STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 000	INITIAL COMMENTS A complaint survey was completed on 6/6/25. The complaint was substantiated (intake #NC00230663). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 6 and has a current census of 6. The survey sample consisted of audits of 6 current clients.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their	V 108		

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V 108	Continued From page 1 equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that 3 of 3 staff had current training in First Aid and Cardiopulmonary Resuscitation (CPR), (Staff #1, #2 and Qualified Professional (QP)). The findings are: Review on 5/28/25 of staff #1's record revealed: -Hired 9/1/11. -First Aid and CPR training expired 3/7/25. Review on 5/22/25 of staff #2's record revealed: -Hired 8/8/23 -First Aid and CPR training expired 4/10/25. Review on 5-20-25 of the QP's record revealed: -Hired 1/15/19. -First Aid and CPR training 3/7/25. Interview on 5/29/25 with staff #1 revealed: -One staff worked on each 7 day shift rotation (7 days on and 7 days off). -Worked Tuesday to Tuesday on the rotating shift. -Was not aware First Aid and CPR training had expired. Interview on 5/28/25 with staff #2 revealed:	V 108		

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V 108	Continued From page 2 -Was aware First Aid and CPR training had expired. -"I've been asking (QP) about the training but it's a matter of them (Licensee) getting me set up." -The QP kept up with training updates and reminded staff. -Worked Monday to Monday on the rotating shift. Interview on 5/28/25 and 6/3/25 with the QP revealed: -Was not aware First Aid and CPR training for Staff #1, #2 had expired. -One staff worked on each shift. -Worked at the facility "at least 2 days a week", 8 hr/day, 16 hours total. -Was supervisor for the 3 staff at the facility. -"As far as scheduling, that falls on me" and reminders were sent "from the main office" before First Aid and CPR expired. -Did not have an explanation for why the First Aid and CPR trainings had not been updated. -Had scheduled a First Aid and CPR training for staff on 6/3/25. Interview on 5/28/25 with the Director/Licensee revealed: -Did not know Staff #1, #2, and QP training for First Aid and CPR was not up to date. -QP was responsible for scheduling all training for facility staff and keeping up with training updates. -QP had scheduled 6/3/25 class to bring First Aid and CPR current. Review on 5/28/25 of an email dated and received on 5/28/25 from the QP revealed: -First Aid and CPR recertification training scheduled for June 3, 2025. -No First Aid and CPR re-certifications were received for Staff #1, #2 and the QP by survey exit date.	V 108		

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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. (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, 1 of 3	V 110		

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paraprofessional staff (Staff #2) failed to demonstrate the knowledge, skills, and abilities required by the population served. The findings are:

Review on 5/27/25 of the facility's records revealed:
-"General Event Report" and documentation of the 5/19/25 incident findings with the following summary:
-"Left (Staff #2) at 2:25 to pick up clients from day program. At 3:00 pm staff (#2) realized that he had left [client #1] at the Group Home. Staff (#2) returned to the Group Home around 3:20 pm and went in to check on client (#1), who was still in his room playing his video games. Staff (#2) made sure client (#1) was ok and had another staff (#3) to check on him as well. Staff (#2) contacted his Qualified Professional (QP) around 3:30 and reported the incident to her. I (Staff #2)was then asked to write a statement as to what had happened.
-Actions Taken-Talked to Client (#1) to assure him that he had not done anything wrong and what had happened was Staff's (#2) fault and responsibility to make sure he was safe and to let him no that it would not happen again.
-Plan of Future Corrective Actions-to be determined"
-Internal report of findings with the following "Conclusion and Recommendations: ...although the staff (Staff #2) did not mean leave the resident (client #1) in the home (facility), it is substantiated because he (client #1) was left at the home unsupervised for approximately 55 minutes. This is against our contractual ratio's and BCH (Baptist Children's Home) policy...We (Facility) will now wait for the DSS (Department of Social Services) findings to take place. They (DSS) may decide to refer to DHHS (Department

