

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL010-084</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>LINDLEY COLLEGE IX</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1513 NORTH HOWE STREET, SUITE H SOUTHPORT, NC 28461</b>		
(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 survey was completed on May 28, 2025. The complaint was unsubstantiated (intake #NC00229688). A deficiency was cited.  This facility is licensed for the following service category: NCAC 27G .5400 Day Activity for Individuals of All Disability Groups.  The facility has a current census of 29. The survey sample consisted of audits of 4 current clients.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan  10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL010-084</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>LINDLEY COLLEGE IX</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1513 NORTH HOWE STREET, SUITE H SOUTHPORT, NC 28461</b>		
(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 112	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to develop and implement goals and strategies to address the needs of 1 of 4 audited clients (#4). The findings are:</p> <p>Review on 05/15/25 of client #4's record revealed: -Admission date of 11/09/22. -Diagnoses included Autistic Disorder, Mild-Intellectual Disabilities, and Seizure Disorder. -There was no documentation of the vagus nerve stimulation (VNS) implant in client #4's record.</p> <p>Review on 05/19/25 of client #4's Individual Support Plan (ISP) dated 08/01/24 revealed: -Client #4 had a seizure disorder. -The seizure disorder "can be spontaneous" and "it is felt that he is having more seizures than what are witnessed." - Client #4 displayed "various types of seizures, some are very violent in nature" and he "may pass out." -"It is noted by supports that his fists may tighten up, loosen, and tighten again and this is felt to be a seizure coming on or currently happening." -"[Client #4] may also bite his tongue and/or lip, which may cause bleeding."</p> <p>Review on 05/19/25 of the facility Individual</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL010-084</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>LINDLEY COLLEGE IX</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1513 NORTH HOWE STREET, SUITE H SOUTHPORT, NC 28461</b>		
(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 112	<p>Continued From page 2</p> <p>Details Form (IDF) for client #4 updated 06/13/24 revealed:</p> <p>-Other Medical Information - "He suffers from various types of seizures, some are very violent in nature and he may pass out, and for others the opposite may be seen, where he will have little effect afterward. Sometimes this may affect his memory as well."</p> <p>-Emergency Orders - "[Client #4]'s seizures typically last 1-2 minutes. For any seizure, immediately call mom. If the seizure lasts more than 4 minutes or [client #4] begins to lose continues, call 911."</p> <p>Review on 05/16/25 of facility incident reports between 12/10/25 and 02/27/25 revealed: (02/6/25)</p> <p>-Client #4 had a seizure on 02/06/25 at 12:30pm.</p> <p>-Local emergency medical services (EMS) and client #4's parents were contacted on 02/06/25.</p> <p>-Client #4 "had a seizure not lasting more than 2 minutes" and staff "assisted him to the floor for safety."</p> <p>-Plan of future corrective actions included "maintaining conversation with staff and parents on seizure protocol."</p> <p>(02/27/25)</p> <p>-Client #4 had a seizure on 02/27/25 at 10:20am.</p> <p>-Local EMS and client #4's parents were contacted on 02/27/25.</p> <p>-Client #4 was evaluated by EMS.</p> <p>-The seizure lasted 4 minutes.</p> <p>-Plan of future corrective actions included a review of seizure protocols, ISP, IDF, and potential triggers.</p> <p>Interview on 05/20/25 of client #4's Local Management Entity (LME)/Managed Care Organizations (MCO) Care Coordinator stated:</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL010-084</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>LINDLEY COLLEGE IX</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1513 NORTH HOWE STREET, SUITE H SOUTHPORT, NC 28461</b>		
(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 112	<p>Continued From page 3</p> <ul style="list-style-type: none"> <li>-Client #4 had surgery for a VNS implant on 01/29/25 to address seizures.</li> <li>-The VNS implant was activated two weeks later.</li> <li>-She had not updated the current ISP to reflect the addition of the VNS device yet.</li> <li>-She did not realize the VNS implant was needed in the plan.</li> <li>-She had scheduled a review of the ISP for 06/11/25.</li> <li>-She was going to add the addition of the VNS device prior to the 06/11/25 meeting.</li> </ul> <p>Interview on 05/21/25 with the Clinical Coordinator for client #4's Neurologist stated:</p> <ul style="list-style-type: none"> <li>-The VNS sent impulses to the brain to prevent and stop seizure activity.