STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL013-251	A. BUILDING: _____ B. WING _____	C 07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL WAYS	518 EAST C STREET KANNAPOLIS, NC 28083

(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 000	INITIAL COMMENTS A complaint survey was completed on 7/17/25. Four complaints were substantiated (intakes #NC00230491, NC00232280, NC00232213, NC00232283), and one complaint was unsubstantiated (intake #NC00232206). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for 4 and has a current census of 3. The survey sample consisted of audits of 3 current clients and 1 former client.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained	V 108		

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V 108	Continued From page 1 to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure at least one staff member who was trained in basic first aid (FA) and cardiopulmonary resuscitation (CPR) was available in the facility at all times when a client was present for 3 of 6 audited staff (former staff (FS) #1, staff #3, and staff #5). The findings are: Review on 6/30/24 of (FS) #1's personnel file revealed: -Direct Care Specialist. -Hire date of 4/9/25. -Termination date of 7/7/25. -American Heart Association CPR card dated 4/14/25. -No American Heart Association FA card. Review on 7/9/25 of staff #3's personnel file revealed: -Direct Care Specialist. -Hire date of 6/4/25. -CPR/FA Certificate signed by CPR/FA trainer dated 3/27/25.	V 108		

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V 108	Continued From page 2 -American Heart Association CPR card dated 3/27/25. -No American Heart Association FA card. Review on 7/14/25 of staff #5's personnel file revealed: -Direct Care Specialist. -Hire date of 3/19/25. -CPR/FA Certificate signed by CPR/FA trainer dated 6/4/25. -American Heart Association CPR card dated 6/4/25. -No American Heart Association FA card. Interview on 7/2/25 with FS #1 revealed: -Had worked alone in the facility. -Frequently worked 4pm to 11pm with staff #3. -Watched a PowerPoint presentation on the computer for CPR/FA. -Did not receive the in person demonstration portion of the training. -Did not practice CPR on a mannequin. Interview on 7/2/25 with staff #3 revealed: -Had worked alone in the facility and transported clients alone. -Frequently worked 4pm to 11pm with FS #1. -CPR/FA was completed on the computer in a Zoom class. -Did not receive the in person demonstration portion of the training. -Did not practice CPR on a mannequin. Interview on 7/7/25 with staff #5 revealed: -Had worked alone in the facility. -Completed CPR/FA training virtually on the computer. -Did not receive the in person demonstration portion of the training. -Did not practice CPR on a mannequin.	V 108		

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V 108	Continued From page 3 Interview on 7/7/25 with the CPR/FA Trainer revealed: -Contracted with the facility to provide CPR/FA training. -Taught FA and CPR on the same day, but only got the CPR cards (not the FA cards) from the American Heart Association because it was cheaper. -Provided the facility with a computer printed FA certificate. -Sometimes taught CPR/FA virtually on the computer. -Utilized role playing when teaching virtual classes. -Participants used a "teddy bear or baby doll" for the demonstration portion during virtual training. Interview on 7/14/25 with the Director/Associate Professional revealed: -FA/CPR training should include an in person component. -Did not have staff sign in sheets.	V 108		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based	V 110		

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V 110	Continued From page 4 employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record review and interview, 1 of 5 audited paraprofessionals (Licensee/Direct Care Specialist) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are: Review on 6/30/25 of the Licensee/Direct Care Specialist's personnel file revealed: -Hire date of 6/28/21. -Evidence Based Protective Interventions-Base Plus (EBPI) 2/3/25. Interview on 7/3/25 with former client (FC) #2 revealed: -"[Licensee/Direct Care Specialist] communicated threats to me and [client #3]	V 110		

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V 110	Continued From page 5 -"He (Licensee/Direct Care Specialist) said (to me), 'You are coming willingly or forcefully,' and took everything out of his pockets." -"I think he wanted me to come inside (facility). I was on the front porch because [client #1] was running his mouth." -The licensee/Direct Care Specialist made a similar statement to client #3 in a separate incident (date unknown). Interview on 7/1/25 with client #3 revealed: -Locked himself in his room because he did not "want to go on a community outing. -The Licensee/Direct Care Specialist "came and busted down the door." -Told the Licensee/Direct Care Specialist, "I don't want to go anywhere." -"He said, 'You will come willingly or forcefully.'" -The Licensee/Direct Care Specialist made the same comment (You will come willingly or forcefully) to [FC #2] 2 weeks later (date unknown). -The Licensee/Direct Care Specialist handed his keys to somebody like he was going "to do something" to FC #2. Interviews with client #1 and #4 on 7/1/25 revealed: -Denied hearing the Licensee/Direct Care Specialist make threats to clients. Interview on 7/9/25 with the Licensee/Direct Care Specialist revealed: -Arrived at the facility and all of the clients were on the front porch (date unknown). -Was attempting to deescalate the situation and get the clients to go inside. -FC #2 "started cursing and said, 'I don't want to be here.'" -I told him you can go "willingly or we can get the	V 110		

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V 110	Continued From page 6 police to make you go in (the facility)." -FC #2 complied and the police were not called. -Client #3 did not want to go to the gym (date unknown). -Had to "bust" the door open. -Staff didn't know if he was self-harming. -Talked to client #3 and he went to the gym. Interview on 7/17/25 with the Director/Associate Professional revealed: -It would not be appropriate for a direct care staff to threaten a client to move him willingly or forcefully.	V 110		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be	V 112		

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V 112	Continued From page 7 obtained. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to develop and implement goals and strategies to meet the needs of 1 of 3 audited clients (#1). The findings are: Review on 6/27/25 of client #1's record revealed: -Admission date of 4/11/25. -13 years old. -Diagnoses of Conduct Disorder, Unspecified; Trauma and Stressor Related Disorder; Attention Deficit Hyperactivity Disorder, Combined Presentation. -Comprehensive Clinical Assessment (CCA) Addendum dated 3/18/25: History of being absent without leave (AWOL). -Treatment Plan dated 10/28/24 and updated 5/7/25 and 6/5/25: "[Client #1] does not currently have access to any unsupervised community areas." No goals or strategies for AWOL behaviors. Review on 6/30/25 of the North Carolina Incident Response Improvement System from 4/1/25 to 6/30/25 revealed: -5/30/25 "At approximately 6:00 PM, staff prompted all clients to begin their scheduled chores as outlined in the house routine. [Client	V 112		

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V 112	Continued From page 8 #1] was observed not completing his assigned task. Staff approached to model the expected behavior and offer support. [Client #1] became visibly upset and stated that he would not complete the chore. Staff documented the behavior and redirected attention to assisting other clients. [Client #1's] agitation escalated following a point deduction for noncompliance. Without permission, he exited the home, retrieved a metal pole from outside the premises, and charged at staff in a threatening manner. He then used the pole to strike and damage household furniture. Staff attempted verbal de-escalation techniques and redirection; however, [client #1] exited the home again without authorization. He remained in view across the street but eventually left the area around 8:00 PM. Staff searched the neighborhood by foot and vehicle for approximately 45 minutes but were unable to locate the client. Law enforcement was contacted at 9:00 PM. At approximately 9:15 PM, local police returned [client #1] to the group home (facility). Staff engaged in processing with the client, during which he shared that his emotional outburst was triggered by his friend moving away. [client #1] was redirected to complete his nighttime hygiene routine and go to bed, which he did without further incident." -6/3/25 "[Client #1] went AWOL following an incident involving another consumer. The initial incident was de-escalated by staff; however, shortly after, [client #1] became aggressively upset and disregarded staff directives to remain inside the home. [Client #1] exited the residence without staff permission. [Client #1] remained within staff line of sight for approximately 15 to 20 minutes before leaving the visible area. Staff immediately conducted a search for the client both on foot and by vehicle for 45 minutes but were unsuccessful in locating him. At	V 112		

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V 112	Continued From page 9	V 112		

approximately 8:00 p.m., law enforcement was notified in accordance with facility policy and protocol, as [Client #1] had exceeded the allowable time away without supervision. At approximately 1:06 a.m. the following morning, [Client #1] was returned to the home (facility) by police. He was unharmed upon return."

