	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CONTRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMPLETED	
	MHL042-055 B. WING			06/27/2025		
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LYONS A	NGELS		ELIAN SPRIN E RAPIDS, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	ΓS	V 000			
	on 6/26/25. The col (intake #NC002315	aplaint survey was completed mplaint was unsubstantiated 512). Deficiencies were cited				
	This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living.					
		sed for 2 and has a current urvey sample consisted of				
V 318	130 .0102 HCPR -	24 Hour Reporting	V 318			
	The reporting by he Department of all a personnel as define including injuries of done within 24 hour becoming aware of the health care facility.	Investigating and LTH care personned against health care facilities to the legations against health care and in G.S. 131E-256 (a)(1), for unknown source, shall be are of the health care facility of the allegation. The results of lity's investigation shall be expartment in accordance with				
	failed to report an a to the Health Care	et as evidenced by: view and interview, the facility allegation of neglect and abuse Personnel Registry (HCPR) becoming aware of the				

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

(X6) DATE TITLE

STATEMEN	OF THE ALTH SET VICE TO NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL042-055		B. WING		06/27/2025		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
LYONS A	NGELS		LIAN SPRIN			
	ROANON			C 27870		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 318	Continued From pa	ge 1	V 318			
	allegation. The findi	ngs are:				
	(AFL) Provider's red - Hired: 10/27/09 - Title: AFL Provi  Review on 6/17/25 - Admit date: 2/5 - Diagnoses: Sch Intellectual Disabilit Disorder moderate, Use Disorder, Rheu - Facility incident am that revealed: - "Staff (AFL client (Client #1). Cli Supervisor (Qualifies staff called 911Cli from going over the word] put in the hos - "AFL Provic phone. Both me (Qi guardian. PM (Prog	der of Client #1's record revealed: /24 nizophrenia unspecified, y/Intellectual Development Bipolar Disorder, Tobacco matoid Arthritis report dated 6/6/25 at 7:40  Provider) went to check on ient were weak. Staff called ad Professional (QP#1)) and ent had [illegible word] bruises floor all night. Client [illegible				
	Improvement Syste - Level III incider neglect by client #1 Provider completed	of the Incident Response m (IRIS) revealed: t on 6/13/25 of allegations of s guardian against the AFL by the Program Manager submitted on 6/16/25				
	- "Introduction - ( June 6. 2025, Progr					

Division of Health Service Regulation

STATE FORM RSKM11 If continuation sheet 2 of 14

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL042-055	B. WING		06/2	7/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
LYONS A	NGELS		LIAN SPRIN			
		ROANOKI	E RAPIDS, N	C 27870		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
V 318	Continued From pa	ge 2	V 318			
	reported concerns to being neglected by 2:05pm on Friday, Professional) [QP#2 Manager] to be bried investigation."  - Client #1's guare 6/9/25 and 6/13/25 concerns about the receiving from [AFL nutrition, weight lost proper medical cares.					
	guardian reported: - Client #1 went to remained in critical - Client #1 was do bruises and sores whospital on 6/6/25 - The hospital de admission on 6/6/25 fracture in her arm - Client #1 was not of her concerns of remained in critically not of her concerns of remained in critical was not so the concerns of remained in critical was not so the concerns of remained in critical was not so the concerns of remained in critical was not so the concerns of remained in critical was not so the concerns of remained in critical was not so the concerns of remained in critical was not so the concerns of remained in critical was not so the concerns of remained in critical was not so the concerns of remained in critical was do by the concerns of remained in critical was do by the concerns of the concerns	irty and had unexplained when she arrived at the termined since her (Client #1) that she had an untreated nalnourished and dehydrated fied the facility staff on 6/6/25				
	<ul> <li>An internal invergering Client #1"</li> <li>Client #2 was n investigation was control of the Program Management</li> </ul>	5 the QP #1 reported: stigation had been completed s legal guardian's allegations noved from the facility until the empleted spleted the investigation and ger spoke with Client #1's legal leted the reporting for the				

