STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL055093	A. BUILDING: _____ B. WING _____	C 10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRIOT LANE	1252 GEORGETOWN ROAD LINCOLNTON, NC 28092

(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 October 30, 2025. The complaint was substantiated (intake #NC00233603). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27 G .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 2 current clients. A sister facility is identified in this report. The sister facility will be identified as sister facility A. Staff will be identified using the letter of the facility and a numerical identifier.	V 000		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the North Carolina Health Care Personnel Registry (HCPR) was accessed prior to hire for 1 of 2 audited staff (Former Staff	V 131		

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V 131	Continued From page 1 (FS) #1). The findings are: Review on 10/30/25 of FS #1's personnel record revealed: -Job Title/Position: Direct Support Professional (DSP). -Date of Hire: 1/16/24. -Date of HCPR check: 5/3/24. Interview on 10/30/25 with the Staffing Coordinator of Operations revealed: -She was responsible for HCPR checks, "I have been doing that since last year, mid January 2024." -FS #1's HCPR check was completed late because the person "teaching me my role at the time...taught me at the time that HCPR was included on the background check reports. When I realized it later, I found out we had to access it ourselves, so I then ran one for [FS #1]. Ever since then, I have accessed HCPR on everyone hired..." This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 131		
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).	V 318		

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V 318	Continued From page 2	V 318		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to report an allegation of neglect to the Health Care Personnel Registry (HCPR) within 24 hours of becoming aware of the allegation(s). The findings are:

Review on 10/30/25 of Former Staff (FS) #1's record revealed:
-Date of Hire:1/16/24.
-Title/Position: Direct Support Professional (DSP).
-Terminated 9/12/25.

Review on 10/30/25 of Client #1's record revealed:
-Date of Admission: 4/18/12.
-Diagnoses: Supraventricular tachycardia; Asthma; Acquired Absence of Left Leg Above Knee; Depression, Unspecified; Obesity; Diabetes Insipidus; Disruptive Mood Dysregulation Disorder; Severe Intellectual Disabilities.
-Assessment dated 5/9/25 included " ...wears a prosthetic leg on his left limb ...working on making informed choices ...and identifying safety signs in the community ...needs support in all areas of his activities of daily living (ADL's) ...experiences difficulty getting up and down from a seated position ..."
-No documentation of consent for unsupervised time.

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V 318	Continued From page 3 Review on 10/30/25 of Client #2's record revealed: -Date of Admission: 2/26/24. -Diagnoses: Autistic Disorder; Attention Deficit Hyperactivity Disorder; Moderate Intellectual Disability; Down Syndrome; Intermittent Explosive Disorder; Bipolar Disorder, Unspecified; History of Malnutrition and Possible Seizures; Tourette's Disorder. -Assessment dated 7/17/25 included " ...requires support with daily living skills, personal care and safety skills ...can trigger at the slightest things ...history of wandering away, must be monitored to ensure ...(he is) not leaving the home ..." -No documentation of consent for unsupervised time. Review on 10/30/25 of the North Carolina Incident Response Improvement System (IRIS) revealed: -Date of Incident: 9/11/2025. -Date Provider Learne of Incident: 9/112/2025 -Incident Type: Neglect. -Allegation Made Against: Staff -Incident Originally Submitted: 9/17/25. Attempted Interview on 10/30/25 with FS #1 was unsuccessful due to no response to phone calls. Interview on 10/30/25 with Client #1 revealed: -"[FS #1] left us (clients) in the house (facility) ..." -FS #1 no longer worked for the facility. Interview on 10/30/25 with Client #2 revealed: -He was left alone at the facility "just once. [FS #1] went away. I was in my room. I went next door (to Sister Facility A). I told someone (Staff A1). Nobody got hurt, or anything. Not alone for a long time that day. Never left alone since."	V 318		

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V 318	Continued From page 4 Interview on 10/30/25 with Staff A1 revealed: -While working at Sister Facility A, "one of the clients from next door (Patriot Lane) walked over ...and said the staff (FS #1) left. I walked to the door of my facility and had my eyes on all clients. One of the clients (Client #2) was with me, and the other (Client #1) was sitting outside. I kept eyes on (all clients) until the (oncoming shift) staff showed up, which was 15 minutes or so later. [FS #1] had not given me any knowledge that he was leaving. I have not seen [FS #1] at work since ..." Interview on 10/30/25 with the Qualified Professional (QP) revealed: -On 9/11/25, "[Client #1] and [Client #2] were at Patriot Lane and [FS #1] just left. I don't know why he left, there was no excuse at all ...Clients were left alone for about 15 minutes. [Client #1] had gone over (to Sister Facility A) and ...and at that point it was noticed ...[FS #1] was immediately terminated, it is an automatic termination if a staff abandons the clients ..." -There was an investigation and FS #1 was terminated. -Attempted to submit the 9/11/25 incident report into IRIS, but "the system was down." -She "kept trying" to submit the report. -She notified the facility Administrator and emailed the report to the IRIS team. -The 9/11/25 incident report "was finally able to be submitted on September 17, (2025) ..." Interview on 10/30/25 with the Administrator revealed: -On 9/11/25, Staff A1 reported to her supervisor that FS #1 had left. "One of the clients (Client #2) had gone over to the facility next door (Sister Facility A) ...and proceeded to tell her the staff (FS #1) was gone ..." -"We brought [FS #1] in for questioning on	V 318		

