

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL0601625</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/04/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GIVING HOPE FOR ALL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3715 HUBBARD ROAD</b> <b>CHARLOTTE, NC 28269</b>
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V 000	<p><b>INITIAL COMMENTS</b></p> <p>A complaint survey was completed on 11/4/25. The complaint was unsubstantiated (intake #NC00233939). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.</p> <p>This facility is licensed for 6 and has a current census of 4. The survey sample consisted of audits of 1 former client.</p> <p>This survey has been amended to include rule G.S.131E -256 Health Care Personnel Registry (V132) which was discussed but excluded from the initial Statement of Deficiency.</p>	V 000		
V 132	<p>G.S. 131E-256(G) HCPR-Notification, Allegations, &amp; Protection</p> <p>G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes:</p> <p>a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.</p> <p>b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.</p>	V 132		

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

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V 132	<p>Continued From page 1</p> <p>c. Misappropriation of the property of a healthcare facility.</p> <p>d. Diversion of drugs belonging to a health care facility or to a patient or client.</p> <p>e. Fraud against a health care facility or against a patient or client for whom the employee is providing services).</p> <p>Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to protect clients from harm during an investigation, failed to ensure an allegation of abuse was reported to the Health Care Personnel Registry (HCPR) within 5 days of being notified of an allegation, and failed to report, within 5 working days, the results of the investigation to the Department. The findings are:</p> <p>Review on 10/22/25 of the facility's Internal Incident report revealed: -9/12/25 Internal Incident Investigation signed by Associate Professional (AP) and Licensee/Qualified Professional (QP) and dated 9/13/25. -Client: [Former client #5 (FC#5)]; Staff involved: [staff #3]. -"Incident description-[FC #5] stated the staff, [staff #3] took him into a smoke shop, offered him a marijuana pen and edible. Also stated the staff, [staff #3] told the boys, ' one blunt makes me high. ' " Witness statements-According to both [client #1] and [client #2], they didn ' t hear the staff, [staff</p>	V 132		

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V 132	<p>Continued From page 2</p> <p>#3] say anything like that." Evidence Collected-Based on the first day of school at [FC #5's school]. [FC #5] returned to Giving Hope For All with the smell of marijuana on him and also with two lighters. Findings-Based on the witness statements and evidence, we found nothing to collaborate with [FC #5] ' s story. Corrective Actions/Recommendations-room restriction, no activities, room sweep." -9/12/25 Internal Incident Investigation signed by AP and Licensee/QP and dated 9/13/25. -Client: [Former client #5 (FC#5)]; Staff involved: [staff #3]. -"Incident Description: [FC #5] stated he found marijuana stored in the living room couch (facility). Witness statements-According to [staff #4], [staff #2], [AP], and [staff ], there haven ' t been any traces of marijuana in Giving Hope For All. Evidence Collected-QP [Licensee/QP] reviewed the cameras to collaborate story. Findings-There was no evidence of marijuana after reviewing cameras." -No documentation the HCPR was notified of the allegation staff #3 took FC #5 into a smoke shop, offered him a marijuana pen and edible.</p> <p>Interview on 10/22/25 with staff #1 revealed: -Licensee/QP conducted interviews 9/13/25 with clients. -He did not work on the 9/12/25, the date of the incident. -Did not know if staff #3 had worked on 9/12/25 or continued to work after the incident.</p> <p>Interview on 10/30/25 with staff #3 revealed: -Licensee/QP conducted investigation of the 9/12/25 incidents, which included allegation that staff #3 took FC #5 into a smoke shop, offered</p>	V 132		