Interview on 7/1/25 with client #1 revealed:
-"Sometimes staff or kids (clients) piss me off and I go AWOL."
-Left the facility "4 or 5 times" without supervision.
-"I went to downtown [local town] to look for friends. Found a $10 bill so I bought myself food."
-Was gone for about 3 hours each time.
-Staff did not make any changes to prevent AWOLs.

Interview on 7/2/25 with former staff #1 revealed:
-Client #1 did not have goals or strategies to prevent AWOL behavior.

Interview on 7/1/25 with staff #3 revealed:
-Client #1 did not have goals or strategies to prevent AWOL behavior.
-No changes were made to the treatment plan to prevent AWOL behavior.
-Was instructed to keep clients who went AWOL "in sight as much as we can. We (staff) at least go to the end of the block and if they don't come back in at least 40 minutes we call the authorities."

Interview on 7/8/25 with the Qualified Professional revealed:
-Was not sure if client #1's treatment plan had goals and strategies to address AWOL behavior. "I would have to check documentation. "He (client #1) had a history of AWOL." I want to say

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V 112	Continued From page 10 that there were goals in place." -Had not made revisions to client #1's treatment plan to include goals and strategies to address AWOL behavior. Interview on 7/1/25 and 7/8/25 with the Director/Associate Professional revealed: -Client #1 had a history of AWOL behavior prior to being admitted to the facility. -Client #1 did not have goals or strategies to prevent AWOL behavior in his treatment plan. - Client #1's treatment plan would be updated in July 2025 to add a goal and strategies to address the AWOL behavior.	V 112		
V 132	G.S. 131E-256(G) HCPR-Notification, 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	V 132		

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V 132	Continued From page 11	V 132		

facility or to a patient or client.
e. Fraud against a health care facility or against 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.

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure all allegations or acts of abuse, neglect or exploitation, including injuries of an unknown source were investigated, failed to make every effort to protect clients and failed to ensure the results of all investigations were reported to the HCPR within five working days from the initial notification to the Department.
The findings are:

Finding #1:

Review on 6/27/25 of client #1's record revealed:
-Admission date of 4/11/25.
-13 years old.
-Diagnoses of Conduct Disorder, Unspecified; Trauma and Stressor Related Disorder; Attention Deficit Hyperactivity Disorder, Combined Presentation.

Review on 7/9/25 of staff #3's personnel file revealed:
-Direct Care Specialist.
-Hire date of 6/4/25.
-Evidence Based Protective Interventions (EBPI)-Base Plus 6/4/25.

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V 132	Continued From page 12 Review on 6/30/25 of the North Carolina Incident Response Improvement System (IRIS) from 4/1/25-6/30/25 revealed: -"On June 26, 2025, at approximately 8:52 PM, the Director (Director/Associate Professional (AP) was notified by staff (#3) that an altercation had occurred between staff (former staff (FS) #1) and client (#1) during evening chores. Staff (#3) reported that law enforcement had been called. The Qualified Professional (QP) arrived on site within 30 minutes, and the Director (Director/AP) followed shortly after. Police were already present. Upon arrival, client (#1) was seated on the porch with visible surface scratches to the chest, which did not require medical attention. Staff (FS #1) was in the yard and reported no injuries. [Client #1] stated he was washing dishes when staff (FS #1) began rushing him. When he didn't comply, [FS #1] removed the dish rag from him and sat down. [Client #1] retrieved the rag and resumed cleaning. [FS #1] returned to the kitchen, yelling. [Client #1] sprayed her with water, which escalated into physical contact, including pushing and exchanging blows. The conflict moved outdoors before they were separated ...Staff (#3) was present during the incident but did not intervene and left the scene when police arrived. Both client (#1) and staff (FS #1) were assessed for injury by QP and Director /AP." Review on 7/2/25 of video #1 recorded by staff #3 of the incident on 6/26/25 revealed: -Video was 28 seconds long. -In the living room, FS #1 was struggling with client #1 on the sofa and was pulling client #1's hair. -Both of FS #1's hands were holding client #1's hair. -FS #1 was on top of client #1.	V 132		

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-Staff #3 was yelling at client #1 to stop and telling him "Police are coming and they are going to take your a*s to jail."
-Client #1 said, "Tell her to get the f**k off me."
-Staff #3 said, "If she gets off of you what ... (unintelligible)."
-FS #1 got off the sofa, continued to grip and pull client #1's hair with both hands.
-Staff #3 said, "What benefit?" and yelled, "Stop, oh my God."
-Client #1 and FS #1 continued to struggle with one another until the video ended.
- Staff #3 did not attempt to physically intervene.

Review on 7/2/25 of video #2 recorded by staff #3 of the incident on 6/26/25 revealed:
-Video was 33 seconds long.
-FS #1 was on the floor pulling client #1's hair with both hands.
-FS #1 and client #1 continued to struggle with one another as FS #1 wrapped her legs around Client #1's legs as she was pulling his hair.
-Client #1 slapped FS #1 on the right shoulder and FS #1 released Client #1's hair.
-FS#1 then kicked client #1's head while they were still both on the floor.
-An unknown person yelled, "You are on your own [client #1]."
-Client #1 got to his feet and moved away from FS #1.
-FS #1 grabbed client #1's ankle when client #1 attempted to kick her.
-Staff #3 said,"[Client #1], s**t, stop, stop."
-Client #1 grabbed a football and threatened to throw it at FS #1's head.
-Staff #3 did not attempt to physically intervene.
-The video ended.

Interview on 7/1/25 with client #1 revealed:
-On 6/26/25 FS #1 took away the dish rag while

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he was doing dishes.
-FS #1 "pushed me" and "I pushed her back."
-FS #1 "hit me in the stomach or chest so I started hitting her back."
-"Had a few scratches on my chest and one on my arm and forgot were the rest of the scratches were."
- FS #1 "pulled out chunks of my hair in little balls everywhere."
-Staff #3 did not physically intervene to stop FS #1.

Interview on 7/1/25 with client #3 revealed:
-On 6/26/25, client #1 was cleaning his dishes.
-Heard arguing and saw FS #1 "snatch" the dish towel.
-FS #1 went to her seat and client #1 tried to "grab her."
-FS #1 "pushed" client #1.
-Client #1 and FS #1 "started tussling-grabbed each other pulling hair, kicking."
-They were fighting, wrestling on the floor for about 8 minutes. "Somehow it ended up outside."
-Staff #3 called the law enforcement and recorded some of the altercation.
-Staff #3 "stayed for 3 minutes to talk to the cops and pulled off (left facility) and said, she quit."

Interview on 7/1/25 with client #4 revealed:
-On 6/26/25 there was an argument and a "physical altercation" between client #1 and FS #1.
-Staff #3 called the police and "filmed the whole thing."
-Staff #3 "told them (FS #1 and Client #1) to stop."

Interview on 7/2/25 with FS #1 revealed:
-On 6/26/25 client #1 was washing dishes and

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playing in the sink when she told him to go to bed.
- She and client #1 argued back and forth about turning off the water until client #1 "pushed and shoved" her.
- She grabbed client #1 by his hair "trying to restrain him."
- They continued to struggle with one another and ended up outside on the facility's porch.
-Staff #3 did not help.
- Staff #3 recorded the incident and called the police.
- When the police arrived, staff #3 explained her part and "left (facility)."
- Staff #3 would not give out any information (to the police), "like her address."

Interview on 7/2/25 with staff #3 revealed:
-On 6/26/25, Client #1 was washing dishes when FS #1 "was asking [client #1] to get ready for bed. He told her no."
-FS #1 and Client #1 "started going back and forth" verbally.
-"I told him (client #1) to do dishes and her (FS #1) to calm down."
- When Client #1 continued to play in the water, FS #1 turned the water off.
- Client #1 sprayed FS #1 with the water and said, "Do you want to have a water fight."
- FS #1 pushed client #1 and they both started "pushing and shoving."
-"[Client #1] was choking [FS #1]. I wasn't recording at this time."
-"I called the police."
- FS #1 and Client #1 "continued to fight like strangers."
- FS #1 was "pulling client #1's hair. Some of it came out."
- Client #1 grabbed a football and threw it at FS #1. "I didn't want to trigger him, so I stopped recording."