Division of Health Service Regulation

STATE FORM RSKM11 If continuation sheet 3 of 14

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL042-055	B. WING		06/27/2025	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS. CITY. S	STATE, ZIP CODE		
LVONO	NOTI O		LIAN SPRIN			
LYONS ANGELS ROANOK			E RAPIDS, N	C 27870		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
V 318	Continued From pa	ge 3	V 318			
V 318	Interview on 6/18/2s - She assisted withe allegations of al - Internal incident the AFL Provider ar - QP #1 typically in this case, the Provider distribution of 6/25/2s reported: - She did not corbut was aware of it - The QP #2 comshe submitted the I - Client #2 was not into get it done. Typically the Question of 6/13/25 because I'm such a do it to get it done. IRIS report station 6/13/25 because hospital it was because I'm such and it was neglect - "Went on and jubecause she cried with took it back." somet beginning of 2025 - When the IRIS 6/16/25, she did the day - They reached a someone and would Interviews on 6/17/2 Provider reported: - The facility received.	5 the QP #2 reported: ith the internal investigation of buse and neglect for Client #1 treports were completed by and were sent to the QP#1 did the incident reporting but begram Manager completed it 5 the Program Manager anduct the internal investigation appleted the investigation but RIS report and the facility while as completed the second the second that the incident occurred the weak player, sometimes I will be that the incident occurred the weak player, sometimes I will be that the incident occurred the weak player when she first went to the second the investigation wolf before but immediately ime around the end of 2024 or report was completed on the HCPR notification that same but and said they had assigned	V 318			
	hospital	e QP#1 about Client #1's				

Division of Health Service Regulation

STATE FORM RSKM11 If continuation sheet 4 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL042-055	B. WING		06/2	27/2025
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
LYONS A	ANGELS		LIAN SPRIN E RAPIDS, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 318	condition the morni - Client #1's lega all these allegations - She submitted the QP#1 on 6/6/25 - An internal inve Client #2 was remo course of the intern 6/10/25	ng of 6/6/25 and called 911 I guardian had been "calling in 5" of abuse and neglect the facility incident report to estigation was completed and ved from her care during the al investigation from 6/6/25-	V 318			
V 367	10A NCAC 27G .06 REPORTING REQUITED CATEGORY A AND (a) Category A and level II incidents, existe provision of billic consumer is on the incidents and level to whom the provide 90 days prior to the responsible for the services are provide becoming aware of be submitted on a f Secretary. The rep in person, facsimile means. The report information:  (1) reporting identification inform  (2) client iden  (3) type of incident	UIREMENTS FOR B PROVIDERS B providers shall report all accept deaths, that occur during able services or while the providers premises or level III all deaths involving the clients of the incident to the LME catchment area where and within 72 hours of the incident. The report shall orm provided by the ort may be submitted via mail, or encrypted electronic shall include the following provider contact and ation; atification information; cident; n of incident; he effort to determine the	V 367			

Division of Health Service Regulation

STATE FORM RSKM11 If continuation sheet 5 of 14

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND FLAN OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COM	LLILD	
	MHL042-055	B. WING		06/27/2025		
NAME OF PROVIDER OR SUPPLIE	R STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
	804 AUR	ELIAN SPRIN	IGS ROAD			
LYONS ANGELS		E RAPIDS, N				
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF T	ULD BE	(X5) COMPLETE DATE	
V 367 Continued From p	age 5	V 367				
(6) other incor responding. (b) Category A armissing or incompshall submit an upreport recipients be day whenever: (1) the provinformation providerroneous, mislea (2) the proving required on the inunavailable. (c) Category A arupon request by the obtained regardin (1) hospital information; (2) reports (3) the provider regardin (1) hospital information; (2) reports (3) the provider regardin (4) Category A are of all level III incided Mental Health, Desubstance Abuse becoming aware of providers shall se incidents involving Health Service Resulting aware of client death within or restraint, the primmediately, as reconstructed to category A arreport quarterly to cated mentally to cated menta	dividuals or authorities notified d B providers shall explain any plete information. The provider plated report to all required by the end of the next business dider has reason to believe that ed in the report may be ding or otherwise unreliable; or ider obtains information cident form that was previously d B providers shall submit, the LME, other information g the incident, including: records including confidential by other authorities; and ider's response to the incident. d B providers shall send a copy ent reports to the Division of velopmental Disabilities and Services within 72 hours of of the incident. Category A and a copy of all level III a client death to the Division of egulation within 72 hours of the incident. In cases of seven days of use of seclusion ovider shall report the death equired by 10A NCAC 26C CAC 27E .0104(e)(18). d B providers shall send a the LME responsible for the here services are provided. e submitted on a form provided in electronic means and shall information as follows:					