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V 110	Continued From page 5 of Health and Human Services]. My (Licensee/Director) recommendation is for our Department to put in place something for a headcount to take place in the van, so not one is left behind during each outing. Things can be busy everyday but our residents health and safety are our priority." Review on 5/22/25 of client #1's record revealed: -Admitted on 10/1/21. -Assessment dated 10/1/21. -Treatment plan dated 10/31/23. -Diagnosis: Mild Intellectual Developmental Disability (IDD). -No documentation in treatment plan of unsupervised time. Review on 5/29/25 of client #2's record revealed: -Admitted on 2/19/05. -Assessment dated 2/18/05. -Treatment plan dated 8/28/24. -Diagnoses: Down Syndrome, Psoriasis, Celiac, Heart Valve. -No documentation in treatment plan of unsupervised time. Review on 5/29/25 of client #3's record revealed: -Admitted on 12/4/04. -Assessment dated 12/4/04. -Treatment plan dated 8/20/24. -Diagnosis: Mild IDD. -No documentation in treatment plan of unsupervised time. Review on 5/29/25 of client #4's record revealed: -Admitted on 7/1/08. -Assessment dated 4/25/08. -Individual Service Plan (Treatment plan) dated 12/1/24 -Diagnoses: Mild IDD; Traumatic Brain Injury:	V 110		

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Psychosocial Stressors, Mild.
-Wheelchair with Innovations Personal Care and one on one support.
-No documentation in treatment plan of unsupervised time.

Review on 5/29/25 of client #5's record revealed:
-Admitted 3/1/05.
-Assessment dated 3/1/05.
-Treatment plan dated 8/20/24.
-Diagnoses: IDD, Mild; Hearing Impairment; Hypertension; Seizure Disorder.
-Non-verbal
-No documentation in treatment plan of unsupervised time.

Review on 5/29/25 of client #6's record revealed:
-Admitted on 3/27/21.
-Assessment dated 3/27/21.
-Treatment plan dated 7/18/23.
-Diagnosis: Mild IDD.
-No documentation in treatment plan of unsupervised time.

Review on 5/22/25 of Staff #2's record revealed:
-Job title: Direct Support Professional (DSP).
-Hired 8/8/23.
-Written statement by Staff #2 regarding 5/19/25 incident, dated and signed on 5/19/25 revealed: "I [Staff #2] on 5/19/25 left the group (facility) shortly after 2pm to pick everyone (clients #2, #3, #4, #5, #6) up from [Day Program]. I unintentionally left a client [client #1] in his room playing video games, while thinking he was at [grocery store] working. I returned to the Group Home around 3:15 pm and went straight to his room to make sure he was okay. Client said he was fine and liked being home by himself. I asked another staff (Staff #3) to also talk to him to make sure he was ok. I then called my QP to

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V 110	Continued From page 7 let her know what had happened. The incident will be reported and I take fully responsibility of the incident." Finding #1: Review on 5/22/25 and 6/6/25 of the North Carolina Incident Response Improvement System (IRIS) from 2/1/25 through 6/6/25 revealed: -5/19/25 Client #1 was left alone for approximately 55 minutes in the facility by Staff #2 while Staff #2 went to pick up other residents from the day program. -Submitted on 5/22/25 after start of survey. Interviews on 5/28/25 and 5/29/25 with client #1 revealed: -Recalled the incident when he was left alone by Staff #2 "happened last week (5/19/25) and I was scared to death." -"Nobody (staff) said, 'Hey, come on...he (Staff #2) never said anything; he just left me here (facility), [Staff #2]...and I said, 'I can't believe I was in this place (facility) by myself.'" -Realized staff was gone when his bedroom door was opened and he noticed the facility was quiet. -Was in the facility alone for "2 hours" while Staff #2 went to pick up the other clients -Staff #2 checked on him upon returning to the facility, "I said, 'You're not supposed to be doing that dude, you're not supposed to be leaving a resident (client) here by themselves.'" -Had never been left alone in the facility before and had always accompanied the staff to pick up clients. -He talked with his mother (Legal Guardian (LG)/mother) on "the same day" (5/19/25) and told her what happened, "...told her I was afraid" and his mother reassured him, "...she (LG/mother) said, 'What he (Staff #2) did, he's	V 110		

