STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL042-055	A. BUILDING: _____ B. WING _____	06/27/2025

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LYONS ANGELS	804 AURELIAN SPRINGS ROAD ROANOKE RAPIDS, NC 27870

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on 6/26/25. The complaint was unsubstantiated (intake #NC00231512). Deficiencies were cited. . This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living. This facility is licensed for 2 and has a current census of 2. The survey sample consisted of audits of 2 clients.	V 000		
V 318	13O .0102 HCPR - 24 Hour Reporting 10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g). This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report an allegation of neglect and abuse to the Health Care Personnel Registry (HCPR) within 24 hours of becoming aware of the	V 318	Type text here	

RECEIVED BY
MHL & C 8/15/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Sharon Lyons AFL Provider | 8-12-25

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 318	Continued From page 1 allegation. The findings are: Review on 6/18/25 of the Alternative Family Living (AFL) Provider's record revealed: - Hired: 10/27/09 - Title: AFL Provider Review on 6/17/25 of Client #1's record revealed: - Admit date: 2/5/24 - Diagnoses: Schizophrenia unspecified, Intellectual Disability/Intellectual Development Disorder moderate, Bipolar Disorder, Tobacco Use Disorder, Rheumatoid Arthritis - Facility incident report dated 6/6/25 at 7:40 am that revealed: - "Staff (AFL Provider) went to check on client (Client #1). Client were weak. Staff called Supervisor (Qualified Professional (QP#1)) and staff called 911...Client had [illegible word] bruises from going over the floor all night. Client [illegible word] put in the hospital today 6-6-25" - "AFL Provider reported issue this AM via phone. Both me (QP#1) and AFL spoke to guardian. PM (Program Manager) has been contacted for next steps. Incident report done 6/6/25" Review on 6/18/25 of the Incident Response Improvement System (IRIS) revealed: - Level III incident on 6/13/25 of allegations of neglect by client #1's guardian against the AFL Provider completed by the Program Manager - IRIS report was submitted on 6/16/25 Review on 6/18/25 of facility's internal Investigation Summary revealed: - "Date(s) of Investigation 6/6/25-6/12/25" - "Introduction - On the afternoon of Friday, June 6. 2025, Program Coordinator, [Program Manager] was contacted by Guardian, [Client #1's	V 318	Our agency takes all allegations of abuse with the highest level of seriousness. Policies and state regulations require that every allegation be reported immediately and documented through a completed incident report. This documentation is critical for ensuring the safety and well-being of the individuals we serve, initiating timely investigations, and maintaining compliance with all legal and regulatory requirements. In this instance, the required incident report for the allegation of abuse was not completed as mandated. This represents a breach of agency policy and does not reflect the standards of care and accountability we uphold. The Program Manager will address this matter through including retraining on incident reporting procedures, reinforcing mandated reporting requirements, and implementing oversight measures to prevent recurrence. We remain committed to protecting the rights and safety of the individuals in our care and to ensuring that all staff understand and fulfill their reporting responsibilities.	

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V 318	Continued From page 2 legal guardian]. [Client #1's legal guardian] reported concerns that her sister, [Client #1] was being neglected by AFL Staff, [AFL Provider]...At 2:05pm on Friday, June 6. 2025, QP (Qualified Professional) [QP#2] was contacted by [Program Manager] to be briefed on the situation and begin investigation." - Client #1's guardian was interviewed on 6/9/25 and 6/13/25 and "expressed serious concerns about the care [Client #1] had been receiving from [AFL Provider]" including proper nutrition, weight loss, unexplained bruising, proper medical care and hygiene Interview on 6/18/25 and 6/26/25 Client #1's legal guardian reported: - Client #1 went to the hospital on 6/6/25 and remained in critical condition - Client #1 was dirty and had unexplained bruises and sores when she arrived at the hospital on 6/6/25 - The hospital determined since her (Client #1) admission on 6/6/25 that she had an untreated fracture in her arm - Client #1 was malnourished and dehydrated - She initially notified the facility staff on 6/6/25 of her concerns of neglect and abuse - She had made prior allegations on 1/30/25 and 3/9/25 Interview on 6/17/25 the QP #1 reported: - An internal investigation had been completed regarding Client #1's legal guardian's allegations - Client #2 was moved from the facility until the investigation was completed - The QP #2 completed the investigation and the Program Manager spoke with Client #1's legal guardian and completed the reporting for the incident	V 318		

