STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
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		250129	B. WING			9/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AL AMAR	ICE HOMES II	502 WEST	GATE DRIV	E		
ALAMAN	ICE HOMES II	ELON, NO	27244			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	rs	V 000			
	on May 9, 2025. Th (intake #NC002298 This facility is licens category: 10A NCA Living for Adults wit This facility is licens census of 3. The su	low up survey was completed e complaint was substantiated 65). Deficiencies were cited.  sed for the following service C 27G .5600A Supervised h Mental Illness.  sed for 6 and has a current urvey sample consisted of clients and 1 former client.				
V 110	SUPERVISION OF  (a) There shall be a paraprofessionals.  (b) Paraprofession associate profession professional as spe Subchapter.  (c) Paraprofessional knowledge, skills are population served.  (d) At such time as employment system then qualified professionals shall	204 COMPETENCIES AND PARAPROFESSIONALS no privileging requirements for all shall be supervised by an mal or by a qualified ecified in Rule .0104 of this all shall demonstrate and abilities required by the a competency-based is established by rulemaking, ssionals and associate demonstrate competence. In all be demonstrated by sincluding: edge; ess; ess;	V 110			
	(6) communication (7) clinical skills.					

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
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		250129	b. WING		05/0	9/2025
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ALAMAN	ICE HOMES II	502 WES ELON, NO	TGATE DRIV 27244	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 110	This Rule is not me Based on record re two audited parapro Director/Licensee) knowledge, skills an population served.  Cross Reference: CCARE PERSONNE Based on record re failed to ensure the Registry (HCPR) we employment affectin Professional (QP).  Cross Reference: CCARE PERSONNE Based on record re failed to ensure the Registry (HCPR) we employment affectin Professional (QP).  Cross Reference: CCARE PERSONNE Based on record refacility failed to ensure the CCARE PERSONNE Based on record refacility failed to ensure the CCARE PERSONNE Based on record refacility failed to ensure the CCARE PERSONNE Based on record refacility failed to ensure the CCARE PERSONNE Based on Record refacility failed to Ensure the CCARE PERS	poody for each facility shall ment policies and procedures he individualized supervision ch paraprofessional.  Let as evidenced by: Views and interviews one of ofessionals (the failed to demonstrate the nd abilities required for the The findings are:  L.S. §131E-256 HEALTH LE REGISTRY (Tag 131) View and interview, the facility Health Care Personnel as accessed prior to ng one of one Qualified  L.S. §131E-256 HEALTH LE REGISTRY (Tag 132) View and interviews, the ure an allegation of abuse was Care Personnel Registry	V 110	DEFICIENCY)		
	Based on record re facility failed to imp	view and interviews, the lement a policy governing their Il incidents as required.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
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		250129	B. WING		1	9/2025
NAME OF PROVIDI	ER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ALAMANCE HO	OMES II	502 WEST ELON, NO	TGATE DRIV 27244	E		
	EACH DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
Cross INCII CATE Base facilit to the Orga when become consider the INTE Base gove abus (DSS Revie personal Property of the Incidence of the In	DENT REPOREGORY A ANE EGORY A ANE EGORY A ANE EGORY A ANE EGORY A END EGORY A	IOA NCAC 27G .0604 RTING REQUIREMENTS FOR DB PROVIDERS (367) Eview and interviews, the ure an incident was reported lement Entity/Managed Care /MCO) for the catchment area provided within 72 hours of it the incident.  IOA NCAC 27D .0101 POLICY RICTIONS AND (500) Eview and interviews, the ed to report an allegation of the the Director/Licensee evealed:  //6/14.  If former client (FC) #4's  6/20/19.  zophrenia, Bipolar Disorder, min D Deficiency, scess-Right Knee and	V 110			

Division of Health Service Regulation

STATE FORM 6899 E6XZ11 If continuation sheet 3 of 31

Division of Health Service Regulation	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A PUBLICATION	(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING:	COMPLETED
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250129 B. WING	05/09/2025
NAME OF PROVIDER OR SUPPLIED.	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
ALAMANCE HOMES II 502 WESTGATE DRIVE	
ELON, NC 27244	
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PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE AF	
DEFICIENCY)	
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."	
ubusc.	
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."	
WOOK.	
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 facilityAt that time FC #4 did not specify which staff.	

Division of Health Service Regulation STATE FORM

female staff.

