STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	250129	A. BUILDING: _____ B. WING _____	R-C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOMES II	502 WESTGATE DRIVE ELON, NC 27244

(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 000	INITIAL COMMENTS A complaint and follow up survey was completed on May 9, 2025. The complaint was substantiated (intake #NC00229865). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 6 and has a current census of 3. The survey sample consisted of audits of 3 current clients and 1 former client.	V 000		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills.	V 110		

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V 110	Continued From page 1 (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record reviews and interviews one of two audited paraprofessionals (the Director/Licensee) failed to demonstrate the knowledge, skills and abilities required for the population served. The findings are: Cross Reference: G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (Tag 131) Based on record review and interview, the facility failed to ensure the Health Care Personnel Registry (HCPR) was accessed prior to employment affecting one of one Qualified Professional (QP). Cross Reference: G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (Tag 132) Based on record review and interviews, the facility failed to ensure an allegation of abuse was reported to Health Care Personnel Registry (HCPR) within five working days. Cross Reference: 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (Tag 366) Based on record review and interviews, the facility failed to implement a policy governing their response to Level III incidents as required.	V 110		

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V 110	Continued From page 2 Cross Reference: 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (367) Based on record review and interviews, the facility failed to ensure an incident was reported to the Local Management Entity/Managed Care Organization (LME/MCO) for the catchment area where services are provided within 72 hours of becoming aware of the incident. Cross Reference: 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (500) Based on record review and interviews, the governing body failed to report an allegation of abuse to the Department of Social Services (DSS). Review on 5/2/25 of the Director/Licensee personnel record revealed: -Date of hire was 7/6/14. Review on 5/2/25 of former client (FC) #4's record revealed: -Admission date of 6/20/19. -Diagnoses of Schizophrenia, Bipolar Disorder, Osteoarthritis, Vitamin D Deficiency, Hyperlipidemia, Abscess-Right Knee and Abdominal Bruit. -Discharge date of 4/24/25. Review on 5/6/25 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed: -Incident report dated 5/5/25 completed by the Qualified Professional (QP)-"On the morning of 4/24/2025 an allegation of abuse, staff hit [Former Client (FC) #4] on the ear was reported to the staff at [Name of Day Program]. [The Director/Licensee] Alamance Homes II was	V 110		

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V 110	Continued From page 3	V 110		

notified and he went to the facility to interview [FC #4]. [The Director/Licensee] was denied access to [FC #4] to complete an interview. [The Director/Licensee] went to the group home to interview [staff #1] and the residents at the home. [Staff #1] denied hitting [FC #4] as reported. The other 3 residents in the home stated they did not see [staff #1] hit [FC #4]. [The Director/Licensee] stated he was not able to substantiate any abuse."

Interview on 5/6/25 with staff #1 revealed:
-"[The Director/Licensee] talked to me on Friday (5/2/25) evening after you left the facility about an abuse allegation."
-"That was the first time I heard about the allegation of abuse [FC #4] made against me.
-There was an incident on 4/24/25 with FC #4.
-FC #4 got upset threw a cup and started hitting himself in "his own face."
-"I never hit [FC #4] during that incident.
-She was not suspended from the facility, "I worked the entire time."
-"I have been working alone with clients since last week."

Interview on 5/5/25 with the Former QP #1 revealed:
-Her daughter worked at Day Program FC #4 attended and reported an incident to her.
-She was told FC #4 came to the Day Program "upset" and reported there was an incident at the facility.
-The incident allegedly happened on 4/24/25 at the facility.
-FC #4 told staff at the Day Program he was hit in his "ear area" by a staff at the facility.
-At that time FC #4 did not specify which staff.
-The Director/Licensee only had one staff, a female staff.

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V 110	Continued From page 4 -She spoke with staff #1 on 4/24/25 because she was still the QP. -Staff #1 denied there was an incidents with FC #4 at the facility. -She also spoke with the Director/Licensee that same day (4/24/25). -The Director/Licensee also denied any incidents with FC #4 and staff #1. -"I felt like [the Director/Licensee] was pushing the incident under the rug." -The Director/Licensee kept talking about an incident that occurred with another client at the facility. -She decided to resign on 4/24/25 because of that incident. -"[The Director/Licensee] was pushing the incident under the rug and I'm not going to put my license in jeopardy." Interview on 5/6/25 with the QP revealed: -He spoke with the Director/Licensee and staff #1 last evening (5/5/25) about the alleged allegation of abuse. -Staff #1 said in April 2025 (4/24/25) she had to redirect FC #4 because he was trying to wash his face in the kitchen sink. -Staff #1 said FC #4 got upset with her and started hitting himself in the face. -Staff #1 denied hitting FC #4. -He informed the Director/Licensee he had to do an investigation related to the allegation of abuse. -He told the Director/Licensee that staff #1 should have been suspended until an investigation was completed. -The Director/Licensee informed him he did an investigation because he talked to staff and the 3 clients currently residing at the facility on 4/24/25. -The Director/Licensee said he did not document the investigation. -"I told the Director/Licensee if it's not	V 110		

