26.

Review on 4/23/26 of DC #5's record revealed:
-Date of Admission: 1/7/26.
-Program: SACOT (Substance Abuse Comprehensive Outpatient Treatment).
-Diagnoses: Opioid Use Disorder, Severe; Alcohol Use Disorder, Severe; Gastroesophageal Reflux Disease, and PTSD.
-Date of Death: 2/8/26.
-Discharge Date: 2/9/26.

Review on 4/23/26 of internal facility incident reports from 10/1/25 to 4/23/26 revealed:

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- "Date of incident: 2/12/26.
-...2/15/26 [Admissions/Former Director of Operations (A/FDO)] made contact with the client's emergency contact to inform her that their daughter (DC #4), had missed the last 3-4 scheduled sessions for her Virtual IOP Programming...mother informed [A/FDO]...she took her own life on Thursday (2/12/26)."
-Incident report was unsigned.
-No documentation that the facility determined or reviewed the cause of the incidents.
-No documentation that the facility developed and implemented corrective measures.
-No documentation of person(s) assigned to be responsible for implementation of corrections and preventative measures.
-No incident report regarding DC #5's death.

Review on 4/23/26 of the North Carolina Incident Response Improvement System (IRIS) from 10/1/25 to 4/23/26 revealed:
-No incident reports.

Interview on 4/22/26 with the A/FDO revealed:
-Current role was Admissions; was Former DO from approximately Sept 2025 to March 2026.
-Responsible for incident reporting when DC #4 and DC #5 passed away.
-Unsure about reporting requirements, including risk cause analysis with Level III incidents based on licensure rules.
-"[DC #4] was in our virtual program (VIOP)...reached out to her emergency contact to see...Mom responded that she had killed herself...Again, I don't think we filed with IRIS."
-DC #5 had completed the SACOT program and "graduated on Friday (2/6/26)..the plan was for him to continue in some capacity...in IOP (SAIOP)...Got a call...saying that the family had reached out and he overdosed...It (incident

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report) didn't get filed..."

Interview on 4/22/26 with Therapist #4 revealed:
-Was assigned to be therapist for DC #4. DC #4 did not show up for her scheduled session on 2/12/26.
-Completed a discharge summary on 2/16/26 for DC #4 after being told by the Executive Director (ED) on 2/16/26 that "DC #4 was no longer with us."
-Did not participate in any case review regarding DC #4.
-Did not complete an incident report regarding DC #4's death.
-Heard about DC #5's death but was not involved in his treatment.

Interviews on 4/22/26 and 4/24/26 with the ED revealed:
-Had internal incident report for DC #4 but not for DC #5.
-A/FDO would have been responsible for incident reporting for DC #4 and DC#5.
-Unaware that the deaths for DC #4 and DC #5 had to be reported to the Local Management Entity/Managed Care Organization (LME/MCO) through IRIS system and a risk cause analysis completed for each client.

Interview on 4/22/26 with the DO revealed:
-Had been in this position for "about a month."
-Was now responsible for incident reporting and response.
-A/FDO was responsible for incident reporting and response at the time of DC #4 and DC #5's death.

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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 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,

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OTTER HOUSE WELLNESS	**40 NORTH FRENCH BROAD AVENUE ASHEVILLE, NC 28801**

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V 367	Continued From page 92 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 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)	V 367		

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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 III incidents to the Local Management Entity/Managed Care Organization (LME/MCO) within 72 hours as required. The findings are:

Review on 4/23/26 of Deceased Client #4's (DC #4) record revealed:
-Date of Admission: 2/2/26
-Program: Virtual Substance Abuse Intensive Outpatient Program (SAIOP), also known as Virtual Intensive Outpatient Program (VIOP).
-Diagnoses: Major Depressive Disorder, Recurrent Episode Severe; and Post Traumatic Stress Disorder (PTSD).
-Date of death: 2/12/26.
-Discharge Date: 2/16/26.

Review on 4/23/26 of DC #5's record revealed:
-Date of Admission: 1/7/26.
-Program: SACOT (Substance Abuse Comprehensive Outpatient Treatment).
-Diagnoses: Opioid Use Disorder, Severe; Alcohol Use Disorder, Severe; Gastroesophageal Reflux Disease, and PTSD.
-Date of Death: 2/8/26.
-Discharge Date: 2/9/26.