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V 132	<p>Continued From page 3</p> <p>him a marijuana pen and edible. -Did not miss any work time as a result of the investigation.</p> <p>Interview on 10/22/25 with the Licensee/QP revealed: -Conducted investigation with the AP. -Had interviewed clients and staff as part of investigation. -Would check to see if staff #3 had worked 9/13/25 during the investigation."</p> <p>Interview on 10/23/25 with the Licensee/QP revealed: -Staff #3 finished working his shift on 9/12/25. -Staff #3 was not scheduled to work on the weekend, 9/13/25-9/14/25. -The investigation was completed on 9/13/25. -Staff #3 resumed his regular work schedule 9/15/25. -Was responsible for ensuring the HCPR was notified. -Would immediately ensure the HCPR was made aware of the allegation staff #3 took FC #5 into a smoke shop, offered him a marijuana pen and edible.</p>	V 132		
V 364	<p>G.S. 122C- 62 Additional Rights in 24 Hour Facilities</p> <p>§ 122C-62. Additional Rights in 24-Hour Facilities. (a) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-61, each adult client who is receiving treatment or habilitation in a 24-hour facility keeps the right to: (1) Send and receive sealed mail and have access to writing material, postage, and staff assistance when necessary;</p>	V 364		

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V 364	<p>Continued From page 4</p> <p>(2) Contact and consult with, at his own expense and at no cost to the facility, legal counsel, private physicians, and private mental health, developmental disabilities, or substance abuse professionals of his choice; and</p> <p>(3) Contact and consult with a client advocate if there is a client advocate.</p> <p>The rights specified in this subsection may not be restricted by the facility and each adult client may exercise these rights at all reasonable times.</p> <p>(b) Except as provided in subsections (e) and (h) of this section, each adult client who is receiving treatment or habilitation in a 24-hour facility at all times keeps the right to:</p> <p>(1) Make and receive confidential telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party;</p> <p>(2) Receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over therapies;</p> <p>(3) Communicate and meet under appropriate supervision with individuals of his own choice upon the consent of the individuals;</p> <p>(4) Make visits outside the custody of the facility unless:</p> <p>a. Commitment proceedings were initiated as the result of the client's being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found not guilty by reason of insanity or incapable of proceeding;</p> <p>b. The client was voluntarily admitted or committed to the facility while under order of commitment to a correctional facility of the Division of Adult Correction of the Department of Public Safety; or</p>	V 364		

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V 364	<p>Continued From page 5</p> <p>c. The client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; A court order may expressly authorize visits otherwise prohibited by the existence of the conditions prescribed by this subdivision;</p> <p>(5) Be out of doors daily and have access to facilities and equipment for physical exercise several times a week;</p> <p>(6) Except as prohibited by law, keep and use personal clothing and possessions, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002;</p> <p>(7) Participate in religious worship;</p> <p>(8) Keep and spend a reasonable sum of his own money;</p> <p>(9) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes; and</p> <p>(10) Have access to individual storage space for his private use.</p> <p>(c) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-57 and G.S. 122C-59 through G.S. 122C-61, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to have access to proper adult supervision and guidance. In recognition of the minor's status as a developing individual, the minor shall be provided opportunities to enable him to mature physically, emotionally, intellectually, socially, and vocationally. In view of the physical, emotional, and intellectual immaturity of the minor, the 24-hour facility shall provide appropriate structure, supervision and control consistent with the rights given to the minor pursuant to this Part. The facility shall also, where practical, make reasonable efforts to ensure that each minor client receives treatment apart and separate from adult clients unless the treatment needs of the</p>	V 364		

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V 364	<p>Continued From page 6</p> <p>minor client dictate otherwise.</p> <p>Each minor client who is receiving treatment or habilitation from a 24-hour facility has the right to:</p> <p>(1) Communicate and consult with his parents or guardian or the agency or individual having legal custody of him;</p> <p>(2) Contact and consult with, at his own expense or that of his legally responsible person and at no cost to the facility, legal counsel, private physicians, private mental health, developmental disabilities, or substance abuse professionals, of his or his legally responsible person's choice; and</p> <p>(3) Contact and consult with a client advocate, if there is a client advocate.</p> <p>The rights specified in this subsection may not be restricted by the facility and each minor client may exercise these rights at all reasonable times.</p> <p>(d) Except as provided in subsections (e) and (h) of this section, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to:</p> <p>(1) Make and receive telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party;</p> <p>(2) Send and receive mail and have access to writing materials, postage, and staff assistance when necessary;</p> <p>(3) Under appropriate supervision, receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over school or therapies;</p> <p>(4) Receive special education and vocational training in accordance with federal and State law;</p> <p>(5) Be out of doors daily and participate in play, recreation, and physical exercise on a regular basis in accordance with his needs;</p>	V 364		