AND DUAN OF CODDECTION DENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
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V 110	Continued From pa	ge 4	V 110			
	-She spoke with sta was still the QP. -Staff #1 denied the #4 at the facility. -She also spoke wir same day (4/24/25) -The Director/Licen with FC #4 and staft -"I felt like [the Direct the incident under t -The Director/Licen incident that occurr facility. -She decided to rest that incident. -"[The Director/Licen incident under the rest	aff #1 on 4/24/25 because she ere was an incidents with FC th the Director/Licensee that it. see also denied any incidents if #1. ctor/Licensee] was pushing he rug." see kept talking about an ed with another client at the sign on 4/24/25 because of ensee] was pushing the rug and I'm not going to put my				
	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 abuseStaff #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 sinkStaff #1 said FC #4 got upset with her and started hitting himself in the faceStaff #1 denied hitting FC #4He informed the Director/Licensee he had to do an investigation related to the allegation of abuseHe told the Director/Licensee that staff #1 should have been suspended until an investigation was completedThe Director/Licensee informed him he did an investigation because he talked to staff and the 3 clients currently residing at the facility on 4/24/25The Director/Licensee said he did not document the investigation.					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER. A. BUILDING:	COMPLETED
250129 B. WING	R-C <b>05/09/2025</b>
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
ALAMANCE HOMES II. 502 WESTGATE DRIVE	
ALAMANCE HOMES II ELON, NC 27244	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPLICATION DEFICIENCY)	OULD BE COMPLETE
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 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	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY	
		250129	B. WING		1	-C <b>09/2025</b>
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V 110	Continued From pa -"[The QP] and I ha yet."	ge 6 d not come to a conclusion	V 110			
V 112	10A NCAC 27G .02 TREATMENT/HABI PLAN (c) The plan shall be assessment, and in legally responsible of admission for clie receive services be (d) The plan shall in (1) client outcome( achieved by provision projected date of accept (2) strategies; (3) staff responsible (4) a schedule for a nanually in consultar responsible person (5) basis for evaluation outcome achievement (6) written consent responsible party, or	de developed based on the partnership with the client or person or both, within 30 days ents who are expected to yond 30 days. Include:  s) that are anticipated to be on of the service and a chievement;  e; review of the plan at least attion with the client or legally or both; attion or assessment of	V 112			

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Division of Health Service Regulation		0.00 1.00 7.00	E CONCERNATION	L ((0) D ATE	OLIDA (EX	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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V 112	Continued From pa This Rule is not me	_	V 112			
	Based on observati interviews, the facili of a plan at least an and implement a go	on, record review and ity failed to schedule a review inually and failed to develop bal and strategies to meet the ee audited current clients (#1).				
	1-Review on 5/2/25 of client #1's record revealed: -Admission date of 4/15/24Diagnoses of Schizophrenia, Bipolar Disorder, Alcohol Abuse, Chronic Obstructive Pulmonary Disease, Hypertension and InsomniaPerson Centered Plan (PCP) dated 4/15/24There 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 recordHe confirmed the facility failed to schedule a review of a plan at least annually for client 1.					
	<ul> <li>2. Observation on 5/2/25 at approximately 11:00 am of the facility's den area revealed:</li> <li>-The couch had a fitted sheet, a pillow and a blanket.</li> <li>-On the floor near the television stand there were 2 pictures in a frame and a greeting card.</li> </ul>					
		f client #1's record revealed: gies to address sleeping on t.				
	-He slept in the den	with client #1 revealed: on the couch every night. on the couch in the den				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 112	Continued From pa	ge 8	V 112			
	since they moved in ago. -"I don't like sleepin	nto the facility a few months				
	-She worked at the -Client #1 had beer overnightClient #1 had beer since she started w month ago"For some reason his bedroom." -"I cannot convince -The other clients s televisionShe talked to the E #1 sleeping on the	with staff #1 revealed: facility for about 30 days. In sleeping in the den area orking at the facility about a  [client #] thinks the den area is him to sleep in his bedroom." at in the den area to watch  Director/Licensee about client couch. see said "leave that man				
	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.					
	and must be correct	stitutes a re-cited deficiency ted within 30 days.				
V 131	G.S. 131E-256 (D2 Verification	) HCPR - Prior Employment	V 131			
	G S 8131F-256 HF	FALTH CARE PERSONNEL				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
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		250129	B. WING		1	9/2025
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
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V 131	REGISTRY (d2) Before hiring health care facility health care facility of health care facility of access in the appropriate of access in the access in	ealth care personnel into a preservice, every employer at a shall access the Health Care and shall note each incident propriate business files.  et as evidenced by: view and interview, the facility Health Care Personnel as accessed prior to any one of one Qualified The findings are:	V 131	DEFICIENCY)		
	QP revealed: -Date of hire was 4, -No documentation prior to hire.  Interview on 5/6/25 revealed: -He did not access when he hired him -"[The QP] worked know I had to do th -He confirmed the f HCPR was accessed employment.	with the Director/Licensee the HCPR check for the QP last month (April 2025). for me in the past and I did not e HCPR check again." racility failed to ensure the ed for the QP prior to				

