STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-361	A. BUILDING: _____ B. WING _____	R 01/20/2026

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SPRINGWELL NETWORK, INC-EBERT STREET GROU	3830 EBERT STREET WINSTON-SALEM, NC 27127

(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 An annual, complaint and follow up survey was completed on 1/20/26. The complaint was unsubstantiated (intake #NC00235198). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. The facility is licensed for 5 and currently has a census of 4. The survey sample consisted of audits of 2 current clients and 1 deceased client.	V 000		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and	V 118		

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V 118	Continued From page 1 (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to keep the MAR current affecting 2 of 4 audited clients (#1, #2) and 1 of 1 deceased client (DC) #3. The findings are: Review on 1/13/26 of Client #1's record revealed: -Admission date of 8/20/07; -Diagnoses included Moderate Intellectual Developmental Disability, Autism, Schizophrenia and Constipation; -Physician orders dated 2/26/25 and 1/6/26 for: -Calcium Antacid 500 milligrams (mg) (supplement), chew 1 tablet by mouth (po) twice daily (BID) at 8:00am and 8:00pm; -Calcium 600mg plus D plus Minerals (supplement), chew 1 tablet po daily at 5:00pm; -Divalproex Sodium (SOD) Delayed Release (DR) 250mg (mood symptoms), take 1 tablet po daily at 5:00pm; -Divalproex SOD DR 500mg (mood symptoms), take 2 tablets po daily at 8:00pm; -Multivitamin with Minerals (supplement), take 1 tablet po daily at 5:00pm; -Polyethylene Glycol 3350 Powder (constipation), mix 1 capful in liquid and drink daily at 8am;	V 118		

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V 118	Continued From page 2 -Quetiapine Extended Release 300mg (mood disorder), take 1 tablet po daily at 5:00pm. Review on 1/15/26 of Client #1's MAR for the month of December 2025 revealed: -No documentation that the following medications had been administered: -Calcium Antacid on 12/5/25 at 8:00pm, 12/13/25 at 8:00pm, 12/14/25 at 8:00am, 12/19/25 at 8:00pm and 12/27/25 at 8:00am; -Calcium plus Minerals on 12/13/25, 12/21/25 and 12/28/25; -Divalproex SOD 250mg on 12/13/25, 12/21/25, 12/22/25, and 12/28/25; -Divalproex SOD 250mg on 12/5/25, 12/13/25, and 12/19/25; -Multivitamin on 12/13/25, 12/21/25, and 12/28/25; -Polyethylene Glycol on 12/14/25 and 12/27/25; -Quetiapine on 12/13/25, 12/21/25 and 12/28/25; -Client #1 had a total of 23 blanks where there was no documentation that medication had been administered during the above review period. Review on 1/13/26 of Client #2's record revealed: -Admission date of 10/11/93; -Diagnoses included Severe Intellectual Developmental Disability, Down Syndrome, Obsessive Compulsive Disorder and Impulse Control Disorder; -Physician order dated 10/16/25 for: -Buspirone Hydrochloride (HCL) 180mg (anxiety), take 1 tablet po BID at 8:00am and 4:00pm; -Famotidine 10mg (acid reflux), take 1 tablet po BID at 8:00am and 8:00pm; -Fexofenadine HCL 180mg (allergies), take 1 tablet po daily at 8:00am;	V 118		

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V 118	Continued From page 3 -Melatonin 1mg (sleep), take 1 tablet po daily at 8:00pm; -Metamucil Powder (fiber supplement), mix water with 2 tablespoons of powder and drink daily at 8am; -Risperidone 25mg (antipsychotic), take 1 tablet po three times daily at 8:00am, 4:00pm and 8:00pm; -Vitamin B12 100 micrograms (mcg) (supplement), Take 1 tablet po daily at 8:00am; -Vitamin D3 25mcg (supplement), take 1 tablet po daily at 8:00am; -Zinc Oxide-Cod Liver Oil 40 percent topical paste (moisturizer), apply daily at 8:00pm. Review on 1/15/26 of Client #2's MAR for the month of December 2025 revealed: -No documentation that the following medications had been administered: -Buspirone on 12/13/25 at 4:00pm, 12/14/25 at 8:00am, and 12/21/25 at 4:00pm; -Famotidine on 12/12/25 at 8:00pm, 12/13/25 at 8:00pm, 12/14/25 at 8:00am, 12/19/25 at 8:00pm and 12/27/25 at 8:00pm; -Fexofenadine on 12/14/25; -Melatonin on 12/5/25, 12/12/25, 12/13/25, 12/19/25, and 12/27/25; -Metamucil on 12/14/25; -Risperidone on 12/12/25 at 8:00pm, 12/13/25 at 4:00pm and 8:00pm, 12/14/25 at 8:00am, 12/19/25 at 8:00pm, 12/21/25 at 4:00pm and 12/27/25 at 8:00pm; -Vitamin B12 on 12/14/25; -Vitamin D3 on 12/14/25; -Zinc Oxide on 12/5/25, 12/12/25, 12/13/25, 12/19/25 and 12/27/25; -Client #2 had a total of 28 blanks where there was no documentation that medication had been administered during the above review period.	V 118		