Division of Health Service Regulation STATE FORM

RSKM11 If continuation sheet 6 of 14

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		MHL042-055	B. WING		06/2	7/2025
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LYONS ANGELS			LIAN SPRIN E RAPIDS, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 367	definition of a level (2) restrictive the definition of a le (3) searches (4) seizures of the possession of a (5) the total r incidents that occur (6) a statement been no reportable incidents have occur meet any of the crit	on errors that do not meet the II or level III incident; interventions that do not meet evel II or level III incident; of a client or his living area; of client property or property in a client; number of level II and level III red; and ent indicating that there have incidents whenever no surred during the quarter that eria as set forth in Paragraphs calle and Subparagraphs (1)	V 367			
	facility failed to report Local Management Organization (LME) findings are:  Review on 6/17/25  - Admit date: 2/5  - Diagnoses: Scl Intellectual Disability Disorder moderate, Use Disorder, Rheuter Facility incident am that revealed:  - "Staff (AFL)	view and interviews, the ort a Level III incident to the Entity/Managed Care (MCO) within 72 hours. The of Client #1's record revealed: /24 nizophrenia unspecified, y/Intellectual Development Bipolar Disorder, Tobacco				

Division of Health Service Regulation

STATE FORM RSKM11 If continuation sheet 7 of 14

TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  V 367  Continued From page 7  Supervisor (Qualified Professional (QP#1)) and staff called 911Client had [illegible word] bruises from going over the floor all night. Client [illegible word] put in the hospital today 6-6-25"  - "AFL Provider reported issue this AM via phone. Both me (QP#1) and AFL spoke to guardian. PM (Program Manager) has been contacted for next steps. Incident report done 6/6/25"  Review on 6/18/25 of the Incident Response Improvement System (IRIS) revealed:  - Level III incident on 6/13/25 of allegations of neglect by client #1's guardian against the AFL Provider completed by the Program Manager  - IRIS report was submitted on 6/16/25  Review on 6/18/25 of facility's internal Investigation Summary revealed:  - "Date(s) of Investigation 6/6/25-6/12/25"  - "Introduction - On the afternoon of Friday, June 6. 2025, Program Coordinator, [Program Manager] was contacted by Guardian, [Client #1's legal guardian] [Client #1's legal guardian] [Client #1's legal guardian] [Client #1] was	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ATE SURVEY DMPLETED	
LYONS ANGELS  SUMMARY STATEMENT OF DEFICIENCIES TAG  (X4,) ID REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 367  Continued From page 7  Supervisor (Qualified Professional (QP#1)) and staff called 911 Client had [illegible word] bruises from going over the floor all night. Client [illegible word] put in the hospital today 6-6-25"  "AFL Provider reported issue this AM via phone. Both me (QP#1) and AFL spoke to guardian. PM (Program Manager) has been contacted for next steps. Incident report done 6/6/25"  Review on 6/18/25 of the Incident Response Improvement System (IRIS) revealed:  Level III incident on 6/13/25 of allegations of neglect by client #1's guardian against the AFL Provider completed by the Program Manager  - IRIS report was submitted on 6/16/25  Review on 6/18/25 of Incident Response Investigation Sofiacies.  "Date(s) of Investigation of 6/6/25-6/12/25"  - "Introduction - On the afternoon of Friday, June 6. 2025, Program Coordinator, [Program Manager] was contacted by Guardian, [Client #1's legal guardian] reported concerns that her sister, [Client #1] was			MHL042-055	B. WING		06/2	27/2025
