AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDIN MHL010-091 B. WING _ NAME OF PROVIDER OR SUPPLIER WALLBROWN HOME SOUTHPORT, NC 2	E DRIVE 28461 PROVIDER'S PLAN OF CORRECTION (X5)	=TE
NAME OF PROVIDER OR SUPPLIER WALLBROWN HOME STREET ADDRESS, CITY 949 NORTH SHORE SOUTHPORT, NC 2	Y, STATE, ZIP CODE E DRIVE 28461 PROVIDER'S PLAN OF CORRECTION (ASS) (COMPLE' CROSS-REFERENCED TO THE APPROPRIATE DATE	ETE.
WALLBROWN HOME 949 NORTH SHORE SOUTHPORT, NC 2	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE	ETE.
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SOUTHPORT, NC 2	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLE' CROSS-REFERENCED TO THE APPROPRIATE DATE	ETE
	(EACH CORRECTIVE ACTION SHOULD BE COMPLE CROSS-REFERENCED TO THE APPROPRIATE DATE	:TE
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		
V 000 INITIAL COMMENTS V 000		
An annual and follow up survey was completed on 7/18/25. A deficiency was cited.	•	
The facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living.		
This facility is licensed for 3 and has a current census of 1. The survey sample consisted of audits of 1 current client.		
V 290 27G .5602 Supervised Living - Staff V 290		
(a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by	RECEIVED BY MHL & C 8/8/25	
the governing body; or Division of Health Service Regulation	, i	

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

If continuation sheet 1 of 4

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING MHL010-091 07/18/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 949 NORTH SHORE DRIVE WALLBROWN HOME SOUTHPORT, NC 28461 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) V 290 Continued From page 1 V 290 children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assess a client's capability of remaining in the community without staff supervision affecting 1 of 1 clients (#1). The findings are: Record review on 7/16/25 of Client #1's record revealed: Admitted: 4/1/19 Diagnoses: Smith Magenis Syndrome, Eczema, Herpes Simplex No documentation of an unsupervised time assessment

Interview on 7/16/25 Client # 1 reported:

week without staff supervision

Went to the local college program 4 days a

Division of Health Service Regulation								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
	MHL010-091	B. WING		07/18	8/2025			
NAME OF PROVIDER OR SUPPLIE	R STREET AD	DRESS, CITY.	STATE, ZIP CODE					
949 NORTH SHORE DRIVE								
WALLBROWN HOME SOUTHPORT, NC 28461								
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROIDEFICIENCY)	LD BE COMPLETE				
to the college pro- The bus came front" (of the facili The bus drop afternoon The Alternativ or Staff #1 was no college during the Interview on 7/18, Client #1 had program for abou There was a p was "contracted w Client #1 up at the The bus woul facility in the after The bus could the public on it Client #1 was 2:30pm He and Staff the college with C He did not kn assessment was Interview on 7/18, reported: Had been at t Visited the fac Was aware th program for abou Was "unawar public transportat "It never cross was taking public Was "unawar college program w	cous" (public transportation) to go gram e to the facility to pick him up "in ty) ped him off at the facility in the re Family Living (AFL) Provider of with him on the bus or at the day 25 the AFL Provider reported: been going to the college to a year cublic transportation bus that with the college" that picked e facility at 8:30am of return Client #1 back at the moon at 3:15pm of have about 15-18 people from at the local college from 9am to #1 did not go on the bus or to lient #1 bow what an unsupervised time 25 the Qualified Professional the facility for 2.5 years cility monthly that Client #1 went to the college to a year e" that Client #1 was using on to get the college program sed my mind that he (Client #1) transportation by himself" e" that Client #1 was at the without any staff e for Client #1 to be assessed	V 290	Client #1's ISP states that he atte Brunswick Interagency Program the Brunswick Community Collegorogram is "a nationally acclaimed initiative dedicated to supporting with intellectual and development disabilities." Their mission is "to students to fully integrate into the community, achieve their highest potential, gain independence, accengage in their communities, and successfully transition into the workforce." In addition, Client #1 states that he receives 1:1 assist while at the program. Client #1 at transportation to and from the prowhich is provided by BIP. Client receives support during his ride to from the program by BIP staff. Client #1 does not attend a traditic college program and is supported while attending the BIP. Client #1 not ride public transportation to a the facility but private transportation to a support provided by BIP staff. The AFL Provider and QP, when interviewed, were referring to the when referencing college as BIP located on the community college as BIP's mission is to fully integra participants into the campus com The "bus" is actually BIP's transported and monitored by BIP staff.	(BIP) at ge. This ged adults tal empower e campus to tively describes ogram and ional describes and from ion es es also rides ogram and the second se				

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R B. WING MHL010-091 07/18/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 949 NORTH SHORE DRIVE WALLBROWN HOME SOUTHPORT, NC 28461 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 290 Continued From page 3 V 290 According to Client #1's ISP, he requires 24 hour supervision. Client #1 for unsupervised time does not receive any unsupervised time as it initially appeared to be. The QP has reviewed with the AFL Provider to ensure that when referencing the program Client #1 attends and the transportation he receives to be clear of what actually is occurring so there is no misunderstanding where one perceives that Client #1 does not receive monitoring as indicated in his plan of care.

Division of Health Service Regulation