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V 318	Continued From page 3 Interview on 6/18/25 the QP #2 reported: - She assisted with the internal investigation of the allegations of abuse and neglect for Client #1 - Internal incident reports were completed by the AFL Provider and were sent to the QP#1 - QP #1 typically did the incident reporting but in this case, the Program Manager completed it Interview on 6/25/25 the Program Manager reported: - She did not conduct the internal investigation but was aware of it - The QP #2 completed the investigation but she submitted the IRIS report - Client #2 was moved from the facility while the investigation was completed - "Typically the QP submits the IRIS reports but because I'm such a team player, sometimes I will do it to get it done" - IRIS report stated that the incident occurred on 6/13/25 because "when she first went to the hospital it was because it was just medical" - Client #1's legal guardian later stated she felt it was neglect - "Went on and just did the investigation because she cried wolf before but immediately took it back" sometime around the end of 2024 or beginning of 2025 - When the IRIS report was completed on 6/16/25, she did the HCPR notification that same day - They reached out and said they had assigned someone and would be following up Interviews on 6/17/25 and 6/26/25 the AFL Provider reported: - The facility received a complaint on 6/6/25 because Client #1 was sick and admitted to the hospital - She notified the QP#1 about Client #1's	V 318		

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V 318	Continued From page 4 condition the morning of 6/6/25 and called 911 - Client #1's legal guardian had been "calling in all these allegations" of abuse and neglect - She submitted the facility incident report to the QP#1 on 6/6/25 - An internal investigation was completed and Client #2 was removed from her care during the course of the internal investigation from 6/6/25-6/10/25 - She did not know who was responsible for completing the HCPR report	V 318		
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 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	V 367		

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V 367	Continued From page 5 (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 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:	V 367		

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V 367	Continued From page 6 (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 record review and interviews, the facility failed to report a Level III incident to the Local Management Entity/Managed Care Organization (LME/MCO) within 72 hours. The findings are: Review on 6/17/25 of Client #1's record revealed: - Admit date: 2/5/24 - Diagnoses: Schizophrenia unspecified, Intellectual Disability/Intellectual Development Disorder moderate, Bipolar Disorder, Tobacco Use Disorder, Rheumatoid Arthritis - Facility incident report dated 6/6/25 at 7:40 am that revealed: - "Staff (AFL Provider) went to check on client (Client #1). Client were weak. Staff called	V 367	The incident was documented upon discovery of the omission and Level III was reported to as required. Program Manager will conduct supervision to make sure staff is aware of incident reporting guidelines.	

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V 367	Continued From page 7 Supervisor (Qualified Professional (QP#1)) and staff called 911...Client had [illegible word] bruises from going over the floor all night. Client [illegible word] put in the hospital today 6-6-25" - "AFL Provider reported issue this AM via phone. Both me (QP#1) and AFL spoke to guardian. PM (Program Manager) has been contacted for next steps. Incident report done 6/6/25" Review on 6/18/25 of the Incident Response Improvement System (IRIS) revealed: - Level III incident on 6/13/25 of allegations of neglect by client #1's guardian against the AFL Provider completed by the Program Manager - IRIS report was submitted on 6/16/25 Review on 6/18/25 of facility's internal Investigation Summary revealed: - "Date(s) of Investigation 6/6/25-6/12/25" - "Introduction - On the afternoon of Friday, June 6. 2025, Program Coordinator, [Program Manager] was contacted by Guardian, [Client #1's legal guardian]. [Client #1's legal guardian] reported concerns that her sister, [Client #1] was being neglected by AFL Staff, [AFL Provider]...At 2:05pm on Friday, June 6. 2025, QP (Qualified Professional) [QP#2] was contacted by [Program Manager] to be briefed on the situation and begin investigation." - Client #1's guardian was interviewed on 6/9/25 and 6/13/25 and "expressed serious concerns about the care [Client #1] had been receiving from [AFL Provider]" including proper nutrition, weight loss, unexplained bruising, proper medical care and hygiene Interview on 6/18/25 and 6/26/25 Client #1's legal guardian reported: - Client #1 went to the hospital on 6/6/25 and	V 367		

