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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on April 10, 2025. The complaint was substantiated (intake #NC00229078). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 5 and currently has a census of 3. The survey sample consisted of audits of 2 current clients and 1 former client.	V 000		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection 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: 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. 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. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against	V 132		

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a patient or client for whom the employee is providing services).
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.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure an allegation of abuse was reported to Health Care Personnel Registry (HCPR) within five working days. The findings are:

Review on 4/7/25 of a personnel record for Staff #1 revealed:
-Date of hire was 4/26/24.
-She was hired as a Paraprofessional.

Review on 4/7/25 of an in-house incident report dated 4/26/25 revealed:
"[FC #1] became increasingly agitated, and charged toward [Staff #1]. When [FC #1] charged towards [Staff #1] he was able to hit her in the face so hard that it caused her nose ring to fly off her face. As [Staff #1] attempted to move out of [FC #1's] path, he quickly grabbed her again in the kitchen area and again attempted to strike her in the face. [Staff #1] attempted to calm [FC #1] down by redirecting him to stop and to calm down asking him questions such as "what's going on, this is not like you" but he preceded towards her and wouldn't stop, stating "I'm going to Kill you, I'm going to kill you". [FC #1] then attempted to bite [Staff #1] on the neck multiple of times. [Staff #1] kept moving away from [FC #1] encouraging him to stop and to calm down. Due to the inability

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V 132	Continued From page 2 to safely disengage [FC #1], and by the staff attempting to cook the frying pan hit [FC #1] in the face. (a small frying pan intended for meal prep)." Review on 4/7/25 of the North Carolina (NC) Incident Response Improvement System (IRIS) dated 3/26/25 revealed: -There was a level III incident report submitted 3/27/25 for an incident with FC #1 exhibiting aggressive behaviors towards staff #1. -The report did not identify for the HCPR to be notified for the allegations of abuse by Staff #1 towards FC #1. -There was no evidence that Staff #1's name had been reported to HCPR for abuse. Interview on 4/8/25 with the Qualified Professional revealed: -She was responsible for reporting incidents to HCPR. -She was informed that HCPR did not have to be notified because FC #1 was no longer at the facility and was discharged on 3/27/25. -She confirmed the agency failed to report the allegation of abuse to HCPR.	V 132		
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 3 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, interviews and obsevration, one of three staff (#1) abused one of one former clients (FC #1). The findings are: Review on 4/7/25 of FC #1's record revealed: -Admission date of 2/15/21. -Diagnoses of Intellectual Developmental Disability (IDD); Schizophrenia; Autism Spectrum Disorder; Hypothyroidism. Review on 4/7/25 of Staff #1's personnel record revealed: -Date of hire was 4/26/24. Review on 4/7/25 of an Incident Response Improvement System (IRIS) incident report dated 3/27/25 revealed: "At approximately 3:00 PM, [FC #1] returned home (facility) from his day program. Upon entering the residence, he placed his lunchbox in its designated area and greeted staff and peers in	V 512		

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his usual manner. Staff began the process of transitioning [FC #1] for his afternoon routine, which included shower preparation and medication administration. Staff verbally prompted [FC #1] to begin gathering his hygiene supplies and informed him that medication administration would follow shortly. Shortly after being prompted to prepare for his shower, [FC #1] went to his bedroom. Staff observed [FC #1] pacing back and forth and overheard him making verbal threats stating intentions to harm his mother, grandmother, sister, and others by stating he wanted to kill them by first 'stabbing and slicing them in the knees.' Staff immediately contacted Staff supervisor (administrator/management) to report the concerning behavior and notified her of the plan to administer a PRN (as needed) medication as part of crisis de-escalation. [FC #1] was then redirected to the living room to watch cartoons while staff briefly stepped into the restroom. Upon returning, staff observed [FC #1] engaging in conversation with his roommate. [FC #1] was heard stating again his intentions of 'I'm going to kill her,' directed toward staff. Staff calmly attempted to redirect [FC #1] to return to the living room area (In effort to have him watch his favorite TV program and to get his mind off of negative thoughts. [FC #1] refused, became increasingly agitated, and charged toward staff. When he charged towards her he was able to hit her in the face so hard that it caused her nose ring to fly off her face. As staff attempted to move out of [FC #1's] path, he quickly grabbed her again in the kitchen area and again attempted to strike her in the face. Staff attempted to calm him down by redirecting him to stop and to calm down asking him questions such as 'what's going on, this is not like you' but he preceded towards her and wouldn't stop, stating 'I'm going to Kill you, I'm

