STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601476	A. BUILDING: _____ B. WING _____	R 08/12/2025

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FARM POND GROUP HOME	4933 FARM POND LANE CHARLOTTE, NC 28212

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on August 12, 2025. The complaint was unsubstantiated (intake #NC00231107). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 3 and has a current census of 3. The survey sample consisted of audits of 3 current clients.	V 000		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have	V 291		

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V 291	Continued From page 1 activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record reviews, observation and interviews, the facility failed to maintain coordination of services between the facility operator and the qualified professionals who are responsible for treatment/habilitation for 1 of 3 clients (Client #1). The findings are: Review on 7/24/25 of Client #1's record revealed: -Admission date of 3/1/21. -Diagnoses of Vitamin D Deficiency, Schizoaffective Disorder, Intermittent Explosive Disorder, Severe Intellectual Developmental Disabilities, Seizures, Hypertension, Bipolar Type, Hypo-Osmolality, Hyponatremia, Cataract and Idiopathic Epilepsy. -History of seizures, anger outbursts and aggressive behavior. Review on 7/24/25 of the North Carolina Incident Response Improvement System revealed: -"On Monday, May 12, 2025, VP (Vice President) of Operation received a statement from nursing. [Registered Nurse] (RN) alleged two staff (The House Manager and Former Staff (FS) #1) did not follow instructions to call EMS (Emergency Medical Services) for [Client #1] due to abdominal pain and vital signs." Review on 7/25/25 of Client #1's hospital	V 291		

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discharge documents dated 5/13/25 revealed:
-Diagnosis of Acute Cholecystitis.
-Admitted on 5/9/25 and discharged on 5/13/25.
-"Recommended starting with low fiber for several weeks while recovering from abdominal surgery involving the intestines or bowel then slowly resume your preop home diet."
-Follow up appointment on 5/20/25 with Primary Care Physician.

Observation on 7/24/25 at 12:50pm of Client #1 revealed:
-Three 2 inch incisions on his abdomen.

Interview on 7/24/25 with Client #1 revealed:
-He had 3 incisions on his abdomen from surgery.
-Answered "yes" to all questions.

Interview on 7/25/25 with the RN revealed:
-On the afternoon of 5/8/25 the House Manager (1st shift) contacted her because Client #1 was complaining of stomach pain.
-"I told her [House Manager] to monitor him (Client #1) and to call me back if it gets worse. I then called and advised the doctor (facility's on call doctor), and he said to give [Client #1] a laxative in the morning (relayed the on call doctor's message to 1st shift staff, the House Manager). The next morning (5/9/25) at about 6:00 am I received a call (from 2nd shift, Staff #4) saying he (Client #1) could not get out of bed. I could hear him moaning and groaning in pain through the phone. I told the staff (Staff #4) to get him to the hospital immediately or call Emergency Medical Services immediately."
-Called the House Manager the morning of 5/9/25 and advised her Client #1 needed to get to the hospital immediately.
-Was aware there was only one staff at the

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facility, but not aware there was not any staff available to take Client #1 to the hospital immediately.
-There were two shifts, 6:00am- 6:00pm and 6:00pm- 6:00am, and one staff per shift.
-Did not call EMS because she thought staff at the facilty would call EMS.
-"I found out he (Client #1) had emergency surgery on 5/12/25 when he was being discharged from the hospital."
-"I told [Regional Administrator] that [FS #1] and [the House Manager] did not get him (Client #1) to the hospital immediately as I asked them to."
After learning Client #1 had to have gallbladder removal surgery on 5/12/25.

Interview on 7/25/25 with the House Manager revealed:
-Worked 1st shift 6:00am- 6:00pm on 5/8/25 , the day prior to Client #1 going to the hospital.
-Only one staff per shift.
-On 5/8/25 Client #1 complained to her about his stomach hurting.
-Gave Client #1 some warm tea to help sooth his stomach.
-Called and advised the RN that Client #1 was experiencing stomach pain and had not had a bowel movement on 5/8/25.
-The RN said to monitor "[Client #1] and call her back if the pain continues."
-"He (Client #1) seemed to be doing okay after I gave him some warm tea, but I passed along the message (2nd shift staff, Staff #4) to call the nurse (RN) if [Client #1] did not have a bowel movement and his stomach pain continued."
-On 5/9/25 she was not scheduled to work but she received a call from the RN at 6:00 am stating Client #1 needed to go to the hospital immediately.
-"I was off that day (5/9/25) and I live over an hour

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away from the house (facility). I had to get up and get dressed and take my children to school before I could get there to help."
-Called the facility and told FS #1 (1st shift staff) to call EMS for Client #1 to go to the hospital because Staff #4 had left and FS #1 said Client #1 was "fine and did not need to go to the hospital, and he wasn't taking him (Client #1) because of some old policy."
-Staff #4 had left the facility because her shift ended at 6:00am.
-Arrived at the facility at 8:30 am on 5/9/25 and took Client #1 to the local emergency room where he was admitted for emergency gallbladder removal surgery.
-Stayed at the hospital with Client #1 until he came out of surgery on 5/9/25.
-"I left when they (hospital staff) said that he (Client #1) would have to stay a few days (did not remember the exact number of days)."
-Did not know why FS #1 and Staff #4 did not call EMS.
-Policy said that if a client must be transported by EMS, a staff must accompany them.
-There was no other staff available to help transport Client #1 to the hospital because there was one staff per shift.
-She was suspended on 5/12/25 pending internal investigation for not getting Client #1 medical attention immediately even though she was not scheduled to work on 5/12/25.