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V 118	Continued From page 4	V 118		

Review on 1/13/26 of DC #3's record revealed:
-Admission date of 10/1/08;
-Date of death of 12/25/25;
-Diagnoses included Mild/Moderate Intellectual Developmental Disability, Seizure Disorder, Depressive Disorder, Anxiety Disorder, Hyperlipidemia and Calcium Deficiency;
-Physician order dated 12/3/25 for:
-Calcium with D 600/400 (supplement), take 1 tablet po BID at 8:00am and 8:00pm;
-Cetirizinr 10mg (antihistamine), take 1 tablet po daily at 8:00pm;
-Diatlian 100mg (seizures), take 1 capsule po daily at 8:00am;
-Docusate Sodium 100mg (constipation), take 1 capsule po daily at 8:00am;
-Ferrous Sulfate 325mg (iron supplement), take 1 tablet po BID at 8:00am and 8:00pm;
-Lorazepam .5mg (anxiety), take 1 tablet po daily at 8:00am;
-Rosuvastatin Calcium 10mg (cholesterol), take 1 tablet po at 8:00pm;
-Senna 8.6mg (constipation), take 1 tablet po BID at 8:00am and 8:00pm;
-Sertraline 100mg (depression), take 1 tablet po daily at 8:00am;
-Vitamin D3 2000 unit (supplement), take 1 tablet po daily at 8:00am.

Review on 1/15/26 of DC #3's MAR for the month of December 2025 revealed:
-No documentation that the following medications had been administered:
-Calcium on 12/5/25 at 8:00pm, 12/12/25 at 8:00pm, 12/13/25 at 8:00am and 8:00pm, 12/14/25 at 8:00am and 12/19/25 at 8:00pm;
-Cetirizinr on 12/5/25, 12/12/25, 12/13/25 and 12/19/25;
-Diatlian on 12/13/25 and 12/14/25;
-Docusate Sodium on 12/13/25 and 12/14/25;

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V 118	Continued From page 5 -Ferrous Sulfate on 12/5/25 at 8:00pm, 12/12/25 at 8:00pm, 12/13/25 at 8:00am and 8:00pm, 12/14/25 at 8:00am and 12/19/25 at 8:00pm; -Lorazepam on 12/13/25 and 12/14/25; -Rosuvastatin Calcium on 12/5/25, 12/12/25, 12/13/25 and 12/19/25; -Senna on 12/5/25 at 8:00pm, 12/12/25 at 8:00pm, 12/13/25 at 8:00am and 8:00pm, 12/14/25 at 8:00am and 12/19/25 at 8:00pm; -Sertraline on 12/13/25 and 12/14/25; -Vitamin D3 on 12/13/25 and 12/14/25; -DC #3 had a total of 39 blanks where there was no documentation that medication had been administered during the above review period. Attempted interviews on 1/13/26 with Clients #1 and #2 were not successful as they were both unable to answer questions reliably due to their functioning levels. Interview on 1/15/26 with Staff #3 revealed: -During the month of December 2025, he worked weekends and administered medications; -He always administered medications to the clients as ordered; -The facility changed the computerized system they used to document the administration of medications in December so maybe he had entered the information incorrectly. Interview on 1/15/26 with Staff #4 revealed: -During the month of December 2025, she worked 2nd shift and administered medications; -She always administered medications to the clients as ordered; -When the facility changed the computerized system they used to document the administration of medications in December, she felt there was not enough training provided.	V 118		

