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V 000	INITIAL COMMENTS A follow-up survey was completed on April 2, 2025. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600B Supervised Living for Minors with Developmental Disability. This facility is licensed for 4 and has a current census of 2. The survey sample consisted of audits of 2 current clients.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to develop and implement goals and strategies in the treatment plan to address the clients' needs for two of two clients (#1 and #2) and failed to obtain a written consent by a guardian for one of two clients (#1). The findings are:

Finding #1:
Review on 3/25/25 and 4/1/25 of client #1's record revealed:
-15 years old.
-Date of Admission: 8/28/24.
-Diagnoses: Intellectual Developmental Disorder-Moderate, Oppositional Defiant Disorder (ODD) - Moderate, Attention Deficient Hyperactivity Disorder (ADHD), Predominantly inattentive presentation, High expressed emotion level within family, Sibling relational problem and Academic or educational problem.
-Comprehensive Clinical Assessment (CCA) dated 9/25/24: "Presenting Complaints and History of the Problem: ...August of 2023 to February 2024, [Client #1] had two hospitalizations due to suicidal ideation and attempting suicide by standing on balcony outside of the guard rails and by pulling a knife... [Client #1] walked into traffic, jumped into a pool and attempted to jump off/sit on a balcony opposite of the guard rails, with the intention of harming himself."

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V 112	Continued From page 2 -Person Centered Plan (PCP) (Treatment Plan) dated 9/25/24: "Short-range Goal 1: Over the next six months, [Client #1] will improve emotional regulation as evidenced by learning and using positive coping skills to address mental health symptoms at least 5 out of 7 days per week, and will utilize effective communication skills so that he can verbally express his emotions at least 5 out of 7 days per week." -The PCP did not include strategies to address suicidal ideation or suicidal attempts. -The PCP did not contain documentation of a written consent by the guardian. Interview on 3/25/25 client #1 stated: -He had lived at the facility for a few months. -He did not know what his goals were. Finding #2 Review on 3/25/25 and 4/1/25 of client #2's record revealed: -14 years old. -Date of Admission: 1/24/25. -Diagnoses: Moderate Intellectual Disabilities, Reaction to Severe Stress, ODD, Unspecified Trauma and Stressor Related Disorder. -Individual Support Plan (ISP) (Treatment Plan) dated 1/17/25: "Long-range Goal 1..."[Client #2] requires Residential Supports Level 4 as he requires one on one support and close supervision to make sure he is healthy and safe and due to extreme high behaviors such as: inappropriate sexual behaviors, stealing, bullying others in the home (facility), community and school, profanity, verbal aggression, and property damage." -"Long-range Goal 2: [Client #2] will increase independence and community access skills acquisition....Where I am now: [Client #2] attendance to the [local fitness center] will help	V 112		

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him stay healthy by walking, participating in swimming, playing basketball, and completing other classes which will also help with inclusion within the community."
-"Behavioral Health Support Needs: [Client #2] shows sexual aggression and inappropriate sexual behaviors. [Client #2] is court ordered to not use ANY ELECTRONICS due to breaking the 65 TV (television) and searching and watching inappropriate websites."
-There were no strategies to address client's inappropriate sexual behaviors, no electronic use as court order or attendance at the local fitness center.

Interview on 3/25/25 client #2 stated:
-He did not remember if staff "went over" his goals with him.
-His goals were personal space and hygiene.
-Staff helped him with his goals.
-He had not attended the local fitness center since he had been admitted to the facility.

Interview on 4/1/25 client #2's Department of Social Services (DSS) legal guardian stated:
-She was not aware of client #2's residential goals.
-The Operations Manager had stated the facility worked with client #2 on anger management, personal boundaries and telling the truth.
-Client #2 had a membership to the local fitness center.
-Client #2 needed a monitoring goal for sexualized behaviors and looking at pornography online.
-Client #2 could use electronics but needed to "be monitored."