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V 512	Continued From page 5 going to kill you.' [FC #1] then attempted to bite staff on the neck multiple of times. Staff kept moving away from him encouraging him to stop and to calm down. Due to the inability to safely disengage [FC #1], and by the staff attempting to cook the frying pan hit him in the face. (a small frying pan intended for meal prep). It did not stop him and he continue to charge after her still stating his intentions of causing her harm stating 'I'm going to kill you, my mama, grandma and sister.' A male client [Client #1] intervenes and pushed him into his room away from the staff. He stayed in his room still pacing and stating verbiage that was not recognizable. He did not come back out of his room but could be heard stating 'I'm going to kill you' over and over again. Following the incident, [FC #1] was examined by the nurse onsite, he was treated for the injuries he sustained and transported to [a local hospital] for medical and psychiatric evaluation. Upon arrival, [FC #1] stated to the hospital staff that he wanted to harm himself, his family, and facility staff, he repeated it with each hospital staff member that came into the room to speak with him of his plan. The attending physician was made aware of the audio recording capturing [FC #1's] threatening statements. The physician expressed clinical concern, noting that the repetitive content in the recording indicated ongoing homicidal ideation that could result in future harm to others. Based on the evaluation, [FC #1] was admitted to the psychiatric unit for further observation and stabilization." Review on 4/7/25 of the local hospital Emergency Department After Visit Summary dated 3/26/25 revealed: -"Reason for visit - facial swelling." -"Diagnosis - closed fracture of nasal bone, initial encounter."	V 512		

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V 512	Continued From page 6 Interview and observation on 4/7/25 with Staff #1 at approximately 9:30 a.m. of the object used to hit FC #1 revealed: -12-quart stock pot, approximately 2" to 3" long dent on the side. -Staff #1 reported that she caused the dent when she hit FC #1 in the face with the stock pot. -On 3/26/25 at approximately 3:00 p.m. Staff #1 was the only staff present at the facility. -FC #1 returned to the facility from the day program. -FC #1 went to the kitchen, put his lunchbox up and greeted everyone. -FC #1 seemed "perfectly fine," when he returned to the facility -Staff #1 administered FC #1's medication around 3:45 p.m. in the kitchen area and watched him take it. - FC #1 went to his bedroom and paced after he was administered his medication. -Staff #1 went to FC #1's bedroom door and asked if he was alright and how the day program was. - FC #1 did not answer her and stated that he was going to slice his mom's and sister's knees, and kill everyone in the day program and the facility. -She verbally redirected FC #1. -She called the HM (House Manager), per protocol, while still standing at FC #1's bedroom door and in his presence. -She informed the HM of FC #1's behavior and her intent to administer a PRN (as needed) medication. -The HM stated that it was "okay" to administer the PRN and and a PRN was administered. -The HM informed her to closely monitor FC #1. -They both sat in the living room and watched a cartoon.	V 512		

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V 512	Continued From page 7 - FC #1 seemed "fine and acted like his usual self." -Staff #1 went to the bathroom for no more than 2 minutes. -When Staff #1 stepped out of the bathroom she observed FC #1 in the living room pacing back and forth with his pajamas in his hands. .-She redirected FC #1 to take his pajamas to his bedroom and to come back and watch television. - FC #1 took his pajamas back to his bedroom. -She watched FC #1 as he took his pajamas to his bedroom. - FC #1 came back into the living room and pretended that he was actually going to sit on the couch. -Staff #1 stood at the entrance of the kitchen, separating the kitchen and the living room, and had turned slightly to enter the kitchen. -Staff #1 was still at the entrance of the doorway as FC #1 slowly pretended to sit down. - FC #1 walked towards her, slapped her in the face, and knocked her nose ring out of her nose. - FC #1 grabbed her and attempted to bite her neck, but she was able to push him away. - FC #1 ran into his bedroom and she called the HM. -She informed the HM that FC #1 attacked her. -The HM stated that she and the Administrator (A)/Qualified Professional (QP) informed her they were on their way to the facility. -The HM stayed on the phone with her and arrived at the facility within 15 minutes. -She was in the kitchen on the speaker phone with the HM and FC #1 came into the kitchen. - FC #1 was "swinging/fighting, throwing both hands" at her lower abdomen, but not anywhere specifically. - FC #1 was hitting her with open and closed hands. - FC #1grabbed her right hand and bit the top of	V 512		

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her index, middle and pinky fingers.
-She grabbed the pot and "struck a few hits at his (FC #1's) lower abdomen."
-The "hits connected" but FC #1 continued to attack her.
-She "swung the pot back and hit FC # 1 in the face."
- FC #1 "screamed" and ran into his bedroom.
- FC #1's nose was bleeding and there was blood on the kitchen floor.
-She verbally redirected, "attempted to de-escalate," FC #1 during the attack.
-She attempted to hold FC #1 back by holding his shoulders, using "physical de-escalation," when FC #1 initially started to attack.
-She noticed that she was not able to physically hold FC #1 because he was stronger than her.
-The HM and A/QP arrived within 10 to 15 minutes, around 3:50 and 3:55 pm.
- FC #1 was given another PRN before they took him to the hospital.
-During the incident, Client #1 and Client #2 were in their bedrooms Client #3 "went to the back of the house because he was scared."
-She worked at the facility for one year and never experienced physical aggression from FC #1.