	of Health Service Re		1		1			
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED		
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				DEFICIENCY)				
V 132	Continued From pa	ge 10	V 132					
	•							
V 132	G.S. 131E-256(G) I		V 132					
	Allegations, & Prote	ection						
	C C 8131E 356 UE	EALTH CARE PERSONNEL						
	REGISTRY	EALTH CARE PERSONNEL						
		lities shall ensure that the						
		ied of all allegations against						
		nel, including injuries of						
	•	hich appear to be related to						
		odivision (a)(1) of this section.						
	(which includes:	, , ,						
	a. Neglect or abus	se of a resident in a healthcare						
		to whom home care services						
		131E-136 or hospice services						
		131E-201 are being provided.						
		n of the property of a resident						
		ility, as defined in subsection						
		cluding places where home fined by G.S. 131E-136 or						
		defined by G.S. 131E-130 of						
	are being provided.							
		n of the property of a						
	healthcare facility.							
		igs belonging to a health care						
	facility or to a patier	nt or client.						
		health care facility or against						
		or whom the employee is						
	providing services).							
		e evidence that all alleged						
		d and must make every effort						
		from harm while the						
	investigation is in pi	rogress. The results of all						
		ive working days of the initial						
	notification to the D							
		oparanone.						
	This Rule is not me	et as evidenced bv:						
		view and interviews, the						
		ure an allegation of abuse was						
		Care Personnel Registry						

DIVISION	of Health Service Re	egulation				
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
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				DEFICIENCY)		
V/ 122	Cantinuad Frame	11	V 132			
V 132	Continued From pa	ige 11	V 132			
	(HCPR) within five	working days. The findings				
	are:	0 , 0				
	Review on 5/6/25 o	f the North Carolina (NC)				
		Improvement System (IRIS)				
	revealed:	, , ,				
	-Incident report date	ed 5/5/25 completed by the				
		nal (QP)-"On the morning of				
		ation of abuse, staff hit [Former				
	Client (FC) #4] on t	he ear was reported to the				
	staff at [Name of Da	ay Program]. [The				
	Director/Licensee]	Alamance Homes II was				
	notified and he wen	nt to the facility to interview [FC				
	#4]. [The Director/L	icensee] was denied access				
	to [FC #4] to compl	ete an interview. [The				
	Director/Licensee] v	went to the group home to				
	interview [staff #1] a	and the residents at the home.				
	[Staff #1] denied hit	tting [FC #4] as reported. The				
	other 3 residents in	the home stated they did not				
	see [staff #1] hit [F0	C #4]. [The Director/Licensee]				
		ible to substantiate any				
	abuse."					
		omplete report to HCPR				
	Investigations Bran					
	-There was no infor	rmation for allegation the				
	portion.					
		was not completed,				
		s were blank and witnesses				
	portion was blank.					
		with the Former QP #1				
	revealed:	L (D D = 50.11)				
		ed at Day Program FC #4				
		ted an incident to her.				
		4 came to the Day Program				
		d there was an incident at the				
	facility.	Heat				
		edly happened on 4/24/25 at				
	the facility.					
	-⊢C #4 told staff at	the Day Program he was hit in				

DIVISION	of Health Service Re	egulation				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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			B. WING		R-	
		250129	D. WING		05/0	9/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
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ALAMAN	ALAMANCE HOMES II		_	<b>-</b>		
		ELON, NO	27244			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
TAG	REGULATORTORE	SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	FINAIL	D, II L
				,		
V 132	Continued From pa	ge 12	V 132			
		-4-66 -444 - 6				
	his "ear area" by a					
		did not specify which staff.				
		see only had one staff, a				
	female staff.	4/04/05				
	•	on 4/24/25 because she was				
	still the QP.	50				
		ere was an incidents with FC				
	#4 at the facility.					
		th the Director/Licensee that				
	same day (4/24/25)					
		see also denied any incidents				
	with FC #4 and staf					
		ctor/Licensee] was pushing				
	the incident under t	he rug."				
		with the QP revealed:				
		Director/Licensee and staff #1				
	• • • • • • • • • • • • • • • • • • • •	5) about the alleged allegation				
	of abuse.					
		ril 2025 (4/24/25) she had to				
		ause he was trying to wash his				
	face in the kitchen					
		4 got upset with her and				
	started hitting himse	elf in the face.				
	-Staff #1 denied hit					
		irector/Licensee he had to do				
		ated to the allegation of abuse.				
		or/Licensee that staff #1 should				
	have been suspend	ded until an investigation was				
	completed.					
		see informed him he did an				
	investigation becau	se he talked to staff and the 3				
	clients currently res	siding at the facility on 4/24/25.				
	-The Director/Licen	see said he did not document				
	the investigation.					
	-"I told the Director/	Licensee if it's not				
	documented it does	s not count as an				
	investigation."					
		or/Licensee] first bought this				
		ition on 5/2/25, I was under the				