Interview on 7/28/25 with Staff #4 revealed:
-Worked 2nd shift 6:00pm- 6:00am on 5/8/25.
-On 5/8/25 the House Manager reported to her that Client #1 was complaining of stomach pain and to call the RN if the stomach pain continued.
-"That night (5/8/25) I asked him (Client #1) if he had a bowel movement that day and he (Client #1) said yes, but he says yes to everything..."

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V 291	Continued From page 5 -The next morning on 5/9/25 around 6:00 am Client #1 woke up experiencing abdominal pain. -"I called the nurse (RN) and she said to take him (Client #1) to the hospital immediately, but I was the only person here (facility) and there was no one here to supervise the other clients." -Called the Qualified Professional (QP) but did not get an answer. -Called the Regional Administrator and she contacted the House Manager. -FS #1 refused to take Client #1 to the hospital because Client #1 was acting normal. -"[House Manger] came eventually and got him (Client #1) to the hospital. My shift had ended before [House Manager] got there (facility)." Attempted interviews with FS #1 on 7/24/25, 7/28/25 and 8/1/25 but he did not return calls. Interview on 7/25/25 with the Regional Administrator revealed: -In the early morning of 5/9/25 Staff #4 called to informed her "[Client #1] was having GI (gastrointestinal) issues and could not have a bowel movement." -The RN called her after she spoke to Staff #4 the morning of 5/9/25 and said [Client #1] needed to go to the hospital immediately. -"Since it was only one staff I began trying to make transportation arrangements (on 5/9/25 by calling around to see if any staff could help)." -The House Manager said she would take Client #1 to the hospital but she was an hour away. -"We (staff) would have called EMS, but someone would still have to go with the client (Client #1) according to our protocol." -No protocol available in the event there is one staff and an emergency happens. -There was no other staff close by to help get Client #1 to the hospital.	V 291		

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V 291	Continued From page 6 -The House Manager arrived two hours later and took Client #1 to the local emergency room. -Client #1 was hospitalized from 5/9/25 to 5/12/25. -Client #1 did not have a history of stomach pain prior to 5/8/25. -Did not have a reason as to why she did not call EMS. -Was not available to take Client #1 to the hospital because she was over an hour away. -Would speak to management about making some policy changes to address emergency transport situations, and provide more training on coordinating emergency transports. Review on 8/12/25 of the facility's Plan of Protection dated 8/12/25 and signed by the Regional Administrator revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? The staff at Farm Pond as well as all the staff in the Albemarle Unit will be trained on Nursing Policy #611.1 Emergency Medical Services. This policy indicates staff should: "Call 911 immediately, if in judgement of the staff such action is warranted. If there is any doubt that Emergency Medical Services should be secured, then the 911 call should be made. The EMS personnel should be instructed as to where the individual's hospital choice is. However, if it is an eminent life-threatening situation, the nearest hospital will be used." The policy will be reviewed during the next Policy Review Committee Meeting (in September 2025). 'Emphasis is always placed on calling 911 first for any situation that may be considered a medical emergency, or the potential for serious medical problem/injury. Staff should call the supervisor and/or nurse after calling 911 for major medical emergencies.' -Describe your plans to make sure the above	V 291		

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V 291	Continued From page 7 happens. The Administrator will ensure this training is completed by 8/13/25 will all staff at the [Local Unit]. Proof of training will be submitted to the Vice President and QA (quality assurance) Director. This will continue to be trained at least monthly for the next 3 months at each house (facility) meeting to ensure staff are aware of calling 911 immediately. During observations in the home (facility) staff will be questioned on policies and procedures related to calling 911. Any staff who is unaware will be trained on the spot and observer will follow-up with staff supervisor to ensure additional training is provided." This facility serves clients with diagnoses of Intellectual Developmental Disabilities. On the afternoon of 5/8/25 Client #1 began experiencing stomach pain. The House Manager who was working 1st shift called and advised the facility's RN that Client #1 was having stomach pain. The RN advised the House Manager to continue monitoring Client #1. The RN consulted with the facility's on call doctor who recommended to give Client #1 a laxative the next morning. When the RN called back to the facility to relay the recommendations from the doctor, 2nd shift at the facility had started. The RN advised Staff #4 (2nd shift staff) to give Client #1 a laxative in the morning and to call her back if Client #1's stomach pain worsened. On 5/9/25 at 6:00 am Client #1 woke up with severe stomach pain and could not get out of bed. Staff #4 called the RN to let her know Client #1 was now in severe pain and the RN advised Staff #4 that Client #1 needed to get to the hospital immediately. Staff #4's shift ended at 6:00 am so she passed the message that Client #1 needed to get to the	V 291		

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V 291	Continued From page 8 hospital immediately to first shift staff (FS #1). There was only one staff on shift leaving no staff available to transport Client #1 to the hospital or monitor the other clients while Client #1 was transported to the hospital. No one called EMS for Client #1 and he was not able to get to the hospital until 2 hours later. Client #1 had to be admitted into the hospital to have emergency gallbladder removal surgery. The facility failed to coordinate services to get Client #1 to the hospital immediately which could have resulted in serious harm. This deficiency constitutes a Type A2 rule violation for substantial risk of serious harm and must be corrected within 23 days.	V 291		