Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: ______ B. WING ______	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD TREATMENT CENTER	2002 A, B, D, E & G SHACKLEFORD ROAD KINSTON, NC 28504

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 5/18/26. One complaint was substantiated (intake #NC00236954) and three complaints were unsubstantiated (intake #'s NC00236854, NC00236589 and NC00236319. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents. This facility is licensed for 42 and has a current census of 35. The survey sample consisted of audits of 5 current clients and 2 former clients.	V 000		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name;	V 118		

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V 118	Continued From page 1 (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to administer medications on the written order of a physician affecting four of five audited clients (#12, #15, #17 and #24). The findings are: Finding #1: Review on 04/16/26 of client #12's record revealed: - Admission date of 10/29/26. - 14 year old. - Diagnoses of Major Depressive Disorder, Post Traumatic Stress Disorder, Oppositional Defiant Disorder Review on 04/17/26 and 04/20/26 of medication orders revealed: 01/20/26 - Depakote ER (extended release) (manic episodes) 250 milligram (mg)- 1 at bedtime. - Depakote ER- 500mg- 1 at bedtime. - Risperidone- (antipsychotic) 1mg- 1 three times daily.	V 118		

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V 118	Continued From page 2 04/7/26 - Sertraline HCI (hydrochloride) (mood) 150mg- 1 at bedtime. Review on 4/16/26 and 4/20/26 of client #12's April 2026 MARs revealed: -No staff initials to indicate the following medications were administered: Depakote ER 250mg on 4/4/26 and 4/8/26 at 8pm. Depakote ER 500mg on 4/4/26 and 4/8/26 at 8pm. Sertraline HCI 150mg on 4/8/26 at 8pm. Risperidone 1mg was on 4/4/26 and 4/8/26 at 8pm. Interview on 04/20/26 client #12 stated he took his medications daily. Finding #2: Review on 04/17/26 of client #15's record revealed: - 14 year old male. - Admission date of 10/30/25. - Diagnoses of Conduct Disorder Adolescent Onset Type and Attention Deficit Hyperactivity Disorder (ADHD)-Combined Type. Review on 04/17/26 of client #15's medication orders revealed: 10/30/25 - Guanfacine (ADHD) 4mg - one at bedtime. 02/10/26 Melatonin (sleep) 6mg - one at bedtime. Review on 04/17/26 of client #15's March 2026 MAR revealed: - No staff initials to indicate Guanfacine or Melatonin was administered 03/04/26, 03/09/26,	V 118		

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03/10/26, 03/17/26 and 03/19/26.

Finding #3:
Review on 04/16/26, 04/17/26 and 04/20/26 of client #17's record revealed:
- 14 year old male.
- Admission date of 10/20/25.
- Diagnoses of Disruptive Mood Dysregulation Disorder, ADHD-Combined Type and Borderline Intellectual Functioning.
- Discharged: 04/20/26.

Review on 04/17/26 and 04/20/26 of client #17's medication orders revealed:
10/21/25
- Zyrtec (Cetirizine - allergies) 10 mg take once daily.
- Zyprexa (antipsychotic) 15mg - take at bedtime.
- Zyprexa 5mg - take twice daily.
- Amantadine (tremors) 100mg - take twice daily.

01/16/26
- Melatonin (sleep) 6mg - take at bedtime.

04/07/26
- Clonidine (hypertension) 0.2mg - take twice daily.

Review on 04/17/26 and 04/20/26 of client #17's February 2026 and April 2026 MARs revealed:
- No staff initials to indicate the following medications were administered:
Amantadine 100mg on 02/01/26 and 02/09/26 at 5pm.
Zyprexa 5mg on 02/01/26 and 02/09/26 at 5pm.
Cetirizine 10mg on 04/07/26 at 8pm.
Melatonin 6mg on 04/07/26 at 8pm.
Zyprexa 15mg on 04/07/26 at 8pm.
Clonidine 0.2mg on 04/07/26 at 8pm.

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Interview on 04/21/26 client #17 stated he received his medications daily.

Finding #4:
Review on 04/17/26, and 04/20/26 of client #24's record revealed:
- 17 year old female.
- Admission date 10/17/25.
- Diagnoses of Post Traumatic Stress Disorder, Mood Disorder, Attention Deficit Hyperactivity Disorder-Combined Type, Borderline Intellectual Functioning, Bipolar Disorder.

