Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING: B. WING MHL092-967 07/17/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6531 MERIDIEN DRIVE. SUITE 103 LINDLEY COLLEGE-RALEIGH RALEIGH, NC 27616 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRFFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 000 INITIAL COMMENTS V 000 A complaint survey was completed on July 17, 2025. The complaint was substantiated (intake #NC00231450). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5400 Day Activity for Individuals of All Disability Groups. This facility has a current census of 40. The survey sample consisted of audits of 2 current clients and 1 former client. V 132 G.S. 131E-256(G) HCPR-Notification, V 132 Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

> RECEIVED BY MHL & C 8/4/25

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING: B. WING MHL092-967 07/17/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6531 MERIDIEN DRIVE, SUITE 103 LINDLEY COLLEGE-RALEIGH RALEIGH, NC 27616 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 132 Continued From page 1 V 132 a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. The organization makes every effort to This Rule is not met as evidenced by: 9/12/2025 Based on record review and interview the facility ensure all incidents are reported timely, including submission of an IRIS failed to notify the Health Care Personnel Registry (HCPR) of an allegation for neglect. The report within reporting timeframes. findings are: The QM Director will inservice QPs on Review on 7/16/25 of an IRIS (incident response their responsibility of submitting an improvement system) report dated 12/20/24 for IRIS report within timeframes. client #1 revealed: "...there were noises coming from the The QP who manages the client case kitchen...[client #1] inappropriately touching on of the incident will submit reports another client (former client) [FC#2]...he says the timely, including an IRIS report as other consumer (FC#2) gave him permission indicated. to...informed him that just because permission was given doesn't make it right..." For this particular missing report, the "describe the cause of the incident: staff not QP assigned Client #2's case, will being around their consumer at all times. Allowing submit the report, noting that the their consumer to walk away from them to an report was not reported at the time of area where they are no longer in eye sight" the incident. An investigation was "incident prevention: this incident could have conducted, and the report will be been prevented by following facilities protocol uploaded into the report once it has where your client needs to be within arms length been completed. at all times." no level III incident report for FC#2 The Director and QM will follow up after the expectation of the submission Review on 7/16/25 of the facility's internal of IRIS reports to ensure the reports investigation for the 12/20/24 incident revealed: have been submitted accordingly.

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"conclusion: video footage verified that two students (client #1 & FC#2) were left unattended and engaged in consensual inappropriate

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-967			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING		07/17/2025		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
LINDLEY COLLEGE-RALEIGH 6531 MERIDIEN DRIVE, SUITE 103 RALEIGH, NC 27616						
(X4) ID PREFIX TAG	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETE
V 132 Continued From page 2		V 132				
s.	activities although s two within a very sh	taff member discovered the ort time frametherefore, the t, failing to supervise is		• •		
	HCPR reported: - aware of the 12 & FC#2 - an IRIS report f the completed HCP (FS#3)	7/16/25 a representative with 1/20/24 incident with client #1 for FC#2 was not received with PR section for former staff was needed to complete a for FS#3				
	reported: - she was out on 12/20/24 incident - an investigation completed and sen - was not sure w sent to HCPR - Directors do no investigations and sen - will double check	t complete internal submit to the HCPR ck behind the Clinical ure HCPR are aware of				
V 366	10A NCAC 27G .06 RESPONSE REQUIRED CATEGORY A AND (a) Category A and implement written presponse to level I, shall require the pro-	IREMENTS FOR	V 366			

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING: B. WING MHL092-967 07/17/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6531 MERIDIEN DRIVE, SUITE 103 LINDLEY COLLEGE-RALEIGH RALEIGH, NC 27616 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) V 366 V 366 Continued From page 3 of individuals involved in the incident; determining the cause of the incident; (2)developing and implementing corrective (3)measures according to provider specified timeframes not to exceed 45 days: developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days: assigning person(s) to be responsible (5)for implementation of the corrections and preventive measures: 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 maintaining documentation regarding (7)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: immediately securing the client record (1)by: obtaining the client record; (A) (B) making a photocopy; (C) certifying the copy's completeness; and transferring the copy to an internal (D) review team: convening a meeting of an internal (2)

review team within 24 hours of the incident. The

FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING: B. WING MHL092-967 07/17/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6531 MERIDIEN DRIVE, SUITE 103 LINDLEY COLLEGE-RALEIGH RALEIGH, NC 27616 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 366 Continued From page 4 V 366 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 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 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 immediately notifying the following: (3)(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604:

(B) different; (C) the LME where the client resides, if

the provider agency with responsibility

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: MHL092-967 07/17/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6531 MERIDIEN DRIVE, SUITE 103 LINDLEY COLLEGE-RALEIGH RALEIGH, NC 27616 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) The QM Director will inservice QPs on V 366 Continued From page 5 V 366 9/12/2025 their responsibility of submitting an for maintaining and updating the client's IRIS report within timeframes. treatment plan, if different from the reporting provider: The QP is instructed during the 24 (D) the Department: hour team meeting to complete an (E) the client's legal guardian, as IRIS report within the 24 hour applicable; and timeframe and submit notification to (F) any other authorities required by law. QM of this completion. For information that the QP may not have access to, such as an accused staff member's social security number, they are instructed to consult with HR for this information. The QP who manages the client case of the incident will submit IRIS reports timely. This Rule is not met as evidenced by: Based on record review and interview the facility For this particular missing report, the failed to submit pertinent documents of an QP assigned Client #2's case, will incident to the Local Management/Managed Care submit the report, noting that the report Organization (LME/MCO). The finding are: was not reported at the time of the incident. An investigation was Review on 7/16/25 of an IRIS (incident response conducted, and the report will be improvement system) reported dated 12/20/24 for uploaded into the report once it has client #1 revealed: "...there were noises coming from the been completed. kitchen...[client #1] inappropriately touching on another client former client #2 [FC#2]...he says The Director and QM will follow up the other consumer gave him permission after the expectation of the submission to...informed him that just because permission of IRIS reports to ensure the reports was given doesn't make it right..." have been submitted accordingly. no level III IRIS report for FC#2 with the Health Care Personnel Registry section completed for former staff (FS#3) During interview on 7/16/25 a representative with HCPR reported: aware of the incident between client #1 & FC#2 FS #3's demographic information had been requested several times with no response

an investigation on FS#3 could not be

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL092-967 07/17/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6531 MERIDIEN DRIVE, SUITE 103 LINDLEY COLLEGE-RALEIGH RALEIGH, NC 27616 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) V 366 Continued From page 6 V 366 conducted until HCPR received FS#3's demographic information During interview on 7/17/25 the Interim Director reported: she was out on "medical leave" during the 12/20/24 incident does not recall any emails that requested FS#3's demographic information V 367 27G .0604 Incident Reporting Requirements V 367 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 be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic

Division of Health Service Regulation

or responding.

information:

identification information:

cause of the incident; and

type of incident;

description of incident;

(1)

(2)

(3)

(4)

(5)

means. The report shall include the following

reporting provider contact and

client identification information;

status of the effort to determine the

other individuals or authorities notified

PRINTED: 07/23/2025 FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING: B. WING MHL092-967 07/17/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6531 MERIDIEN DRIVE, SUITE 103 LINDLEY COLLEGE-RALEIGH RALEIGH, NC 27616 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) V 367 Continued From page 7 V 367 (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 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: hospital records including confidential (1) information; reports by other authorities; and (2)(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 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:

definition of a level II or level III incident:

medication errors that do not meet the

PRINTED: 07/23/2025 FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING: B. WING MHL092-967 07/17/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6531 MERIDIEN DRIVE, SUITE 103 LINDLEY COLLEGE-RALEIGH RALEIGH, NC 27616 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 8 V 367 The QM Director will inservice QPs on 9/12/2025 their responsibility of submitting an restrictive interventions that do not meet (2)IRIS report within timeframes. the definition of a level II or level III incident; searches of a client or his living area; (3)The QP is instructed during the 24 hour seizures of client property or property in (4)team meeting as an action item to the possession of a client: complete an IRIS report within the 24 the total number of level II and level III hour timeframe and submit notification incidents that occurred; and to QM of this completion. Completion of a statement indicating that there have the IRIS report will include notifications been no reportable incidents whenever no

to the MCO, guardian, etc. The QP

who manages the client case of the

incident will submit IRIS reports timely.

For this particular missing report, the QP assigned Client #2's case at the time of the incident, will submit the report, noting that the report was not reported at the time of the incident. An investigation was conducted, and the report will be uploaded into the report

The Director and QM will follow up after

IRIS reports to ensure the reports have

the expectation of the submission of

once it has been completed.

been submitted accordingly.