Interview on 4/2/25 client #2's Local Management Entity/Managed Care Organization (LME/MCO)

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V 112	Continued From page 4 Care Manager stated: -She was responsible for the development of the long range goals for client #2. -The facility was to develop short range goals. -Goals and strategies were based on what they were trying to achieve for client #2. -She would review the facility's short range goals during her upcoming quarterly assessment. -Client #2 needed monitoring goals to address what he said or watch due to his sexualized behaviors. -Client #2 was court ordered not to have electronics due to breaking a TV, watching pornography online and contact with his family. Interview on 3/25/25 staff #1 stated: -She was not aware any strategies for the clients' goals. Interview on 3/25/25 staff #2 stated: -Staff received instruction on how to implement the goals at staff meetings every month. Interview on 3/25/25 staff #3 stated: -Staff worked on 9-14 goals a day with the clients. -There was a monthly staff meeting with the Director of Services/Qualified Professional (DOS/QP) to discuss goals in online documentation system. -"If a new client comes we will see the interactions of the client and that is how we see how we as staff are to address their goals." -"I see goals in online documentation system I don't see strategies, we are basically making our own strategies." Interview on 4/1/25 staff #4 stated: -There was a list of goals in online documentation system. -"I have not seen what staff is to do to help	V 112		

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V 112	Continued From page 5 toward the goals." -"I have not seen it before, but now I do. The goals sections looks a little different than before right now." Interview on 3/25/25 the Office Administrator stated: -"Per the QP (DOS/QP) the short range goals are not in [online documentation system] because they don't have an ISP." -She could not locate short range goals for either client. -In order to see the goals in online documentation system she had to acknowledge the goals. Interview on 3/25/25 the Operations Manager stated: -Staff document progress towards goals in the online documentation system. -The DOS/QP will develop the goals and implement the goals in online documentation system. Interviews on 3/25/25, 3/26/25 and 4/1/25 the DOS/QP stated: -She was responsible for the development of the short range goals for the treatment plan. -Client #1 "does not receive residential services." -"[Client #1] receives a new service according to his LME/MCO care manager he does not require an ISP plan for that particular service." -She developed residential goals for client #2 so "my staff would have something work on." -She did not have any strategies for goals identified for client #1 or client #2. -Staff document progress towards the goals. -The strategies may be in the online documentation system. -It may be something only she as the DOS/QP could see, not direct care staff.	V 112		

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V 112	Continued From page 6 3/26/25 -She was able to print strategies from the online documentation system. -Staff had to acknowledge the goal to see the strategies. -The strategies were always in the online documentation system. -The strategies were developed when the treatment plan was completed. -"If it was not included, I will go in and include inappropriate sexual behaviors." 4/1/25 -"[Client #1] did not want his past suicidal ideation included in his treatment plan." -Client #2 was admitted to the facility with a completed treatment plan. Interview on 4/1/25 the Licensee stated: -"[Client #1's] past suicidal ideation should be included in the Behavioral Plan not the ISP." -"The ISP is based on what is happening now, not in the past." -"[Client #1] did not want the past suicidal ideation in his treatment plan." -"It would be a client's rights issue to put what the client doesn't want in their own treatment plan." Review on 4/1/25 of the Plan of Protection (POP) dated 4/1/25 written by the DOS/QP revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? As stated, Shinelight (Licensee) was not a part of the individual initial ISP plan. Everything discussed during meetings was listed in the plan. Goals are created from the long range goals in the plan. Whatever is mentioned in the persons plan is where the goals come from, not past evaluations. Anything that the staff needs to work on for that individual will be part of the goals, based off of conversations with that 'person' and	V 112		

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the team.
-Describe your plans to make sure the above happens. Same as above. Make sure that whatever the individual wants in the plan is in the plan. Goals and strategies will address the 'needs' of the 'person''

