

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/02/2025
NAME OF PROVIDER OR SUPPLIER WILKINSON FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 635 NORTH WILKINSON DRIVE SAINT PAULS, NC 28384			
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V 000	INITIAL COMMENTS A follow-up survey was completed on April 2, 2025. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600B Supervised Living for Minors with Developmental Disability. This facility is licensed for 4 and has a current census of 2. The survey sample consisted of audits of 2 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			

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DHSR-MH Licensure Sect

Division of Health Service Regulation

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

TITLE

(X6) DATE 5/2/25

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V 112	<p>Continued From page 2</p> <p>-Person Centered Plan (PCP) (Treatment Plan) dated 9/25/24: "Short-range Goal 1: Over the next six months, [Client #1] will improve emotional regulation as evidenced by learning and using positive coping skills to address mental health symptoms at least 5 out of 7 days per week, and will utilize effective communication skills so that he can verbally express his emotions at least 5 out of 7 days per week."</p> <p>-The PCP did not include strategies to address suicidal ideation or suicidal attempts.</p> <p>-The PCP did not contain documentation of a written consent by the guardian.</p> <p>Interview on 3/25/25 client #1 stated:</p> <p>-He had lived at the facility for a few months.</p> <p>-He did not know what his goals were.</p> <p>Finding #2</p> <p>Review on 3/25/25 and 4/1/25 of client #2's record revealed:</p> <p>-14 years old.</p> <p>-Date of Admission: 1/24/25.</p> <p>-Diagnoses: Moderate Intellectual Disabilities, Reaction to Severe Stress, ODD, Unspecified Trauma and Stressor Related Disorder.</p> <p>-Individual Support Plan (ISP) (Treatment Plan) dated 1/17/25: "Long-range Goal 1..."[Client #2] requires Residential Supports Level 4 as he requires one on one support and close supervision to make sure he is healthy and safe and due to extreme high behaviors such as: inappropriate sexual behaviors, stealing, bullying others in the home (facility), community and school, profanity, verbal aggression, and property damage."</p> <p>-"Long-range Goal 2: [Client #2] will increase independence and community access skills acquisition....Where I am now: [Client #2] attendance to the [local fitness center] will help</p>	V 112		

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V 112	<p>Continued From page 4</p> <p>Care Manager stated:</p> <ul style="list-style-type: none"> -She was responsible for the development of the long range goals for client #2. -The facility was to develop short range goals. -Goals and strategies were based on what they were trying to achieve for client #2. -She would review the facility's short range goals during her upcoming quarterly assessment. -Client #2 needed monitoring goals to address what he said or watch due to his sexualized behaviors. -Client #2 was court ordered not to have electronics due to breaking a TV, watching pornography online and contact with his family. <p>Interview on 3/25/25 staff #1 stated:</p> <ul style="list-style-type: none"> -She was not aware any strategies for the clients' goals. <p>Interview on 3/25/25 staff #2 stated:</p> <ul style="list-style-type: none"> -Staff received instruction on how to implement the goals at staff meetings every month. <p>Interview on 3/25/25 staff #3 stated:</p> <ul style="list-style-type: none"> -Staff worked on 9-14 goals a day with the clients. -There was a monthly staff meeting with the Director of Services/Qualified Professional (DOS/QP) to discuss goals in online documentation system. -"If a new client comes we will see the interactions of the client and that is how we see how we as staff are to address their goals." -"I see goals in online documentation system I don't see strategies, we are basically making our own strategies." <p>Interview on 4/1/25 staff #4 stated:</p> <ul style="list-style-type: none"> -There was a list of goals in online documentation system. -"I have not seen what staff is to do to help 	V 112			

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V 112	<p>Continued From page 6</p> <p>3/26/25</p> <ul style="list-style-type: none"> -She was able to print strategies from the online documentation system. -Staff had to acknowledge the goal to see the strategies. -The strategies were always in the online documentation system. -The strategies were developed when the treatment plan was completed. -"If it was not included, I will go in and include inappropriate sexual behaviors." <p>4/1/25</p> <ul style="list-style-type: none"> -"[Client #1] did not want his past suicidal ideation included in his treatment plan." -Client #2 was admitted to the facility with a completed treatment plan. <p>Interview on 4/1/25 the Licensee stated:</p> <ul style="list-style-type: none"> -"[Client #1's] past suicidal ideation should be included in the Behavioral Plan not the ISP." -"The ISP is based on what is happening now, not in the past." -"[Client #1] did not want the past suicidal ideation in his treatment plan." -"It would be a client's rights issue to put what the client doesn't want in their own treatment plan." <p>Review on 4/1/25 of the Plan of Protection (POP) dated 4/1/25 written by the DOS/QP revealed:</p> <ul style="list-style-type: none"> -"What immediate action will the facility take to ensure the safety of the consumers in your care? As stated, Shinelight (Licensee) was not a part of the individual initial ISP plan. Everything discussed during meetings was listed in the plan. Goals are created from the long range goals in the plan. Whatever is mentioned in the persons plan is where the goals come from, not past evaluations. Anything that the staff needs to work on for that individual will be part of the goals, based off of conversations with that 'person' and 	V 112			

