STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G166	A. BUILDING _____ B. WING _____	C 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YADKIN II & III	3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020

(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) COMPLETION DATE
W 000	INITIAL COMMENTS A complaint survey was completed on 12/15/2025 for intake # NC00234672. The intake was substantiated and deficiencies were cited.	W 000		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on the facility documentation reviews and interview, the facility failed to ensure an abuse investigation was reported timely to external officials in accordance with state laws for client #1. The finding is: Review of internal investigation summary on 12/15/25 revealed an allegation of neglect reported on 9/28/25. Further review of internal investigation summary revealed the investigation began on 10/30/25 and completed on 11/7/25. Continued review of the investigation summary revealed that on 9/28/25 client #1 was ambulating at home and fell, bending her finger causing a laceration. Client #1 showed her hand to staff as it was bleeding and with tendons exposed. Staff called nursing and staff transported the client to Hugh Chatham Hospital. The client had a dislocated finger and the doctors reset her finger and closed the incision with staples and wrapped her hand. The documentation related to the investigation on 10/30/25 for incident that occurred on 9/28/25 revealed no evidence of a timely 24-hour incident response improvement	W 153		

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

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W 153	Continued From page 1 system (IRIS). Interview on 12/15/25 with the qualified intellectual disabilities professional (QIDP) confirmed that the allegation on 9/28/25 was investigated on 10/30/25. Further interview with the QIDP confirmed that the IRIS was completed on 11/7/25.	W 153		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on review of facility records, documents, and interviews, the facility failed to ensure that an abuse allegation was thoroughly investigated after immediately becoming aware of a reported incident for client #1. The finding is: Review of facility documentation on 12/15/25 revealed investigations completed for client #1 for an allegation of neglect reported on 9/28/25. The investigation began on 10/30/25 and concluded on 11/7/25. Review of the investigation summary revealed that on 9/28/25 client #1 was ambulating at home and fell, bending her finger causing a laceration. Client #1 showed her hand to staff as it was bleeding and the tendons were exposed. Staff called nursing and staff transported the client to Hugh Chatham Hospital. The client had a dislocated left finger and the doctors reset her finger and closed the incision with staples and wrapped her hand. Review of statements on 12/15/25 from qualified intellectual disabilities professional (QIDP) dated 11/7/25 revealed that the guardian called on	W 154		

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	34G166	A. BUILDING _____ B. WING _____	C 12/15/2025

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W 154	Continued From page 2 10/30/25 and mentioned a visit with client #1 over the weekend. The guardian reported that she was notified by staff A regarding client #1's finger injury. The QIDP informed the guardian that she was not aware of the incident as she was out of the office sick. The QIDP notified the Executive Director (ED) and Program Manager (PM) regarding guardian concern about injury to client #1. Review of facility investigation and documentation on 12/15/25 revealed an IRIS report for an incident that occurred on 9/28/25 where an IRIS was completed on 11/7/25. Further review of the IRIS report revealed that the 24-hour notification was not completed timely. Continued review of IRIS reporting revealed that the facility did not complete a 5-day working report. Subsequent review revealed that the investigator only interviewed one staff member and no clients were interviewed nor was a reason given as to why no clients were interviewed. Interview with the QIDP on 12/15/25 revealed that QIDP became aware of the 9/28/25 incident during a facility debriefing meeting. Further interview with the QIDP confirmed that only one member of staff was interviewed for the investigation and no clients. Continued interview with the QIDP confirmed that the incident occurred on 9/28/25 and the investigation began on 10/30/25 with IRIS completion on 11/7/25.	W 154		
W 156	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(4) The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law	W 156		

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W 156	Continued From page 3	W 156		

within five working days of the incident.
This STANDARD is not met as evidenced by:
Based on record reviews and interviews, the facility failed to complete the Health Care Personnel Registry (HCPR) within 5 days as required by state statue. The finding is:

Record review on 12/15/25 revealed that an abuse investigation was completed for client #1 for an allegation of neglect reported on 9/28/25. The investigation began on 10/30/25 and concluded on 11/7/25. Review of the investigation summary revealed that on 9/28/25 client #1 was ambulating at home and fell, bending her finger causing a laceration. Client #1 showed her hand to staff as it was bleeding and with tendons exposed. Staff called nursing and staff transported the client to Hugh Chatham Hospital. The client had a dislocated left finger and the doctors reset her finger and closed the incision with staples and wrapped her hand.

Review of facility investigation and documentation on 12/15/25 revealed an IRIS report for an incident that occurred on 9/28/25 where an IRIS was completed on 11/7/25. Further review of the IRIS report revealed that the 24-hour notification notified DSS, guardian, and clinical team leader. Continued review of IRIS reporting revealed that the facility did not complete a 5-day working report.

Interview on 12/15/25 with the qualified intellectual disabilities professional (QIDP) confirmed that an abuse allegation was initiated on 10/30/25 and concluded on 11/7/25. Further interview with the QIDP confirmed that a 5-day working report was not completed.