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V 110	Continued From page 5	V 110		

documented it does not count as an investigation."
-"When [the Director/Licensee] first bought this incident to his attention on 5/2/25, I was under the impression all of this was done by [the Former QP #1]."
-"I didn't know about the allegation of abuse until 5/2/25."
-"When I talked with [the Director/Licensee] on 5/2/25 he made it sound like the incident with the client and staff was resolved."

Interviews on 5/6/25 and 5/7/25 with the Director/Licensee revealed:
-He knew about the allegation of abuse FC #4 alleged against staff on 4/24/25.
-A staff from the Day Program called him, he could not remember which staff called him.
-He went to FC #4's day program on 4/24/25 and tried to talk to FC #4.
-The Day Program staff would not let him see or talk to FC #4.
-"I was confused initially about which staff [FC #4] accused of hitting him because the facility staff and his transportation staff had the same first name."
-"On Friday (5/2/25), I didn't want to tell you something that was not correct so that was why I said I didn't know about the incident."
-He talked to staff #1 about the incident again on 5/2/25 and "her story was the same."
-Staff #1 said she did not hit FC #4 on 4/24/25.
-Staff #1 was not suspended because "I was not able to complete the investigation."
-"I had no access to [FC #4] when I went to talk to him at the day program on 4/24/25."
-The investigation that involved staff #1 and FC #4 was still being investigated.
-"I'm still trying to figure out everything with this investigation."

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V 110	Continued From page 6 -"[The QP] and I had not come to a conclusion yet."	V 110		
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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V 112	Continued From page 7	V 112		

This Rule is not met as evidenced by:
Based on observation, record review and interviews, the facility failed to schedule a review of a plan at least annually and failed to develop and implement a goal and strategies to meet the needs of one of three audited current clients (#1). The findings are:

1-Review on 5/2/25 of client #1's record revealed:
-Admission date of 4/15/24.
-Diagnoses of Schizophrenia, Bipolar Disorder, Alcohol Abuse, Chronic Obstructive Pulmonary Disease, Hypertension and Insomnia.
-Person Centered Plan (PCP) dated 4/15/24.
-There was no documentation of a current plan.

Interview on 5/2/25 with the Director/Licensee revealed:
-"[The Qualified Professional] just recently started and he is in the process of making sure all of the clients paperwork was up to date for the facility."
-He was not sure why client #1's current PCP was not in his record.
-He confirmed the facility failed to schedule a review of a plan at least annually for client 1.

2. Observation on 5/2/25 at approximately 11:00 am of the facility's den area revealed:
-The couch had a fitted sheet, a pillow and a blanket.
-On the floor near the television stand there were 2 pictures in a frame and a greeting card.

Review on 5/2/25 of client #1's record revealed:
-PCP had no strategies to address sleeping on the couch overnight.

Interview on 5/6/25 with client #1 revealed:
-He slept in the den on the couch every night.
-He had been sleeping on the couch in the den

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V 112	Continued From page 8 since they moved into the facility a few months ago. -"I don't like sleeping in my bedroom." Interview on 5/2/25 with staff #1 revealed: -She worked at the facility for about 30 days. -Client #1 had been sleeping in the den area overnight. -Client #1 had been sleeping in the den area since she started working at the facility about a month ago. -"For some reason [client #] thinks the den area is his bedroom." -"I cannot convince him to sleep in his bedroom." -The other clients sat in the den area to watch television. -She talked to the Director/Licensee about client #1 sleeping on the couch. -The Director/Licensee said "leave that man alone." Interviews on 5/2/25 and 5/9/25 with the Director/Licensee revealed: -He was aware of client #1 sleeping on the couch overnight. -"Whenever I work at the home I make [client #] sleep in his bedroom." -"I'm not sure why he will not sleep in his room whenever [staff #1] works at the home." -He confirmed client #1 had no goal or strategies to address sleeping on the couch overnight. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 112		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL	V 131		