(24) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 367  Continued From page 7  Supervisor (Qualified Professional (QP#1)) and staff called 911 Client had [illegible word] bruises from going over the floor all night. Client [illegible word] put in the hospital today 6-6-25"  - "AFL Provider reported issue this AM via phone. Both me (QP#1) and AFL spoke to guardian. PM (Program Manager) has been contacted for next steps. Incident report done 6/6/25"  Review on 6/18/25 of the Incident Response Improvement System (IRIS) revealed: - Level III incident on 6/13/25 of allegations of neglect by client #1's guardian against the AFL Provider completed by the Program Manager - IRIS report was submitted on 6/16/25  Review on 6/18/25 of facility's internal Investigation Summary revealed: - "Date(s) of Investigation 6/6/25-6/12/25" - "Introduction - On the afternoon of Friday, June 6. 2025, Program Coordinator, [Program Manager] was contacted by Guardian, [Client #1's legal guardian]; [Client #1's legal guardian]; reported concerns that her sister, [Client #1] was	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CX4) ID   PREFIX   SUMMARY STATEMENT OF DEFICIENCIES   FREEDED BY FULL   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX   TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE	LYONS	ANGELS					
Supervisor (Qualified Professional (QP#1)) and staff called 911Client had [illegible word] bruises from going over the floor all night. Client [illegible word] put in the hospital today 6-6-25"  - "AFL Provider reported issue this AM via phone. Both me (QP#1) and AFL spoke to guardian. PM (Program Manager) has been contacted for next steps. Incident report done 6/6/25"  Review on 6/18/25 of the Incident Response Improvement System (IRIS) revealed: - Level III incident on 6/13/25 of allegations of neglect by client #1's guardian against the AFL Provider completed by the Program Manager - IRIS report was submitted on 6/16/25  Review on 6/18/25 of facility's internal Investigation Summary revealed: - "Date(s) of Investigation 6/6/25-6/12/25" - "Introduction - On the afternoon of Friday, June 6. 2025, Program Coordinator, [Program Manager] was contacted by Guardian, [Client #1's legal guardian] reported concerns that her sister, [Client #1] was	PRÉFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	COMPLETE
being neglected by AFL Staff, [AFL Provider]At 2:05pm on Friday, June 6. 2025, QP (Qualified Professional) [QP#2] was contacted by [Program Manager] to be briefed on the situation and begin investigation."  - Client #1's guardian was interviewed on 6/9/25 and 6/13/25 and "expressed serious concerns about the care [Client #1] had been receiving from [AFL Provider]" including proper nutrition, weight loss, unexplained bruising, proper medical care and hygiene  Interview on 6/18/25 and 6/26/25 Client #1's legal guardian reported: - Client #1 went to the hospital on 6/6/25 and	V 367	Supervisor (Qualific staff called 911Clifrom going over the word] put in the hose - "AFL Provice phone. Both me (Quardian. PM (Progrontacted for next staff called 918/25]  Review on 6/18/25  Improvement Syste - Level III incider neglect by client #1 Provider completed - IRIS report was  Review on 6/18/25  Investigation Summ - "Date(s) of Investigation Summ - "Date(s) of Investigation Summ - "Introduction - Oune 6. 2025, Progromanager] was contilegal guardian]. [Clireported concerns to being neglected by 2:05pm on Friday, Professional) [QP#: Manager] to be brief investigation." - Client #1's guardians from [AFL nutrition, weight los proper medical care Interview on 6/18/25 guardian reported:	ed Professional (QP#1)) and ient had [illegible word] bruises is floor all night. Client [illegible spital today 6-6-25" der reported issue this AM via P#1) and AFL spoke to gram Manager) has been steps. Incident Response im (IRIS) revealed: into no 6/13/25 of allegations of its guardian against the AFL by the Program Manager is submitted on 6/16/25 of facility's internal mary revealed: estigation 6/6/25-6/12/25" On the afternoon of Friday, ram Coordinator, [Program acted by Guardian, [Client #1's legal guardian] that her sister, [Client #1] was AFL Staff, [AFL Provider]At June 6. 2025, QP (Qualified 2) was contacted by [Program infed on the situation and begin redian was interviewed on and "expressed serious care [Client #1] had been and "expressed serious care [Client #1] had been and hygiene	V 367			