</li> <li>-If the client felt the seizure coming on, the VNS device could have been used to prevent the seizure from happening.</li> <li>-If the client was already having a seizure, the device could have been used to stop the seizure.</li> <li>-The device was manually operated by moving a corresponding magnet past the VNS.</li> </ul> <p>Interview on 05/21/25 client #4's father stated:</p> <ul style="list-style-type: none"> <li>-Client #4 received the VNS implant around 01/27/25 - 01/29/25.</li> <li>-He was not certain when the VNS implant was activated.</li> <li>-The day program was aware that the VNS had been implanted when client #4 returned from surgery.</li> <li>-He spoke with the former Day Program Manager in February 2025 about how the VNS implant worked and what was required with operation of the device.</li> <li>-He was aware of client #4 having two seizures at the day program in the last 6 months.</li> <li>-Client #4's seizures varied in intensity and presented as "zones out" and "unresponsive" to</li> </ul>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL010-084</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>LINDLEY COLLEGE IX</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1513 NORTH HOWE STREET, SUITE H SOUTHPORT, NC 28461</b>		
(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 112	<p>Continued From page 4</p> <p>falling over while walking or sitting.</p> <p>-The duration of client #4's seizures generally lasted "a couple of minutes."</p> <p>-The timing of the seizures had increased over the last 6 months from once every couple of months to every two weeks.</p> <p>-Client #4 used to have seizures after he fell asleep but the timing of the seizure occurrence had also changed.</p> <p>Interview on 05/19/25 client #4 stated:</p> <p>-He was uncertain how often he had seizures or how often they occurred at the day program.</p> <p>-He could not recall the last time he had a seizure at the day program.</p> <p>-He had a device installed in his neck that was activated by a watch that could be swiped next to the device.</p> <p>-He was not certain how long he had the VNS device.</p> <p>Interview on 05/19/25 and 05/28/25 staff #2 stated:</p> <p>-Client #4 had experienced 2 seizures since December, 2024.</p> <p>-Client #4 had a device in his neck that stimulated the brain.</p> <p>-During the seizure on 02/27/25, client #4 started to fall over in his chair before staff #9 caught him and assisted him to the ground.</p> <p>-She and staff #3 attended to client #4 while he was on his side to maintain his head.</p> <p>-Client #4 was shaking, trembling, and was unconscious.</p> <p>-The seizure lasted about 5 minutes.</p> <p>Interview on 05/19/25 and 05/28/25 staff #3 stated:</p> <p>-Over the past two years, he had witnessed client #4 have 2 or 3 seizures.</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL010-084</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>LINDLEY COLLEGE IX</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1513 NORTH HOWE STREET, SUITE H SOUTHPORT, NC 28461</b>		
(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 112	<p>Continued From page 5</p> <p>-The last seizure with client #4 was about 2 - 3 months ago, appeared to be a grand mal seizure, and lasted about 2 - 3 minutes.</p> <p>-Client #4 convulsed, his eyes rolled back in his head, and he shook badly.</p> <p>-EMS were called out for client #4's seizures and client #4's parents were notified.</p> <p>-During the last seizure, client #4 started to fall over in his chair before staff #9 caught him and assisted him to the ground.</p> <p>-Client #4 had a device implanted in his neck that assisted with his seizures by use of "a wand."</p> <p>Interview on 05/19/25 and 05/28/25 staff #5 stated:</p> <p>-She had witnessed client #4 have 2 seizures.</p> <p>-The first seizure she was in the room with her client (unknown) and client #4 when she heard "feet shuffling" and when she turned around, client #4 was on the floor seizing.</p> <p>-She notified the Day Program Manager and 911 was called.</p> <p>-The last seizure for client #4 was about 2 - 3 months ago and lasted about 2 - 3 minutes.</p> <p>-EMS were called out for both seizures and client #4's parents were notified.</p> <p>-During the last seizure, client #4 started to fall over in his chair before staff #9 caught him and assisted him to the ground.</p> <p>-Client #4 twitched and his eyes rolled back into his head.</p> <p>-Client #4 had a device implanted in his neck that assisted with his seizures through use of a "wand."</p> <p>Interview on 05/19/25 and 05/28/25 staff #6 stated:</p> <p>-Client #4 had 2 seizures over the last 6 months.</p> <p>-EMS was called out to the day program for both seizures.</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL010-084</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>LINDLEY COLLEGE IX</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1513 NORTH HOWE STREET, SUITE H SOUTHPORT, NC 28461</b>		