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V 364	<p>Continued From page 7</p> <p>(6) Except as prohibited by law, keep and use personal clothing and possessions under appropriate supervision, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002;</p> <p>(7) Participate in religious worship;</p> <p>(8) Have access to individual storage space for the safekeeping of personal belongings;</p> <p>(9) Have access to and spend a reasonable sum of his own money; and</p> <p>(10) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes.</p> <p>(e) No right enumerated in subsections (b) or (d) of this section may be limited or restricted except by the qualified professional responsible for the formulation of the client's treatment or habilitation plan. A written statement shall be placed in the client's record that indicates the detailed reason for the restriction. The restriction shall be reasonable and related to the client's treatment or habilitation needs. A restriction is effective for a period not to exceed 30 days. An evaluation of each restriction shall be conducted by the qualified professional at least every seven days, at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's record. Restrictions on rights may be renewed only by a written statement entered by the qualified professional in the client's record that states the reason for the renewal of the restriction. In the case of an adult client who has not been adjudicated incompetent, in each instance of an initial restriction or renewal of a restriction of rights, an individual designated by the client shall, upon the consent of the client, be notified of the restriction and of the reason for it. In the case of a minor client or an incompetent adult client, the legally responsible person shall be notified of each instance of an initial restriction</p>	V 364		

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V 364	<p>Continued From page 8</p> <p>or renewal of a restriction of rights and of the reason for it. Notification of the designated individual or legally responsible person shall be documented in writing in the client's record.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure client rights to privacy in a 24 hour facility affecting 4 of 4 clients (#1, #2, #3, #4). The findings are:</p> <p>Review on 11/4/25 of client #1's file revealed: -Age 14 years old. -Admission 10/16/25. -Diagnoses: Attention Deficit Hyperactivity Disorder (ADHD); Post Traumatic Stress Disorder; Intermittent Explosive Disorder; Oppositional Defiant Disorder (ODD); Reactive Attachment Disorder.</p> <p>Review on 11/4/25 of client #2's file revealed: -Age 14 years. -Admission 8/27/25. -Diagnoses: ADHD; ODD.</p> <p>Review on 11/4/25 of client #3's file revealed: -Age 16 years old. -Admission 10/18/25. -Diagnoses: Major Depressive Disorder, with Anxiety Distress, Other Reaction to Severe Stress; ADHD, Combined; ODD.</p> <p>Review on 11/4/25 of client #4's file revealed: -Age 15 years old. -Admission 10/16/25.</p>	V 364		

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V 364	<p>Continued From page 9</p> <p>-Diagnoses: ADHD; Disruptive Mood Dysregulation Disorder.</p> <p>Interview on 10/30/25 with client #1 revealed: -Staff was present when phone calls were made and the call was placed on speaker.</p> <p>Interview on 10/30/25 with client #2 revealed: -When phone calls were placed, "staff is sitting next to me, calls are on speaker."</p> <p>Interview on 10/30/25 with client #3 revealed: -Phone calls were made with staff present, "they (staff) are not listening to the call, but listening to us (clients) speak to them (person on phone), to prevent us from cursing on the phone or getting in arguments or acting out...not on speaker, they (staff) just listen to us speak."</p> <p>Interview on 10/30/25 with client #4 revealed: -Phone calls were monitored by staff. -"Incoming calls from mom or family" have to be verified and "support (facility) staff listen. It's (call) put on speaker for staff to hear."</p> <p>Interview on 10/30/25 with staff #2 revealed: -Phone calls were monitored by staff, "they (clients) don't have to talk on speaker, but they do have to be in the presence of staff."</p> <p>Interview on 10/30/25 with staff #3 revealed: -Phone calls were monitored by staff, "someone (staff) is right there in from of them listening to the calls while they talk on the phone...the call is not on speaker."</p> <p>Interview on 11/4/25 with the Licensee/Director/Qualified Professional revealed: -Phone calls were not monitored by staff.</p>	V 364		