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V 132	Continued From page 16 - Client #1 threw the football at FS #1's face and they "started fighting again." - "I opened up the door (facility) and heard sirens." - "[Client #1] grabbed a stick and attempted to hit (FS #1), and they tussled with the branch (stick)." -"I told them to put the branch down, and they did." - After the police arrived, she let the officers know that the Director/AP and Licensee/Direct Care Specialist were on their way and then " I left (facility)." -"I didn't want to help or assist when she (FS #1) is fighting. It would look like we were ganging up on him (client #1)." -"As soon as they (FS #1 and client #1) were tussling, I jumped up and told them to calm down. Nobody listened so, I called 911." -"Later on, I pulled out my phone to record." -"I didn't get (record) the beginning and didn't get the part on the porch." Interview on 7/8/25 with the Director/AP revealed: - Arrived at the facility on 6/26/25 and staff #3 had already left. - Started the investigation into FS #1's actions during the incident immediately and concluded that FS #1 "did not follow de-escalation protocol putting a client (#1) at risk." - "I haven't been able to substantiate whether or not she (Staff #3) intervened." - Staff #3 recorded a video but did not share it with facility staff. - Staff #3 had not responded to attempts to reach her. - "[Staff #3] indicated that she quit." - "I was going to officially terminate her." -"She (FS #1) won't be back, but I haven't officially given her anything (termination notice) because I haven't gotten her side of the story."	V 132		

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V 132	Continued From page 17 Interview 7/9/25 with the Licensee/Direct Care Specialist revealed: -FS #1 did not "respond appropriately" during the incident with client #1 on 6/26/25. -FS #1 was terminated for lack of de-escalation techniques and the wrong use of EBPI." -Client #1 had some superficial scratches and hair pulled out. Client #1 "declined" medical treatment. -Staff #3 "claims she didn't see anything and "claims she tried to deescalate." -"The police said [staff #3] had video. How are you deescalating when you are recording?" -Staff #3 was "let go" because of neglect. -Staff #3 was in the area (of the incident) but started recording and failed to deescalate or intervene when the verbal escalation started. -"You are supposed to intervene." Finding #2: Review on 6/30/25 of the Licensee/Direct Care Specialist personnel file revealed: -Hire date of 6/28/21. -EBPI-Base Plus 2/3/25. Review on 6/24/25 of former client (FC) #2's record revealed: -Admission date of 3/21/25. -17 years old. -Discharge date of 6/23/25. -Diagnoses of Post-Traumatic Stress Disorder, Conduct Disorder. Interview on 7/3/25 with FC #2 revealed: -"[Licensee/Direct Care Specialist] communicated threats to me and [client #3]." -"He (Licensee/Direct Care Specialist) said (to FC #2), 'You are coming willingly or forcefully,' and	V 132		

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took everything out of his pockets."
-"I think he wanted me to come inside (facility). I was on the front porch because [client #1] was running his mouth."
-Reported the incident to the Complaint Hot Line and his care manager (Local Management Entity/Managed Care Organization (LME/MCO) Care Manager).

Interview on 7/1/25 with client #3 revealed:
-The Licensee/Direct Care Specialist said to FC #2 "You will come willingly or forcefully".
-"He (Licensee/Direct Care Specialist) handed his keys to somebody like he was going to do something (to FC #2)."

Interview on 7/11/25 with FC #2's LME/MCO Care Manager revealed:
-During a phone call on 5/13/25 FC #2 stated he was being mentally abused in the facility.
-"FC #2 said there was an incident going on and [Licensee/Direct Care Specialist] had to deescalate and had to get kids (clients) to move to another area. [Licensee/Direct Care Specialist] said, 'You need to move or I will make you move.'"
-Notified The Licensee/Direct Care Specialist of the allegation on 5/13/25.

Interview on 7/9/25 with the Licensee/Direct Care Specialist revealed:
-Arrived at the facility and all of the clients were on the front porch (date unknown).
-Was attempting to deescalate the situation and get the clients to go inside.
-FC #2 "started cursing and said, 'I don't want to be here.'"
-"I told him you can go willingly or we can get the police to make you go in."
-FC #2 complied and the police were not called.

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V 132	Continued From page 19 -The allegation was not investigated. -Was not suspended. -Was not reported to the HCPR. Interview on 7/8/25 with the Director/AP revealed: -"FC #2] did report that someone was verbally and mentally abusing him, but then when we got on the CFT meeting he indicated that his words were twisted that no one was verbally abusing him." -FC #2 did not name the person who he accused of verbally abusing him. -Did not investigate. -"There was nothing to investigate." -Did not suspend the Licensee/Direct Care Specialist. -Did not report the allegation to the HCPR.	V 132		
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff	V 296		

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V 296	Continued From page 20 during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the minimum staff ratio of two staff for up to 4 adolescents. The findings are: Review on 6/27/25 of client #1's record revealed: -Admission date of 4/11/25.	V 296		

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V 296	Continued From page 21 -13 years old. -Diagnoses of Conduct Disorder, Unspecified; Trauma and Stressor Related Disorder; Attention Deficit Hyperactivity Disorder, Combined Presentation. -Treatment Plan dated 10/28/24 and updated 5/7/25 and 6/5/25. Client #1 "does not currently have access to any unsupervised community areas." Review on 6/24/25 of FC #2's record revealed: -Admission date of 3/21/25. -17 years old. -Discharge date of 6/23/25. -Diagnoses of Post-Traumatic Stress Disorder, Conduct Disorder. -Treatment plan dated 9/4/24 and updated 5/2/25 and 6/2/25. FC #2 "does not currently have access to any unsupervised community areas." Review on 7/14/25 of client #3's record revealed: -Admission date of 3/18/25. -15 years old. -Diagnoses of Conduct Disorder with Limited Prosocial Behavior, Moderate; Attention Deficit Hyperactive Disorder- Inattentive Presentation; Other Specified Trauma and Stressor Related Disorder - Adjustment like Disorders with Prolonged Duration. -Treatment Plan dated 3/4/25 and updated 4/15/25, 5/20/25, and 6/24/25 did not include information related to unsupervised time. Review on 7/14/25 of client #4's record revealed: -Admission date of 3/30/25. -16 years old. -Diagnoses of Reaction To Severe Stress, Unspecified; Major Depressive Disorder. -Treatment plan dated 1/14/25 and updated 4/21/25, 5/27/25, and 6/23/25. Client #4	V 296		

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"receives full-time supervision and does not have unsupervised access to community settings at this time."

Observation on 7/1/25 at a community camp from 12pm to 1:25pm revealed:
-Clients #1, #3, and #4 present with no facility staff.

Interview on 7/1/25 with client #1 revealed:
-There was 1 to 2 staff on shift in the facility.
-"1 staff is there when we leave camp."
-There was "always just" 1 staff on 3rd shift (11pm-7am).
-1 or 2 staff transported clients to and from camp. "Sometimes 1 staff picks up and 2nd staff is waiting at the house."

Interview on 7/3/25 with former client #2 revealed:
-"There are supposed to be 2 staff but 95% of the time there was only 1."
-There was 1 staff on 3rd shift (11pm to 7am).
-"95% of the time there was 1 staff on 2nd shift (4pm to 11pm)."
-Was transported to and from camp by 1 staff "95%" of the time.
-There were no facility staff at camp.

Interview on 7/1/25 with client #3 revealed:
-Attended camp from 7:15am to 5pm or a little later, Monday through Friday. No facility staff were present.
-There were usually 2 staff at the group home, sometimes less, but "not often."
-"A lot of staff are quitting."
-Sometimes 1 staff was in the facility for "a short time" (could not be more specific) at shift change.