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V 131	Continued From page 9 REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Health Care Personnel Registry (HCPR) was accessed prior to employment affecting one of one Qualified Professional (QP). The findings are: Review on 5/2/25 of the personnel record for the QP revealed: -Date of hire was 4/25/25. -No documentation the HCPR was accessed prior to hire. Interview on 5/6/25 with the Director/Licensee revealed: -He did not access the HCPR check for the QP when he hired him last month (April 2025). -"[The QP] worked for me in the past and I did not know I had to do the HCPR check again." -He confirmed the facility failed to ensure the HCPR was accessed for the QP prior to employment. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 131		

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V 132	Continued From page 10	V 132		
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 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 review and interviews, the facility failed to ensure an allegation of abuse was reported to Health Care Personnel Registry	V 132		

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V 132	Continued From page 11 (HCPR) within five working days. The findings are: Review on 5/6/25 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed: -Incident report dated 5/5/25 completed by the Qualified Professional (QP)-"On the morning of 4/24/2025 an allegation of abuse, staff hit [Former Client (FC) #4] on the ear was reported to the staff at [Name of Day Program]. [The Director/Licensee] Alamance Homes II was notified and he went to the facility to interview [FC #4]. [The Director/Licensee] was denied access to [FC #4] to complete an interview. [The Director/Licensee] went to the group home to interview [staff #1] and the residents at the home. [Staff #1] denied hitting [FC #4] as reported. The other 3 residents in the home stated they did not see [staff #1] hit [FC #4]. [The Director/Licensee] stated he was not able to substantiate any abuse." -The QP failed to complete report to HCPR Investigations Branch. -There was no information for allegation the portion. -The accused staff was not completed, investigation results were blank and witnesses portion was blank. Interview on 5/5/25 with the Former QP #1 revealed: -Her daughter worked at Day Program FC #4 attended and reported an incident to her. -She was told FC #4 came to the Day Program "upset" and reported there was an incident at the facility. -The incident allegedly happened on 4/24/25 at the facility. -FC #4 told staff at the Day Program he was hit in	V 132		

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V 132	Continued From page 12	V 132		

his "ear area" by a staff at the facility.
-At that time FC #4 did not specify which staff.
-The Director/Licensee only had one staff, a female staff.
-She spoke staff #1 on 4/24/25 because she was still the QP.
-Staff #1 denied there was an incidents with FC #4 at the facility.
-She also spoke with the Director/Licensee that same day (4/24/25).
-The Director/Licensee also denied any incidents with FC #4 and staff #1.
-"I felt like [the Director/Licensee] was pushing the incident under the rug."

Interview on 5/6/25 with the QP revealed:
-He spoke with the Director/Licensee and staff #1 last evening (5/5/25) about the alleged allegation of abuse.
-Staff #1 said in April 2025 (4/24/25) she had to redirect FC #4 because he was trying to wash his face in the kitchen sink.
-Staff #1 said FC #4 got upset with her and started hitting himself in the face.
-Staff #1 denied hitting FC #4.
-He informed the Director/Licensee he had to do an investigation related to the allegation of abuse.
-He told the Director/Licensee that staff #1 should have been suspended until an investigation was completed.
-The Director/Licensee informed him he did an investigation because he talked to staff and the 3 clients currently residing at the facility on 4/24/25.
-The Director/Licensee said he did not document the investigation.
-"I told the Director/Licensee if it's not documented it does not count as an investigation."
-"When [the Director/Licensee] first bought this incident to his attention on 5/2/25, I was under the

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impression all of this was done by [the Former QP #1].
-"I didn't know about the allegation of abuse until 5/2/25."
-"When I talked with [the Director/Licensee] on 5/2/25 he made it sound like the incident with the client and staff was resolved."
-He put the incident into IRIS on 5/5/25.
-He attempted to report the allegation of abuse to HCPR through the IRIS system, however it did not go through because an error message popped up.
-"I guess the system crashed."
-He confirmed the agency failed to report an allegation of abuse to HCPR within five working days.