Review on 4/1/25 of the revised POP dated 4/1/25 written by the DOS/QP revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care? Plan is based off of person. The things that are 'currently' taking place in the person life. Staff are trained, and made aware of past events. As stated, a meeting/training took place on Jan (January) 21 2025. Each staff will confirm as they were all there. They all have access to his information with the guardians consent. Past events will not be placed in any of our peoples (clients) ISP unless the individual state that is what they want, as it is their right to do so or not
-Describe your plans to make sure the above happens. As we currently do, staff will meet with previous team to be made aware of past events that have occurred in the persons past. This why they are aware of what to do if it occurs. If situation occurs, then a plan will be immediately put in place to update ISP, but only if a past incident occurs, which it has not in the 8 months individual has been with Shinelight"

Client #1 and Client #2 ages 14 &15 had diagnoses that included Moderate Intellectual Disabilities, Reaction to Severe Stress, Oppositional Defiant Disorder and Unspecified Trauma-and Stressor Related Disorder. Client #1 had a history of suicidal attempts which included he had walked in traffic, and pulled a knife, got on a ledge and jumped in a pool all with the intent of

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V 112	Continued From page 8 self harm which resulted in hospitalizations for suicidal attempts or suicidal behaviors. Client #1's PCP did not include any strategies to address his self harm behaviors and was not signed by his legal responsible party. Client #2 had a history of inappropriate sexual behaviors and a court order for no electronic use. Client #2's treatment plan did not include strategies to address inappropriate sexual behaviors, and he was court ordered for no electronic use and to attend the local fitness center. The direct care staff responsible to work with the clients were not aware of any strategies documented to meet the needs of client #1 and client #2. This deficiency constitutes a Continuing Type A1 rule violation originally cited for serious neglect for failure to correct within 23 days.	V 112		
V 318	13O .0102 HCPR - 24 Hour Reporting 10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g).	V 318		

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V 318	Continued From page 9 This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to notify Health Care Personnel Registry (HCPR) within 24 hours of becoming aware of allegations of abuse affecting one of five audited current staff (#2). The findings are: Division of Health Service Regulation Surveyor (DHSR) made Director of Services/Qualified Professional (DOS/QP) aware on 3/26/25 during the DHSR survey of an allegation made by client #2 that staff #2 had put him in a chokehold and pushed him against the wall. Review on 3/26/25 of staff #2's record revealed: -Date of hire: 5/18/2023. -Job title: Direct Support Professional. Review on 4/1/25 of the North Carolina Incident Response Improvement System (IRIS) revealed there were no level III IRIS report to include the HCPR notification for staff #2. Interview on 4/1/25 the DOS/QP stated: -She was responsible for incident reporting. -She had not completed the HCPR notification of the incident reported to her on 3/26/25. -She did not report to the HCPR because she had completed an investigation and found allegations to be not true. No documentation was provided by the DOS/QP of the HCPR notification for staff #2 at exit.	V 318		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR	V 366		

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V 366	Continued From page 10 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 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;	V 366		

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V 366	Continued From page 11 (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 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:	V 366		

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V 366	Continued From page 12 (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; (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 interview the facility failed to implement a policy governing their response to Level II or III incidents as required. The findings are: The Division of Health Service Regulation Surveyor (DHSR) made the Director of Services/Qualified Professional (DOS/QP) aware on 3/26/25 during the DHSR survey of an allegation made by client #2 that staff #2 had put him in a chokehold and pushed him against the wall. Review on 3/25/25 of client #2's record revealed: -14 year old male. -Date of Admission: 1/24/25. -Diagnoses: Moderate Intellectual Disabilities, Reaction to Severe Stress, Attention Deficient Hyperactivity Disorder and Unspecified Trauma and Stressor Related Disorder.	V 366		

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V 366	Continued From page 13 Review on 3/26/25 of staff #2's record revealed: -Date of Hire: 5/2023. -Job Title: Direct Support Professional. Interview on 3/25/25 client #2 stated: -Staff #2 pushed him against the wall and put him in a chokehold. -He could not remember the exact date of the incident. Interviews on 3/26/25 and 4/1/25 the DOS/QP stated: -She was responsible to implement the policies and respond to level III incidents. -She had not determined the cause of the incident or followed the facility's policy in response to the incident. -She had not completed an internal investigation after being notified on 3/26/25 of an allegation of abuse as reported by client #2 against staff #2.	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 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,	V 367		

