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
	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	V131 HCPR was accessed prior to hire for 1 of 2 audited staff. Trainer who trained Staffing Coordinator taught her that HCPR was included in background checks. The incorrect information given to Staffing Coordinator has since been corrected. HCPR was ran on all employees hired and going back to where HCPR information was incorrectly given in January 2024 when Staffing Coordinator was Training.	
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 318	Continued From page 2 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.	V 318	Both QP and Administrator Left message at Partners and Sent email correspondence to Inform of the incident as it was Friday afternoon and that Employee was terminated and no one Was harmed. QP and Administrator left the office at 5:30pm as MCO had been notified by phone and email of incident, outcome and IRIS complications. Partners responded back on Friday at 5:37pm stating We would need to submit by email/scan or fax. and once IRIS was back up enter all information into system.	

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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	Administrator emailed again 9/16/25, and had correspondence again about the scanned IRIS, but nothing further and then Administrator emailed again on 9/17/25 informing Partners QP was able to get into IRIS and was entering and at this time Partners requested for QP to fax the handwritten as well and informed us on 9/17/25 they could not locate the emailed IRIS which was sent on 9/15/25 and Administrator inquired about this several times.	

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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 8 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.	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		