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not supposed to do that.' You can't do that; you can't do that."
-"We were coming back here (facility) from work last Thursday (5/22/25) and Department of Social Services was here. A lady talked with me and I told her what happened, the Department of Social Services came to the house (facility)."
-Did not recall any other staff talking to him about the incident.
-"[Licensee/Director] was here (facility, date unknown) and I talked to her about it (5/19/25 incident). She said, 'First of all, he (Staff #2) can't do that', and me and her talked for a while in the kitchen. A staff member can't leave you by yourself, they can't do that."
-Next time the staff could say, "Hey, time for us to pick up the guys (clients)."
-Staff #2 completed his shift (5/19/25) and worked until it was time for the shift to change on Tuesday (5/20/25).

Interview on 5/29/25 with Client #2 revealed:
-Recalled the 5/19/25 incident when client #1 was left alone in the facility, "[Staff #2] cannot leave that client here (facility); he can't do that, no."
-"[Staff #1] will stay with us all the time. [Staff #2] stays with us all the time."

Interview on 5/29/25 with Client #3 revealed:
-Was aware that Staff #2 had left client #1 alone in the facility on 5/19/25.

Interview on 5/29/25 with Client #4 revealed:
-Was not aware that client #1 had been left alone in the facility by Staff #2 on 5/19/25.
-"...that is not nice, we should not leave anyone in the house (facility) alone; we don't do that. What is he (Staff #2) thinking?...I am never alone. I keep up with my group, no ma'am that is dangerous...stranger danger, you got to be

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careful."

Interview on 5/29/25 with Client #6 revealed:
-Recalled client #1 not being on the van 5/19/25, "yes, we did leave [client #1] here (facility) by himself....he (Staff #2) does it to me too (left alone)"

Interview on 5/28/25 with the LG/mother revealed:
-Was aware of the incident on 5/19/25 and was told "basically that [Staff #2] went to pick up the guys (clients) and totally forgot [client #1]."
-Client #1 noticed everything was really quiet, looked out of his room and noticed he was alone.
-Client #1 did not say how long he was in the facility alone.
-Client #1 was not aware of the time it took to get from the day program to the facility.
-LG/mother was contacted by the QP on 5/19/25 and after talking with the QP, she (LG/mother) made contact with client #1.
-Client #1 did not have unsupervised time.
-When she (LG/mother) spoke with client #1 after the incident on 5/19/25, "He (client #1) just said, 'I can't believe he (Staff #2) left me; I don't know how they left me momma.' He was fine he was more just, 'I don't know how he (Staff #2) left', but he (client #1) was not panicking."
-"To my knowledge, [Staff #2] finished out his shift."

Interview on 5/29/25 with the DSS Social Work Investigator revealed:
-The report made to DSS by the facility was that client #1 was off work, playing video games when he noticed it was quiet in the facility, and he was alone.
-Client #1 had never been left alone at the facility before.
-Client #1 told her he wasn't afraid, but told Staff

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#1 he was afraid.
-Staff #2 advised, "I was stressed, on the phone with the pharmacy dealing with meds (medications). I thought he (client #1) was at work. I made a big mistake. I take responsibility. I picked up the other clients and I raced back to the house (facility) to check on him and he was okay."
-When the QP was asked on 5/21/25 about the outcome of the incident, "...she said he (Staff #2) was 'wrote up' and that he will not be terminated."

Interview on 5/29/25 with Staff #1 revealed:
-Incident on 5/19/25 occurred when he was off shift.
-Came in on shift 5/20/25 that evening client #1 "told me he was left alone at the facility."
-Client #1 stated that "it scared him being left alone."
-Client #1 talked with his LG/mother "and she was not happy."
-"I'm not sure if he (client #1) spoke with her when he was alone in the house (facility) or afterward."
-Unsupervised time was not in client #1's treatment plan.