Review on 04/17/26 and 04/20/26 of client #24's medication orders revealed:
01/20/26
- Trazodone HCI (insomnia) 50mg- 1 at bedtime.
- Chlorpromazine HCI (antipsychotic) 100mg- 1 two times daily.
- Trileptal (mood) 300mg- 1 two times daily.

02/10/26
- Abilify (mood) 15mg- 1 at bedtime.

02/17/26
- Intuniv (mood) 3mg- 1 at bedtime.

02/24/26
- Acetazolamide (glaucoma) 250mg- 1 two times daily.

03/03/26
- Hydroxyzine HCI (anxiety) 25mg- 1 two times daily.

Review on 04/17/26 and 04/20/26 of client #24's March 2026 and April 2026 MARs revealed:
- No staff initials to indicate the following medications were administered:
 Abilify 15mg on 03/18/26 at 8pm.

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V 118	Continued From page 5 Intuniv 3mg on 03/18/26 at 8pm. Trazodone HCI 50mg on 03/18/26 at 8pm. Acetazolamide 250mg on 03/18/26 at 8pm. Hydroxyzine HCI 25mg on 03/18/26 at 8pm. Trileptal 300mg on 03/18/26 at 8pm. Chlorpromazine HCI 100mg on 03/18/26 at 8pm. Abilify 15mg on 04/03/26 and 04/15/26 at 8pm. Intuniv 3mg on 04/03/26 and 04/15/26 at 8pm. Trazodone HCI 50mg on 04/03/26 and 04/15/26 at 8pm. Acetazolamide 250mg on 04/03/26 and 04/15/26 at 8pm. Hydroxyzine HCI 25mg on 04/03/26 and 04/15/26 at 8pm. Trileptal 300mg on 04/03/26 and 04/15/26 at 8pm. Chlorpromazine HCI 100mg on 04/03/26 and 04/15/26 at 8pm. Interview on 04/20/26 client #24 stated she took her medications "on-time everyday." Interview on 4/23/26 the Registered Nurse (RN) #1 stated: - Blanks in the MAR were a red flag. - He "administered the medication on the dates there was a blank but may not have signed the MAR." - Sometimes the facility "had internet issues and the system had not taken the the signature immediately." - Sometimes the "tablets used to document medication administration had not worked in certain buildings." Interview on 04/16/26 RN #2 stated: - Only nurses pass medications. - There should be staff initials on the MARs to reflect medications were administered as ordered.	V 118		

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V 118	Continued From page 6 - She did not know why nursing staff failed to initial the MARs. - Medications were available at the facility for administration. Due to failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician.	V 118		
V 317	27G .1904 Psych. Res. Tx. Fac. - Transfer or Discharge 10A NCAC 27G .1904 TRANSFER OR DISCHARGE (a) The purpose of this Rule is to address the transfer or discharge of a child or adolescent from the facility. (b) A child or adolescent shall not be discharged or transferred from a facility, except in case of emergency, without the advance written notification of the treatment team, including the legally responsible person. For purposes of this Rule, treatment team means the same as the existing child and family team or other involved persons as set forth in Paragraph (c) of this Rule. (c) The PRTF shall meet with existing child and family teams and other involved persons including the parent(s) or legal guardian, area authority or county program representative(s) and other representatives involved in the care and treatment of the child or adolescent including local Department of Social Services, Local Education Agency and criminal justice agency, to make service planning decisions prior to the transfer or discharge of the child or adolescent from the facility. (d) In case of an emergency, the facility shall notify the treatment team including the legally	V 317		

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responsible person of the transfer or discharge the child or adolescent as soon as the emergency situation is stabilized.
(e) In case of an emergency, notification may be by telephone. A service planning meeting as set forth in Paragraph (c) of this Rule shall be held within five business days of an emergency transfer or discharge.

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed: 1) to make advance written notification of the treatment team prior to discharge of a client; and 2) to make service planning decisions prior to discharge of a client, affecting one of five audited clients (#35). The findings are:

Review on 04/28/26 of client #35's record revealed:
- 14 year old.
- Admission date of 10/04/24.
- Diagnoses of Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder - Combined Type, Reaction to Severe Stress Unspecified and Conduct Disorder Unspecified.
- Legal Guardian adoptive mother.
- Discharge date of 04/21/26.