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V 367	Continued From page 14	V 367		

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, 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

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V 367	Continued From page 15 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) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure an incident report was submitted to the Local Management Entity (LME)/Managed Care Organization (MCO) within 72 hours as required. The findings are:	V 367		

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V 367	Continued From page 16 The Division of Health Service Surveyor (DHSR) made the Director of Services/Qualified Professional (DOS/QP) aware on 3/26/25 during the DHSR survey of an allegation made by client #2 that staff #2 had put him in a chokehold and pushed him against the wall. Review on 3/25/25 of client #2's record revealed: -14 year old male. -Date of Admission: 1/24/25. -Diagnoses: Moderate Intellectual Disabilities, Reaction to Severe Stress, Attention Deficient Hyperactivity Disorder and Unspecified Trauma and Stressor Related Disorder. Review on 3/26/25 of staff #2's record revealed: -Date of hire: 5/18/2023. -Job title: Direct Support Professional. Review on 4/1/25 of the North Carolina Incident Response Improvement System (IRIS) revealed there was no level III report submitted within 72 hours as required. Interview on 3/25/25 client #2 stated: -Staff #2 pushed him against the wall and put him in a chokehold. -He could not remember the exact date of the incident. Interview on 4/1/25 the DOS/QP stated: -She had not completed an IRIS report or internal investigation. No documentation was provided by the DOS/QP of an incident report for the allegation of abuse which pertained to and reported by client #2 at exit.	V 367		

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V 500	Continued From page 17	V 500		
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 that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (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: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an	V 500		

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V 500	Continued From page 18 involuntary client who refuses the use of restrictive interventions. (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: (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); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to report to the Department of Social Services (DSS) in the county where services are provided all allegations of suspected abuse by health care personnel. The findings are: The Division of Health Service Surveyor (DHSR) made the Director of Services/Qualified Professional (DOS/QP) aware on 3/26/25 during the DHSR survey of an allegation made by client #2 that staff #2 had put him in a chokehold and pushed him against the wall. Review on 3/25/25 of client #2's record revealed:	V 500		

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V 500	Continued From page 19 -14 year old male. -Date of Admission: 1/24/25. -Diagnoses: Moderate Intellectual Disabilities, Reaction to Severe Stress, Attention Deficient Hyperactivity Disorder and Unspecified Trauma and Stressor Related Disorder. Review on 3/26/25 of staff #2's record revealed: -Date of hire: 5/18/2023. -Job title: Direct Support Professional. Interview on 3/25/25 client #2 stated: -Staff #2 pushed him against the wall and put him in a chokehold. -He could not remember the exact date of the incident. Interviews on 3/26/25 and 4/1/25 DOS/QP stated: -She was responsible to report incidents of allegations of abuse, neglect or exploitation. -She did not report the allegations of abuse when she was made aware of on 3/26/25 to the local DSS. -She did not report to DSS because she had completed an investigation and found allegations to be not true.	V 500		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through	V 512		

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V 512	Continued From page 20 established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on record reviews, observation, and interviews, one of five staff (#2) abused one of two clients (#2). The findings are: Review on 3/26/25 of staff #2's record revealed: -Date of hire: 5/18/2023. -Job title: Direct Support Professional. Review on 3/25/25 and 4/1/25 of client #2's record revealed: -14 years old. -Date of Admission: 1/24/25. -Diagnoses: Moderate Intellectual Disabilities, Reaction to Severe Stress, Oppositional Defiant Disorder, Unspecified Trauma-and Stressor Related Disorder. Review on 3/26/25 of the facility's "A-B-C Checklist" (Antecedent/before behavior-Behavior-Consequence/after behavior) completed 3/5/25 revealed:	V 512		