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V 118	Continued From page 6 Interview on 1/20/26 with the Executive Director revealed: -She was sure that medications had been administered correctly; -During the month of December 2025, the computerized system the facility utilized to document the administration of medications had been changed; -It was her opinion that some of the staff hadn't received enough documentation training for the new computer system. Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician.	V 118		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of	V 512		

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V 512	Continued From page 7 intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on interviews and record reviews, 1 of 3 audited Qualified Professionals (QP) and 4 of 6 audited paraprofessional staff (Staff #1, #2, #3 and #4) neglected 1 of 1 deceased client (DC) (#3). The findings are: Review on 1/13/26 of DC #3's record revealed: -Admission date of 10/1/08; -Date of death of 12/25/25; -Diagnoses included Mild/Moderate Intellectual Developmental Disability, Depressive Disorder, Anxiety Disorder, Seizure Disorder, Mitral Regurgitation, Hyperlipidemia, Calcium Deficiency and history of Small Bowel Obstruction; -Psychological Evaluation dated 5/21/22 included, "Intelligent Quotient Composite 62 (Mild Intellectual Disability);" -He had been declared incompetent and a family member was appointed as his legal guardian on 3/20/07; -Treatment Plan dated 6/12/25 included unsupervised time, "...can remain in the home (facility) alone and or in the community for up to 6 hours per day, he understands safety rules and who to contact in the event of an emergency." Review on 1/13/26 of the QP's personnel file revealed: -Hire date of 8/8/15;	V 512		

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V 512	Continued From page 8 -Job description for a QP; -Documentation of Client's Rights training completed on 1/7/25 and Ethics training completed on 1/12/26. Review on 1/13/26 of Staff #1's personnel file revealed: -Hire date of 1/13/09; -Job description for a Weekday Live-In Paraprofessional. Review on 1/13/26 of Staff #2's personnel file revealed: -Hire date of 12/23/22; -Job description for a Direct Care Worker. Review on 1/20/26 of Staff #3's personnel file revealed: -Hire date of 5/29/24; -Job description for a Direct Care Worker. Review on 1/20/26 of Staff #4's personnel file revealed: -Hire date of 11/10/20; -Job description for a Direct Care Worker. Review on 1/6/26 of the Incident Response Improvement System (IRIS) report submitted by the Operations Director (OD) on 12/24/25 revealed: -Date of Incident: 12/20/25; -Time of Incident: 2:00am; -"Describe the cause of this incident: Consumer (DC #3) woke up early morning complaining of not feeling well and of stomach. EMS (Emergency Medical Services) was Called;" -Incident Comments included, "12/24/25 Consumer (DC #3) woke up over in the early morning complaining of not feeling well and his stomach. EMS was called Consumer (DC #3)	V 512		

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V 512	Continued From page 9 was diagnosed with pneumonia and bowel obstruction...12/29/25 The OD completed the initial report based on information received prior to the incident report being completed in [computer system utilized by facility for documentation]. Based on the subsequent incident report, I am submitting additional information that was received from the QP. [DC #3] was not feeling well, and when asked about the issue, he repeatedly stated that he did not feel well. [DC #3] took his 8:00 PM medications. Staff left [energy drink] and water for him to drink in case he was thirsty. At approximately 2:00 AM, [DC #3] stated that he knocked on the staff's (Staff #3) bedroom door, but they did not hear him. [DC #3] then called EMS. On Thursday (12/25/25) at 3:30 PM, I was informed that the consumer (DC #3) had expired...1/6/26 There had not been any previous complaints of stomach pain prior to this report that I am aware of." Review on 1/6/25 of the Internal Investigation report completed by the QP revealed: -No date of completion or signature; -"Tuesday, December 16, 2025, after going to eat pizza with his classmates, [DC #3] said that he didn't feel good; -He had gone to the restroom at the restaurant a couple of times, but he didn't do anything; -When we arrived home (facility), [DC #3] told me again that he had gone to the bathroom a couple of times at the restaurant, but he didn't do anything; -I asked when the last time had had a bowel movement, and he stated that he didn't know, so I suggested some [over the counter constipation medication]; -Wednesday, December 17, 2025, after breakfast, [DC #3] told the staff that he did not want to go to the day program;	V 512		