Review on 04/28/26 of a facility "Discharge Summary" dated 04/21/26 and signed by Clinical Case Manager #1 revealed:
- Admission date: 10/04/24.
- Discharge date: 04/21/26.
- "Family History: [Client #35] resides with her

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adoptive parents, who are her primary guardian. Despite being raised in a stable home environment, there is significant history of conflict, boundary violations, and mistrust within the family system. Her adoptive mother has expressed safety concerns and emotional fatigue due to the increasing intensity of [Client #35]'s behaviors. [Client #35] has also reported unresolved feelings related to past bullying and parental rejection..."
- "Referral/Recommendations: Clinical Recommendation [Client #35] will need continued supports in order to be successful. the clinical recommendation is for [Discharge Group Home] for management of the symptoms of her diagnosis and Adolescent Day Treatment Services for educational support. The team also strongly recommends Psychiatric Care/Medication Management throughout her treatment process."

Review on 04/28/26 of client #35's "Monthly Treatment Team Review" dated 03/31/26 revealed:
- Adoptive mother signed 04/01/26.
- Goal #1: "I want to learn how to control my anger."
- "Step down/transition plan: As progress is made within NOVA (Licensee) PRTF (Psychiatric Residential Treatment Facility), [Client #35] will need continued supports in order to be successful. The clinical team recommends [Client #35] transition into a level III group home..."

Review on 04/28/26 of client #35's person-centered plan signed by the adoptive mother guardian on 04/01/26 revealed:
- "The clinical team recommends [Client #35] transition into a Level 3 group home."

Review on 04/28/26 of client #35's

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"Transition/Discharge Plan" dated 03/31/26 revealed:
- Adoptive mother signed 04/01/26.
- "03/04/2026 - [Client #35] has demonstrated an improvement in her progress for the past month. The Treatment Team has located Level III Residential placement for her with [discharge level III]. Tentative transition discharge date is set for as soon as placement is ready to accept her."

Interview on 4/23/26 client #35's adoptive mother stated:
- Her physician "advised me not to have [client #35] home because of a prior surgery and if I was hit in my head it could kill me."
- She "learned on 4/21/26 that [client #35] no longer had a bed at the facility."
- She was told by the Director of Clinical Services and the Clinical Case Manager that client #35 needed to be picked up in 30 minutes and she lived 6 hours away.
- She called the facility multiple times on 4/21/26 without reaching anyone and when she finally reached the Director of Clinical Services she was told "[client #35]" no longer had a bed there and that "[client #35] was stable now."
- On 4/21/26 the Director of Clinical Services and the Clinical Case Manager told her if no one came to get client #35 they would take her home and they would be arriving at 3:30pm. The adoptive mother did not identify the time she was told this.
- She told the Director of Clinical Services she "was not equipped to take [client #35]" and that the "facility's decision to bring [client #35] home was not ok." The Director of Clinical Services told her that "[Client #35] and facility staff were on the way."
- Client #35 no longer had a bedroom at her residence and had not been at the residence for

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approximately 3-4 years.
- Client #35 and facility staff arrived at her home between 4:45pm-5:00pm on 4/21/26.
- She took client #35 to a family members residence approximately 35-40 minutes away for her and client #35's safety. One family member was 79 or 80 years old and the other was an aunt that was 54 years old.
- On 04/22/26 the Director of Clinical services started emailing and requested an emergency meeting.
- On 4/22/26 the Director of Clinical Services started to "apologize and said they now have a bed and will come back to get her" (client #35) but she refused and said no.

Interview on 04/29/26 of a representative of client #35's Level III facility stated:
- Client #35 was admitted to their facility on 04/27/26.

Interview on 05/14/26 Case Manager #1 stated:
- He was the case manager for client #35.
- He had worked to secure client #35's placement at a Level III group home.
- He had sent documents for admission to the Level III group home several times.
- The discharge plan was for client #35 to step down to a Level III group home.
- He was told by the Director of Clinical Services to take client #35 to her adoptive mothers's home until placement at the Level III group home could be secured.
- Client #35's adoptive mother would not allow client #35's "items" in the house.
- Client #35's adoptive mother told him to put the items in the back of a "truck."
- Client #35 was "crying and unsettled" at the way her adoptive mother treated her.