Interviews on 5/6/25 and 5/7/25 with the Director/Licensee revealed:
-He knew about the allegation of abuse FC #4 alleged against staff on 4/24/25.
-A staff from the Day Program called him, he could not remember which staff called him.
-He went to FC #4's day program on 4/24/25 and tried to talk to FC #4.
-The Day Program staff would not let him see or talk to FC #4.
-"I was confused initially about which staff [FC #4] accused of hitting him because the facility staff and his transportation staff had the same first name."
-"On Friday (5/2/25), I didn't want to tell you something that was not correct so that was why I said I didn't know about the incident."
-He talked to staff #1 about the incident again on 5/2/25 and "her story was the same."
-Staff #1 said she did not hit FC #4 on 4/24/25.
-Staff #1 was not suspended because "I was not able to complete the investigation."
-"I had no access to [FC #4] when I went to talk to

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOMES II	502 WESTGATE DRIVE ELON, NC 27244

(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 132	Continued From page 14 him at the day program on 4/24/25." -The investigation that involved staff #1 and FC #4 was still being investigated. -"I'm still trying to figure out everything with this investigation." -"[The QP] and I had not come to a conclusion yet." -He confirmed the agency failed to report an allegation of abuse to HCPR within five working days.	V 132		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or	V 290		

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V 290	Continued From page 15 (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to assess the continued capability for one of three audited current clients (#3) to be unsupervised in the community. The findings are: Observation on 5/6/25 at approximately 3:20 pm revealed: -Client #3 was walking near street adjacent to a shopping center. Review on 5/2/25 of client #3's record revealed: -Admission date of 6/17/19. -Diagnoses of Schizophrenia, Chronic Obstructive Pulmonary Disease, Hyperlipidemia, and Type II Diabetes.	V 290		

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V 290	Continued From page 16 -Unsupervised Time Assessment dated 7/1/22-Client #3 can leave the facility for 30 minutes but no more than an hour. -There was no documentation the facility assessed the continued capability for client #3 to remain unsupervised in the community. Observation and Interview on 5/6/25 at 3:25 pm with client #3 revealed: -Client #3 had approximately five used cigarette butts in his hand. -Client #3 stated he took those used cigarette butts from a canister in the parking near the supermarket. -He was going to smoke those cigarettes butts later. -He was walking back to the facility. -He was allowed to have unsupervised time in the community daily. -He walked to the shopping center most days. Interview on 5/6/25 with staff #1 revealed: -Client #3 walked away from the facility unsupervised a few times. -"[Client #3] is twice my size and I can't stop him from leaving." -Client #3 was at the facility earlier today; however he left the facility a little while ago. -He possibly walked to a restaurant right down the street. -"[Client #3] seems to think he works at [name of restaurant]. -Client #3 was also possibly at that restaurant begging for money or trying to get cigarettes butts. -Client #3 was out of cigarettes because the Director/Licensee had not bought any by the facility. -She knows client #3 begged at the restaurant because he "rarely" had money.	V 290		

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V 290	Continued From page 17 -Client #3 would return to the facility with a pack of cigarettes or pick used cigarette butts off the ground. -She saw client #3 smoke those used cigarette butts. Interviews on 5/6/25, 5/7/25 and 5/9/25 with the Director/Licensee revealed: -Client #3 had unsupervised time in the community. -He had unsupervised time for several years. -He was aware of client #3 getting used cigarette butts while he was in the community whenever he was unsupervised. -"I have to stay on [client #3] about that." -Client #3 had been doing that for "several" years. -He wasn't aware of client #3 begging for cigarettes and/or money during his unsupervised time in the community. -The Former Qualified Professional #2 was supposed to update his unsupervised time assessment a few months ago. -He confirmed the facility failed to assess the capability for client #3 to be unsupervised in the community. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 290		
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	V 366		

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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;
(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

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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:
(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

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V 366	Continued From page 20 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 record review and interviews, the facility failed to implement a policy governing their response to Level III incidents as required. The findings are: Review on 5/2/25 of former client (FC) #4's record revealed: -Admission date of 6/20/19. -Diagnoses of Schizophrenia, Bipolar Disorder, Osteoarthritis, Vitamin D Deficiency, Hyperlipidemia, Abscess-Right Knee and Abdominal Bruit. -Discharge date of 4/24/25. Reviews on 5/2/25 and 5/6/25 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed: -On 5/2/25 there was no level III incident report submitted by the facility related to an allegation of abuse against staff #1. FC #4 alleged staff #1 hit him in his ear. -On 5/5/25 a Level III incident report was added by the Qualified Professional (QP)-"On the morning of 4/24/2025 an allegation of abuse, staff hit [FC #4] on the ear was reported to the staff at	V 366		

