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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on July 1, 2025. Complaint intake #NC00231808 was unsubstantiated. Complaint intake #NC00231764 was substantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 4 and has a current census of 2. The survey sample consisted of audits of 2 current clients and 1 former client.	V 000		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes. (b) The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate the facility's response to fire emergencies. (d) Each facility shall have a first aid kit accessible for use.	V 114		

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V 114	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire and disaster drills were completed quarterly on each shift. The findings are: Review on 7/1/25 of the facility's fire drills log from July 2024 through July 2025 revealed: -There was no documentation that a fire drill was conducted for 1st, 2nd or 3rd shift for the following: -4th quarter (October, November, December) of 2024. -1st quarter (January, February, March) of 2025. Review on 7/1/25 of the facility's disaster drills log from July 2024 through July 2025 revealed: -There was no documentation that a fire drill was conducted for 1st, 2nd or 3rd shift for the following: -4th quarter (October, November, December) of 2024. -1st quarter (January, February, March) of 2025. Interview on 7/1/25 with the Facility Coordinator/Qualified Professional revealed: -Facility recently changed license classification. -Facility was closed last year for a period of time. -He was not aware that the fire and disaster drills had not been conducted by the staff at the facility. -He confirmed the facility failed to conduct fire and disaster drills under conditions that simulate emergencies quarterly and for each shift.	V 114		

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V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain coordination of care between the facility operator and the	V 291		

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professionals who are responsible for the clients' treatment, affecting 1 of 3 clients (Former Client #3). The findings are:

Review on 7/1/25 of Former Client #3 (FC #3)'s record revealed:
-Admission date of 4/7/25.
-Discharge date of 6/10/25.
-Diagnosis of Autism.
-Care Management Comprehensive Assessment dated 3/11/25:
-Is there anything else you would like us to know about you or any additional notes you feel like need to be included and documented in this assessment?" ...[FC #3] receives support through a behavior support plan that provides intervention for elopement, physical and verbal aggression, self-injurious behaviors and property destruction."
-Treatment plan signed on 3/25/25:
-Goal: [FC #3] will maintain his health and safety.
-Status explanation: "[FC #3] requires 24 hour support to ensure his health and safety. He requires someone to know where he is at all times. He does have a history of elopement and all exits should be monitored for this reason."
-Goal: [FC #3] will engage in appropriate behaviors.
-Status explanation: [FC #3] participates in inappropriate behaviors. These may include aggression, self injurious behaviors, property destruction and elopement. He has a history of urinating and defecating on the floor. It is noted that he experiences heightened anxiety in the months surrounding the holidays. A behavior support plan will be created and staff will implement interventions."
-Psychological evaluation from previous provider dated 2/28/25.
-Background Information: "... [FC #3] was

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admitted for treatment of behavior challenges including aggression, self injurious behavior, property damage and elopement. [FC #3] has a history of attempting to damage parts of his home as well as his own shoes. Unsanitary behavior began in 2023, and its motives are unclear. He may perceive that urinating or defecating in his clothes or onto surfaces is a means of damaging them. [FC #3] has verbalized and enacted his desire to damage buildings throughout his placement. It must be noted that, over the course of his placement at [previous provider], these challenges have not occurred when he was angry or agitated. Rather, they have occurred when he was bored and not receiving direct attention from staff."

Review on 7/1/25 of the North Carolina Incident Response Improvement System (IRIS) revealed:
-Incidents reported for FC #3 on the following dates:
-6/3/25- Aggressive behavior, elopement, police and emergency medical services called. Logged on 6/5/25.
-6/4/25- Aggressive behavior, elopement attempt, police called.
-6/7/25- Aggressive and destructive behavior, police and emergency medical services called, client taken to hospital for evaluation.
-6/10/25-Aggressive and destructive behavior, attacked staff, police and emergency medical services called, client taken to hospital for evaluation.

Interview on 7/1/25 with the Managed Care Organization Care Coordinator revealed:
-She did not have direct access to IRIS. Her supervisors did have access, but they would have to be notified in order for them to review the incidents.

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-She had received FC #3's incident reports from the provider last Monday.
-FC #3 was stepping down from a higher level of care. He had to transition down due to him aging out. He was 22 years old.
-"Care managers are supposed to be informed within 24 hours of when an incident occurs."
-She was aware of the incidents when FC #3 was peeling the paint off the walls or picking on the flooring and also when he would defecate on himself, but was never aware of the aggressive incident.
-All the aggressive incidents and the eloping occurred in the period of 6/3/25-6/10/25.
-On 6/10/25, she first received the 60 days notification of discharge and was then notified that he was going to be discharged that day.
-During transition meeting from when FC #3 was in process of being discharged from former placement and into the new one, they had spoke about a 1:1 staff if he would require it. Staff from new facility would had to request it.
-The new provider had indicated to them that they were confident they would be able to care for FC #3. "They indicated that the facility had door chimes that would help prevent the eloping."
-During discharge planning from previous provider, a 2:1 staffing was never brought up. It was not supposed to have been planned prior of FC #3 moving into the new facility.
-During the week of 6/3/25-6/10/25, she was out of the office from 6/4/25-6/9/25, but she had a back up staff.
-Back up staff never received any notifications from the provider about FC #3.
-When she returned on 6/10/25, that was when she was informed on the situation with FC #3.