Review on 4/23/26 of the North Carolina Incident Response Improvement System (IRIS) from

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V 367	Continued From page 94 10/1/25 to 4/23/26 revealed: -No incident reports. Interview on 4/22/26 with the Admissions/Former Director of Operations (A/FDO) revealed: -Current role was Admissions; was former DO from approximately Sept 2025 to March 2026. -Was responsible for incident reporting. -Unaware of reporting timeframe requirements for Level III incidents. Interviews on 4/22/26 and 4/24/26 with the Executive Director (ED) revealed: -Unaware that the deaths for DC #4 and DC #5 had to be reported to the Local Management Entity/Managed Care Organization (LME/MCO) through IRIS system within 72 hours. Interview on 4/24/26 with CEO (Chief Executive Officer) revealed: -Responsible for "everything" for the facility. -The ED was responsible for incident reporting. -Did not know why incident reports for DC #4 and DC #5 had not been submitted into IRIS.	V 367		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and	V 536		

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V 536	Continued From page 95 other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for	V 536		

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escalating behavior;
(8) communication strategies for defusing and de-escalating potentially dangerous behavior; and
(9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).
(h) Service providers shall maintain documentation of initial and refresher training for at least three years.
(1) Documentation shall include:
(A) who participated in the training and the outcomes (pass/fail);
(B) when and where they attended; and
(C) instructor's name;
(2) The Division of MH/DD/SAS may review/request this documentation at any time.
(i) Instructor Qualifications and Training Requirements:
(1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.
(2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.
(3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
(4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule.
(5) Acceptable instructor training programs shall include but are not limited to presentation of:

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(A) understanding the adult learner;
(B) methods for teaching content of the course;
(C) methods for evaluating trainee performance; and
(D) documentation procedures.
(6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach.
(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.
(8) Trainers shall complete a refresher instructor training at least every two years.
(j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.
(1) Documentation shall include:
(A) who participated in the training and the outcomes (pass/fail);
(B) when and where attended; and
(C) instructor's name.
(2) The Division of MH/DD/SAS may request and review this documentation any time.
(k) Qualifications of Coaches:
(1) Coaches shall meet all preparation requirements as a trainer.
(2) Coaches shall teach at least three times the course which is being coached.
(3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.
(l) Documentation shall be the same preparation as for trainers.

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure 2 of 4 audited staff (Therapist #1 and Clinical Director/Consultant (CD/C)) received initial training and 1 of 4 audited staff (Admissions/Former Director of Operations (A/FDO)) received annual training for competency-based training in alternatives to restrictive interventions prior to the provision of services. The findings are:

Review on 4/22/26 of the facility staff list provided by the Executive Director (ED) revealed:
-Date of Hire:
- -Therapist #1: 2/4/26.
- -CD/C: 3/31/26.
- -A/FDO: not provided.

Review on 4/27/26 of a Former and Current Staff List since October 1, 2025, to present (4/25/26) for the facility, emailed by the Chief Executive Officer (CEO) on 4/27/26 at 1:13AM revealed:
-Date of Hire:
- -Therapist #1: 1/24/26.
- -CD/C: 12/10/25.
- -A/FDO: 7/7/23.

Review on 4/22/26 of Therapist #1's personnel record revealed:
-Date of Hire: 1/20/26.
-Licensure: North Carolina (NC) Addictions Specialist Professional Practice Board, Certified Alcohol and Drug Counselor (CADC) issued

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5/30/22, expiration 5/29/26.
-No documentation of training in alternative to restrictive interventions.

Review on 4/27/26 of the A/FDO's personnel record revealed:
-Date of Hire: 12/1/23.
-Date of training in alternatives to restrictive interventions: 11/6/23 with expiration date of 11/6/24.
-No documentation of annual updated training.

Review on 4/22/26 of the CD/C's personnel record revealed:
-No hire date documented.
-Licensure: NC Licensed Clinical Social Worker (LCSW) issued 3/30/26, expiration 3/30/28.
-No documentation of training in alternatives to restrictive interventions.

Interview on 4/22/26 with the A/FDO revealed:
-Had transitioned from Director of Operations (DO) role to Admissions "about a month ago."
-"I was doing onboarding for new employees (Human Resource (HR) duties)."
-Had been in that role since "September 2025 to March 2026."
-"Kind of like with [DO] being new, looking at her taking that over (HR duties)."

Interview on 4/22/26 with the DO revealed:
-Had only been in the role for "about a month and a week."
-Was going to be responsible for the "...day to day operations...overseeing the system as a whole..."

Interviews on 4/22/26 and 5/4/26 with the ED revealed:
-The facility did not have a HR department or

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role.
-The A/FDO was responsible for personnel requirements.
-There had not been a specific person responsible for ensuring trainings were up to date, the Executive Assistant would be taking on that role.

Interview on 4/24/26 with the CEO revealed:
-Was responsible for "everything."
-Did not do restrictive interventions, only deescalation.
-"As of today [Executive Assistant] (will be in the HR role). She has been with me for 60 days...no one specific person (was in that role prior)."