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V 112	Continued From page 8 self harm which resulted in hospitalizations for suicidal attempts or suicidal behaviors. Client #1's PCP did not include any strategies to address his self harm behaviors and was not signed by his legal responsible party. Client #2 had a history of inappropriate sexual behaviors and a court order for no electronic use. Client #2's treatment plan did not include strategies to address inappropriate sexual behaviors, and he was court ordered for no electronic use and to attend the local fitness center. The direct care staff responsible to work with the clients were not aware of any strategies documented to meet the needs of client #1 and client #2. This deficiency constitutes a Continuing Type A1 rule violation originally cited for serious neglect for failure to correct within 23 days.	V 112			
V 318	130 .0102 HCPR - 24 Hour Reporting 10A NCAC 130 .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).	V 318			

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V 366	Continued From page 10 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; (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;	V 366		

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V 366	<p>Continued From page 12</p> <p>(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;</p> <p>(B) the LME where the client resides, if different;</p> <p>(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;</p> <p>(D) the Department;</p> <p>(E) the client's legal guardian, as applicable; and</p> <p>(F) any other authorities required by law.</p> <p>This Rule is not met as evidenced by: Based on interview the facility failed to implement a policy governing their response to Level II or III incidents as required. The findings are:</p> <p>The Division of Health Service Regulation Surveyor (DHSR) made the Director of Services/Qualified Professional (DOS/QP) aware on 3/26/25 during the DHSR survey of an allegation made by client #2 that staff #2 had put him in a chokehold and pushed him against the wall.</p> <p>Review on 3/25/25 of client #2's record revealed: -14 year old male. -Date of Admission: 1/24/25. -Diagnoses: Moderate Intellectual Disabilities, Reaction to Severe Stress, Attention Deficient Hyperactivity Disorder and Unspecified Trauma and Stressor Related Disorder.</p>	V 366			

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V 367	Continued From page 14 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 Health Service Regulation within 72 hours of becoming aware of the incident. In cases of	V 367			

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V 500	Continued From page 17	V 500			
V 500	<p>27D .0101(a-e) Client Rights - Policy on Rights</p> <p>10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS</p> <p>(a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66.</p> <p>(b) The governing body shall develop and implement policy to assure that:</p> <p>(1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and</p> <p>(2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications.</p> <p>(c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies:</p> <p>(1) any restrictive intervention that is prohibited from use within the facility; and</p> <p>(2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client.</p> <p>(d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify:</p> <p>(1) the permitted restrictive interventions or allowed restrictions;</p> <p>(2) the individual responsible for informing the client; and</p> <p>(3) the due process procedures for an</p>	V 500			

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V 500	<p>Continued From page 18</p> <p>involuntary client who refuses the use of restrictive interventions.</p> <p>(e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes:</p> <p>(1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E);</p> <p>(2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and</p> <p>(3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to report to the Department of Social Services (DSS) in the county where services are provided all allegations of suspected abuse by health care personnel. The findings are:</p> <p>The Division of Health Service Surveyor (DHSR) made the Director of Services/Qualified Professional (DOS/QP) aware on 3/26/25 during the DHSR survey of an allegation made by client #2 that staff #2 had put him in a chokehold and pushed him against the wall.</p> <p>Review on 3/25/25 of client #2's record revealed:</p>	V 500			

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V 512	<p>Continued From page 20</p> <p>established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.</p> <p>This Rule is not met as evidenced by: Based on record reviews, observation, and interviews, one of five staff (#2) abused one of two clients (#2). The findings are:</p> <p>Review on 3/26/25 of staff #2's record revealed: -Date of hire: 5/18/2023. -Job title: Direct Support Professional.</p> <p>Review on 3/25/25 and 4/1/25 of client #2's record revealed: -14 years old. -Date of Admission: 1/24/25. -Diagnoses: Moderate Intellectual Disabilities, Reaction to Severe Stress, Oppositional Defiant Disorder, Unspecified Trauma-and Stressor Related Disorder.</p> <p>Review on 3/26/25 of the facility's "A-B-C Checklist" (Antecedent/before behavior-Behavior-Consequence/after behavior) completed 3/5/25 revealed:</p>	V 512			