Interview on 4/9/25 with the HM revealed:
-On 3/26/25, she received a phone call from Staff #1.
-Staff #1 informed her that FC #1 was talking about killing and stabbing her and his family members.
-Staff #1 also inquired about FC #1's PRN.
-It was protocol for staff to contact the HM during a crisis, maintenance or if anything was needed.
-Staff #1 gave FC #1 a PRN.
-Staff #1 called back, with her on speaker, and stated that FC #1 had attacked her.
-She stayed on the phone with Staff #1 and FC

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V 512	Continued From page 9 #1 attacked her while they were on the phone. -Staff #1 stated that FC #1 was trying to bite her. -She and the A/QP were on the way to the facility. -She arrived at the facility and observed that Staff #1 had been bitten on the hands. -Staff #1 stated that she hit FC #1 in the face with the pot to defend herself. -The Registered Nurse (RN) arrived and medically assessed FC #1 for getting hit in the face with the pot. -FC #1 was calm and continued to state that he wanted to kill or hurt staff, his grandmother, mother and sister. -FC #1 was taken to the emergency room (ER) at approximately 4:00 p.m. -The police were not called because "it wasn't at that point, he (FC #1) stopped attacking her and the PRN had started to work because FC #1 was a lot calmer." -EMS (Emergency Medical Services) was not called because the RN was there to medically assess and because they transported him to the ER shortly after. -Staff #1 continued to work with the clients because she was not a safety issue, she defended herself from FC #1. -"The clients love her (Staff #1), and she was not a threat to the other clients." -FC #1 bit her on the arm in 01/2024. He had not been physically aggressive to any staff prior to his admission in 02/2021. -FC #1 "randomly bit [Staff #1] for no apparent reason and it was out of nowhere." -Staff "loved" FC #1 and attempted to work with him on his behaviors. -FC #1 was redirected by staff and staff followed strategies in his BSP (behavior support plan). -Staff redirected FC #1, allowed him to assist with the grocery list, watch a cartoon, positive interactions, or gave him his PRN.	V 512		

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V 512	Continued From page 10 Interview on 4/8/25 with Client #1 revealed: -Client #1 was in his bedroom and heard a commotion. -FC #1 went into the kitchen and Staff #1 told him to go to his bedroom. -FC #1 tried to "push and hurt" Staff #1. -Staff #1 "pushed" FC #1 away from her. -Staff #1 would not have made physical contact with FC #1 if he did not come towards her. -Staff #1 was "alright" and she is a "good lady." -He felt safe around Staff #1 and at the facility. Interview on 4/8/25 with the QP revealed: -She was informed of the incident on 3/26/25 and there were no precipitating factors or triggers that led to FC #1's attack on Staff #1. -She was informed that Staff #1 hit FC #1 in the face with a pot in self defense. -FC #1 was usually easy to direct. -FC#1 was discharged on 3/27/25. -FC #1 met the criteria of discharge due to endangerment. -Staff were re-educated on how to redirect and de-escalate the clients, understanding a crisis, and restrictive interventions. -The 3/27/25 training covered all levels of abuse, physical and verbal. The training also covered violence on television shows. Interview on 4/8/25 with the RN revealed: -On 3/26/25, she received a phone call saying that FC #1 was in a crisis and attacked staff. -She understood that FC #1 attacked Staff #1 twice. -Staff #1 used EBPI to get to a safe point during the first attack. -Staff #1was not able to de-escalate using EBPI physical method - disengage from FC #1 during the second attack.	V 512		

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-Staff #1 used a pot to disengage the interaction because FC #1 could have hurt her "really bad."
-She arrived at the facility and assessed FC #1.
-On FC #1, she observed facial swelling, an open wound to bridge of his nose, and a laceration on his upper left eye near his eyebrow.
-She assessed for additional bruises but did not see any.
-FC #1 was still in crisis and made threatening remarks; kill and hurt Staff #1, stab and kill his mother.
-FC #1 was unpredictable and was given another PRN.
-FC #1 was taken to the hospital for medical care as well as psychological care.