Interview on 5/28/25 and with Staff #2 revealed:
-Admitted he left client #1 in the facility alone while he picked up other clients from the day program.
-"On last Monday,...I think the 19th (5/19/25)...Monday was a hectic day, a lot was going on and I had in my mind that [client #1] was at work."
-Had gotten the clients loaded in the van to return to the facility from the day treatment program when he realized he had left client #1 at the facility alone..."At that point, I had been gone 30-35 minutes, or something like that."

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V 110	Continued From page 11 -Proceeded back to the facility and stopped at the local supermarket on the way to pick up client #3 who was getting off work. -Did not call client #1 or the QP once he realized that client #1 was left alone in the facility. -When he arrived back at the facility, he got the clients off the van and then went to check on client #1. -Called the QP after checking on client #1. -Was instructed by the QP to document the incident, he continued with his daily routine and completed his shift. -"I've been off (schedule) and was supposed to come back on yesterday (5/27/25). I did not resume working (5/27/25) and I was suspended until every thing is done. I will be off until this is over with and training or whatever the main office says I have to do." -Staff #3 was present in the facility on 5/19/25 and had not seen client #1. Interview on 5/28/25 with Staff #3 revealed: -Worked at the facility from about 1:30pm until about 5pm, part-time, about 3.5 hours a day on Monday through Thursday weekly. -Provided 1:1 support services with client #4. -Was at the facility on 5/19/25 and had gotten there early to do the laundry for client #4 and rode with Staff #2 on the van to assist with getting client #4 on and off the van once client #4 was picked up from the day program. -Did not see client #1 in the facility on 5/19/25. -"[Staff #2] made me aware that he had left [client #1], I guess when we were coming back from the [Day Program] and he (Staff #2) had already picked up [client #3] from work...we were half way back (to the facility)" -When Staff #2 and Staff #3 returned to the facility, client #1 said staff (#2, #3) left him. -Was preparing to end his shift for the day	V 110		

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because he could not work over his part time hours.
-Worked on Tuesday (5/27/25)
-Staff #2 was not at work and had completed his shift.
-The QP asked him about the incident on that Wednesday (5/21/25) and Thursday (5/22/25), then he spoke with the Licensee/Director and the QP together to get details of the incident from 5/19/25.

Interview on 5/22/25 with the QP revealed:
-Was aware and had been informed of the 5/19/25 incident that Staff #2 left client #1 alone in the facility.

Interview on 5/29/25 and 6/3/25 with the Licensee/Director revealed:
-Was aware of 5/19/25 incident with client #1.
-"I did the internal investigation on 5/20 (2025)... [QP] spoke with [client #1] to make sure he was okay and she (QP) called his (client #1) mom..."
-Spoke with client #1 on 5/20/25.
-Interviewed Staff #2, "[Staff #2] was confused (5/19/25) and a phone call that threw him off...right now, [Staff #2] is on paid leave pending investigation and we'll (facility) be putting things in place for this not to happen again, depending on what happens with the investigation (DSS and Division of Health Service Regulation)..."

Finding #2:

Interviews on 5/28/25 and 5/29/25 with Client #1 revealed:
-"One time we (clients) were at [Retail Chain store#1] (May 2025) and I went to get a video game. It was me and [client #3] and the staff (#2) just let us go by ourselves. The video games are in the back of the store and he said just go on

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V 110	Continued From page 13 back there and get the game, by ourselves." Interview on 5/29/25 with Client #2 revealed: -"[Staff #1] will stay with us all the time. [Staff #2] stays with us all the time." -In the Retail Chain store #1 with Staff #2, " we (clients) had to call staff (#2) on the phone and say, 'where are you?' If you go to the outing, you got to stay with staff all the time." Interview on 5/29/25 with Client #3 revealed: -"He (Staff #2) gives us a choice (of stores) and he is usually with us the whole time. I couldn't find him (Staff #2) and I looked up each isle, probably at the thrift store or something. I think it was last weekend (5/23/25-5/25/25) when we went to the drugstore,..." Interview on 5/29/25 with Client #6 revealed: -"....he (Staff #2) does it to me too (left alone; [Staff #2], when I was shopping he left me all by myself a couple of weeks ago (May 2025)." -"I was looking high and low for him (Staff #2). I was sad and nervous by myself." -"It happened at [Retail Chain store #2] and at [Retail Chain store #1] twice." -"I had to leave my food...go to get my own shopping cart, then I had to go back and get my food again...all by myself...I found my food, but it was hard." -"I don't understand that...I was nervous and I didn't appreciate that...is he mad at us? what's the rule? Can he do that? I don't why he does that." -"He (Staff #2) needs to stay close to us (clients), that's dangerous." -"I found him (Staff #2) all the way at the cashier. We went in the (store) together, then he went this way and I went that way. -He had not reported instances of being unsupervised in the community.	V 110		