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V 364	Continued From page 10  -Was not aware that the client phone calls had been monitored. -Did not know that staff were having client phone calls placed on speaker. -"I have told them (staff) to supervise the call, meaning stay in the vicinity during the call, not put the call on speaker and listen." -Will review clients' right regarding phone call privacy with staff.	V 364		
V 366	27G .0603 Incident Response Requirements  10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers	V 366		

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V 366	<p>Continued From page 11</p> <p>shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.</p> <p>(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:</p> <p>(1) immediately securing the client record by:</p> <p>(A) obtaining the client record;</p> <p>(B) making a photocopy;</p> <p>(C) certifying the copy's completeness; and</p> <p>(D) transferring the copy to an internal review team;</p> <p>(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 services at the time of the incident. The internal review team shall complete all of the activities as follows:</p> <p>(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;</p> <p>(B) gather other information needed;</p> <p>(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</p> <p>(D) issue a final written report signed by the</p>	V 366		

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V 366	<p>Continued From page 12</p> <p>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</p> <p>(3) immediately notifying the following:</p> <p>(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;</p> <p>(B) the LME where the client resides, if different;</p> <p>(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;</p> <p>(D) the Department;</p> <p>(E) the client's legal guardian, as applicable; and</p> <p>(F) any other authorities required by law.</p> <p>This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to implement written policies governing their response to Level I and II incidents. The findings are:</p>	V 366		

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V 366	<p>Continued From page 13</p> <p>Review on 10/22/25 of former client (FC) #5's file revealed:</p> <ul style="list-style-type: none"> <li>-Age 16 years old.</li> <li>-Admission 8/14/25.</li> <li>-Discharged 9/12/25.</li> <li>-Emergency Dismissal Notice dated 9/12/25: "...formal documentation of the dismissal of [FC #5]...effective immediately, due to serious violations...that placed himself, other residents, staff and the home at significant risks. On September 6th - September 12th 2025, the following incidents occurred...displayed ongoing verbal aggression toward staff on a daily basis...left the residence multiple times without permission or supervision...walked down the driveway and into wooded areas, creating significant safety risks...Self Harm, September 6th...transported to Behavioral Health for evaluation...September 12th [FC #5] was observed exiting the restroom with a sharp metal object and a bandage...was seen bleeding from his hand. Staff conducted a thorough room search and located several sharp metal pieces. [FC #5] admitted to having more but refused to disclose their location. Police and emergency medical personnel were contacted...was transported for further evaluation...</li> <li>-Emergency Child and Family Team Meeting dated 9/16/25.</li> <li>-Diagnoses: Major Depressive Disorder, Moderate Episode; Oppositional Defiant Disorder; Attention Deficit Hyperactivity Disorder, Combined; Cannabis Use Disorder Mild; Tobacco Use Disorder Mild.</li> </ul> <p>Review on 10/22/25 of the facility's incident reports from 8/1/25 - 10/22/25 revealed:</p> <ul style="list-style-type: none"> <li>-9/12/25, FC #5 accused staff #3 of taking FC #5 to a vape shop, offering him a marijuana pen, an edible and told him "one blunt makes me high."</li> </ul>	V 366		