Interview on 7/1/25 with client #4 revealed:

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V 296	Continued From page 23 -There was "1 to 2" staff on shift in the facility. -Attended camp from 7:30am to 4pm or 5pm Monday through Friday. No facility staff were present. -Was "usually" transported by 1 staff. Interview on 7/2/25 with former staff #1 revealed: -Had worked by herself "once ...or a few times." -Worked alone "overnight a couple of times from 11pm to 7 or 8am (during school). They (clients) are pretty much asleep in their rooms." -"It is supposed to be 2 (staff) on all shifts." -"I believe I worked 2pm or 3pm to 11pm by myself every now and then." Interview on 7/2/25 with staff #3 revealed: -There was only 1 staff on 3rd shift (11pm to 7am). -"[Staff #6] let me know that until I got hired in the beginning of June (2025), she was the only staff that worked 2nd shift." -Never worked an entire shift alone, but other staff had. -Went to pick up the clients from camp alone. -"1 staff is a safety risk." Interview on 7/7/25 with staff #4 revealed: -Worked 11pm to 8am. -Had worked 3rd shift alone. -"We are understaffed right now." -"When I have had to do it (work) by myself we have had to try to get someone to come in." -"That shift (3rd) doesn't keep people." -Unable to tell the number of times he worked alone. -Transported the clients to and from camp alone. Interview on 7/7/25 with staff #5 revealed: -"There were a few shifts where I was alone just in the crossing over (shift change)."	V 296		

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V 296	Continued From page 24 -"I was there (at facility) 30 minutes maximum alone." Interview on 7/8/25 with the Qualified Professional (QP) revealed: -There were always 2 staff in the facility on 2nd shift (4pm or 5 pm to 11pm) and 3rd shift (11pm to 8am). -There are no staff working 1st shift (8am to 4pm or 5pm) Monday through Friday because the clients went to camp. -Camp staff provided supervision while the clients were at camp. -Did not know how the camp was staffed or the training they received. Interview on 7/8/25 with the Director/Associate Professional (AP) revealed: -Clients attended camp from 8am until around 5pm. -There were 2 staff on all shifts when clients were in the facility. -Sometimes, when staff called out of work, there may have been only one staff until someone could get there, no more than 30 minutes. Interview on 7/9/25 with the Licensee/Direct Care Specialist revealed: -2 staff worked on all shifts. -"If we have an emergency, [Director/AP] or [QP] are no more than 30 minutes away, if we have a call out." -Clients were transported to camp by 2 staff. -Camp counselors were responsible for supervision when the clients were at camp.	V 296		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT	V 366		

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V 366	Continued From page 25 RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (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:	V 366		

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V 366	Continued From page 26 (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and	V 366		

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V 366	Continued From page 27 (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement written policies governing their response to level II incidents and failed to issue written preliminary findings of facts within five working days of the incident to the LME. The findings are: Review on 6/30/25 of the North Carolina Incident Response Improvement System from 4/1/25-6/30/25 revealed: -No report submitted for the allegation by FC #2 that the Licensee/Direct Care Specialist was verbally abusive. -No documentation of findings of the investigation, corrective and preventative measures, and person(s) responsible for implementation of corrective and preventative measures.	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 366	Continued From page 28 Interview on 7/3/25 with FC #2 revealed: -"[Licensee/Direct Care Specialist] communicated threats to me and [client #3]." -"He (Licensee/Direct Care Specialist) said (FC #2), 'You are coming willingly or forcefully,' and took everything out of his pockets." -"I think he wanted me to come inside (facility). I was on the front porch because [client #1] was running his mouth." -Reported the incident to the Complaint Hot Line and his care manager (Local Management Entity/Managed Care Organization (LME/MCO) Care Manager). Interview on 7/1/25 with client #3 revealed: -The Licensee/Direct Care Specialist said to FC #2 "You will come willingly or forcefully." -"He (Licensee/Direct Care Specialist) handed his keys to somebody like he was going to do something (to FC #2)." Interview on 7/11/25 with FC #2's LME/MCO Care Manager revealed: -During a phone call on 5/13/25 FC #2 stated he was being mentally abused in the facility. -"FC #2 said there was an incident going on and [Licensee/Direct Care Specialist] had to deescalate and had to get kids (clients) to move to another area. [Licensee/Direct Care Specialist] said, 'You need to move or I will make you move.'" -Notified The Licensee/Direct Care Specialist of the allegation on 5/13/25. Interview on 7/9/25 with the Licensee/Direct Care Specialist revealed: -Arrived at the facility and all of the clients were on the front porch (date unknown). -Was attempting to deescalate the situation and	V 366		

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V 366	Continued From page 29 get the clients to go inside. -FC #2 "started cursing and said, 'I don't want to be here.'" -"I told him you can go willingly, or we can get the police to make you go in." -FC #2 complied and the police were not called. -The allegation was not investigated. -Was not suspended. Interview on 7/8/25 with the Director/AP revealed: -"[FC #2] did report that someone was verbally and mentally abusing him, but then when we got on the Child and Family Team meeting he indicated that his words were twisted, that no one was verbally abusing him." -FC #2 did not name the person who he accused of verbally abusing him. -Did not investigate the allegation. -"There was nothing to investigate." -Did not suspend the Director/Licensee or other staff in relation to the allegation. -Did not complete an investigation including findings, corrective and preventative measures, and person(s) responsible for implementation of corrective and preventative measures.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where	V 367		

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V 367	Continued From page 30 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 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	V 367		

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V 367	Continued From page 31 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: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to report all Level II incident reports to the	V 367		

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local management entity (LME)/Managed Care Organization (MCO) responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are:

Review on 6/30/25 of the North Carolina Incident Response Improvement System (IRIS) revealed:
-No report submitted for the allegation by FC #2 that the Licensee/Direct Care Specialist was verbally abusive.

Interview on 7/3/25 with FC #2 revealed:
-"[Licensee/Direct Care Specialist] communicated threats to me and [client #3]."
-"He (Licensee/Direct Care Specialist) said (to FC#2), 'You are coming willingly or forcefully,' and took everything out of his pockets."
-"I think he wanted me to come inside (facility). I was on the front porch because [client #1] was running his mouth."
-Reported the incident to the Complaint Hot Line and his LME/MCO Care Manager.

Interview on 7/1/25 with client #3 revealed:
-The Licensee/Direct Care Specialist said to FC #2 "You will come willingly.
-"He (Licensee/Direct Care Specialist) handed his keys to somebody like he was going to do something (to FC #2)."

Interview on 7/11/25 with FC #2's LME/MCO Care Manager revealed:
-During a phone call on 5/13/25 FC #2 stated he was being mentally abused in the facility.
-FC #2 "said there was an incident going on and [Licensee/Direct Care Specialist] had to deescalate and had to get kids (clients) to move to another area. [Licensee/Direct Care Specialist] said, 'You need to move, or I will make you

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V 367	Continued From page 33 move.'" -Notified the Licensee/Direct Care Specialist of the allegation on 5/13/25. Interview on 7/9/25 with the Licensee/Direct Care Specialist revealed: -Arrived at the facility and all of the clients were on the front porch (date unknown). -Was attempting to deescalate the situation and get the clients to go inside. -FC #2 "started cursing and said, 'I don't want to be here.'" -"I told him you can go willingly, or we can get the police to make you go in." -FC #2 complied and the police were not called. -The allegation of was not investigated. -Was not suspended. Interview on 7/8/25 with the Director/AP revealed: -"[FC #2] did report that someone was verbally and mentally abusing him, but then when we got on the CFT meeting he indicated that his words were twisted that no one was verbally abusing him." -FC #2 did not name the person who he accused of verbally abusing him. -Was responsible for investigating allegations of abuse. -Did not investigate. -"There was nothing to investigate." -Did not submit the incident within 72 hours of becoming aware of the allegation. -Did not determine the cause of the incident.	V 367		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that	V 500		

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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:
(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
(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.
(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:
(1) any restrictive intervention that is prohibited from use within the facility; and
(2) 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;
(2) the individual responsible for informing the client; and
(3) the due process procedures for an 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

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V 500	Continued From page 35 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); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) 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 reviews and interviews, the facility failed to ensure all instances of alleged or suspected abuse, neglect or exploitation were reported to the county department of social services (DSS). The findings are: Finding #1: Review on 6/27/25 of client #1's record revealed: -Admission date of 4/11/25. -13 years old. -Diagnoses of Conduct Disorder, Unspecified; Trauma and Stressor Related Disorder; Attention Deficit Hyperactivity Disorder, Combined Presentation. Review on 7/9/25 of staff #3's personnel file revealed: -Direct Care Specialist.	V 500		