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V 110	Continued From page 14 -Wanted to ensure report was made to the QP, "I was nervous and I didn't appreciate that (being left unsupervised in the store)..." -"...[Staff #2] left us (clients) alone and left us at [Retail Chain #1] once and [Retail Chain #2] once..." Interview on 5/29/25 with Staff #1 revealed: -Had reported his concerns to the QP on 5/21/25 after he heard clients' (#1, #3, #6) discussion on the van of being unsupervised in the community while with Staff #2. -"...the other residents knew that [client #1] had been left alone (5/19/25) and they were talking about [Staff #2] not supervising the residents when they go shopping at [Retail Chain store #1]." -"[Client #3] and [client #1] stated that they do their own shopping while [Staff #2] stays with [client #4] and [client #5]." -Clients said they don't always know where Staff #2 is in the store which clients said made them "nervous". -"They (clients) articulate that he (Staff #2) is not watching them." Interview on 6/2/25 with Staff #2 revealed: -Had not left clients alone while in the community. -Provided supervision when with clients. -Clients would wander when in the community and would always be in his eyesight. -"We go shopping every week and we might be getting something for [client #4], usually he and [client #5] are with me, and they (clients #1, #2, #3, #6) may walk on down the aisle looking at something they want." -There was never a time when a client was looking for him in a store when he was not available.	V 110		

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V 110	Continued From page 15 Interviews on 5/28/25 and 5/29/25 with the QP revealed: -Prior to 5/29/25, was not aware and had not been informed of clients' report of being unsupervised in the community with Staff #2. -Staff #2 shared in supervision that he was "uneasy" about clients walking off without his permission and staying with him while they are in the community. -Had worked out a plan to alternate taking clients personal shopping, Staff #1 and Staff #2 every other month. Interview on 5/29/25 and 6/3/25 with the Licensee/Director revealed: -Was aware that Staff #2 had shared in supervision with the QP that he had concerns about clients staying with him when they were in the community. -Was not made aware of reports from clients on 5/29/25 that they were unsupervised in May 2025 by Staff #2 while in the community. Review on 6/4/25 of the Plan of Protection dated 6/4/25 written by the QP revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? -QP, [QP] will implement a Monthly Head-Count Accountability Chart kept in the company vehicles. (Analytical Skills, Technical Knowledge) -All of Staff will receive CPR Re-Certifications (Clinical Skills, Technical Knowledge, Decision-Making) -QP will hold a meeting with all staff revising them on the Client's Person-Centered Plans (treatment plans), specifically each of their Crisis Plans within the coming week. This will be completed by June 18th (2025). (Clinical Skills, Communication Skills, Interpersonal Skills, Cultural Awareness)	V 110		

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V 110	Continued From page 16 -Describe your plans to make sure the above happens. -Head-Count Accountability Form is to be use before leaving the property of Stegall Home, when dropping a client to their day program or work in the community, and when picking up (clients) at these scheduled places. This Spreadsheet will have a section to write any notes and reasoning if someone (client) is missing from the Head Count. For Example: John Doe is on Home Visit with family, he left on June 1st and will be back on June 3rd. -This CPR class was completed on June 3rd 10am, can provide Certificates for each Staff Member. -Will Document attendance for this Revision of Each of the Client's Person-Centered Plan with an Attendance sheet Signed and dated by staff. Additional note: QP [QP] has Person Centered Plan meeting with [client #1's initial] and his Mother (LG/mother) June 11th (2025) QP [QP] has Person Centered Plan meeting with [client #6's initial] and Team June 12th (2025)" Review on 6/5/25 of the amended of the Plan of Protection dated 6/5/25 written by the QP revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? -Before departing from the group home, our group home staff will conduct a thorough (Their final Check) routine (client check), ensuring that all residents are accounted for and comfortability seated in their spaces on the van. This process will be documented on a log, creating a seamless communication and thread that reinforces our continued commitment to a safe and nurturing environment for everyone. Staff will ensure they finish all calls before they leave the property to	V 110		