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V 367	Continued From page 8 remained in critical condition - Client #1 was dirty and had unexplained bruises and sores when she arrived at the hospital on 6/6/25 - The hospital determined since her (Client #1) admission on 6/6/25 that she had an untreated fracture in her arm - Client #1 was malnourished and dehydrated - She initially notified the facility staff on 6/6/25 of her concerns of neglect and abuse - She had made prior allegations on 1/30/25 and 3/9/25 Interview on 6/17/25 the QP #1 reported: - An internal investigation had been completed regarding Client #1's legal guardian's allegations - Client #2 was moved from the facility until the investigation was completed - The QP #2 completed the investigation and the Program Manager spoke with Client #1's legal guardian and submitted the IRIS report Interview on 6/18/25 the QP #2 reported: - She assisted with the internal investigation of the allegations of abuse and neglect for Client #1 - Internal incident reports were completed by the AFL Provider and were sent to the QP#1 - QP #1 typically did IRIS reports but in this case, the Program Manager completed it Interview on 6/25/25 the Program Manager reported: - She did not conduct the internal investigation but was aware of it - Client #2 was moved from the facility while the investigation was completed - The QP #2 completed the investigation but she submitted the IRIS report - "Typically the QP submits the IRIS reports but because I'm such a team player, sometimes I will	V 367		

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V 367	Continued From page 9 do it to get it done" - IRIS report stated that the incident occurred on 6/13/25 because "when she first went to the hospital it was because it was just medical" - Client #1's legal guardian later stated she felt it was neglect - "Went on and just did the investigation because she cried wolf before but immediately took it back" sometime around the end of 2024 or beginning of 2025 Interviews on 6/17/25 and 6/26/25 the AFL Provider reported: - The facility received a complaint on 6/6/25 because Client #1 was sick and admitted to the hospital - She notified the QP#1 about Client #1's condition the morning of 6/6/25 and called 911 - Client #1's legal guardian had been "calling in all these allegations" of abuse and neglect - She submitted the facility incident report to the QP#1 on 6/6/25 - An internal investigation was completed and Client #2 was removed from her care during the course of the internal investigation from 6/6/25-6/10/25 - She did not know who was responsible for completing the IRIS report	V 367		
V 540	27F .0103 Client Rights - Health, Hygiene And Grooming 10A NCAC 27F .0103 HEALTH, HYGIENE AND GROOMING (a) Each client shall be assured the right to dignity, privacy and humane care in the provision of personal health, hygiene and grooming care. Such rights shall include, but need not be limited to the:	V 540		