Division	<u>of Health Service Re</u>	egulation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		250129	B. WING		R-C <b>05/09/2025</b>	
NAME OF I		CTDEET AD		CTATE ZID CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ALAMANCE HOMES II ELON, NO		GATE DRIV	<u> </u>			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 132	impression all of the QP #1].  -"I didn't know about 5/2/25."  -"When I talked with 5/2/25 he made it so client and staff was -He put the incident -He attempted to re HCPR through the not go through becapopped up.  -"I guess the syster -He confirmed the allegation of abuse days.  Interviews on 5/6/20 Director/Licensee relationship -He knew about the alleged against staff -A staff from the Dacould not remember	s was done by [the Former  It the allegation of abuse until In [the Director/Licensee] on ound like the incident with the resolved." Into IRIS on 5/5/25. Into IRIS on 5/5/25. Into IRIS on 5/5/25. In allegation of abuse to IRIS system, however it did ause an error message In crashed." Into HCPR within five working Into HCPR within five working Into Additional action of abuse FC #4	V 132			
	tried to talk to FC # -The Day Program talk to FC #4"I was confused in accused of hitting h and his transportati name." -"On Friday (5/2/25 something that was said I didn't know a -He talked to staff # 5/2/25 and "her sto -Staff #1 was not so able to complete th	4. staff would not let him see or tially about which staff [FC #4] im because the facility staff on staff had the same first ), I didn't want to tell you not correct so that was why I bout the incident." 141 about the incident again on ry was the same." id not hit FC #4 on 4/24/25. uspended because "I was not				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		250129	B. WING			R-C <b>09/2025</b>
	PROVIDER OR SUPPLIER	502 WES	DDRESS, CITY, S'	,		
, (=, (, , , , ,		ELON, N	C 27244			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 132	Continued From pa	ge 14	V 132			
	#4 was still being in -"I'm still trying to fig investigation." -"[The QP] and I ha yet." -He confirmed the a	hat involved staff #1 and FC				
V 290	27G .5602 Supervis	sed Living - Staff	V 290			
	numbers specified of this Rule shall be enable staff to resp needs.  (b) A minimum of opresent at all times premises, except whabilitation plan docapable of remaining without supervision as needed but not I the client continues the home or commispecified periods of (c) Staff shall be profollowing client-staff child or adolescent (1) children of abuse disorders show of one staff present clients present. Hopresent during sleep	os above the minimum in Paragraphs (b), (c) and (d) e determined by the facility to ond to individualized client one staff member shall be when any adult client is on the then the client's treatment or cuments that the client is ing in the home or community. The plan shall be reviewed ess than annually to ensure to be capable of remaining in unity without supervision for a time. The plan shall be reviewed essent in a facility in the fratios when more than one client is present: In a dolescents with substance all be served with a minimum of the foreign fours if specified by the procedures determined by				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		250129	B. WING			R-C <b>09/2025</b>	
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST TGATE DRIVE C 27244				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 290	(2) children of developmental disas one staff present for present and two star more clients present duspecified by the endetermined by the endeter	or adolescents with abilities shall be served with ar every one to three clients aff present for every four or at. However, only one staff uring sleeping hours if a regency back-up procedures governing body. The serve clients whose primary nace abuse dependency: The staff member who is on a lie of a lie of a lie of a certified substance all be available on an	V 290				
	interviews, the facil continued capability current clients (#3) community. The fir Observation on 5/6 revealed: -Client #3 was walk	ons, record review and ity failed to assess the y for one of three audited to be unsupervised in the					
	-Admission date of -Diagnoses of Schi	zophrenia, Chronic nary Disease, Hyperlipidemia,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		250129	B. WING		R-C <b>05/09/2025</b>		
					1 03/0	9/2025	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
ALAMAN	ICE HOMES II	ELON, NC	GATE DRIV	E			
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTI	ON.	(V5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 290	Continued From pa	ge 16	V 290				
	-Unsupervised Time Assessment dated 7/1/22-Client #3 can leave the facility for 30 minutes but no more than an hourThere 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 handClient #3 stated he took those used cigarette butts from a canister in the parking near the supermarketHe was going to smoke those cigarettes butts laterHe was walking back to the facilityHe was allowed to have unsupervised time in the community dailyHe walked to the shopping center most days.						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		250129	B. WING		1	-C <b>09/2025</b>
	PROVIDER OR SUPPLIER		TGATE DRIVI	TATE, ZIP CODE ≣		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUNDS OF THE APPRINCED TO THE APPRI	JLD BE	(X5) COMPLETE DATE
V 290	-Client #3 would ret of cigarettes or pick groundShe saw client #3 butts.  Interviews on 5/6/29 Director/Licensee re-Client #3 had unsucommunityHe had unsupervisel-He was aware of cobutts while he was was unsupervised. about that." -Client #3 had beer-He wasn't aware or cigarettes and/or mitime in the communityThe Former Qualiff supposed to update assessment a few repability for client is community.	curn to the facility with a pack a used cigarette butts off the smoke those used cigarette  5, 5/7/25 and 5/9/25 with the evealed: spervised time in the sed time for several years. lient #3 getting used cigarette in the community whenever he lient #3 getting used cigarette in the community whenever he lient #3 begging for oney during his unsupervised nity. See his unsupervised time months ago. See his unsupervised time months ago. Second #2 was a see his unsupervised time months ago. Second #3 to be unsupervised in the setitutes a re-cited deficiency	V 290			
V 366	10A NCAC 27G .06 RESPONSE REQU CATEGORY A AND (a) Category A and implement written presponse to level I, shall require the pro	JIREMENTS FOR	V 366			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SLIDVEV	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '		COMPLETED	
			A. BUILDING:	<del></del>		
					R-C	
		250129	B. WING		05/0	9/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET AN	DRESS CITY S	STATE, ZIP CODE		
IVAIVIL OF I	NOVIDEN ON SOLT EIEN					
ALAMAN	ICE HOMES II		GATE DRIV	<b>E</b>		
		ELON, NO	21244			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION SHOULD		(X5) COMPLETE
PRÉFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		DATE
1710		,	,,,,,	DEFICIENCY)		
1/000	0 " 15	40	14000			
V 366	Continued From pa	ge 18	V 366			
	of individuals involv	ed in the incident;				
		ng the cause of the incident;				
		g and implementing corrective				
		g to provider specified				
	timeframes not to e					
		g and implementing measures				
		cidents according to provider				
		es not to exceed 45 days;				
		person(s) to be responsible				
		of the corrections and				
	preventive measure					
	(6) adhering t	to confidentiality requirements				
	set forth in G.S. 75,	Article 2A, 10A NCAC 26B,				
	42 CFR Parts 2 and	d 3 and 45 CFR Parts 160 and				
	164; and					
	(7) maintainir	ng documentation regarding				
	Subparagraphs (a)(	1) through (a)(6) of this Rule.				
	(b) In addition to th	e requirements set forth in				
		s Rule, ICF/MR providers				
		ents as required by the federal				
		FR Part 483 Subpart I.				
		e requirements set forth in				
		s Rule, Category A and B				
		g ICF/MR providers, shall				
		nent written policies governing				
		level III incident that occurs				
		delivering a billable service				
		on the provider's premises.				
	-	equire the provider to respond				
	by:					
	` '	ely securing the client record				
	by:					
		the client record;				
		photocopy;				
	. ,	the copy's completeness; and				
	` ',	g the copy to an internal				
	review team;					
		g a meeting of an internal				
	review team within	24 hours of the incident. The				1