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V 512	Continued From page 21 -"Name:[Client #2] -Date: 3/5/25 -Time: 6:30 am -Location: Bedroom -Antecedent: Did not want to get out the bed for school. Started cursing at staff and attempted to hit staff but staff moved. After about a couple of minutes he got dressed and went to school -Behavior: Verbal threats to staff, using profanity/cursing, grabbing/hitting/swinging/punching at someone: staff, refusing to get ready for school -Consequences: Used coping skill: Time-out/cool-down, duration: 5 min (minutes), place: bedroom -[Client #2] later apologized and said that he was just upset and had nothing to do with staff but he was thinking about stuff before he came to group home -Staff/Observer: [Staff #2]." Observation on 3/25/25 during a tour of the facility between 4:46 pm - 5:05 pm revealed: -Client #2's bedroom wall had a hole approximately one foot in diameter below the left window. Interview and observation on 3/25/25 at 3:45 pm client #2 stated: -He was not getting up for school "fast enough" for staff #2. -"[Staff #2] would not leave me alone." -"I got out of the bed and [Staff #2] pushed me against the wall." -"He pushed me very hard against the wall with force." -His head hit the wall when he was pushed by staff #2. -He did not tell any staff about his head hitting the wall when pushed by staff #2.	V 512		

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-"I felt dizzy when I hit my head."
-"My head still hurts a little bit in the back."
-Staff #2 put him in a chokehold.
-Client #2 demonstrated how staff #2 put him in a chokehold by wrapping his arm around his neck and applied pressure.
-He could "not breathe" during the chokehold.
-He broke away from the chokehold and they both fell on the ground.
-"[Staff #2] hit the wall" when they fell which caused "a hole" in his wall.
-He told the Operations Manager about the incident the same day (3/5/25), that "[staff #2] put me in a restraint."
-He did not tell the Operations Manager any other information about the incident.
-He was not sure the exact date of the chokehold and being pushed against the wall by staff #2.
-The chokehold happened a few weeks ago on a Monday at approximately 6:30 am (3/5/25) in his bedroom.

Interview on 4/1/25 client #2's Department of Social Services legal guardian stated:
-She was contacted by the Operations Manager who informed her of a "state review."
-The Operations Manager stated client #2 was "dishonest" with the Division of Health Services Regulation (DHSR) Surveyors but she did not go into detail.
-She was not informed of an allegation made by client #2.
-She observed client #2's bedroom in February 2025 and there were no holes in the wall.

Interview on 3/25/25 and 4/1/25 client #1 stated:
-There was an incident about a month ago between client #2 and staff #2.
-He was awakened by client #2 "going back and forth" with staff #2.

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V 512	Continued From page 23 -He heard client #2 say "I will beat your 'a' word." -He went to his bedroom door and saw across the hall staff #2 sitting on client #2's back. -Staff #2 straddled client #2 with his feet on the ground facing client #2's head. -Staff #2 said to client #2 "When I let you go, you better not do anything else." -He also heard during the incident staff #2 tell client #2 "If you touch me again I will have to put you down." -He told the Operations Manager about the incident the same day (3/5/25), that "[staff #2] sat on [client #2]'s back." Interview on 3/25/25 staff #1 stated: -She was informed during shift change of "an altercation" between staff #2 and client #2. -The hole in the wall came from the "altercation." -She did not have any additional information about the incident. Interview on 3/25/25 staff #2 stated: -There was an incident with client #2 a few weeks ago. -He tried to wake client #2 up for school several times. -He turned the lights on in client #2's bedroom and pulled the cover off of client #2's face. -Client #2 yelled at him to get out of his room. -Client #2 got out of bed and "tried to punch at me, but I moved." -He left client #2's room and called his supervisor, the Operations Manager, to inform her about the incident. -When he returned to client #2's bedroom, client #2 was getting dressed for school. -Client #2 left after the incident and went to school. -The incident happened in a 5-10 minute timeframe.	V 512		