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V 366	<p>Continued From page 14</p> <p>-9/12/25, FC #5 reported he found marijuana stored in the living couch of the facility.</p> <p>-9/12/25, documentation of FC #5's room search</p> <p>-No documentation of FC #5's self injury and escalating behaviors from 9/6/25 to 9/12/25 as documented in the emergency dismissal notice dated 9/12/25.</p> <p>-No documentation of room search on 9/11/25 resulting in seizure of contraband in FC #5 bedroom.</p> <p>-No documentation of FC #5's elopements, "left the residence multiple times without permission or supervision", as documented in the emergency dismissal notice dated 9/12/25.</p> <p>There was no documentation of a risk cause analysis of the above incidence to support evaluation that the facility:</p> <p>-Attended to the health and safety needs of clients;</p> <p>-Determined the cause of the incidents;</p> <p>-Developed and implemented corrective measures.</p> <p>-Developed and implemented measures to prevent similar incidents.</p> <p>-Assigned persons to be responsible for implementation of the corrections and preventive measures.</p> <p>Interview 10/22/25 with staff #1 revealed:</p> <p>-Was aware that an investigations was one for the 9/12/25 allegation of staff #3 taking FC #5 to a vape shop, offering him a marijuana pen, an edible and told him "one blunt makes me high."</p> <p>-"I wasn't here (facility) that day."</p> <p>-The Licensee/Director/Qualified Professional (QP) was responsible for the investigation on 9/12/25, "I know the clients #1, #2) were interviewed."</p> <p>-Would have to check with the Licensee/Director/QP to see if staff #3 was taken</p>	V 366		

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V 366	Continued From page 15 off the schedule during the investigation.  Interview on 10/27/25 with staff #2 revealed: -Incident were done by the Licensee/Director/QP.  Interview on 11/4/25 with the Licensee/Director/Qualified Professional revealed: -She was the person responsible for reviewing incident reports. -She was responsible for investigation of all incidents. -Had not investigated other incidents. -She completed an investigation on 9/12/25 when FC #5 accused staff #3 of taking FC #5 to a vape shop, offering him a marijuana pen, an edible and told him "one blunt makes me high." -She interviewed clients (#1 and #2) and staff (#1, #2, #4 and the Associate Professional) and "found nothing to collaborate [FC#5]'s story." -Staff #3 completed his shift on 9/12/25, was scheduled off 9/13/25 - 9/14/25, and resumed his shift on 9/15/25. -Was "coming up with more forms" for better documentation processes.	V 366		
V 367	27G .0604 Incident Reporting Requirements  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	V 367		

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V 367	<p>Continued From page 16</p> <p>services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:</p> <ol style="list-style-type: none"> <li>(1) reporting provider contact and identification information;</li> <li>(2) client identification information;</li> <li>(3) type of incident;</li> <li>(4) description of incident;</li> <li>(5) status of the effort to determine the cause of the incident; and</li> <li>(6) other individuals or authorities notified or responding.</li> </ol> <p>(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:</p> <ol style="list-style-type: none"> <li>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or</li> <li>(2) the provider obtains information required on the incident form that was previously unavailable.</li> </ol> <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <ol style="list-style-type: none"> <li>(1) hospital records including confidential information;</li> <li>(2) reports by other authorities; and</li> <li>(3) the provider's response to the incident.</li> </ol> <p>(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A</p>	V 367		

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V 367	<p>Continued From page 17</p> <p>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:</p> <ol style="list-style-type: none"> <li>(1) medication errors that do not meet the definition of a level II or level III incident;</li> <li>(2) restrictive interventions that do not meet the definition of a level II or level III incident;</li> <li>(3) searches of a client or his living area;</li> <li>(4) seizures of client property or property in the possession of a client;</li> <li>(5) the total number of level II and level III incidents that occurred; and</li> <li>(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) through (4) of this Paragraph.</li> </ol> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report all level II incidents in the</p>	V 367		