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V 512	Continued From page 10 -The staff called to ask if he could stay home and I told him it was okay; -I checked on [DC #3] around noon and he stated that he didn't feel like eating his lunch, but he did drink his shake for breakfast; -I put some chicken noodle soup on the counter and told him that he could eat that when he felt hungry; -The staff (Staff #5) that was there stated that [DC #3] sat on the couch with her for a while and then he stated that he wanted to take a nap; -[DC #3] went to the [recreation center] that afternoon with the other residents; -Thursday, December 18, 2025, [DC #3] told the staff he didn't feel good and did not want to go to the day program because he didn't feel well; -He did not eat breakfast this morning and he did drink his shake for a snack but did not want to eat lunch; -When I came to the group home after dinner, the staff advised me that [DC #3] did not eat dinner; -I told him that he needed to eat, but he said he was afraid that he was going to throw up; -I advised him that he needed to eat something; -I was able to get him to eat some chicken noodle soup and some applesauce; -I asked if anything hurt, and he stated that he did not feel well; -Friday, December 19, 2025, [DC #3] told the staff that he didn't want to go to the day program because he wasn't feeling well; -I advised he could stay at home again; -When the staff (Staff #2) came on duty, [DC #3] was walking around with a blanket wrapped around him; -The staff (Staff #2) called and stated that [DC #3] stated that he did not feel well; -He said that he had thrown up again; -I instructed the staff to go and purchase a COVID test and some Pepto Bismol if he was	V 512		

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V 512	Continued From page 11 throwing up; -The staff (Staff #4) administered the test, and the results came back negative for COVID and the flu; -Staff also gave the Pepto Bismol; -[DC #3] stated that he still wasn't feeling well; -I told [DC #3] to get himself together and take a shower, and the staff would take him to Urgent Care; -He did not want to go; he stated that he wanted to just lie down; -[DC #3] took his 8 pm medication, and the staff left him 2 bottles of water and [energy drink] to drink to make sure that he did not get dehydrated throughout the night; -Saturday Morning, December 20, 2025, I was advised that EMS had been called in the early morning hours, and [DC #3] had gone to the emergency room; -[DC #3] had been admitted...was believed to have intestinal blockage and pneumonia and was being treated with antibiotics, and they were going to attempt to put a tube in his nose down to his stomach to assist with the blockage; -On Wednesday, December 23 (24th), 2025, surgery was performed to address the intestinal obstruction; -On Thursday, December 25th I received a phone call from the (family) Guardian stating that [DC #3] had taken a turn for the worse, and if I wanted to see him, I should come to the hospital immediately." Review on 1/6/26 of the local hospital Summary for DC #3 revealed: -Dates 12/20/25 - 12/25/25; -"...Admitted to the Step down ICU (intensive care unit)...with complaints of nausea/vomiting for a week prior to admission; -CT (computed tomography) scan of the	V 512		

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V 512	Continued From page 12	V 512		

abdomen and pelvis showed multiple loops of dilated proximal small bowel concerning for small bowel obstruction;
-General surgery was consulted and recommended NG (Nasogastric) tube placement...NG tube now to LIWS (low intermittent wall suction);
-He was found bilateral PNA (pneumonia) and Rhinovirus/Enterovirus;
-On the afternoon of 12/21/25 patient became hypotensive;
-Admitted to the ICU for Septic shock secondary to bilateral PNA, Acute hypoxic respiratory failure requiring NC (nasal cannula) 4L (liter) and Hypotension requiring IVF (intravenous fluids) 2L bolus and Levophed;"
-Transferred to step down ICU on 12/22/25;
-"12/23/25 Undergoing SBFT (small bowel follow-through)...now hypertensive;
-12/24/25 Acute decompensation overnight requiring intubation;
-12/25/25 Ongoing deterioration with worsening septic shock plus MODS (multiple organ dysfunction syndrome) despite surgical intervention yesterday...Ongoing vent (ventilator) support."
-DC #3 passed away on 12/25/25.

Review on 1/13/26 of the day program's Clinician Report dated 12/16/25 - 12/19/25 for DC #3 revealed:
-DC #3 only attended the day program on 12/16/25;
-"Task/Activities: He was not feeling well today so he didn't feel up to completing our classroom activities;"
-"Comment: When [DC #3] arrived this morning, he wasn't feeling well. He went to the bathroom several times today. He ate some pizza at [a local restaurant]. I asked if he could go home early, but

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that wasn't possible. So I had him go to the lobby to have some more space this afternoon. We hope he feels better tomorrow."