Division of Health Service Regulation

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<u>Divisio</u> n	of Health Service Re	egulation				
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		250129	B. WING		R-C <b>05/09/2025</b>	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	105 1101450 11		GATE DRIV			
ALAWAN	ICE HOMES II	ELON, NO	27244			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 366	Continued From pa	ge 19	V 366			
	who were not involve were not responsible with direct professions services at the time review team shall of follows:  (A) review the determine the facts and make recommon occurrence of future (B) gather off (C) issue writh within five working of preliminary findings LME in whose catcled located and to the Lift different; and (D) issue a finding owner within three in final report shall be catchment area the LME where the clie final written report sidentified by the interior include all public do incident, and shall in minimizing the occur all documents need available within three LME may give the particular three months to suff (A) the LME rearea where the server Rule .0604;  (B) the LME red different;	in shall consist of individuals ared in the incident and who are for the client's direct care or onal oversight of the client's of the incident. The internal omplete all of the activities as a copy of the client record to and causes of the incident endations for minimizing the endations for minimizing the endations for minimizing the endations for minimizing the endations for minimizing of fact days of the incident. The endated of fact shall be sent to the hument area the provider is and written report signed by the months of the incident. The sent to the LME in whose endated and to the intresides, if different. The shall address the issues ernal review team, shall ocuments pertinent to the make recommendations for arrence of future incidents. If the for the report are not be months of the incident, the own the final report; and eley notifying the following: esponsible for the catchment wices are provided pursuant to where the client resides, if				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		R-C	
		250129	B. WING			9/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
ALAMAN	ALAMANCE HOMES II 502 WES ELON, NO			E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
V 366	for maintaining and treatment plan, if di provider; (D) the Depai (E) the client applicable; and	l updating the client's  fferent from the reporting  tment;  's legal guardian, as  authorities required by law.	V 366			
	Based on record refacility failed to impresponse to Level I findings are:  Review on 5/2/25 orecord revealed: -Admission date of -Diagnoses of Schi Osteoarthritis, Vital Hyperlipidemia, Ab Abdominal BruitDischarge date of	eview and interviews, the lement a policy governing their II incidents as required. The of former client (FC) #4's 6/20/19.  zophrenia, Bipolar Disorder, min D Deficiency, scess-Right Knee and 4/24/25.				
	Carolina (NC) Incid System (IRIS) reve -On 5/2/25 there we submitted by the fa abuse against staff him in his ear. -On 5/5/25 a Level by the Qualified Pro morning of 4/24/20	and 5/6/25 of the North ent Response Improvement aled: as no level III incident report cility related to an allegation of #1. FC #4 alleged staff #1 hit III incident report was added ofessional (QP)-"On the 25 an allegation of abuse, staff ar was reported to the staff at				