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V 512	<p>Continued From page 22</p> <p>- "I felt dizzy when I hit my head."</p> <p>- "My head still hurts a little bit in the back."</p> <p>- Staff #2 put him in a chokehold.</p> <p>- Client #2 demonstrated how staff #2 put him in a chokehold by wrapping his arm around his neck and applied pressure.</p> <p>- He could "not breathe" during the chokehold.</p> <p>- He broke away from the chokehold and they both fell on the ground.</p> <p>- "[Staff #2] hit the wall" when they fell which caused "a hole" in his wall.</p> <p>- He told the Operations Manager about the incident the same day (3/5/25), that "[staff #2] put me in a restraint."</p> <p>- He did not tell the Operations Manager any other information about the incident.</p> <p>- He was not sure the exact date of the chokehold and being pushed against the wall by staff #2.</p> <p>- The chokehold happened a few weeks ago on a Monday at approximately 6:30 am (3/5/25) in his bedroom.</p> <p>Interview on 4/1/25 client #2's Department of Social Services legal guardian stated:</p> <p>- She was contacted by the Operations Manager who informed her of a "state review."</p> <p>- The Operations Manager stated client #2 was "dishonest" with the Division of Health Services Regulation (DHSR) Surveyors but she did not go into detail.</p> <p>- She was not informed of an allegation made by client #2.</p> <p>- She observed client #2's bedroom in February 2025 and there were no holes in the wall.</p> <p>Interview on 3/25/25 and 4/1/25 client #1 stated:</p> <p>- There was an incident about a month ago between client #2 and staff #2.</p> <p>- He was awakened by client #2 "going back and forth" with staff #2.</p>	V 512			