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pick up residents. This will be implemented on June 5th (2025).
-To guarantee that our [Facility] residents receive attentive supervision during community outings, the designated (shift) staff member will be responsible for all direct supervision, actively engaging with each resident, leading the group through the outing, and maintaining constant communication through visual cues and verbal check-ins to ensure everyone feels secure and included throughout the experience. This will be implemented on June 5th (2025).

-Describe your plans to make sure the above happens.
-QP, [QP] will implement the Head Count Accountability Chart and hold training/meeting with [Facility] Staff on Thursday June 5th (2025). Staff in this training will be DSP (Direct Support Professional) on Duty and ISP (Innovation Support Professional) Worker. This Training attendance will be documented by their Supervisions. QP [QP] will train Staff in how they are to use this chart and the importance behind this document, regarding and confirming each resident's safety. This will be checked weekly by QP as well.
**Staff that is off duty now, pending investigation will have the same essential training should he return back into [Facility]. This will also be documented by his Supervision, given by QP [QP].
-QP, [QP] will implement the Buddy System with [Facility] Staff on Thursday June 5th (2025). Staff in this training/meeting will be DSP (Direct Support Professional) on Duty and ISP (Innovation Support Professional) Worker. This Training attendance will be documented by their Supervisions. QP, [QP] will train/reiterate the importance of this system with staff and being

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right beside paired resident at all times in the community, and the staff responsibility with keeping the resident's safe in the community. **Staff that is off duty now, pending investigation will have the same essential training should he return back into [Facility]. This will also be documented by his Supervision, given by QP [QP]."

Review on 6/6/25 of the amended of the Plan of Protection dated 6/5/25 written by the QP revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care?
-To guarantee that our [Facility] residents receive attentive supervision during community outings, we will pair each resident with a buddy resident, fostering both safety and companionship. The staff member should be able to visibly see residents and assigned buddy at all times. This will ensure that everyone feels secure and connected, while exploring their surroundings together. This will be implemented on June 5th (2025)"

This facility served clients with diagnoses of Mild IDD, Traumatic Brain Injury, Psychosocial Stressors, Down Syndrome, Seizure Disorder, and Hearing Impairment. On 5/19/25, client #1 was left at the facility for 55 minutes by Staff #2 when he when to pick up other clients from the Day Treatment Program. It wasn't until he was loading the other clients in the van from the Day Treatment Program when he realized he had left client #1 at the facility. Not only did staff #2 not notify the Qualified Professional when he realized client #1 was left at the facility, he stopped to pick up client #3 from his place of employment. Client #1 said that he was scared. Clients also reported Staff #2 would leave them unsupervised while

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V 110	Continued From page 19 shopping in the community and had difficulty finding staff #2 when in the store. Clients reported they felt scared and nervous. Staff #2 failed to use sound judgement and caution in promoting and ensuring the safety, understanding of individual needs and risks, and overall well-being of clients. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare and must be corrected within 45 days.	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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This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to have an annually updated treatment plan affecting 2 of 6 clients (client #1 and #6). The findings are:

Review on 5/22/25 of client #1's record revealed:
-Admission 10/1/21.
-Diagnosis: Mild Intellectual Developmental Disability.
-Treatment Plan dated 10/31/23.
-There was no updated treatment plan.

Review on 5/29/25 of client #6's record revealed:
-Admission 3/27/21.
-Diagnosis: Mild Intellectual Developmental Disability.
-Treatment plan dated 7/18/23.
-There was no updated treatment plan.

Interview on 5/29/25 with client #1 revealed:
-Was involved in his treatment plan a long-time ago, but no one from the facility had met with him about his treatment plan lately.