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V 500	Continued From page 36 -Hire date of 6/4/25. -Evidence Based Protective Interventions (EBPI)-Base Plus 6/4/25. Refer to V132 Finding #1 details regarding the altercation between Former Staff (FS) #1 and Client #1. Staff #3 video taped the altercation and neglected to to protect Client #1 by not physically intervening during the altercation. Finding #2 details, FC#2 alleged the Director/Licensee/Direct communicated threats to him. Review on 6/30/25 of the North Carolina Incident Response Improvement System from 4/1/25-6/30/25 revealed: -"On June 26, 2025, at approximately 8:52 PM, the Director (Director/Associate Professional) was notified by staff (#3) that an altercation had occurred between staff (former staff (FS) #1) and client (#1) during evening chores. Staff (#3) reported that law enforcement had been called. The Qualified Professional (QP) arrived on site within 30 minutes, and the Director (Director/Associate Professional) followed shortly after. Police were already present. Upon arrival, client (#1) was seated on the porch with visible surface scratches to the chest, which did not require medical attention. Staff (FS #1) was in the yard and reported no injuries. [Client #1] stated he was washing dishes when staff (FS #1) began rushing him. When he didn't comply, [FS #1] removed the dish rag from him and sat down. [Client #1] retrieved the rag and resumed cleaning. [FS #1] returned to the kitchen, yelling. [Client #1] sprayed her with water, which escalated into physical contact, including pushing and exchanging blows. The conflict moved outdoors before they were separated ...Staff (#3) was present during the incident but did not	V 500		

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intervene and left the scene when police arrived. Both client and staff (FS #1 and Client #1 were assessed for injury by QP (Qualified Professional) and Director (Director/Associate Professional (AP))."

Interview on 7/8/25 with the Director/AP revealed:
-Arrived at the facility on 6/26/25 and staff #3 had already left.
-Started the investigation immediately.
-"I don't want to say it was abuse but it was wrong."
-Staff #3 recorded a video, but did not share it with facility staff.
-Staff #3 had not responded to attempts to reach her.
-"[Staff #3] indicated that she quit."
-"I was going to officially terminate her."
-"I haven't been able to substantiate whether or not she intervened."
-"She (staff #3) won't be back, but I haven't officially given her anything (termination notice) because I haven't gotten her side of the story."
-Did not complete the investigation of neglect by staff #3 for failing to protect client #1 from abuse.
-Did not report staff #3 to DSS

Interview with the Licensee/Direct Care Specialist:
-Staff #3 "claims she didn't see anything and "claims she tried to deescalate."
-"The police said [staff #3] had video. How are you deescalating when you are recording?"
-Staff #3 was "let go" because of neglect.
-Staff #3 was in the area (of the incident) but started recording and failed to deescalate or intervene when the verbal escalation started.
-"You are supposed to intervene."
-An investigation of neglect by staff #3 for failing to protect client #1 from abuse was not

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completed.
-Staff #3 was not reported to DSS.

Finding #2:

Review on 6/30/25 of the Licensee/Direct Care Specialist's personnel file revealed:
-Hire date of 6/28/21.
-EBPI-Base Plus 2/3/25.

Review on 6/24/25 of former client (FC) #2's record revealed:
-Admission date of 3/21/25.
-17 years old.
-Discharge date of 6/23/25.
-Diagnoses of Post-Traumatic Stress Disorder, Conduct Disorder.

Interview on 7/3/25 with FC #2 revealed:
-"[Licensee/Direct Care Specialist] communicated threats to me and [client #3]."
-"He (Licensee/Direct Care Specialist) said (to FC #2), 'You are coming willingly or forcefully,' and took everything out of his pockets."
-"I think he wanted me to come inside (facility). I was on the front porch because [client #1] was running his mouth."
-Reported the incident to the Complaint Hot Line and his care manager (Local Management Entity/Managed Care Organization (LME/MCO)) Care Manager.

Interview on 7/11/25 with FC #2's LME/MCO Care Manager revealed:
-During a phone call on 5/13/25 FC #2 stated he was being mentally abused in the facility.
-"FC #2 said there was an incident going on and [Licensee/Direct Care Specialist] had to deescalate and had to get kids (clients) to move

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V 500	Continued From page 39 to another area. [Licensee/Direct Care Specialist] said, 'You need to move or I will make you move.'" -Notified the Licensee/Direct Care Specialist of the allegation on 5/13/25. Interview on 7/9/25 with the Licensee/Direct Care Specialist revealed: -Arrived at the facility and all of the clients were on the front porch (date unknown). -Was attempting to deescalate the situation and get the clients to go inside. -FC #2 "started cursing and said, 'I don't want to be here.'" -"I told him you can go willingly or we can get the police to make you go in." -FC #2 complied and the police were not called. -The allegation was not investigated. -Was not suspended. -Allegation was not reported to DSS. Interview on 7/8/25 with the Director/AP revealed: -"[FC #2] did report that someone was verbally and mentally abusing him, but then when we got on the Child and Family Team meeting he indicated that his words were twisted that no one was verbally abusing him." -FC #2 did not name the person who he accused of verbally abusing him. -Did not investigate. -"There was nothing to investigate." -Did not report the allegation to DSS.	V 500		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance	V 512		

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V 512	Continued From page 40 with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through 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. This Rule is not met as evidenced by: Based on record review and interview, 1 of 4 staff (#3) neglected to protect 1 of 3 current clients (#1) from abuse. The findings are: Review on 6/27/25 of client #1's record revealed: -Admission date of 4/11/25. -13 years old. -Diagnoses of Conduct Disorder, Unspecified; Trauma and Stressor Related Disorder; Attention Deficit Hyperactivity Disorder, Combined Presentation. Review on 7/9/25 of staff #3's personnel file revealed: -Direct Care Specialist.	V 512		

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V 512	Continued From page 41 -Hire date of 6/4/25. -Evidence Based Protective Interventions (EBPI)-Base Plus 6/4/25. Review on 6/30/25 of the North Carolina Incident Response Improvement System (IRIS) from 4/1/25-6/30/25 revealed: -"On June 26, 2025, at approximately 8:52 PM, the Director (Director/Associate Professional (AP)) was notified by staff (#3) that an altercation had occurred between staff (former staff (FS) #1) and client (#1) during evening chores. Staff (#3) reported that law enforcement had been called. The Qualified Professional (QP) arrived on site within 30 minutes, and the Director (Director/AP) followed shortly after. Police were already present. Upon arrival, client (#1) was seated on the porch with visible surface scratches to the chest, which did not require medical attention. Staff (FS #1) was in the yard and reported no injuries. [Client #1] stated he was washing dishes when staff (FS #1) began rushing him. When he didn't comply, [FS #1] removed the dish rag from him and sat down. [Client #1] retrieved the rag and resumed cleaning. [FS #1] returned to the kitchen, yelling. [Client #1] sprayed her with water, which escalated into physical contact, including pushing and exchanging blows. The conflict moved outdoors before they were separated ...Staff (#3) was present during the incident but did not intervene and left the scene when police arrived. Both client (#1) and staff (FS #1) were assessed for injury by QP and Director /AP." Review on 7/2/25 of video #1 recorded by staff #3 of the incident on 6/26/25 revealed: -Video was 28 seconds long. -In the living room, FS #1 was struggling with client #1 on the sofa and was pulling client #1's	V 512		