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V 512	Continued From page 24 -No restraint was used on client #2. -He did not put client #2 in a chokehold or push him against the wall. -Client #2 did not hit his head against the bedroom wall. -He completed an A-B-C checklist regarding the incident. -The hole in client #2's wall came from a discharged client. Interview on 4/1/25 staff #4 stated: -He was aware of one incident between client #2 and staff #2 in March 2025. -The facility had a group chat that communicated the house needs. -He learned from staff #2 about an incident that happened with client #2. -He was told that client #2 "came at" staff #2. -He did not know what happened next. -There was a hole in the wall and a desk which was destroyed from the incident on 3/5/25. -He was unsure on how the hole got in the wall during the incident on 3/5/25. Interviews on 3/25/25 and 3/26/25 the Operations Manager stated: -Staff #2 had a difficult time waking up client #2 up for school on 3/5/25. -Client #2 "attempted to push" staff #2. -Staff #2 moved out of the way. -She was not aware of any other "altercation between the two." -She was not aware of any holds or restraints used. -Client #2 said he was upset when staff #2 "tapped his shoulder" to wake him up. -Client #1 told her staff #2 had a "hard time" getting client #2 up for school every morning. -She denied being aware of staff #2 putting client #2 in a chokehold or pushing him against the	V 512		

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wall.
-Client #2 did not complain about his head hurting.
-The hole in the wall in client #2's bedroom was from a discharged client and not from this incident.

Interviews on 3/26/25 and 4/1/25 the Director of Services/Qualified Professional (DOS/QP) stated:
-She was "not surprised" with client #2's allegation against staff #2.
-She was only informed that client #2 tried to hit staff #2.
-Staff #2 was able to move out of the way and was not hit.
-Client #2 denied trying to hit staff #2.
-Client #2 denied being put in a chokehold or being pushed against the wall and hitting his head.
-"I did not speak to [Staff #2] because I had the A-B-C data sheet and I already knew about that situation."
-It was not reported to her that the incident resulted in a hole in the wall.
-The hole in client #2's bedroom wall was there before client #2 was admitted to the facility.

Interview and Observation on 4/1/25 at 3:00 pm the Licensee stated:
-She was recently at the facility neither client #1 or client #2 reported allegations to her.
-"We will put cameras in the bedroom."
-During exchange with the DOS/QP, "Put in the POP (Plan of Protection) we are going to put cameras in the bedroom, if they (DHSR) don't like it we will discharge [client #2]."

Review on 4/1/25 of the POP dated 4/1/25 written by the DOS/QP revealed:
-"What immediate action will the facility take to

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V 512	Continued From page 26 ensure the safety of the consumers in your care? If a person served makes an allegation, after completing internal review agency will report to the proper people/persons within the expected timeline. After internal investigation, individual stated that he did not state those allegations about staff to anyone. -Describe your plans to make sure the above happens. QP (DOS/QP) will continue to complete training on abuse, neglect and exploitation, and duty to report" Review on 4/1/25 of the revised POP dated 4/1/25 written by the DOS/QP revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? In the event of an allegation, QP (DOS/QP) will complete internal review. Staff will be removed from schedule until after investigation is over. If allegation is true, proper people/persons will be notified. HCPR (Health Care Personal Registry), guardians, DSS. Internal interview was completed and individual stated that he did not say any of those things mentioned, therefore staff was not removed from schedule. Individual will be discharged from Shinelight (Licensee) if he lies again against staff and a camera will be placed in his room -Describe your plans to make sure the above happens. Continue to complete training on abuse, neglect, and exploitation" The facility served clients ages 14 and 15 years old with diagnoses to include Moderate Intellectual Disabilities, Reaction to Severe Stress, Oppositional Defiant Disorder, Unspecified Trauma-and Stressor Related Disorder, Predominantly inattentive presentation, High expressed emotion level within family,	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-330	A. BUILDING: _____ B. WING _____	R 04/02/2025