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V 367	<p>Continued From page 18</p> <p>North Carolina Incident Response Improvement System (IRIS) within 72 hours of becoming aware of the incident. The findings are:</p> <p>Review on 10/22/25 of former client (FC) #5's file revealed:</p> <ul style="list-style-type: none"> <li>-Age 16 years old.</li> <li>-Admission 8/14/25.</li> <li>-Discharged 9/12/25.</li> <li>-Dismissal Notice dated 9/12/25: "...formal documentation of the dismissal of [FC #5]...effective immediately, due to serious violations...that placed himself, other residents, staff and the home at significant risks. On September 6th - September 12th 2025, the following incidents occurred...displayed ongoing verbal aggression toward staff on a daily basis...left the residence multiple times without permission or supervision...walked down the driveway and into wooded areas, creating significant safety risks...Self Harm, September 6th...transported to Behavioral Health for evaluation...September 12th [FC #5] was observed exiting the restroom with a sharp metal object and a bandage...was seen bleeding from his hand. Staff conducted a thorough room search and located several sharp metal pieces. [FC #5] admitted to having more but refused to disclose their location. Police and emergency medical personnel were contacted...was transported for further evaluation...</li> <li>-Diagnoses: Major Depressive Disorder, Moderate Episode; Oppositional Defiant Disorder; Attention Deficit Hyperactivity Disorder, Combined; Cannabis Use Disorder Mild; Tobacco Use Disorder Mild.</li> </ul> <p>Reviews on 10/22/25 of the facility's incident reports from 8/1/25 - 10/22/25 revealed: 9/12/25, FC #5 accused staff #3 of taking FC #5</p>	V 367		

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V 367	<p>Continued From page 19</p> <p>to a vape shop, offering him a marijuana pen, an edible and told him "one blunt makes me high." 9/12/25, FC #5 reported he found marijuana stored in the living couch of the facility.</p> <p>Review on 10/22/25 of IRIS from 8/1/25 - 10/22/25 revealed:</p> <ul style="list-style-type: none"> <li>-No submission of incidents in IRIS.</li> <li>-No level II report of FC #5's self injury and escalating behaviors 9/6/25 to 9/12/25.</li> <li>-No reports for police contacts to the facility twice on 9/7/25 and twice on 9/12/25.</li> <li>-No level II report of FC #5's accusation of staff #3 of taking FC #5 to a vape shop, offering him a marijuana pen, an edible and told him "one blunt makes me high."on 9/12/25.</li> <li>-No level II report of room search on 9/11/25 resulting in contraband used by FC #5 to self harm.</li> <li>-No level II report FC #5 "left the residence multiple times without permission or supervision."</li> </ul> <p>Interview on 10/27/25 with staff #2 revealed:</p> <ul style="list-style-type: none"> <li>-Incident were done by the Licensee/Director/QP.</li> </ul> <p>Interview on 11/4/25 with the Licensee/Director/Qualified Professional revealed:</p> <ul style="list-style-type: none"> <li>-She was the person responsible for reviewing incident reports.</li> <li>-She was the person responsible for reporting in IRIS.</li> <li>-She was responsible for investigation of all incidents.</li> <li>-Had not investigated other incidents.</li> <li>-She completed an investigation on 9/12/25 when FC #5 accused staff #3 of taking FC #5 to a vape shop, offering him a marijuana pen, an edible and told him "one blunt makes me high."</li> <li>-She interviewed clients (#1 and #2) and staff (#1,</li> </ul>	V 367		

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V 367	Continued From page 20  #2, #4 and the Associate Professional) and "found nothing to collaborate [FC#5]'s story." -Staff #3 completed his shift on 9/12/25, was scheduled off 9/13/25 - 9/14/25, and resumed his shift on 9/15/25. -Reported she had submitted the 9/12/25 incidents with FC #5 in IRIS. -Had been calling contact listed for IRIS and "all the numbers were disconnected." -She had verification number from IRIS for the 9/12/25 incident and the incident on 9/6/25 that she thought had been submitted in IRIS. -Had not entered reports in IRIS correctly. -Was "coming up with more forms" for better documentation processes.	V 367		
V 500	27D .0101(a-e) Client Rights - Policy on Rights  10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy	V 500		

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V 500	<p>Continued From page 21</p> <p>that identifies:</p> <p>(1) any restrictive intervention that is prohibited from use within the facility; and</p> <p>(2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client.</p> <p>(d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify:</p> <p>(1) the permitted restrictive interventions or allowed restrictions;</p> <p>(2) the individual responsible for informing the client; and</p> <p>(3) the due process procedures for an involuntary client who refuses the use of restrictive interventions.</p> <p>(e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes:</p> <p>(1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E);</p> <p>(2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and</p> <p>(3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention.</p>	V 500		