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V 512	Continued From page 42 hair. -Both of FS #1's hands were holding client #1's hair. -FS #1 was on top of client #1. -Staff #3 was yelling at client #1 to stop and telling him "Police are coming and they are going to take your a*s to jail." -Client #1 said, "Tell her to get the f**k off me." -Staff #3 said, "If she gets off of you what ... (unintelligible)." -FS #1 got off the sofa, continued to grip and pull client #1's hair with both hands. -Staff #3 said, "What benefit?" and yelled, "Stop, oh my God." -Client #1 and FS #1 continued to struggle with one another until the video ended. - Staff #3 did not attempt to physically intervene. Review on 7/2/25 of video #2 recorded by staff #3 of the incident on 6/26/25 revealed: -Video was 33 seconds long. -FS #1 was on the floor pulling client #1's hair with both hands. -FS #1 and client #1 continued to struggle with one another as FS #1 wrapped her legs around Client #1's legs as she was pulling his hair. -Client #1 slapped FS #1 on the right shoulder and FS #1 released Client #1's hair. -FS#1 then kicked client #1's head while they were still both on the floor. -An unknown person yelled, "You are on your own [client #1]." -Client #1 got to his feet and moved away from FS #1. -FS #1 grabbed client #1 ankle when client #1 attempted to kicked her. him. -Staff #3 said,"[Client #1], s**t, stop, stop." -Client #1 grabbed a football and threatened to throw it at FS #1's head.	V 512		

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V 512	Continued From page 43 -Staff #3 did not attempt to physically intervene. -The video ended. Interview on 7/1/25 with client #1 revealed: -On 6/26/25 FS #1 took away the dish rag while he was doing dishes. -FS #1 "pushed me" and "I pushed her back." -FS #1 "hit me in the stomach or chest so I started hitting her back." -"Had a few scratches on my chest and one on my arm and forgot were the rest of the scratches were." - FS #1 "pulled out chunks of my hair in little balls everywhere." -Staff #3 did not physically intervene to stop FS #1. Interview on 7/1/25 with client #3 revealed: -On 6/26/25, client #1 was cleaning his dishes. -Heard arguing and saw FS #1 "snatch" the dish towel. -FS #1 went to her seat and client #1 tried to "grab her." -FS #1 "pushed" client #1. -Client #1 and FS #1 "started tussling-grabbed each other pulling hair, kicking." -They were fighting, wrestling on the floor for about 8 minutes. "Somehow it ended up outside." -Staff #3 called the law enforcement and recorded some of the altercation. -Staff #3 "stayed for 3 minutes to talk to the cops and pulled off (left facility) and said, she quit." Interview on 7/1/25 with client #4 revealed: -On 6/26/25 there was an argument and a "physical altercation" between client #1 and FS #1. -Staff #3 called the police and "filmed the whole thing."	V 512		

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V 512	Continued From page 44 -Staff #3 "told them (FS #1 and Client #1) to stop." Interview on 7/2/25 with FS #1 revealed: -On 6/26/25 client #1 was washing dishes and playing in the sink when she told him to go to bed. - She and client #1 argued back and forth about turning off the water until client #1 "pushed and shoved" her. - She grabbed client #1 by his hair "trying to restrain him." - They continued to struggle with one another and ended up outside on the facility's porch. -Staff #3 did not help. - Staff #3 recorded the incident and called the police. - When the police arrived, staff #3 explained her part and "left (facility)." - Staff #3 would not give out any information (to the police), "like her address." Interview on 7/2/25 with staff #3 revealed: -On 6/26/25, Client #1 was washing dishes when FS #1 "was asking [client #1] to get ready for bed. He told her no." -FS #1 and Client #1 "started going back and forth" verbally. -"I told him (client #1) to do dishes and her (FS #1) to calm down." - When Client #1 continued to play in the water, FS #1 turned the water off. - Client #1 sprayed FS #1 with the water and said, "Do you want to have a water fight." - FS #1 pushed client #1 and they both started "pushing and shoving." -"[Client #1] was choking [FS #1]. I wasn't recording at this time." -"I called the police." - FS #1 and Client #1 "continued to fight like strangers."	V 512		

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- FS #1 was "pulling client #1's hair. Some of it came out."
- Client #1 grabbed a football and threw it at FS #1. "I didn't want to trigger him, so I stopped recording."
- Client #1 threw the football at FS #1's face and they "started fighting again."
- "I opened up the door (facility) and heard sirens."
- "[Client #1] grabbed a stick and attempted to hit (FS #1), and they tussled with the branch (stick)."
-"I told them to put the branch down, and they did."
- After the police arrived, she let the officers know that the Director/AP and Licensee/Direct Care Specialist were on their way and then " I left (facility)."
-"I didn't want to help or assist when she (FS #1) is fighting. It would look like we were ganging up on him (client #1)."
-"As soon as they (FS #1 and client #1) were tussling, I jumped up and told them to calm down. Nobody listened so, I called 911."
-"Later on, I pulled out my phone to record."
-"I didn't get (record) the beginning and didn't get the part on the porch."

Interview on 7/8/25 with the Director/AP revealed:
- Arrived at the facility on 6/26/25 and staff #3 had already left.
- Started the investigation into FS #1's actions during the incident immediately and concluded that FS #1 "did not follow de-escalation protocol putting a client (#1) at risk."
- "I haven't been able to substantiate whether or not she (Staff #3) intervened."
- Staff #3 recorded a video but did not share it with facility staff.
- Staff #3 had not responded to attempts to reach her.

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V 512	Continued From page 46 - "[Staff #3] indicated that she quit." - "I was going to officially terminate her." -"She (FS #1) won't be back, but I haven't officially given her anything (termination notice) because I haven't gotten her side of the story." Interview 7/9/25 with the Licensee/Direct Care Specialist revealed: -FS #1 did not "respond appropriately" during the incident with client #1 on 6/26/25. -FS #1 was terminated for lack of de-escalation techniques and the wrong use of EBPI." -Client #1 had some superficial scratches and hair pulled out. Client #1 "declined" medical treatment. -Staff #3 "claims she didn't see anything and "claims she tried to deescalate." -"The police said [staff #3] had video. How are you deescalating when you are recording?" -Staff #3 was "let go" because of neglect. -Staff #3 was in the area (of the incident) but started recording and failed to deescalate or intervene when the verbal escalation started. -"You are supposed to intervene." Review on 7/14/25 of the Plan of Protection dated 7/14/25 written by the Director/AP revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? -The QP or a designated staff member will conduct informal check-ins with each consumer within the next 24 hours to ensure they feel safe, address any concerns, and identify needs for emotional support. This will be documented in the consumer's chart. -All direct care staff, QPs, and supervisors will complete refresher training on abuse, neglect, and exploitation within 10 business days. -The Director/AP will update the IRIS report to include all staff implicated in the abuse incident.	V 512		

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V 512	Continued From page 47 -If specific staff are involved in or suspected of contributing to the neglect they will be removed from direct consumer contact while the matter is investigated. Staff will be adjusted using available relief or PRN (as needed) staff to maintain adequate supervision. Termination of employee involved (termination completed July 7th). -Starting immediately, brief team huddles at the start and end of each shift will be used to review safety concerns, ensure all assigned duties are understood, and allow staff to raise any issues impacting consumer care. -The House Manager or QP will increase walkthroughs for the next two weeks to observe staff-consumer interactions, verify proper supervision, and provide immediate coaching if concerns arise. -Describe your plans to make sure the above happens. -The QP will document each consumer check-in in their chart. Any issues identified will be communicated to the clinical team and addressed within 48 hours. The Facility Director will review documentation to ensure completion. -The resubmission of the IRIS report/Health Case (Care) Registry will be reflective of the additional staff being implicated -The QP or Director will schedule training sessions and circulate attendance rosters. Topics will include definitions of abuse/neglect, mandatory reporting procedures, and prevention strategies. Attendance will be documented, and copies of materials and sign-in sheets will be stored in staff records for verification. Any future incidents will trigger immediate staffing adjustments per policy. -The "Home Base" app (scheduling software) will be used to log start- and end-of-shift huddles. The QP will set daily reminders and provide space within the app for staff to record any	V 512		

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concerns. Entries will be monitored weekly.
-A standardized "Walkthrough Observation Log" will be used to record staff-consumer interactions, supervision practices, and any coaching provided. Walkthroughs will occur throughout the week for the next two weeks. Logs will be reviewed by the Facility Director for compliance."