Review on 1/6/25 of the facility's Clinician Report dated 12/16/25 - 12/19/25 revealed:
-12/17/25: Comment completed by Staff #4 for the time period of 3:00pm - 10:00pm "[DC #3] wasn't feeling well today. [DC #3] did clean and set the dinner table with 3 verbal prompts. [DC #3] didn't participate at the YMCA. [DC #3] ate dinner and went to bed."

Review on 1/14/25 of the facility's Communication Log revealed:
-12/16/25: Comment documented by Staff #1..."[DC #3] did not eat breakfast. He said he was not feeling well. I think he is saving his appetite for [local restaurant];"
-12/17/25: Comment documented by Staff #1..."[DC #3] is not feeling well. He says he threw up twice this morning. [QP] says he can stay home;"
-12/17/25: Comment documented by Staff #4..."I worked with [DC #3] today. He stated he didn't feel good. He went to the [recreation center] he sat with me on the bench. he ate little at dinner. I got him to eat a granola bar before he took his 8pm meds (medicines);"
-12/17/25: Comment documented by Staff #2..."[Client #4] completed [DC #3] chores because he was sick;"
-12/18/25: Comment documented by Staff #1..."[DC #3] is still not feeling well. He says he threw up last night and this morning. He is taking another sick day;"
-12/18/25: Comment documented by Staff #4..."[DC#3] stayed home again today because he didn't feel good. [DC #3] vomited on both rugs and left it (bathroom rugs). I washed both rugs.

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V 512	Continued From page 14 -12/19/25: Comment documented by Staff #1..."[DC #3] is still sick;" -12/19/25:Comment documented by Staff #4..."I purchased a COVID test and Pepto Bismol for [DC #3]. [DC #3's] COVID and Flu results were negative. I encouraged [DC #3] to take a shower, drink [energy drink] and take [Pepto Bismol];" -12/19/25:Comment documented by Staff #4..."Continue giving [DC #3] [energy drink]/water. Pepto Bismol for upset stomach. Encourage [DC #3] to eat soup." Interview on 1/13/26 with DC #3's day program teacher revealed: -She texted the facility QP on 12/16/25 to inform her that DC #3 wasn't feeling well and had asked to return to the facility; -The QP never responded to her; -She asked another day program staff member (refused to name) to contact the QP and ask for guidance; -The QP informed the staff member that DC #3 was fine and was saying he didn't feel well so he didn't have to stay at the day program and was not allowed to leave early. Interview on 1/14/26 with Staff #1 revealed: -She was the live in staff and worked Sunday evenings to Friday mornings; -She typically worked 6:00am - 9:00am and 5:00pm - 10:00pm; -DC #3 complained of a stomach ache beginning on 12/16/25 when she started her shift; -"We (staff) thought it was just constipation. He was given Miralax, I think [the QP] gave him Miralax;" -She had notified the QP on the morning of 12/17/25 that DC #3 said he wasn't feeling well and had thrown up twice that morning; -The QP advised her to allow DC #3 to stay at the	V 512		

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facility with 1st shift rather than attend the day program;
-She had notified the QP on the morning of 12/18/25 that DC #3 said he wasn't feeling well and had thrown up the evening before and that morning;
-The QP advised her to allow DC #3 to stay at the facility with 1st shift rather than attend the day program;
-She had again notified the QP on the morning of 12/19/25 that DC #3 said he wasn't feeling well;
-The QP advised her to allow DC #3 to stay at the facility by himself since 1st shift had called out;
-As far as she knew, DC #3's physician was not notified of his issues;
-She believed DC #3's needs were being met;
-You couldn't tell by looking at DC #3, but, "he was really sick."