DIVISION	of Health Service Re	guiation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R-	.c
		250129	B. WING		1	9/2025
					1 00/0	0,2020
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ALAMAN	ICE HOMES II		GATE DRIV	E		
		ELON, NO	27244			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 366	Continued From page 21		V 366			
	Alamance Homes I the facility to intervior Director/Licensee] to complete an interviewent to the group hither residents at the [FC #4] as reported home stated they differ to substantiate. There was no documented correct the provider specific 45 days; no measured according to provide exceed 45 days and	was denied access to [FC #4] rview. [The Director/Licensee] ome to interview [staff #1] and home. [Staff #1] denied hitting. The other 3 residents in the id not see [staff #1] hit [FC icensee] stated he was not any abuse."  Immentation to determine: The nt; If the facility developed and ctive measures according to ed timeframes not to exceed res to prevent similar incidents of assigning person(s) to be dementation of the corrections				
	-He spoke with the last evening (5/5/25 of abuseStaff #1 said in Aproper redirect FC #4 becardate in the kitchen substant -Staff #1 said FC #4 started hitting himselustrated -Staff #1 denied hitting -Staff #1 denied hitting -Twhen [the Director incident to his attentimpression all of this QP #1]." -"I didn't know about 5/2/25."	fact upset with her and a self in the face.				
		ound like the incident with the				

Division of Health Service Regulation

client and staff was resolved."

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7. BOILDING:		R-C	
		250129	B. WING			9/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ALAMAN	ICE HOMES II	502 WEST ELON, NO	「GATE DRIV :27244	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 366	Continued From pa	ge 22	V 366			
	-He confirmed the facility failed to implement a policy governing their response to Level III incidents as required.					
	Director/Licensee r -He knew about the alleged against stat -"I was confused in accused of hitting h and his transportati name." -"On Friday (5/2/25 something that was said I didn't know a -He talked to staff # 5/2/25 and "her sto -Staff #1 said she o -"I had no access to him at the day prog -The investigation t #4 was still being in -"I'm still trying to fig investigation." -"[The QP] and I ha yet." -He confirmed the figure	e allegation of abuse FC #4 If on 4/24/25. Itially about which staff [FC #4] Itim because the facility staff on staff had the same first  It didn't want to tell you so not correct so that was why I bout the incident." If about the incident again on any was the same." It did not hit FC #4 on 4/24/25. It is [FC #4] when I went to talk to aram on 4/24/25." It hat involved staff #1 and FC avestigated. If gure out everything with this and not come to a conclusion If acility failed to implement a a pair response to Level III				
V 367	27G .0604 Incident	Reporting Requirements	V 367			
	level II incidents, ex the provision of billa	UIREMENTS FOR				

DIVISION	of Health Service Re	guiation			1	
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	<del></del>	COMPLETED	
					R-	C
		250129	B. WING			9/2025
		230129			05/0	9/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	IOE LIOMEO II	502 WEST	GATE DRIV	E		
ALAMAN	ICE HOMES II	ELON, NO	27244			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
				DEFICIENCY)		
V 367	Continued From pa	ge 23	V 367			
	•	_				
		II deaths involving the clients				
		er rendered any service within				
		incident to the LME				
		catchment area where				
		ed within 72 hours of				
	O	the incident. The report shall				
		orm provided by the				
		ort may be submitted via mail,				
	in person, facsimile or encrypted electronic					
	means. The report shall include the following					
	information:					
		provider contact and				
	identification inform					
		ntification information;				
	(3) type of inc					
		n of incident;				
	` '	he effort to determine the				
	cause of the incider	•				
	` '	viduals or authorities notified				
	or responding.	Dunasidana akallasudain aus				
		B providers shall explain any				
		ete information. The provider				
		ated report to all required the end of the next business				
		the end of the flext business				
	day whenever: (1) the provid	er has reason to believe that				
		d in the report may be				
		ing or otherwise unreliable; or				
		er obtains information				
		dent form that was previously				
	unavailable.	done form that was providedly				
		B providers shall submit,				
		E LME, other information				
		the incident, including:				
		ecords including confidential				
	information;	Journal Indicating Confidential				
		other authorities; and				
		er's response to the incident.				
		B providers shall send a copy				