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V 500	<p>Continued From page 22</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure all incidents of alleged abuse were reported to the county Department of Social Services (DSS). The findings are:</p> <p>Review on 10/22/25 of the facility incident reports revealed: -9/12/25 incident report of allegation of staff #3 taking FC #5 to a vape shop, offering him a marijuana pen, an edible and told him "one blunt makes me high." -9/12/25, Licensee/Director/Qualified Professional (QP)'s internal investigation of #3 of taking FC #5 to a vape shop, offering him a marijuana pen, an edible and told him "one blunt makes me high."</p> <p>Interview with on 10/30/25 with client #1 revealed: -Knew FC #5 "he [FC #5] was smoking, I think, probably." -Was not sure where FC #5 was getting vapes and marijuana from, "he (FC #5) didn't say where he got it from." -"I wasn't with him (FC #5) and I didn't hear him talking to [staff #3] about smoking." -The Licensee/Director/Qualified Professional (QP) "talked to us (clients #1 and #2) , she didn't ask any questions, she just asked if we knew anything about it and whether we heard [staff #3] talking about smoking marijuana." -The Licensee/Director/QP asked did we (client #1 and #2) know he (FC #5) had weed and did we know where he got it from. -No staff had ever taken anyone to a vape shop and "I have never heard [staff #3] talking about vaping or smoking marijuana."</p> <p>Interview on 10/30/25 with client #2 revealed:</p>	V 500		

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NAME OF PROVIDER OR SUPPLIER  <b>GIVING HOPE FOR ALL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3715 HUBBARD ROAD</b> <b>CHARLOTTE, NC 28269</b>
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V 500	<p>Continued From page 23</p> <p>-"I knew [FC #5] when he was here (facility)."                      -"I don't know anything about vapes or smoking; no one here (facility) uses vapes or smokes."                      -Had not heard staff #3 talking to FC #5 "about smoking marijuana and [staff #3] never took us (clients) to a vape store."</p> <p>Interview on 10/30/25 with staff #2 revealed:                      -In September, FC #5 "accused [staff #3] of taking him (FC #5) to a vape store, but that is a lie and can be debunked because he (FC #5) would have never been alone with staff."</p> <p>Interview on 10/30/25 with staff #3 revealed:                      -Had been working at the facility "since the facility first opened."                      -There were past incident when FC #5 "...was caught smoking in the bedroom (FC #5). I don't remember the exact date, it was the first time he (FC #5) was caught."                      -FC #5 had been "...acting out, being rebellious and didn't want to stay in his room while on room restriction, he was disrespectful and was making racial slurs."                      -"I couldn't tell what he (FC #5) was smoking; I could just see the smoke, he was in the bathroom (ensuite) that was in his bedroom."                      -Staff #3 denied the allegation (9/12/25) of taking FC #5 to a vape shop, offering him a marijuana pen, an edible and told him "one blunt makes me high."                      -"I don't know where the allegation (9/12/25) came from about the vape store, because I never took him (FC #5) to a vape store; I never had a conversation with him about marijuana, there was never any talk about it (marijuana)."</p> <p>Interview on Interview on 11/4/25 with the Licensee/Director/Qualified Professional revealed:</p>	V 500		

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V 500	Continued From page 24  -Was person responsible for reporting incidents of allegations involving staff to DSS. -Had started the investigation on 9/12/25 of the allegation of staff #3 taking FC #5 to a vape shop, offering him a marijuana pen, an edible and told him "one blunt makes me high." -Staff #3 had continued on the schedule and denied the allegation (9/12/25). -Had not reported the allegation to DSS of staff #3 taking FC #5 to a vape shop, offering him a marijuana pen, an edible and told him "one blunt makes me high."	V 500		
V 503	27D .0103 Client Rights - Search And Seizure Policy  10A NCAC 27D .0103 SEARCH AND SEIZURE POLICY (a) Each client shall be free from unwarranted invasion of privacy. (b) The governing body shall develop and implement policy that specifies the conditions under which searches of the client or his living area may occur, and if permitted, the procedures for seizure of the client's belongings, or property in the possession of the client. (c) Every search or seizure shall be documented. Documentation shall include: (1) scope of search; (2) reason for search; (3) procedures followed in the search; (4) a description of any property seized; and (5) an account of the disposition of seized property.  This Rule is not met as evidenced by: Based on record review and interview, the facility	V 503		