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V 512	<p>Continued From page 24</p> <ul style="list-style-type: none"> -No restraint was used on client #2. -He did not put client #2 in a chokehold or push him against the wall. -Client #2 did not hit his head against the bedroom wall. -He completed an A-B-C checklist regarding the incident. -The hole in client #2's wall came from a discharged client. <p>Interview on 4/1/25 staff #4 stated:</p> <ul style="list-style-type: none"> -He was aware of one incident between client #2 and staff #2 in March 2025. -The facility had a group chat that communicated the house needs. -He learned from staff #2 about an incident that happened with client #2. -He was told that client #2 "came at" staff #2. -He did not know what happened next. -There was a hole in the wall and a desk which was destroyed from the incident on 3/5/25. -He was unsure on how the hole got in the wall during the incident on 3/5/25. <p>Interviews on 3/25/25 and 3/26/25 the Operations Manager stated:</p> <ul style="list-style-type: none"> -Staff #2 had a difficult time waking up client #2 up for school on 3/5/25. -Client #2 "attempted to push" staff #2. -Staff #2 moved out of the way. -She was not aware of any other "altercation between the two." -She was not aware of any holds or restraints used. -Client #2 said he was upset when staff #2 "tapped his shoulder" to wake him up. -Client #1 told her staff #2 had a "hard time" getting client #2 up for school every morning. -She denied being aware of staff #2 putting client #2 in a chokehold or pushing him against the 	V 512			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/02/2025
NAME OF PROVIDER OR SUPPLIER WILKINSON FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 635 NORTH WILKINSON DRIVE SAINT PAULS, NC 28384			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
V 512	<p>Continued From page 26</p> <p>ensure the safety of the consumers in your care? If a person served makes an allegation, after completing internal review agency will report to the proper people/persons within the expected timeline. After internal investigation, individual stated that he did not state those allegations about staff to anyone.</p> <p>-Describe your plans to make sure the above happens. QP (DOS/QP) will continue to complete training on abuse, neglect and exploitation, and duty to report"</p> <p>Review on 4/1/25 of the revised POP dated 4/1/25 written by the DOS/QP revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? In the event of an allegation, QP (DOS/QP) will complete internal review. Staff will be removed from schedule until after investigation is over. If allegation is true, proper people/persons will be notified. HCPR (Health Care Personal Registry), guardians, DSS. Internal interview was completed and individual stated that he did not say any of those things mentioned, therefore staff was not removed from schedule. Individual will be discharged from Shinelight (Licensee) if he lies again against staff and a camera will be placed in his room</p> <p>-Describe your plans to make sure the above happens. Continue to complete training on abuse, neglect, and exploitation"</p> <p>The facility served clients ages 14 and 15 years old with diagnoses to include Moderate Intellectual Disabilities, Reaction to Severe Stress, Oppositional Defiant Disorder, Unspecified Trauma-and Stressor Related Disorder, Predominantly inattentive presentation, High expressed emotion level within family,</p>	V 512			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/02/2025
NAME OF PROVIDER OR SUPPLIER WILKINSON FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 NORTH WILKINSON DRIVE SAINT PAULS, NC 28384		
(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 736	<p>Continued From page 28</p> <ul style="list-style-type: none"> -The stair rails which led to the downstairs area was loose on both sides. -The left stair rail leading upstairs was loose and missed a connector to the wall. -The hall closet upstairs had no knob. -The hallway bathroom door did not latch. -The left bathroom door did not have a door knob. -Client #1's bedroom door had a hole on the left side approximately 6 inches long, the screen on the window had a tear approximately 6 inches long and the connected bathroom had approximately 6 loose tiles on the floor that were soft to the step/touch. -Client #2's bedroom door frame had a crack in it and not flush to the wall, there was hole approximately 4 inches in diameter to the right of the closet door and there was a hole under the left window approximately one foot wide near the baseboard. -Vacant bedroom #1 had an electrical receptacle covering missing on the left side of the room. -The hallway ceiling had an approximate 3 foot by 3 foot square shaped area that was discolored with dark residue. <p>Interview on 3/25/25 the Operations Manager stated: -"I knew there was some property damage that needed to be fixed before [client #2] moved into his bedroom, but the they (guardian) wanted him to be moved in so quick." -A work order was completed when something was broken in the facility. -A maintenance company would come to the facility to repair it.</p> <p>Multiple attempts made on 4/1/25 to contact Operation Manager, no call back or response by exit of survey.</p>	V 736			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/02/2025
NAME OF PROVIDER OR SUPPLIER WILKINSON FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 635 NORTH WILKINSON DRIVE SAINT PAULS, NC 28384		
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V 774	<p>Continued From page 30</p> <p>revealed:</p> <ul style="list-style-type: none"> -Vacant room #1 did not have a bedside table. -Vacant room #2 had a bedframe with no mattress, bedding, pillow or bedside table. <p>Interview on 3/25/25 the Operations Manager stated:</p> <ul style="list-style-type: none"> -One of the previous clients damaged the dresser and night stand, the Director of Services/Qualified Professional (DOS/QP) ordered a new night stand and dresser for a vacant rooms. <p>Multiple attempts made on 4/1/25 to contact Operation Manager, no call back or response by exit.</p> <p>Interview on 3/25/25 the DOS/QP stated:</p> <ul style="list-style-type: none"> -"We are working on getting the vacant rooms done." -She had put an order in for a mattress and a box spring. <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 774		

Findings	Corrective Measures	Preventive Measures	Responsible Party/ How often	Time Frame
10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan	An ISP is an individualized plan which means the individual has the opportunity to have a plan written, about them, how they choose. Staff are trained on the individuals behavior plan, cca and psychological. Any information not in ISP plan is still knowledgeable to the staff who are working with the individual so that they are still aware of past trauma or events that occurred in the past	An ISP is an individualized plan which means the individual has the opportunity to have a plan written, about them, how they choose. Staff are trained on the individuals behavior plan, cca and psychological. Any information not in ISP plan is still knowledgeable to the staff who are working with the individual so that they are still aware of past trauma or events that occurred in the past	Individual Care Manager Guardian House Manager QP	23 Days
10A NCAC 130 .0120 Investigating and reporting health care registry	In the event that an incident occurs, where there is a complaint, the agency will investigate the situation. Depending on the findings a report will be complete and sent to the necessary parties	In the event that an incident occurs, where there is a complaint, the agency will investigate the situation. Depending on the findings a report will be complete and sent to the necessary parties	House Manager Administrative Team QP	
10A NCAC 27G .0603 Incident Response Requirements	In the event of an incident occurs a report will be completed and sent to the proper parties	In the event of an incident occurs a report will be completed and sent to the proper parties	House Manager QP	
10A NCAC 27D .0101 Policy On Rights Restrictions and Interventions	In the event of an incident occurs a report will be completed and sent to the proper parties	All staff have been trained on the correct use of policy, rights restrictions and interventions	QP	
10A NCAC 27D .0304 Protection from Harm,	A staff meeting was conducted in reference to abuse, neglect,	Staff meetings will continue to be conducted to address	House manager Operational Manager	23 Days