Division of Health Service Regulation						
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
				R-C		
250129		B. WING		05/09/2025		
	200//050 00 01/00/150	0.755.7.15		TATE TO CODE		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ALAMAN	ICE HOMES II		GATE DRIV	E		
		ELON, NO	27244			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
1710		,	17.0	DEFICIENCY)		
1/ 267	0	04	1/ 207			
V 367	Continued From pa	ge 24	V 367			
	of all level III incide	nt reports to the Division of				
		elopmental Disabilities and				
	Substance Abuse S	Services within 72 hours of				
		the incident. Category A				
		d a copy of all level III				
		a client death to the Division of				
	_	ulation within 72 hours of				
		the incident. In cases of				
		seven days of use of seclusion vider shall report the death				
		juired by 10A NCAC 26C				
		AC 27E .0104(e)(18).				
		B providers shall send a				
		he LME responsible for the				
		ere services are provided.				
		submitted on a form provided				
	by the Secretary via	a electronic means and shall				
		formation as follows:				
	· ,	n errors that do not meet the				
		II or level III incident;				
	\ /	interventions that do not meet				
		evel II or level III incident;				
		of a client or his living area; of client property or property in				
	(4) seizures of the possession of a					
		number of level II and level III				
	incidents that occur					
		ent indicating that there have				
		incidents whenever no				
	incidents have occu	ırred during the quarter that				
	meet any of the crit	eria as set forth in Paragraphs				
		tule and Subparagraphs (1)				
	through (4) of this F	Paragraph.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	` '		(3) DATE SURVEY COMPLETED	
			A. BUILDING:		R-C		
		250129 B. WING		1	05/09/2025		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
ALAMAN	ICE HOMES II	502 WES ELON, NO	TGATE DRIV 27244	E			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
V 367	Continued From pa	nge 25	V 367				
	Based on record refacility failed to ensite to the Local Managorganization (LME, where services are becoming aware of Review on 5/2/25 or record revealed: -Admission date of -Diagnoses of Schi Osteoarthritis, Vitar Hyperlipidemia, Abadominal BruitDischarge date of	zophrenia, Bipolar Disorder, min D Deficiency, scess-Right Knee and					
	Incident Response revealed: -Incident report dat Qualified Professio 4/24/2025 an allega Client (FC) #4] on t staff at [Name of D Director/Licensee] notified and he wer #4]. [The Director/L to [FC #4] to compl Director/Licensee] interview [staff #1] at [Staff #1] denied his other 3 residents in see [staff #1] hit [FG stated he was not a abuse."	Improvement System (IRIS) ed 5/5/25 completed by the nal (QP)-"On the morning of ation of abuse, staff hit [Former he ear was reported to the					

DIVISION	of Health Service Re	eguiation				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		250129	B. WING		R-C <b>05/09/2025</b>	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			GATE DRIV			
ALAMAN	ICE HOMES II	ELON, NO	27244			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 367	Continued From pa	ge 26	V 367			
	last evening (5/5/25 of abuseStaff #1 said in Apredirect FC #4 becaface in the kitchen: -Staff #1 said FC #4 started hitting himse-Staff #1 denied hitt-"When [the Director incident to his attentimpression all of this QP #1]." -"I didn't know about 5/2/25." -"When I talked witt 5/2/25 he made it solient and staff wase-He put the incident He confirmed the fabove incident to Lill Interviews on 5/6/25 Director/Licensee re-He knew about the alleged against staft-"I was confused in accused of hitting hand his transportatiname." -"On Friday (5/2/25 something that was said I didn't know a -He confirmed the facconfirmed the facconfir	4 got upset with her and elf in the face. ting FC #4. or/Licensee] first bought this tion on 5/2/25, I was under the s was done by [the Former at the allegation of abuse until in [the Director/Licensee] on ound like the incident with the resolved." tinto IRIS on 5/5/25. facility failed to report the ME/MCO within 72 hours. 5 and 5/7/25 with the evealed: a allegation of abuse FC #4 on 4/24/25. Itially about which staff [FC #4] tim because the facility staff on staff had the same first on to correct so that was why I				
V 500	, ,	ent Rights - Policy on Rights	V 500			
	10A NCAC 27D 01	01 POLICY ON RIGHTS				