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V 366	Continued From page 21 [Name of Day Program]. [The Director/Licensee] Alamance Homes II was notified and he went to the facility to interview [FC #4]. [The Director/Licensee] was denied access to [FC #4] to complete an interview. [The Director/Licensee] went to the group home to interview [staff #1] and the residents at the home. [Staff #1] denied hitting [FC #4] as reported. The other 3 residents in the home stated they did not see [staff #1] hit [FC #4]. [The Director/Licensee] stated he was not able to substantiate any abuse." -There was no documentation to determine: The cause of the incident; If the facility developed and implemented corrective measures according to the provider specified timeframes not to exceed 45 days; no measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days and assigning person(s) to be responsible for implementation of the corrections and preventive measures. Interview on 5/6/25 with the QP revealed: -He spoke with the Director/Licensee and staff #1 last evening (5/5/25) about the alleged allegation of abuse. -Staff #1 said in April 2025 (4/24/25) she had to redirect FC #4 because he was trying to wash his face in the kitchen sink. -Staff #1 said FC #4 got upset with her and started hitting himself in the face. -Staff #1 denied hitting FC #4. -"When [the Director/Licensee] first bought this incident to his attention on 5/2/25, I was under the impression all of this was done by [the Former QP #1]." -"I didn't know about the allegation of abuse until 5/2/25." -"When I talked with [the Director/Licensee] on 5/2/25 he made it sound like the incident with the client and staff was resolved."	V 366		

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V 366	Continued From page 22 -He confirmed the facility failed to implement a policy governing their response to Level III incidents as required. Interviews on 5/6/25 and 5/7/25 with the Director/Licensee revealed: -He knew about the allegation of abuse FC #4 alleged against staff on 4/24/25. -"I was confused initially about which staff [FC #4] accused of hitting him because the facility staff and his transportation staff had the same first name." -"On Friday (5/2/25), I didn't want to tell you something that was not correct so that was why I said I didn't know about the incident." -He talked to staff #1 about the incident again on 5/2/25 and "her story was the same." -Staff #1 said she did not hit FC #4 on 4/24/25. -"I had no access to [FC #4] when I went to talk to him at the day program on 4/24/25." -The investigation that involved staff #1 and FC #4 was still being investigated. -"I'm still trying to figure out everything with this investigation." -"[The QP] and I had not come to a conclusion yet." -He confirmed the facility failed to implement a policy governing their response to Level III incidents as required.	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	V 367		

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incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:
(1) reporting provider contact and identification information;
(2) client identification information;
(3) type of incident;
(4) description of incident;
(5) status of the effort to determine the cause of the incident; and
(6) other individuals or authorities notified or responding.
(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:
(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, 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

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V 367	Continued From page 24 of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.	V 367		

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V 367	Continued From page 25 This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure an incident was reported to the Local Management Entity/Managed Care Organization (LME/MCO) for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are: Review on 5/2/25 of former client (FC) #4's record revealed: -Admission date of 6/20/19. -Diagnoses of Schizophrenia, Bipolar Disorder, Osteoarthritis, Vitamin D Deficiency, Hyperlipidemia, Abscess-Right Knee and Abdominal Bruit. -Discharge date of 4/24/25. Review on 5/6/25 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed: -Incident report dated 5/5/25 completed by the Qualified Professional (QP)-"On the morning of 4/24/2025 an allegation of abuse, staff hit [Former Client (FC) #4] on the ear was reported to the staff at [Name of Day Program]. [The Director/Licensee] Alamance Homes II was notified and he went to the facility to interview [FC #4]. [The Director/Licensee] was denied access to [FC #4] to complete an interview. [The Director/Licensee] went to the group home to interview [staff #1] and the residents at the home. [Staff #1] denied hitting [FC #4] as reported. The other 3 residents in the home stated they did not see [staff #1] hit [FC #4]. [The Director/Licensee] stated he was not able to substantiate any abuse." Interview on 5/6/25 with the QP revealed:	V 367		