Interview on 5/22/25 and 5/29/25 with the Qualified Professional revealed:
-Treatment plans were completed at intake and should be updated at least yearly.
-The treatment plan dated 10/31/25 was the most recent for client #1.

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V 112	Continued From page 21 -Was aware Client #6 Treatment Plan was not updated.-Responsible for updating clients' treatment plans. -"...there's probably no good excuse (treatment plans not current), really...unfortunately it's something I need to work on."	V 112		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL 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 1 of 3 staff (#1) and 1 of 1 Qualified Professional (QP). The findings are: Review on 5/28/25 of Staff #1's employee record revealed: -Hired 9/1/11. -HCPR was accessed 10/22/13. Review on 5/28/25 of the QP's employee record revealed: -Rehired 1/15/19.	V 131		

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V 131	Continued From page 22 -HCPR was accessed 8/9/17. Interview on 6/2/25 with the Senior Director of Human Resources (HR) revealed: -Was responsible for overseeing the hiring process. -Was not aware that HCPR checks were not done prior to hire date for Staff #1 and the QP. -Had recently hired staff to perform pre-hire background checks. -Would ensure the HCPR is requested prior to hire for all new staff moving forward.	V 131		
V 133	G.S. 122C-80 Criminal History Record Check G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT. (a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter. (b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record	V 133		

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V 133	Continued From page 23 check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider.	V 133		

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V 133	Continued From page 24 All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency. (c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant: (1) The level and seriousness of the crime. (2) The date of the crime. (3) The age of the person at the time of the conviction. (4) The circumstances surrounding the commission of the crime, if known. (5) The nexus between the criminal conduct of the person and the job duties of the position to be filled. (6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed. (7) The subsequent commission by the person of a relevant offense. The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant. (d) Limited Immunity. - A provider and an officer or employee of a provider that, in good faith,	V 133		

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complies with this section shall be immune from civil liability for:
(1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual.
(2) Failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section.
(e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public

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V 133	Continued From page 26 Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5. (f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor. (g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met: (1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10. (2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.)	V 133		

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V 133	Continued From page 27 This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure the criminal history record check was requested within five business days of making the conditional offer of employment affecting 2 of 3 staff (#1, #2). The findings are: Review on 5/28/25 of staff #1's employee record revealed: -Hired 9/1/11. -A criminal history check was requested on 5/3/13. Review 5/29/25 on of staff #3's employee record revealed: -Hired 8/22/19. -A criminal history check was requested on 4/26/19. Interview on 5/28/25 the Licensee/Director stated: -Human Resource (HR) is responsible for criminal history checks. Interview on 6/2/25 with the Senior Director of Human Resources (HR) revealed: -Was responsible for overseeing the hiring process. -Was not aware that criminal history checks were not done within 5 days of hire. -"We (HR) just hired someone and they are being trained to do pre-hire background checks." -Would ensure the criminal history check was requested prior to hire for all new staff moving forward.	V 133		
V 318	13O .0102 HCPR - 24 Hour Reporting	V 318		

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V 318	Continued From page 28 10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g). This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to notify Health Care Personnel Registry (HCPR) within 24 hours of becoming aware of allegations of abuse affecting one of five audited current staff (#2). The findings are: Review on 5/22/25 of the Staff #2's personnel record revealed: -Hired 8/8/23. -Paid administrative leave effective 5/23/25. Review on 6/6/25 of the Incident Response Improvement System (IRIS) revealed: -Date of incident 5/19/25. -HCPR "Neglect" allegation was incomplete. -No HCPR notification for allegation that Staff #2 left clients (#1, #2, #3, #6) while shopping in the community (May 2025).	V 318		