Review on 7/15/25 of the amended Plan of Protection dated 7/15/25 written by the Director/AP revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care?
-All direct care staff, QPs, and supervisors will complete refresher training on abuse, neglect, and exploitation by July 24th, 2025.
-The Director will update the June 26, 2025, IRIS report to include all staff implicated in the abuse incident. The report was updated July 14, 2025 to add the staff member.
-If specific staff are involved in or suspected of contributing to the neglect in the June 26, 2025 incident, they will be removed from direct consumer contact while the matter is investigated. Staff will be adjusted using available relief or PRN staff to maintain adequate supervision. Staff involved in the incident were suspended the same day as the incident June 26, 2025. Termination of employee involved (termination completed July 7th)."

Client #1 was diagnosed with Conduct Disorder, Unspecified; Trauma and Stressor Related Disorder; and Attention Deficit Hyperactivity Disorder, Combined Presentation. On June 26, 2025, FS #1 and Client #1 were involved in a physical altercation in which FS #1 pulled Client #1's hair and kicked him in his head causing scratches to Client #1's chest and arm. Staff #3 neglected client #1 by not intervening to stop FS

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V 512	Continued From page 49 #1 from abusing client #1, rather, she video recorded the incident, made comments that further escalated the crisis, and did not respond to client #1's calls for help. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 512		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service	V 536		

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V 536	Continued From page 50 provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time.	V 536		

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V 536	Continued From page 51 (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain	V 536		

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(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 536	Continued From page 52 documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 5 audited staff (former staff (FS) #1) demonstrated competence in alternatives to restrictive interventions. The findings are: Review on 6/30/24 of FS #1's personnel file revealed: -Direct Care Specialist. -Hire date of 4/9/25. -Termination date of 7/7/25.	V 536		

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V 536	Continued From page 53 -Evidence Based Protective Interventions (EBPI)-Base Plus 4/16/25. Review on 6/30/25 of the North Carolina Incident Response Improvement System (IRIS) from 4/1/25-6/30/25 revealed: -"On June 26, 2025, at approximately 8:52 PM, the Director (Director/Associate Professional (AP) was notified by staff (#3) that an altercation had occurred between staff (former staff (FS) #1) and client (#1) during evening chores. Staff (#3) reported that law enforcement had been called. The Qualified Professional (QP) arrived on site within 30 minutes, and the Director (Director/AP) followed shortly after. Police were already present. Upon arrival, client (#1) was seated on the porch with visible surface scratches to the chest, which did not require medical attention. Staff (FS #1) was in the yard and reported no injuries. [Client #1] stated he was washing dishes when staff (FS #1) began rushing him. When he didn't comply, [FS #1] removed the dish rag from him and sat down. [Client #1] retrieved the rag and resumed cleaning. [FS #1] returned to the kitchen, yelling. [Client #1] sprayed her with water, which escalated into physical contact, including pushing and exchanging blows. The conflict moved outdoors before they were separated ...Staff (#3) was present during the incident but did not intervene and left the scene when police arrived. Both client (#1) and staff (FS #1) were assessed for injury by QP and Director /AP." Review on 7/2/25 of video #1 recorded by staff #3 of the incident on 6/26/25 revealed: -Video was 28 seconds long. -In the living room, FS #1 was struggling with client #1 on the sofa and was pulling client #1's hair.	V 536		

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V 536	Continued From page 54 -Both of FS #1's hands were holding client #1's hair. -FS #1 was on top of client #1. -Staff #3 was yelling at client #1 to stop and telling him "Police are coming and they are going to take your a*s to jail." -Client #1 said, "Tell her to get the f**k off me." -Staff #3 said, "If she gets off of you what ... (unintelligible)." -FS #1 got off the sofa, continued to grip and pull client #1's hair with both hands. -Staff #3 said, "What benefit?" and yelled, "Stop, oh my God." -Client #1 and FS #1 continued to struggle with one another until the video ended. - Staff #3 did not attempt to physically intervene. Review on 7/2/25 of video #2 recorded by staff #3 of the incident on 6/26/25 revealed: -Video was 33 seconds long. -FS #1 was on the floor pulling client #1's hair with both hands. -FS #1 and client #1 continued to struggle with one another as FS #1 wrapped her legs around Client #1's legs as she was pulling his hair. -Client #1 slapped FS #1 on the right shoulder and FS #1 released Client #1's hair. -FS#1 then kicked client #1's head while they were still both on the floor. -An unknown person yelled, "You are on your own [client #1]." -Client #1 got to his feet and moved away from FS #1. -FS #1 grabbed client #1's ankle when client #1 attempted to kick her. -Staff #3 said,"[Client #1], s**t, stop, stop." -Client #1 grabbed a football and threatened to throw it at FS #1's head. -Staff #3 did not attempt to physically intervene. -The video ended.	V 536		

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V 536	Continued From page 55 Review on 7/9/25 of the facility's termination letter to FS #1 dated 7/7/25 and written by the Director/Associate Professional (AP) revealed: -"This letter serves as formal notice of the termination of your employment with Peaceful Ways Residential Services, effective immediately." -"Following a recent incident involving an altercation between yourself and a client residing in our facility, an internal investigation was conducted. The findings of this investigation determined that you were the aggressor in the situation and failed to adhere to the agency's established protocols, including approved de-escalation techniques. Your actions directly violated our safety policies and placed the client at significant risk." Interview on 7/1/25 with client #1 revealed: -On 6/26/25 FS #1 took away the dish rag while he was doing dishes. -FS #1 "pushed me" and "I pushed her back." -FS #1 "hit me in the stomach or chest so I started hitting her back." -"Had a few scratches on my chest and one on my arm and forgot were the rest of the scratches were." - FS #1 "pulled out chunks of my hair in little balls everywhere." -Staff #3 did not physically intervene to stop FS #1. Interview on 7/1/25 with client #3 revealed: -On 6/26/25, client #1 was cleaning his dishes. -Heard arguing and saw FS #1 "snatch" the dish towel. -FS #1 went to her seat and client #1 tried to "grab her." -FS #1 "pushed" client #1.	V 536		

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V 536	Continued From page 56 -Client #1 and FS #1 "started tussling-grabbed each other pulling hair, kicking." -They were fighting, wrestling on the floor for about 8 minutes. "Somehow it ended up outside." -Staff #3 called the law enforcement and recorded some of the altercation. -Staff #3 "stayed for 3 minutes to talk to the cops and pulled off (left facility) and said, she quit." Interview on 7/1/25 with client #4 revealed: -On 6/26/25 there was an argument and a "physical altercation" between client #1 and FS #1. -Staff #3 called the police and "filmed the whole thing." -Staff #3 "told them (FS #1 and Client #1) to stop." Interview on 7/2/25 with FS #1 revealed: -On 6/26/25 client #1 was washing dishes and playing in the sink when she told him to go to bed. - She and client #1 argued back and forth about turning off the water until client #1 "pushed and shoved" her. - She grabbed client #1 by his hair "trying to restrain him." - They continued to struggle with one another and ended up outside on the facility's porch. -Staff #3 did not help. - Staff #3 recorded the incident and called the police. - When the police arrived, staff #3 explained her part and "left (facility)." - Staff #3 would not give out any information (to the police), "like her address." Interview on 7/2/25 with staff #3 revealed: -On 6/26/25, Client #1 was washing dishes when FS #1 "was asking [client #1] to get ready for bed.	V 536		

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V 536	Continued From page 57 He told her no." -FS #1 and Client #1 "started going back and forth" verbally. -"I told him (client #1) to do dishes and her (FS #1) to calm down." - When Client #1 continued to play in the water, FS #1 turned the water off. - Client #1 sprayed FS #1 with the water and said, "Do you want to have a water fight." - FS #1 pushed client #1 and they both started "pushing and shoving." -"[Client #1] was choking [FS #1]. I wasn't recording at this time." -"I called the police." - FS #1 and Client #1 "continued to fight like strangers." - FS #1 was "pulling client #1's hair. Some of it came out." - Client #1 grabbed a football and threw it at FS #1. "I didn't want to trigger him, so I stopped recording." - Client #1 threw the football at FS #1's face and they "started fighting again." - "I opened up the door (facility) and heard sirens." - "[Client #1] grabbed a stick and attempted to hit (FS #1), and they tussled with the branch (stick)." -"I told them to put the branch down, and they did." - After the police arrived, she let the officers know that the Director/AP and Licensee/Direct Care Specialist were on their way and then " I left (facility)." -"I didn't want to help or assist when she (FS #1) is fighting. It would look like we were ganging up on him (client #1)." -"As soon as they (FS #1 and client #1) were tussling, I jumped up and told them to calm down. Nobody listened so, I called 911." -"Later on, I pulled out my phone to record."	V 536		