Interview on 7/1/25 with Staff #5 revealed:
-FC #3 eloped several times "[FC #3] walked off a

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lot.
-FC #3 needed constant eyes on him. "He would walk away."
-FC #3 went to the hospital a few times. "He was just erratic. Aggressive. Too aggressive. He would bite you, kick you. He scratched the crap out of me. He would do things impulsively."
-"He would get nails into the floor and pull out the rug. He needed constants monitoring."
-"He was non verbal."
-"He was uncontrollable."
-"Some days, he would be alright. He would have laugh outbursts."
"If you don't watch him, he would tear things out. One day, he was just moving his hands on top of the couch, before you know it, the whole couch was all torn out."
-FC #3 needed something to do constantly.
-She felt that she usually connected with the clients. She felt that she was never able to do so with FC #3.
She usually connects with the clients, she feels that she was never able to connect with him.
-She was not sure if FC #3 was still in the hospital or if he went to another place.
-"His parents came and picked up all his belongings already from the facility."

Interview on 7/1/25 with the Facility Coordinator/Qualified Professional revealed:
-We have had numerous episodes with [FC #3] regarding eloping, we had to get the police. We had to search for him to locate. He would just run."
-"The last thing that happened ws that he had attacked [Staff #5]. He scratched her and was trying to hit and kick her."
-FC #3 had to be taken to the hospital several times. "He just increasingly got worst."
-Agency had to put in a notification of discharge,

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but once FC #3 became aggressive they just discharged him.
-Facility did an emergency discharge.
-He is planning to put in a complaint with the Managed Care Coordinator.
-He was never informed informed of the severity of FC #3's symptoms and that his baseline was that he was aggressive. "It was never disclosed."
-The facility did not match FC #3's needs.
-"We thought he would need residential- We take clients that may have behaviors and work on coping skills, daily living skills and independent skills for them to one day be on their own. FC #3 needed constant 2:1 care. We were not able to do 1:1 care. It was never disclose to us.".
"He was kicking holes on the wall, peeling tiles off the floor, peeling paint off the walls. He even did that at the day program that he went to."
-"They knew that he was not verbal. His baseline was being aggressive. It was never shared with us."
-Facility was not rushed admitting FC #3. "They just were never told about his behaviors."
-They had several meetings prior to admission. "We were never told anything."
-They were never told the full scope of FC #3's behaviors.
-FC #3 came from an intensive care facility.
-"We knew of his behaviors. We just did not know how frequent it was. We did not know how constant the behaviors were. We have dealt with folks with behavior issues and trying to decrease them, and we have been successful at doing that, but [FC #3] was a constant thing."
-They had completed a 60 days notice on the morning of 6/10/25. It was completed prior to the incident when FC #3 attacked the staff-
-After the incident, the Facility Coordinator met with the Director to discuss the issue. It was accorded that they were going to discharge FC #3

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on that day due to the safety of staff and other clients at the facility- They were not able to take him back.
-The Managed Care Organization care coordinator later talked to them explaining that they could provide a 1:1.
-"They never recommended that before. We should have provided that from the beginning. They should have provided that information from the beginning."
-Faciity had an emergency discharge policy. It was given when the safety of the other clients or staff was at risk due to the client's behavior.
-The Managed Care Organization was informed of the emergency discharge on 6/10/25. The day of the incident.
-Family was informed of the emergency discharge on the same day. 6/10/25.
-He was unsure if FC #3 had been discharged from the hospital. "As of last week, he was still there."
-"The aggressive attack was a lot to contend with. The intent of the 60 days notification was to try to work something out for FC #3. Find placement. At the same time, we do have to look out for ourselves. Make sure everyone is safe. [FC #3]'s care manager did not disclose any of the things needed to provide the best services for him. We could only go by with what they give us."
-On 6/10/25, he called and informed FC #3's guardian as we as the Managed Care Coordinator.
-He felt that the Care Coordinator left them out in the dark regarding the needs of FC #3.
-The Manage Care Organization and guardian in all of the prior meetings had, never discussed the need of enhanced services for FC #3.
-"No one ever mentioned the need for an extra staff (2:1) for [FC #3]."
-Even his prior placement was under the

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V 291	Continued From page 9 impression that it was to happen as he had received an email from them informing that it was something that should had been placed. -All of FC #3's level 2 incidents happened within a week In June. -From the 3rd to the 10th, he only communicated with the guardian. -He communicated with the guardian during that time by phone only. -When the Managed Care Coordinator last came to the facility for a home visit on 6/2, FC #3 was only displaying the property damage. "He had not displayed the aggression towards the staff." -The times that FC #3 went to the hospital, he was not kept. -FC #3 did not meet the criteria to go to a behavioral setting. -"The hospital was of not help. They talked about his Autism. They saw that he needed help, but they were not sure how he needed the help, so they would just send him back home." -"On 6/10/25, the intent was not even to go to the hospital that day. He just got worst on the rest of the afternoon." -"Staff #5 was attacked by FC #3. Sheriff was called. Director just made the decision not to take him. Too much of a liability." -"The Managed Care Coordinator suggested a 2:1 staff ration plan, but it was too late. -They wanted the provider to take him back, but nothing on their end was in place. "We were the ones having to deal with him." -He acknowledges that from the 6/3/25 to 6/10/25, they had no communication with the Managed Care Coordinator. Provider only communicated with FC #3's guardian. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 291		