This Rule is not met as evidenced by: Based on record review and interview the facility failed to submit a level III incident report to the Local Management/Managed Care Organization (LME/MCO). The finding are:

incidents have occurred during the quarter that

(a) and (d) of this Rule and Subparagraphs (1)

through (4) of this Paragraph.

meet any of the criteria as set forth in Paragraphs

Review on 7/16/25 of an IRIS (incident response improvement system) reported dated 12/20/24 for client #1 revealed:

- "...there were noises coming from the kitchen...[client #1] inappropriately touching on another client former client [FC#2]...he says the other consumer gave him permission to...informed him that just because permission was given doesn't make it right..."
- "describe the cause of the incident: staff not being around their consumer at all times. Allowing their consumer to walk away from them to an area where they are no longer in eye sight"

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING: MHL092-967 B. WING 07/17/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6531 MERIDIEN DRIVE, SUITE 103 LINDLEY COLLEGE-RALEIGH RALEIGH, NC 27616 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 367 Continued From page 9 V 367 "incident prevention: this incident could have been prevented by following facilities protocol where your client needs to be within arms length at all times." no level III incident report completed for FC#2 An attempted call on 7/16/25 to LME/MCO revealed messages left with no return phone calls During interview on 7/17/25 the Interim Director reported: she was out on "medical leave" during the 12/20/24 incident an investigation for the 12/20/24 incident was completed and sent to HCPR was not sure why a level III incident report for FC#2 was not completed will double check behind the Clinical Supervisors to ensure level II & level III incident reports were submitted in IRIS

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: MHL092-967 07/17/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6531 MERIDIEN DRIVE, SUITE 103 LINDLEY COLLEGE-RALEIGH RALEIGH, NC 27616 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) V 367 V 367 Continued From page 10 there was no IRIS report for FC#2 with accused FS#3's demographic information provided to HCPR V 500 27D .0101(a-e) Client Rights - Policy on Rights V 500 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (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. (b) The governing body shall develop and implement policy to assure that: 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 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. (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: any restrictive intervention that is prohibited from use within the facility; and

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Division of Health Service Regulation (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C MHL092-967 07/17/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6531 MERIDIEN DRIVE, SUITE 103 LINDLEY COLLEGE-RALEIGH RALEIGH, NC 27616 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) V 500 Continued From page 11 V 500 in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (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: (1) the permitted restrictive interventions or allowed restrictions: the individual responsible for informing (2)the client; and the due process procedures for an (3)involuntary client who refuses the use of restrictive interventions. (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: (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); the designation of an individual to be responsible for reviews of the use of restrictive interventions; and the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on record review and interview the facility

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C MHL092-967 07/17/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6531 MERIDIEN DRIVE, SUITE 103 LINDLEY COLLEGE-RALEIGH RALEIGH, NC 27616 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **TAG** DEFICIENCY) V 500 Continued From page 12 V 500 9/12/2025 During the QP inservice of IRIS submissions by the QM Director, the failed to notify the Department of Social Services topic of notification to DSS will be of an allegation of neglect. The findings are: included. The QP will be directed to request a letter from DSS of Review on 7/16/25 of an IRIS (incident response notification of a Level III incident and improvement system) reported dated 12/20/24 for client #1 revealed: their decision regarding how they will address the report. The letter received "...there were noises coming from the kitchen...[client #1] inappropriately touching on from DSS will be uploaded into the another client former client [FC#2]...he says the IRIS report accordingly. other consumer gave him permission to...informed him that just because permission Should the QP require assistance with was given doesn't make it right..." the notification to DSS, the Director will "describe the cause of the incident: staff not assist accordingly. being around their consumer at all times. Allowing their consumer to walk away from them to an QM will follow up with the QP to area where they are no longer in eye sight" ensure the letter from DSS has been "incident prevention: this incident could have received and uploaded into the IRIS been prevented by following facilities protocol report. where your client needs to be within arms length at all times." Review on 7/16/25 of the facility's internal investigation for the 12/20/24 incident revealed: "conclusion: video footage verified that two students were left unattended and engaged in consensual inappropriate activities although staff member discovered the two within a very short time frame...therefore, the allegation of neglect, failing to supervise is substantiated..." During interview on 7/17/25 the Interim Director reported: she was out on "medical leave" during the 12/20/24 incident was not sure why DSS was notified of the incident for client #1 but not FC#2 will double check behind the Clinical Supervisors to ensure DSS was aware of any allegations against all staff