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V 318	Continued From page 29 Interview on 5/22/25 and 6/6/25 with the Qualified Professional revealed: -Responsible for reporting incidents to HCPR, Department of Social Services (DSS), Local Management Entity/Managed Care Organizations, and in IRIS. -Was made aware of the incident on 5/19/25 and was made aware on 5/29/25 that staff had left clients in the store while shopping. -Staff #2 was suspended and placed on administrative leave with pay, pending completion of investigations by DSS and Division of Health Service Regulation (DHSR). -Staff #2's would remain on suspension pending findings from DSS and DHSR investigations. -No report was made for allegation that Staff #2 had left clients (#1, #2, #3, #6) while shopping while in the community (May 2025). -Had received a letter from HCPR and was not aware that the "Neglect" allegations in the IRIS report had not been completed. -Had issues completing the "HCPR" allegation section in the IRIS report.	V 318		
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 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;	V 366		

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V 366	Continued From page 30 (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 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	V 366		

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V 366	Continued From page 31 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 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	V 366		

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V 366	Continued From page 32 applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement written policies governing their response to level II and III incidents and failed to report the incident to the Local Management Entity (LME)/Managed Care Organization (MCO). The findings are: Review on 5/27/25 and 6/6/25 of the facility's records revealed: -"General Event Report" 5/19/25 incident of Staff #2 leaving client #1 alone in the facility while Staff #2 went to pick up other clients from the day program. -There was no documentation of client #1, #2, #6, #6 being left alone by staff #2 while shopping. Review on 5/22/25 of the North Carolina Incident Response Improvement System (IRIS) revealed: -5/22/25: incident report for the 5/19/25 incident of Staff #2 leaving client #1 alone in the facility while he picked up clients from the day program. Interview on 5/22/25 and 6/6/25 with the Qualified Professional revealed: -Made self-report of neglect to the Department of Social Services on 5/19/25 once she was made aware of the incident of staff #2 leaving the client #1 at the facility. -Had not provided the information regarding the incident to the LME/MCO.	V 366		

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V 366	Continued From page 33 -Was responsible for completing the IRIS reports and the Licensee/Director was responsible for completing incident investigations. -Failed to attend to the health and safety need of individuals involved, determine the cause of the incident, develop and implement corrective action, develop and implement measures to prevent similar incidents and assigning persons to be responsible for implementation of corrections and preventive measures.-Was not aware the sections of the IRIS report were incomplete. -Became aware on 5/29/25 from facility clients' (#1, #2, #3, #6) reports that they had not been supervised (May 2025) in the community. Interview on 5/29/25 and 6/3/25 with the Licensee/Director revealed: -Was aware of 5/19/25 incident of Staff #2 leaving client #1 alone in the facility while Staff #2 went to pick up other clients from the day program. -Completed the internal investigation of staff #2 leaving client #1 alone in the facility.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall	V 367		

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V 367	Continued From page 34	V 367		

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 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

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V 367	Continued From page 35 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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to submit a level II and III incidents to the Local Management Entity (LME)/ Managed Care Organization (MCO) responsible for the	V 367		

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V 367	Continued From page 36 catchment area where services are provided within 24 hours and 72 hours of becoming aware of the incident. The findings are: Review on 5/22/25 and 6/6/25 of the North Carolina Incident Response Improvement System (IRIS) from February 1, 2025- May 30, 2025 revealed: -There was no documentation for client #1 being left at the facility by staff #2 on 5/19/25. -There was no documentation for Staff #2 leaving clients while shopping in the community. Interview on 5/22/25 and 6/6/25 with the Qualified Professional (QP) revealed: -Was responsible for completing the IRIS reports. -Had not submitted report in IRIS for the 5/19/25 incident of Staff #2 leaving client #1 alone in the facility while Staff #2 went to pick up other clients from the day program until 5/22/25 after start of survey. -Failed to complete all the sections of the IRIS report including the description of the incident, the cause, and preventative measures. -Had not submitted report in IRIS for Staff #2 leaving clients while shopping in the community. Interview on 5/29/25 and 6/3/25 with Licensee/Director revealed: -Was aware of 5/19/25 incident with client #1 being left at the facility by staff #2 on 5/19/25. -"I did the internal investigation on 5/20 (2025)... [QP] spoke with client #1 to make sure he was okay and she (QP) called his (client #1) mom (legal Guardian)..." -Was not aware of Staff #2 leaving clients while shopping in the community.	V 367		