Interviews on 4/8/25 and 4/9/25 with the A/QP revealed:
-On 3/26/25, she received a phone call from the HM stating that FC #1 attacked Staff #1 and that he continued to attack her.
-She arrived at the facility and FC #1 was sitting on his bed and was bleeding from his nose.
-Staff #1 informed her that she hit FC #1 in the face with a pot to defend herself.
-FC #1 told her that he wanted to stab and kill Staff #1, stab his mother, grandmother, and sister.
-The HM and RN arrived at the facility.
-FC #1 was assessed and taken to the hospital.
-She and the HM transported FC #1 to the hospital.
-Staff #1 continued her shift because FC #1 was removed from the facility.
-Staff #1 was "not a threat to the clients."
-The clients felt safe around Staff #1 and she had a good rapport with the clients.
-Staff #1's last day would be this week.
-She could not recall the actual day.
- FC #1 saw the psychologist about a week prior

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	Continued From page 12	V 512		

to the incident.
-There were no changes to his medication.
-The police were not called because the situation had not "gotten to that point."
-EMS were not called because the RN arrived at the facility and medically assessed FC #1.

Review on 4/9/25 of Staff #1's work schedule from 3/26/25 through 4/9/25 revelaed:
-3/26/25 - 1:30 p.m. - 8:00 p.m.
-3/30/25 - 8:00 p.m. - 8:00 a.m.
-4/2/25 - 1:30 p.m. - 8:00 p.m.
-4/3/25 - 8:00 p.m. - 8:00 a.m
-4/6/25 - 8:00 a.m. - 8:00 p.m.

Interview on 4/9/25 with the QP confirmed Staff #1 worked in the facility alone on the above dates. She stated Staff #1 has resigned and her last day of employment is 4/14/25.

Review on 4/10/25 of a Plan of Protection written by the QP dated 4/10/25 revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care? It is the policy of Fayetteville Street Community Living Home to provide a safe and secure environment for the safety of the program. All staff members at each facility will be thoroughly trained on all safety measures and safety matters involving the group home or the residents. When unsafe conditions are noted the Administrator and Qualified Professional should be informed immediately. Administrator / Qualified Professional will take appropriate steps to ensure that the conditions are corrected at the facility. FSCLH (Fayetteville Street Community Living Home) will address Safety Committee concerns/issues immediately documenting the resolution of the tools utilize that work successfully and what did not work. Staff should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-445	A. BUILDING: _____ B. WING _____	R-C 04/10/2025

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V 512	Continued From page 13 be aware of the fact that repeated safety violations and that it may constitute disciplinary actions. All staff will familiarize themselves and follow the foregoing safety regulations, this will include the following: Treatment Plans (Review treatment plans) Behavioral Plans (Review behavioral Plans to identify coping strategies) Medical Notes (progress, changes or concerns etc.) Successful De-escalation noted in chart (What worked and what didn't work). Safety Committee (Updates and review of additional standards to support safety). Safety representative will be responsible for ensuring that all employee working with residents in their respective areas are aware of the procedures, expectations and consequences. Describe your plans to make sure the above happens. Fayetteville Street Community Living Home (FSLCH) plans to ensure that this "Plan of Protection" will be followed by each staff member. FSCLH plans to continue with accurate/thorough training of staff members Per the following: Strong Orientation (addressing any area needing additional training before working at facility) Safety Training (Addressing all safety concerns or issues) Understanding forms of abuse (Addressing all levels of abuse) When to call 911 (Addressing what a crisis looks like) Client Rights (Addressing areas that a right can be identified as a violation) What is safe and what is not (Addressing all safety issues including staff concerns immediately).	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 512	Continued From page 14 Learn the residents in your care and monitor any change behaviors. Intent and other options of escape (safety)." FC #1's diagnoses included: IDD; Schizophrenia; Autism Spectrum Disorder; Hypothyroidism. There was an incident on 3/26/25 involving FC #1 and Staff #1. FC #1 made threats of violence against Staff #1 and attacked her twice. FC #1 slapped Staff #1 and hit her in the face during the first attack. FC #1 grabbed and attempted to bite Staff #1's neck. Staff #1 pushed FC #1 away and he ran into his bedroom. FC #1 attacked Staff #1 again by hitting her lower abdomen and biting the knuckles of her right index, middle and pinky fingers. Staff #1 struck FC #1 in the face and lower abdomen with a 12-quart aluminum stock pot. FC #1 was medically assessed by the facility's RN and transported to the local ER. FC #1 was treated for facial bleeding swelling and was diagnosed with a closed fracture of nasal bone. Facility management believed Staff #1 was defending and protecting herself from FC #1. Staff #1 was allowed to continue to work in the facility alone with the clients for a total of five days after the incident on 3/26/25. This deficiency constitutes a Type A1 rule violation for serious abuse and must be corrected within 23 days.	V 512		