(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 112	<p>Continued From page 6</p> <p>-Client #4 appeared to go into shock and shook really bad.</p> <p>-The last seizure on 02/27/25 was about 4 - 5 minutes long.</p> <p>-Client #4 had surgery on his neck about 4 months ago and started having seizures following the surgery.</p> <p>Interview on 05/16/25 and 05/28/25 staff #7 stated:</p> <p>-Client #4 had 2 - 5 seizures since December 2024.</p> <p>-The seizures lasted for 5 - 6 minutes.</p> <p>-She was not working on 02/27/25 when client #4 had his last seizure.</p> <p>-Client #4 had an implant in his neck to assist with the seizures.</p> <p>Interview on 05/16/25 and 05/28/25 staff #8 stated:</p> <p>-Client #4 had not had a seizure for a couple of months.</p> <p>-She could not recall how many seizures client #4 had over the last 6 months.</p> <p>-Client #4 had a device in his neck.</p> <p>-During the last seizure on 02/27/25, she was unable to view client #4 seizure due to clients and staff which obstructed her view.</p> <p>-She approximated the length of client #4's seizure to be about 2 minutes.</p> <p>Interview on 05/28/25 staff #9 stated:</p> <p>-Client #4 had 2 seizures over the last 6 months.</p> <p>-Client #4's seizures presented in the same manner.</p> <p>-With the first seizure, client #4 was sitting next to him, and then started leaning to his side.</p> <p>-He caught client #4 as he leaned over, and assisted him to the floor while he seized.</p> <p>-Client #4's eyes rolled back in his head, and he</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL010-084</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>LINDLEY COLLEGE IX</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1513 NORTH HOWE STREET, SUITE H SOUTHPORT, NC 28461</b>		
(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 112	<p>Continued From page 7</p> <p>was"just shaking hard while curled up in the fetal position."</p> <p>-Client #4 's "tremors were violent tremors."</p> <p>-Client #4's seizures were each about 2 - 3 minutes in length.</p> <p>Interview on 05/19/25 the Qualified Professional stated:</p> <p>-Client #4 had 2 seizures over the last 2 - 3 months.</p> <p>-A device had been surgically implanted in client #4 at the beginning of the year to assist with seizures.</p> <p>Interview on 05/20/25 the facility's Service Line Coordinator stated:</p> <p>-She had previously been employed as the Program Manager for the day program but had taken a new position as the Service Line Coordinator in recent weeks.</p> <p>-Client #4 had surgery where a device had been implanted in his neck to reduce seizure activity.</p> <p>-Client #4's seizure activity was generally a nighttime occurrence and was not something that occurred very often at the day program.</p> <p>-In the 2.5 years that client #4 had attended the day program, staff had witnessed 4 seizures, with only two of those in the last year.</p> <p>-In the event of a seizure, staff are trained to turn client #4 to his side, call 911, and monitor to avoid head injury.</p> <p>Review on 05/28/25 of a "Plan of Protection - Completed by the Regional Vice President and signed by the Regional Vice President and dated 05/28/25 revealed:</p> <p>-"What immediate action will the facility take to ensure the safety of the consumers in your care? Program manager was able to obtain training materials for the VNS device and added to clients</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL010-084</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>LINDLEY COLLEGE IX</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1513 NORTH HOWE STREET, SUITE H SOUTHPORT, NC 28461</b>		
(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 112	<p>Continued From page 8</p> <p>clinical documentation. All program staff were trained on the device May 21st (2025). -"Describe your plans to make sure the above happens. The team is meeting with the Care Manager on June 11th (2025) and will request the information is added to the clients ISP. In future circumstances, we will ensure we document all efforts to obtain medical information from LRP (legal representative/legal responsible person), care manager or physicians."</p> <p>Client #4 was diagnosed with autistic disorder, mild-intellectual disabilities, and seizure disorder. On 01/29/25, client #4 had a VNS device surgically implanted to address concerns with seizures. Client #4 had seizures at the day program on 02/06/25 and 02/27/25 which lasted 2 - 4 minutes in duration. There were no goals or strategies developed or implemented for the prevention and minimization of seizures which followed client #4's VNS implant on 01/29/25. Due to client #4's history of seizures, and the failure to develop and implement strategies for the use of the VNS implant, this deficiency constitutes a Type B rule violation which is detrimental to the health, safety, and welfare of the client and must be corrected within 45 days.</p>	V 112		