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V 317	Continued From page 11 Interview on 05/14/26 Case Manager #2 stated: - She assisted with the transportation of client #35 to the adoptive mothers home on 04/21/26. - Client #35's adoptive mother was sitting in a swing outside when they arrived. - Client #35's adoptive mother said "This is not ok." - Client #35 had asked to call her grandmother. - "[Client #35] said she was nervous and she started shaking and crying." - Client #35's adoptive mother would not allow client #35's personal items in the house and requested they be put in the back of a truck. - She and Case Manager #1 discussed what occurred at the adoptive mother's home with the Director of Clinical Services after they left the home. Interview on 04/28/26 and 05/18/26 the Director of Clinical Services stated: - The treatment team had discussed on 03/31/26 the transition of client #35 to a Level III group home. - The Level III group home needed additional authorization for 1:1 services. - The original date of discharge was 04/17/26. - Client #35 was then scheduled for discharge on 04/20/26 because the Level III facility could not accept on 04/17/26. - The team felt the Level III group home had all they needed to accept client #35. - The facility admitted another client on 04/20/26 and therefore had to discharge client #35. - She "explained" to client #35's adoptive mother the facility had to move forward with client #35's discharge to home. - Client #35 "had been doing well." - The team thought the Level III would get authorization at anytime to admit client #35. - Client #35's adoptive mother did not want the	V 317		

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client at the home.
- Client #35 was discharged to her adoptive mother's house on 04/21/26.
- We "did not feel (client #35) was a danger to herself or others."
- We discussed if the Level III did not take client #35 on 04/22/26 Oakwood would pick her back up.

Interview on 04/28/26 the Chief Executive Officer (CEO) stated:
- Client #35 had been doing "better" at their facility.
- She was aware the accepting facility for client #35 were waiting for an additional rate for services.
- Client #35's discharge did occur to the Level III facility on 04/20/26 and another client was admitted.
- Client #35 was transported to her mother's home.
- She became aware of client #35's treatment at the mom's after she was dropped off and she asked to see if the facility could pick her back up.
- Client #35 had been taken to her grandmother's home.
- "I accept it. It should not have happened."

Review on 05/18/26 of a Plan of Protection signed by the CEO and dated 05/18/26 revealed:
- "What immediate action will the facility take to ensure the safety of the consumers in your care? The Director of Clinical Services will oversee implementation and ongoing compliance with discharge transition procedures. The clinical case manager, therapist, managed care organization (LME (Local Management Entity)/MCO), and legal guardian will collaborate to ensure discharge planning is consistent and continuous. Once placement is identified a service-planning

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: ______ B. WING ______	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD TREATMENT CENTER	2002 A, B, D, E & G SHACKLEFORD ROAD KINSTON, NC 28504

(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 317	Continued From page 13 meeting will be held prior to the scheduled discharge, so all parties are current on discharge plan and responsibilities. Residents will be discharged to the clinically recommended level of care specified at time of discharge. if a planned discharge is successful but certain circumstances require deviation from the discharge plan, the resident will remain in treatment at Oakwood Treatment center until placement in the identified step-down program can be completed safely. Planned discharges will be based on clinically documented progress, assessed needs, and the resident's preferences, following logical step-down in treatment and services designed to protect the resident's safety and continuity of care. Describe your plans to make sure the above happens? The Director of Clinical Services will monitor all planned discharges to ensure compliance with appropriate transitions of care upon discharge. We will continue to adhere to the established policy 'Patient Care: 18 - Consumer Discharge.' We will create, implement, and train staff on discharge checklist to ensure that all procedures and policies have been followed." The facility served clients with diagnoses that included Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder, Conduct Disorder, Major Depressive Disorder, Post Traumatic Stress Disorder, Oppositional Defiant Disorder, Borderline Intellectual Functioning and Bipolar Disorder ranging from ages 14 - 17 years old. Client #35 was a 14 year old female admitted to the facility 10/04/24. Client #35's Person-Centered Plan, Transition/Discharge Plan and Monthly Treatment Team Meeting dated 03/31/26 had assessed that Client #35 required a Level III group home placement at discharge. The	V 317		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 317	Continued From page 14 discharge summary dated 04/21/26 recommended level of care was to a Level III group home. The facility did not adhere to/nor follow client #35's discharge plan 04/21/26 and client #35 was taken by the facility staff to her parent's residence on the same date. Client #35's mother had health concerns which did not allow for client #35 to return home. Client #35's adoptive mother had made the facility aware it was not okay for client #35 to return home and the facility chose to move forward with client #35's discharge because there was another client being admitted at the facility in client #35's allotted bed. The facility did not follow client #35's discharge plan to transition to a level III placement due to unresolved billing/authorization requirements required by the level III placement to complete Client #35's admission process. The facility's decision to discharge client #35 to her adoptive mother's home had not been an option within client #35's treatment planning. Client #35 was displaced from the recommended level of care from 04/21/26 thru 04/27/26. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 317		