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V 503	<p>Continued From page 25</p> <p>failed to ensure every search or seizure was documented as required. The findings are:</p> <p>Review on 10/31/25 of former client (FC) #5's file revealed: -Age 16 years old. -Admission 8/14/25. -Diagnoses: Major Depressive Disorder, Moderate Episode; Oppositional Defiant Disorder; Attention Deficit Hyperactivity Disorder, Combined; Cannabis Use Disorder Mild; Tobacco Use Disorder Mild.</p> <p>Review on 10/22/25 of the facility's records revealed: -No documentation of a search of FC #5's bedroom on 9/11/25.</p> <p>Interview on 10/30/25 with client #1 revealed: -"I have never had a room search but there was one person who had their room searched, [FC #5] did; I saw them (staff) searching his room, I think it has happened twice (dates unknown)." -The Licensee/Director/Qualified Professional (QP) and staff #2 "did the search of [FC #5]'s room." -Was not told why staff was searching FC#5's bedroom.</p> <p>Interview on 10/30/25 with client #2 revealed: -Had never been searched other than the initial search at admission (8/27/25). -Had not seen staff search peers.</p> <p>Interview on 10/30/25 with client #3 revealed: -Had been searched "when we (clients) initially came in at admission (10/18/25)." -Had not been searched or had his room searched since admission. -Had never seen anyone else searched.</p>	V 503		

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V 503	<p>Continued From page 26</p> <p>Interview on 10/30/25 with client #4 revealed: -Had not had his room searched and had not seen peers' rooms searched.</p> <p>Interview on 10/30/25 with staff #1 revealed: -The facility had done room searched. -No room search had "been done lately." -"We (staff) search their (clients) personal belongings when they first come into the facility (admission)." -Had searched FC #5 "the time he (FC #5) acted out, that was last month (September 2025) that the search was done."</p> <p>Interview on 10/30/25 with staff #2 revealed: -The facility had documented searches. -Staff had client pull out clothing pockets, but not "touching" clients. -Had done a room search with staff #1 for FC #5 (September 2025). -FC #5 "had crunched up pills on his nightstand and that's what made us (staff) search; he (FC #5) said it was [Acetaminophen]." -FC #5 had a bottle of acetaminophen in his bedroom, "I don't know where he got it (acetaminophen) from, which concerned us (staff)." -In September 2025, staff and clients stopped a local store, FC #5 "said he had to go the restroom" and was accompanied by staff #3 "to the restaurant next door to use the bathroom." -Staff #3 went in the bathroom with FC #3 "to check that no one else was in the bathroom." -Staff #3 checked, made sure noone else was in the bathroom, "but he didn't stay in there with him (FC #5)." -"...and when [FC #3] came out of the bathroom he was smelling like weed...We did a search on that day too, that was in September (2025)."</p>	V 503		

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V 503	<p>Continued From page 27</p> <p>-"The only thing we (staff) could do was search him (FC #5); we would check his book bag; we had no real way of trying to figure out what was going on with him..."</p> <p>Interview on 10/22/25 with the Licensee/Director/QP revealed:</p> <ul style="list-style-type: none"> <li>-Conducted random room searches if contraband was suspected.</li> <li>-"The room sweep is when we go in the room because we have suspicions; the search is more so looking through things to make sure there is nothing inappropriate; the sweep is we are removing the residents and checking all corners of the room"</li> <li>-Suspected FC #5 and staff #3 "observed the client smoking inside bedroom."</li> <li>-Was responsible for ensuring the documentation of room searches.</li> <li>-"I didn't do a search report for that (9/11/25 search)."</li> </ul>	V 503		