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V 318	Continued From page 5 September 12th (2025), and he did say that ...They (Client #1 and Client #2) were left unattended for about 15 minutes ..."	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 (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	V 367		

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V 367	Continued From page 6	V 367		

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:
(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

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V 367	Continued From page 7 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 interview, the facility failed to notify the Local Management Entity/Managed Care Organization (LME/MCO) of a level III incident within 72 hours of becoming aware of the incident as required. The findings are: Review on 10/30/25 of Former Staff (FS) #1's record revealed: -Date of Hire:1/16/24. -Title/Position: Direct Support Professional (DSP). -Terminated 9/12/25. Review on 10/30/25 of Client #1's record revealed: -Date of Admission: 4/18/12. -Diagnoses: Supraventricular tachycardia; Asthma; Acquired Absence of Left Leg Above Knee; Depression, Unspecified; Obesity; Diabetes Insipidus; Disruptive Mood Dysregulation Disorder; Severe Intellectual Disabilities. -Assessment dated 5/9/25 included " ...wears a prosthetic leg on his left limb ...working on	V 367		

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making informed choices ...and identifying safety signs in the community ...needs support in all areas of his activities of daily living (ADL's) ...experiences difficulty getting up and down from a seated position ..."
-No documentation of consent for unsupervised time.

Review on 10/30/25 of Client #2's record revealed:
-Date of Admission: 2/26/24.
-Diagnoses: Autistic Disorder; Attention Deficit Hyperactivity Disorder; Moderate Intellectual Disability; Down Syndrome; Intermittent Explosive Disorder; Bipolar Disorder, Unspecified; History of Malnutrition and Possible Seizures; Tourette's Disorder.
-Assessment dated 7/17/25 included " ...requires support with daily living skills, personal care and safety skills ...can trigger at the slightest things ...history of wandering away, must be monitored to ensure ...(he is) not leaving the home ..."
-No documentation of consent for unsupervised time.

Review on 10/30/25 of the North Carolina Incident Response Improvement System (IRIS) revealed:
-Date of Incident: 9/11/2025.
-Date Provider Learne of Incident: 9/112/2025
-Incident Type: Neglect.
-Allegation Made Against: Staff
-Incident Originally Submitted: 9/17/25.

Attempted Interview on 10/30/25 with FS #1 was unsuccessful due to no response to phone calls.

Interview on 10/30/25 with Client #1 revealed:
-"[FS #1] left us (clients) in the house (facility) ..."
-FS #1 no longer worked for the facility.

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V 367	Continued From page 9 Interview on 10/30/25 with Client #2 revealed: -He was left alone at the facility "just once. [FS #1] went away. I was in my room. I went next door (to Sister Facility A). I told someone (Staff A1). Nobody got hurt, or anything. Not alone for a long time that day. Never left alone since." Interview on 10/30/25 with Staff A1 revealed: -While working at Sister Facility A, "one of the clients from next door (Patriot Lane) walked over ...and said the staff (FS #1) left. I walked to the door of my facility and had my eyes on all clients. One of the clients (Client #2) was with me, and the other (Client #1) was sitting outside. I kept eyes on (all clients) until the (oncoming shift) staff showed up, which was 15 minutes or so later. [FS #1] had not given me any knowledge that he was leaving. I have not seen [FS #1] at work since ..." Interview on 10/30/25 with the Qualified Professional (QP) revealed: -On 9/11/25, "[Client #1] and [Client #2] were at Patriot Lane and [FS #1] just left. I don't know why he left, there was no excuse at all ...Clients were left alone for about 15 minutes. [Client #1] had gone over (to Sister Facility A) and ...and at that point it was noticed ...[FS #1] was immediately terminated, it is an automatic termination if a staff abandons the clients ..." -There was an investigation and FS #1 was terminated. -Attempted to submit the 9/11/25 incident report into IRIS, but "the system was down." -She "kept trying" to submit the report. -She notified the facility Administrator and emailed the report to the IRIS team. -The 9/11/25 incident report "was finally able to be submitted on September 17, (2025) ..." Interview on 10/30/25 with the Administrator	V 367		

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V 367	Continued From page 10 revealed: -On 9/11/25, Staff A1 reported to her supervisor that FS #1 had left. "One of the clients (Client #2) had gone over to the facility next door (Sister Facility A) ...and proceeded to tell her the staff (FS #1) was gone ..." -"We brought [FS #1] in for questioning on September 12th (2025), and he did say that ...They (Client #1 and Client #2) were left unattended for about 15 minutes ..."	V 367		