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V 512	Continued From page 27 Sibling relational problem and Academic or educational problem. On 3/5/25 at approximately 6:30 am, staff #2 attempted to awake client #2 for school. Client #2 got of of bed and per client #2 he was not getting ready fast enough and staff #2 pushed him hard against the wall and client #2 hit his head and became dizzy. Staff #2 fell into the wall and it caused a hole in client #2's bedroom wall. Client #2 pushed staff back and staff #2 placed client #2 in a chokehold and client #2 was unable to breathe. Client #2 attempted to free himself from the chokehold, client #2 and staff #2 both fell to the ground. Client #1 observed staff #2 sitting on client #2's back straddled client #2 with his feet on the ground facing client #2's head. This deficiency constitutes a continuing Type A1 rule violation originally cited for serious abuse for failure to correct within 23 days.	V 512		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interviews the facility was not maintained in a safe, clean and attractive manner. The findings are: Observation on 3/25/25 from approximately 4:46 pm-5:15 pm revealed: -The front storm door had the glass part of the door removed/gone from the door. -Front side light windows had a towel which covered the broken window.	V 736		

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V 736	Continued From page 28 -The stair rails which led to the downstairs area was loose on both sides. -The left stair rail leading upstairs was loose and missed a connector to the wall. -The hall closet upstairs had no knob. -The hallway bathroom door did not latch. -The left bathroom door did not have a door knob. -Client #1's bedroom door had a hole on the left side approximately 6 inches long, the screen on the window had a tear approximately 6 inches long and the connected bathroom had approximately 6 loose tiles on the floor that were soft to the step/touch. -Client #2's bedroom door frame had a crack in it and not flush to the wall, there was hole approximately 4 inches in diameter to the right of the closet door and there was a hole under the left window approximately one foot wide near the baseboard. -Vacant bedroom #1 had an electrical receptacle covering missing on the left side of the room. -The hallway ceiling had an approximate 3 foot by 3 foot square shaped area that was discolored with dark residue. Interview on 3/25/25 the Operations Manager stated: -"I knew there was some property damage that needed to be fixed before [client #2] moved into his bedroom, but the they (guardian)wanted him to be moved in so quick." -A work order was completed when something was broken in the facility. -A maintenance company would come to the facility to repair it. Multiple attempts made on 4/1/25 to contact Operation Manager, no call back or response by exit of survey.	V 736		

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V 736	Continued From page 29 Interview on 3/25/25 the Director of Services/Qualified Professional stated: -Maintenance had been notified to fix the holes in client #2's bedroom. -The maintenance company had been at the facility doing various maintenance work in the last two weeks. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		
V 774	27G .0304(d)(7) Minimum Furnishings 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (d) Indoor space requirements: Facilities licensed prior to October 1, 1988 shall satisfy the minimum square footage requirements in effect at that time. Unless otherwise provided in these Rules, residential facilities licensed after October 1, 1988 shall meet the following indoor space requirements: (7) Minimum furnishings for client bedrooms shall include a separate bed, bedding, pillow, bedside table, and storage for personal belongings for each client. This Rule is not met as evidenced by: Based on observation and interviews the facility failed to have minimum furnishings for a client bedroom which included a separate bed, bedding, pillow, bedside table and storage for personal belongings. The findings are: Observation on 3/25/25 at approximately 5:00 pm	V 774		

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V 774	Continued From page 30 revealed: -Vacant room #1 did not have a bedside table. -Vacant room #2 had a bedframe with no mattress, bedding, pillow or bedside table. Interview on 3/25/25 the Operations Manager stated: -One of the previous clients damaged the dresser and night stand, the Director of Services/Qualified Professional (DOS/QP) ordered a new night stand and dresser for a vacant rooms. Multiple attempts made on 4/1/25 to contact Operation Manager, no call back or response by exit. Interview on 3/25/25 the DOS/QP stated: -"We are working on getting the vacant rooms done." -She had put an order in for a mattress and a box spring. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 774		