Division of Health Service Regulation STATE FORM

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<u>Divisio</u> n	of Health Service Re	egulation				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  250129		(X1) PROVIDER/SUPPLIER/CLIA	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B. WING		R-C <b>05/09/2025</b>		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ALAMAN	ICE HOMES II	502 WES <sup>-</sup> ELON, NO	TGATE DRIV 27244	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 500	(a) The governing assures the implem G.S. 122C-65, and (b) The governing implement policy to (1) all instance abuse, neglect or ereported to the Couservices as specific G.S. 7A, Article 44; (2) procedure instituted in accordary practice when a meropresent serious risk Particular attention neuroleptic medicar (c) In addition to the 10A NCAC 27E .01 each facility shall dethat identifies:	ND INTERVENTIONS body shall develop policy that nentation of G.S. 122C-59, G.S. 122C-66. body shall develop and assure that: less of alleged or suspected exploitation of clients are inty Department of Social led in G.S. 108A, Article 6 or and less and safeguards are leance with sound medical edication that is known to a to the client is prescribed. shall be given to the use of	V 500			
	prohibited from use (2) in a 24-ho under which staff at the rights of a client (d) If the governing restrictive interventithe restrictions of continuous (2) the individual (3) the due proposition in the proposition (2) the due proposition (3) the due proposition in the proposition (3) the due proposition in the proposition (4) the due proposition in the proposition (5) the due proposition in the proposition (5) the due proposition in the proposition (5) the proposition (6) the proposition (7) the prop	within the facility; and our facility, the circumstances re prohibited from restricting to body allows the use of ons or if, in a 24-hour facility, lient rights specified in G.S. are allowed, the policy shall tted restrictive interventions or it; dual responsible for informing rocess procedures for an incorefuses the use of				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. Boilbing.		R-C	
		250129	B. WING		1	9/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ALAMAN	ICE HOMES II	502 WEST ELON, NO	TGATE DRIV	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 500	within the facility, the develop and impler compliance with Sumhich includes:  (1) the design has been trained and competence to use provide written authoristrictive intervent renewed for up to a accordance with the NCAC 27E .0104(e)  (2) the design responsible for revisiterventions; and  (3) the estable appeal for the resolution.	ne governing body shall ment policy that assures abchapter 27E, Section .0100, mation of an individual, who and who has demonstrated a restrictive interventions, to norization for the use of ions when the original order is a total of 24 hours in the time limits specified in 10A	V 500			
	Based on record regoverning body fail abuse to the Depar (DSS). The findings Review on 5/6/25 of Incident Response revealed: -Incident report dat Qualified Professio 4/24/2025 an allegated Client (FC) #4] on the staff at [Name of Director/Licensee] notified and he were #4]. [The Director/Licensed Incident Professional Profession	of the North Carolina (NC) Improvement System (IRIS) ed 5/5/25 completed by the nal (QP)-"On the morning of ation of abuse, staff hit [Former the ear was reported to the				

Division of Health Service Regulation

STATE FORM 6899 E6XZ11 If continuation sheet 29 of 31

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		250129	B. WING		R-C <b>05/09/2025</b>	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
			GATE DRIV			
ALAMAN	ICE HOMES II	ELON, NO	27244			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 500	Continued From pa	ge 29	V 500			
	interview [staff #1] a [Staff #1] denied hit other 3 residents in see [staff #1] hit [F0 stated he was not a abuse."	went to the group home to and the residents at the home. ting [FC #4] as reported. The the home stated they did not C #4]. [The Director/Licensee] ble to substantiate any with the Former QP #1				
	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.					
	the incident under t -She contacted FC incident.	ctor/Licensee] was pushing he rug." #4's DSS guardian about the t the local DSS agency.				
	Interview on 5/6/25 with the QP revealed: -He spoke with the Director/Licensee and staff #1					

Division of Health Service Regulation						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
250129		B. WING		R-C <b>05/09/2025</b>		
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ALAMAN	NCE HOMES II	ELON, NO	27244			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 500	Continued From pa	ge 30	V 500			
	redirect FC #4 becaface in the kitchen solution. Staff #1 said FC #4 started hitting himse. Staff #1 denied hitt. He didn't contact Director/Licensee soontacted them. He confirmed the above allegation of Interviews on 5/6/2! Director/Licensee relation. He knew about the alleged against staft. A staff from the Dacould not remembe. He went to FC #4's tried to talk to FC #4. The Day Program talk to FC #4. "I was confused in accused of hitting hand his transportatiname."  "On Friday (5/2/25) something that was said I didn't know a The local DSS was allegation of abuse I didn't think I had #4's] guardian work county.	4 got upset with her and elf in the face. ing FC #4. USS because the aid the Former QP #1 agency failed to report the abuse to DSS. and 5/7/25 with the evealed: allegation of abuse FC #4 on 4/24/25. By Program called him, he r which staff called him. It is day program on 4/24/25 and 4. Staff would not let him see or tially about which staff [FC #4] im because the facility staff on staff had the same first bout the incident." It is never contacted about the against staff #1. It is contact them because [FC ed with DSS in another agency failed to report the				

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