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V 367	Continued From page 26 -He spoke with the Director/Licensee and staff #1 last evening (5/5/25) about the alleged allegation of abuse. -Staff #1 said in April 2025 (4/24/25) she had to redirect FC #4 because he was trying to wash his face in the kitchen sink. -Staff #1 said FC #4 got upset with her and started hitting himself in the face. -Staff #1 denied hitting FC #4. -"When [the Director/Licensee] first bought this incident to his attention on 5/2/25, I was under the impression all of this was done by [the Former QP #1]." -"I didn't know about the allegation of abuse until 5/2/25." -"When I talked with [the Director/Licensee] on 5/2/25 he made it sound like the incident with the client and staff was resolved." -He put the incident into IRIS on 5/5/25. -He confirmed the facility failed to report the above incident to LME/MCO within 72 hours. Interviews on 5/6/25 and 5/7/25 with the Director/Licensee revealed: -He knew about the allegation of abuse FC #4 alleged against staff on 4/24/25. -"I was confused initially about which staff [FC #4] accused of hitting him because the facility staff and his transportation staff had the same first name." -"On Friday (5/2/25), I didn't want to tell you something that was not correct so that was why I said I didn't know about the incident." -He confirmed the facility failed to report the above incident to LME/MCO within 72 hours.	V 367		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS	V 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	250129	A. BUILDING: _____ B. WING _____	R-C 05/09/2025

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V 500	Continued From page 27 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 involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use	V 500		

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V 500	Continued From page 28	V 500		

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 review and interviews, the governing body failed to report an allegation of abuse to the Department of Social Services (DSS). The findings are:

Review on 5/6/25 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed:
-Incident report dated 5/5/25 completed by the Qualified Professional (QP)-"On the morning of 4/24/2025 an allegation of abuse, staff hit [Former Client (FC) #4] on the ear was reported to the staff at [Name of Day Program]. [The Director/Licensee] Alamance Homes II was notified and he went to the facility to interview [FC #4]. [The Director/Licensee] was denied access to [FC #4] to complete an interview. [The

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V 500	Continued From page 29	V 500		

Director/Licensee] went to the group home to interview [staff #1] and the residents at the home. [Staff #1] denied hitting [FC #4] as reported. The other 3 residents in the home stated they did not see [staff #1] hit [FC #4]. [The Director/Licensee] stated he was not able to substantiate any abuse."

Interview on 5/5/25 with the Former QP #1 revealed:
-Her daughter worked at Day Program FC #4 attended and reported an incident to her.
-She was told FC #4 came to the Day Program "upset" and reported there was an incident at the facility.
-The incident allegedly happened on 4/24/25 at the facility.
-FC #4 told staff at the Day Program he was hit in his "ear area" by a staff at the facility.
-At that time FC #4 did not specify which staff.
-The Director/Licensee only had one staff, a female staff.
-She spoke staff #1 on 4/24/25 because she was still the QP.
-Staff #1 denied there was an incidents with FC #4 at the facility.
-She also spoke with the Director/Licensee that same day (4/24/25).
-The Director/Licensee also denied any incidents with FC #4 and staff #1.
-"I felt like [the Director/Licensee] was pushing the incident under the rug."
-She contacted FC #4's DSS guardian about the incident.
-She did not contact the local DSS agency.

Interview on 5/6/25 with the QP revealed:
-He spoke with the Director/Licensee and staff #1 last evening (5/5/25) about the alleged allegation of abuse.

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V 500	Continued From page 30 -Staff #1 said in April 2025 (4/24/25) she had to redirect FC #4 because he was trying to wash his face in the kitchen sink. -Staff #1 said FC #4 got upset with her and started hitting himself in the face. -Staff #1 denied hitting FC #4. -He didn't contact DSS because the Director/Licensee said the Former QP #1 contacted them. -He confirmed the agency failed to report the above allegation of abuse to DSS. Interviews on 5/6/25 and 5/7/25 with the Director/Licensee revealed: -He knew about the allegation of abuse FC #4 alleged against staff on 4/24/25. -A staff from the Day Program called him, he could not remember which staff called him. -He went to FC #4's day program on 4/24/25 and tried to talk to FC #4. -The Day Program staff would not let him see or talk to FC #4. -"I was confused initially about which staff [FC #4] accused of hitting him because the facility staff and his transportation staff had the same first name." -"On Friday (5/2/25), I didn't want to tell you something that was not correct so that was why I said I didn't know about the incident." -The local DSS was never contacted about the allegation of abuse against staff #1. -I didn't think I had to contact them because [FC #4's] guardian worked with DSS in another county. -He confirmed the agency failed to report the above allegation of abuse to DSS.	V 500		