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V 540	Continued From page 10 (1) opportunity for a shower or tub bath daily, or more often as needed; (2) opportunity to shave at least daily; (3) opportunity to obtain the services of a barber or a beautician; and (4) provision of linens and towels, toilet paper and soap for each client and other individual personal hygiene articles for each indigent client. Such other articles include but are not limited to toothpaste, toothbrush, sanitary napkins, tampons, shaving cream and shaving utensil. (b) Bathtubs or showers and toilets which ensure individual privacy shall be available. (c) Adequate toilets, lavatory and bath facilities equipped for use by a client with a mobility impairment shall be available. This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to assure 1 of 2 audited current clients (#1) maintained their rights to privacy. The findings are: Review on 6/17/25 of Client #1's record revealed: - Admit date: 2/5/24 - Diagnoses: Schizophrenia unspecified, Intellectual Disability/Intellectual Development Disorder moderate, Bipolar Disorder, Tobacco Use Disorder, Rheumatoid Arthritis - Treatment plan dated 2/5/25 with an identified goal to reduce incidents of smearing feces Observation on 6/17/25 at 12:20pm of no water hose attached to the spigot at the back of the facility.	V 540	Qualified Professional will provide supervision with AFL Provider in regards proper cleanup residents. Residents will have the right to privacy. Our agency is fully committed to protecting the privacy and dignity of every individual served. All staff are expected to uphold these rights at all times in accordance with state and federal laws and agency policy. Noncompliance will not be tolerated and may result in disciplinary action up to and including termination.	

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V 540	Continued From page 11 Interview on 6/18/25 Client #1's legal guardian reported: - In April, she made an unnannnounced visit to the facility and Client #1 was outside at the back of the facility with a woman that was not a facility staff - Client #1's pants were down and it appeared that the woman was going to spray her with a water hose - The Alternative Family Living (AFL) Provider was inside the facility when she arrived - There were houses around the facility and neighbors would have been able to see Client #1 standing outside Interview on 6/26/25 the Qualified Professional (QP#1) reported: - Client #1's legal guardian had spoken with her about seeing Client #1 outside with her pants down and felt it was "public humiliation" - She met with the AFL Provider about the incident - The AFL Provider reported that Client #1 had a bowel movement while in the facility van and when they arrived at the facility, she was outside being cleaned up before going inside - The AFL Provider had also reported that Client #1 was going outside to get water because "that's what she does at her mom's house" and that her pants fell down when walking outside - Client #1's legal guardian had reported that Client #1 was being hosed off with a water hose, but the AFL Provider did not have a water hose at the facility Interview on 6/25/25 the Program Manager reported: - Client #1's legal guardian recently reported the incident with Client #1 in the back of the facility with the water hose to her	V 540		

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V 540	Continued From page 12 - When the AFL Provider was asked about it, she stated that Client #1's pants were too large and fell down - She was "not sure how the water hose became a part of the equation" - Thought that the QP#1 had supervision with the AFL Provider regarding the incident because "it is suspect and just because it's something you grew up doing in the country doesn't mean you can do it now" Interview on 6/17/25 the AFL Provider reported: - There was a day that the AFL Provider was sitting in the kitchen of the facility with a friend and Client #1 walked through the kitchen with a handful of feces - Client #1 wanted to go outside, went outside on her own and the AFL Provider's friend followed her - When Client #1 got outside, her pants fell around her ankles - Client #1's legal guardian pulled up the facility for a visit while Client #1 and the AFL Provider's friend were outside - Client #1's legal guardian reported that the AFL Provider's friend was going to spray Client #1 off with a water hose but there was not a water hose at the facility - The AFL Provider's friend was washing Client #1's hands at the spigot - Client #1's pants had fallen down because they were too big - Client #1's legal guardian had bought her the pants she was wearing because she did not like the elastic waist pants that the AFL Provider had bought for Client #1 Interview on 6/25/25 the AFL Provider reported: - During the incident with Client #1 in the back of the facility with her pants down, the AFL	V 540		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL042-055	A. BUILDING: _____ B. WING _____	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYONS ANGELS	804 AURELIAN SPRINGS ROAD ROANOKE RAPIDS, NC 27870

(X4) ID PREFIX TAG	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 540	Continued From page 13 Provider's friend had taken Client #1 by the hand and lead her outside to wash her hands - Client #1's pants fell down while walking outside, but her adult incontinence underwear remained up - She had stood at the door while her friend was outside with Client #1	V 540		