Division of Health Service Regulation

STATE FORM RSKM11 If continuation sheet 8 of 14

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(VO) MULTIPL	E CONCEDUCTION	(V2) DATE	CLIDVEY	
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE COMP	
			A. BUILDING:			
MHL042-055		B. WING		06/27/2025		
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
			LIAN SPRIN			
LYONS A	I YONS ANGELS			IC 27870		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
	Continued From paremained in critical - Client #1 was described bruises and sores whospital on 6/6/25 - The hospital desadmission on 6/6/25 - The hospital desadmission on 6/6/25 fracture in her arm - Client #1 was new concerns of new conc	ge 8  condition irty and had unexplained when she arrived at the  termined since her (Client #1) that she had an untreated malnourished and dehydrated ified the facility staff on 6/6/25 meglect and abuse prior allegations on 1/30/25  the QP #1 reported: estigation had been completed s legal guardian's allegations noved from the facility until the properted meleted the investigation and per spoke with Client #1's legal itted the IRIS report  the QP #2 reported: ith the internal investigation of puse and neglect for Client #1 treports were completed by and were sent to the QP#1 did IRIS reports but in this Manager completed it the Program Manager aduct the internal investigation moved from the facility while		CROSS-REFERENCED TO THE APPROP		DATE
	she submitted the I - "Typically the Q	pleted the investigation but				
	Double of the such a	todin playor, sometimes i will				

Division of Health Service Regulation

STATE FORM RSKM11 If continuation sheet 9 of 14

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL042-055	B. WING		06/27/2025	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LYONS ANGELS			LIAN SPRIN E RAPIDS, N			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 367	on 6/13/25 because hospital it was because - Client #1's legal it was neglect - "Went on and ji because she cried took it back" somet beginning of 2025  Interviews on 6/17/2 Provider reported: - The facility received because Client #1's hospital - She notified the condition the morni - Client #1's legal all these allegations - She submitted the QP#1 on 6/6/25 - An internal inversion of the internal folion of t	ed that the incident occurred e "when she first went to the ause it was just medical" all guardian later stated she felt ust did the investigation wolf before but immediately ime around the end of 2024 or 25 and 6/26/25 the AFL eived a complaint on 6/6/25 was sick and admitted to the e QP#1 about Client #1's ng of 6/6/25 and called 911 all guardian had been "calling in s" of abuse and neglect the facility incident report to be estigation was completed and eved from her care during the all investigation from 6/6/25-	V 367			
V 540	Grooming  10A NCAC 27F .01  AND GROOMING  (a) Each client shadignity, privacy and of personal health,	ghts - Health, Hygiene And  03 HEALTH, HYGIENE  Il be assured the right to humane care in the provision hygiene and grooming care. clude, but need not be limited	V 540			

Division of Health Service Regulation

STATE FORM 6899 RSKM11 If continuation sheet 10 of 14

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL042-055	B. WING		06/27/2025	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
LYONS A	ANGELS		E RAPIDS, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 540	(1) opportuni daily, or more often (2) opportuni (3) opportuni barber or a beautic (4) provision paper and soap for individual personal indigent client. Suc not limited to toothy napkins, tampons, utensil. (b) Bathtubs or she individual privacy s (c) Adequate toilet	ty for a shower or tub bath as needed; ty to shave at least daily; ty to obtain the services of a ian; and of linens and towels, toilet each client and other hygiene articles for each other articles include but are easte, toothbrush, sanitary shaving cream and shaving owers and toilets which ensure hall be available. It is a client with a mobility	V 540			
	interviews, the facil audited current clie to privacy. The find  Review on 6/17/25  - Admit date: 2/5  - Diagnoses: Scl Intellectual Disabilit Disorder moderate Use Disorder, Rheuter Treatment plant goal to reduce incid	on, record review and ity failed to assure 1 of 2 nts (#1) maintained their rights ings are:  of Client #1's record revealed: /24 nizophrenia unspecified, y/Intellectual Development Bipolar Disorder, Tobacco				