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V 536	Continued From page 58 -"I didn't get (record) the beginning and didn't get the part on the porch." Interview on 7/8/25 with the Director/AP revealed: - Arrived at the facility on 6/26/25 and staff #3 had already left. - Started the investigation into FS #1's actions during the incident immediately and concluded that FS #1 "did not follow de-escalation protocol putting a client (#1) at risk." - "I haven't been able to substantiate whether or not she (Staff #3) intervened." - Staff #3 recorded a video but did not share it with facility staff. - Staff #3 had not responded to attempts to reach her. - "[Staff #3] indicated that she quit." - "I was going to officially terminate her." -"She (FS #1) won't be back, but I haven't officially given her anything (termination notice) because I haven't gotten her side of the story." Interview with the Licensee/Direct Care Specialist revealed: -FS #1 did not "respond appropriately" during the incident with client #1 on 6/26/25. -"She (FS #1) was terminated for lack of de-escalation techniques and the wrong use of EBPI."	V 536		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated	V 537		

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V 537	Continued From page 59 competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the	V 537		

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rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention);
(4) strategies for the safe implementation of restrictive interventions;
(5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention;
(6) prohibited procedures;
(7) debriefing strategies, including their importance and purpose; and
(8) documentation methods/procedures.
(h) Service providers shall maintain documentation of initial and refresher training for at least three years.
(1) Documentation shall include:
(A) who participated in the training and the outcomes (pass/fail);
(B) when and where they attended; and
(C) instructor's name.
(2) The Division of MH/DD/SAS may review/request this documentation at any time.
(i) Instructor Qualification and Training Requirements:
(1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.
(2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out.
(3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.
(4) The training shall be

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competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
(5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule.
(6) Acceptable instructor training programs shall include, but not be limited to, presentation of:
(A) understanding the adult learner;
(B) methods for teaching content of the course;
(C) evaluation of trainee performance; and
(D) documentation procedures.
(7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule.
(8) Trainers shall be currently trained in CPR.
(9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach.
(10) Trainers shall teach a program on the use of restrictive interventions at least once annually.
(11) Trainers shall complete a refresher instructor training at least every two years.
(k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.
(1) Documentation shall include:
(A) who participated in the training and the outcome (pass/fail);

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V 537	Continued From page 62 (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure annual training, including measurable testing by observation of behavior, in seclusion, physical restraint and isolation time-out was completed for 3 of 6 audited staff (former staff (FS) #1, staff #3, and staff #4) and failed to ensure that staff demonstrated competency in restrictive interventions for 2 of 6 audited staff (FS #1 and staff #3). The findings are: Review on 6/30/24 of FS #1's personnel file revealed: -Direct Care Specialist. -Hire date of 4/9/25. -Termination date of 7/7/25. -Evidence Based Protective Interventions (EBPI)-Base Plus 4/16/25. Review on 7/9/25 of staff #3's personnel file	V 537		

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revealed:
-Direct Care Specialist.
-Hire date of 6/4/25.
-EBPI-Base Plus 6/4/25.

Review on 7/9/25 of staff #4's personnel file revealed:
-Direct Care Specialist.
-Hire date of 3/10/25.
-EBPI-Base Plus 3/12/25.

Interview on 7/2/25 with FS #1 revealed:
-Was trained on EBPI on Zoom.
-Was not trained physically on restraints or blocks.
-There was not an in-person training for EBPI.
-Had been taught to "let them (clients) have their moments and ignore them."

Interview on 7/2/25 with staff #3 revealed:
-EBPI training was completed on zoom.
-"I was the only one in that class. It was me and a guy talking."
-Was not trained physically on restraints or blocks.
-"It did concern me that it was a zoom link (without an in-person class). These boys (clients) charge at us and try to hurt us. We were not properly trained."

Interview on 7/7/25 with staff #4 revealed:
-The de-escalation portion of EBPI training was virtual via Zoom.
-"We didn't get to do the in person (restrictive interventions) yet. We are waiting for the instructor."
-"My restraint experience was from a prior group home."

Interview on 7/11/25 with the EBPI trainer

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V 537	Continued From page 64 revealed: -Prevention portion of the training completed virtually through Zoom. -The prevention portion of the training includes demonstrations by the instructor of blocks and restraints. -Conducted an in-person restrictive intervention training teach the physical techniques. -The in-person restrictive intervention training is usually completed the day after the Zoom training or within the next week. -The EBPI-Base Plus certificate indicated that the trainee received both the preventative and restrictive portions of the training. Interview on 7/14/25 with the Director/Associate Professional revealed: -EBPI training should include an in-person component to demonstrate and practice restrictive intervention techniques. -Did not have staff sign-in sheets.	V 537		
V 539	27F .0102 Client Rights - Living Environment 10A NCAC 27F .0102 LIVING ENVIRONMENT (a) Each client shall be provided: (1) an atmosphere conducive to uninterrupted sleep during scheduled sleeping hours, consistent with the types of services being provided and the type of clients being served; and (2) accessible areas for personal privacy, for at least limited periods of time, unless determined inappropriate by the treatment or habilitation team. (b) Each client shall be free to suitably decorate his room, or his portion of a multi-resident room, with respect to choice, normalization principles, and with respect for the physical structure. Any	V 539		

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V 539	Continued From page 65 restrictions on this freedom shall be carried out in accordance with governing body policy. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure there was an atmosphere conductive to uninterrupted sleep during scheduled sleeping hours and accessible areas for personal privacy affecting 1 of 4 audited clients former client (FC) #1). The findings are: Observation on 7/7/25 in the facility at approximately 1pm revealed: -Bathroom with storage shelves was assessable by walking through FC #1's bedroom. -The door to the bathroom/storage room was locked. Interview on 7/3/25 with FC #1 revealed: -"My room was the one with the closet/staff bathroom (staff bathroom/storage closet). Meds (medications) were stored there." -"Sometimes staff brought clients into the closet (staff bathroom/storage closet) to give meds." -"I told staff not to let them (clients) in my room. It is a safety issue." -"Staff came in to use (through FC #1's bedroom to the staff bathroom/storage closet) the bathroom, even at night. They did not knock." Interview on 7/2/25 with staff #2 revealed: -Medications were stored in the "staff bathroom/storage closet." -Had to go through FC #2's room to get to the staff bathroom/storage closet. Interview on 7/7/7 with staff #4 revealed:	V 539		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL013-251	A. BUILDING: _____ B. WING _____	C 07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 539	Continued From page 66 -It was necessary to go through FC #2's room to get to the staff bathroom/storage closet. -Clients were not allowed to use that bathroom (staff bathroom/storage closet). -Utilized the staff bathroom/storage closet when working 3rd shift (11pm to 8am). -"I make a noise and let him (FC #2) know I am coming." -"I try to be quiet if he is sleeping." Interview on 7/7/25 with staff #5 revealed: -Had to go through FC #2's bedroom to get to the staff bathroom/storage closet. -"We were supposed to knock on door and ask to go through to the bathroom." -"He (FC #2) never said no (we could not go through is room)." Interview on 7/8/25 with the Qualified Professional revealed: -Utilized the bathroom accessed through FC #2's bedroom as the staff bathroom/storage closet." -FC didn't have "any issues" with staff going through his room to get to the staff bathroom/storage closet. Interview on 7/8/25 with the Director/Associate Professional revealed: -The staff bathroom/storage closet was used to store anything that needed to be locked up such as meds, sharps, and chemicals. -Clients were not allowed in the staff bathroom/storage closet. -Staff only utilized the staff bathroom/storage closet when FC #2 was awake.	V 539		