Division of Health Service Regulation STATE FORM

RSKM11 If continuation sheet 11 of 14

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL042-055	B. WING		06/27/2025	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LYONS A	ANGELS		LIAN SPRIN			
	0.0000000000000000000000000000000000000		E RAPIDS, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
V 540	Continued From pa	ge 11	V 540			
	reported: - In April, she mathe facility and Clien of the facility with a staff - Client #1's pant that the woman was water hose - The Alternative was inside the facility - There were houneighbors would has standing outside  Interview on 6/26/2 (QP#1) reported: - Client #1's legather about seeing C	5 Client #1's legal guardian ade an unnannnounced visit to the #1 was outside at the back woman that was not a facility as were down and it appeared as going to spray her with a  Family Living (AFL) Provider atty when she arrived uses around the facility and ave been able to see Client #1  5 the Qualified Professional all guardian had spoken with lient #1 outside with her pants as "public humiliation"				
	down and felt it was "public humiliation"  - She met with the AFL Provider about the incident  - The AFL Provider reported that Client #1 had a bowel movement while in the facility van and when they arrived at the facility, she was outside being cleaned up before going inside  - The AFL Provider had also reported that Client #1 was going outside to get water because "that's what she does at her mom's house" and that her pants fell down when walking outside  - Client #1's legal guardian had reported that Client #1 was being hosed off with a water hose, but the AFL Provider did not have a water hose at the facility  Interview on 6/25/25 the Program Manager reported:  - Client #1's legal guardian recently reported the incident with Client #1 in the back of the					

Division of Health Service Regulation STATE FORM

RSKM11 If continuation sheet 12 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED						
		MHL042-055	B. WING		06/2	7/2025					
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE							
LYONS ANGELS 804 AURELIAN SPRINGS ROAD											
ROANOKE RAPIDS, NC 27870											
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OULD BE COMPLETE						
V 540	Continued From page 12		V 540								
	she stated that Clie and fell down - She was "not so became a part of the Thought that the AFL Provider re "it is suspect and jugrew up doing in the can do it now"	e QP#1 had supervision with garding the incident because st because it's something you e country doesn't mean you									
	<ul> <li>There was a dasitting in the kitcher and Client #1 walke handful of feces</li> <li>Client #1 wante</li> </ul>	5 the AFL Provider reported: by that the AFL Provider was n of the facility with a friend and through the kitchen with a set to go outside, went outside AFL Provider's friend followed									
	- When Client #1 around her ankles - Client #1's lega for a visit while Clie friend were outside - Client #1's lega AFL Provider's frier off with a water hos hose at the facility - The AFL Provid #1's hands at the sp - Client #1's pant they were too big - Client #1's lega pants she was wea	Is had fallen down because I guardian had bought her the ring because she did not like nts that the AFL Provider had									
	- During the incid	5 the AFL Provider reported: lent with Client #1 in the back er pants down, the AFL									

Division of Health Service Regulation

STATE FORM RSKM11 If continuation sheet 13 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED						
		MHL042-055	B. WING		06/2	7/2025					
MHL042-055     B. WING     06/27/2025       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE											
LYONS ANGELS  804 AURELIAN SPRINGS ROAD  ROANOKE RAPIDS, NC 27870											
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	HOULD BE COMPLETE						
V 540	Provider's friend ha and lead her outsid - Client #1's pan outside, but her add remained up	d taken Client #1 by the hand e to wash her hands ts fell down while walking alt incontinence underwear at the door while her friend	V 540								

6899

Division of Health Service Regulation STATE FORM