Interview on 1/14/26 with Staff #5 revealed:
-She worked 1st shift from Wednesday to Friday (8:30am - 3:30pm) at the facility;
-She arrived at the facility at approximately 9:00am on 12/17/25;
-"I read in the communications (log) he [DC #3] was sick and throwing up;"
-DC #3 was lying in bed when she arrived;
-Between 9:30am - 11:30am, DC #3 ate some soup and then returned to bed;
-The QP arrived at the facility at approximately 12:00pm and asked her whether she had seen DC #3 throw up;
-She informed the QP that she had not and the QP rolled her eyes and said he didn't want to go to the day program;
-"It seemed to me that she thought he wasn't sick;"
-The QP informed DC #3 that he had to get out of bed because clients weren't allowed to lie in bed during the day;

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V 512	Continued From page 16 -He got out of bed and went to the living room and watched television until she left the facility at 3:30pm; -On 12/18/25 she arrived at the facility at approximately 8:30am and read that DC #3 had thrown up again; -"I definitely smelled a feces smell" and was informed by Staff #1 the smell was from DC #3 vomiting; -DC #3 was lying in his bed when she arrived and only, "...came out and made small conversation with me and returned to bed;" -She left the facility at 3:30pm and DC #3 didn't eat while she was there despite her encouraging him to do so; -She called in sick on 12/19/25 and didn't work. Interviews on 1/13/26 and 1/14/26 with Staff #2 revealed: -She worked at the facility every Tuesday to Friday (3:00pm - 8:00pm); -She had observed that DC #3's appetite had decreased around 12/9/25; -DC #3 said he wasn't hungry in the evenings, so she offered to prepare him soup; -"His activity level didn't change, and he didn't start complaining of feeling bad and throwing up until 12/16/25 so I didn't think there was anything to tell (the QP);" -On 12/17/25, DC #3 complained about not feeling well so she asked another client to do his chores; -Beginning on 12/17/25, he didn't want to eat anything she offered such as soup; -When she arrived at the facility on 12/19/25, DC #3 was in the living room, and he asked her to help him get to his bedroom; -Normally, DC #3 needed no assistance with ambulation; -"I asked him had he eaten anything. He said no.	V 512		

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I asked him had he bathed and he said no;"
-"He asked me to call [the QP] for him so I used his cell phone to call her;"
-"I don't know what they talked about;"
-"After the call, he walked by himself to his bedroom then to the bathroom;"
-DC #3 normally needed no assistance with bathing but, "I was going to assist him with showering since he wasn't feeling well;"
-"When I got to the bathroom, he was sitting in the floor. He said it felt cool. He was sitting straight up on his butt;"
-Staff #4 was late that day (unable to provide approximate time of arrival) and when she arrived, she instructed her to purchase a COVID/Flu test and Pepto Bismol for DC #3;
-"When DC #3 had talked with the QP, he had asked to be transported to the hospital, but the QP informed him that since it was not an emergency, they would transport him to urgent care instead if he showered;"
-Since he didn't feel like showering, he agreed to be administered a COVID/Flu test, take some Pepto Bismol and see how he was feeling the next day;
-Staff #4 asked DC #3 if he wanted to be assisted with getting up off the bathroom floor before she left and he said no because it was cool and felt good;
-Staff #4 left the facility for approximately 30 minutes and when she returned, he was still sitting on the bathroom floor;
-Staff #3 arrived at the facility at approximately 6:00pm and she explained to him that they had been unable to get DC #3 up off the bathroom floor for the past 2 hours (4:00pm - 6:00pm);
-Staff #3 picked DC #3 up off the bathroom floor and carried him to his bedroom and put him on his bed;
-She didn't hear DC #3 ask to be taken to the

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hospital but if she had, she would have called 911;
-As far as she was aware, DC #3's physician was not consulted about him being sick.

Interview on 1/14/26 with Staff #4 revealed:
-She worked at the facility every Monday-Friday from 3:00pm - 10:00pm;
-On 12/16/25, DC #3 returned from the day program complaining of not feeling well so, "I told him to take it easy;"
-On 12/17/25, DC #3 continued to complain of not feeling well;
-The QP instructed her to try to get DC #3 to participate as much as possible in the normal schedule of activities;
-On 12/17/25 she transported all the clients to the YMCA but DC #3 didn't participate in the activities;
-When they returned to the facility, DC #3 cleaned and set the table after several prompts;
-DC #3 typically didn't need to be prompted more than once to clean and set the table;
-DC #3 ate a few bites of dinner, ate a snack when she administered his medications at 8:00pm then went to bed;
-On 12/18/25, DC #3 complained of not feeling well and he vomited on the bathroom rugs;
-"He was active throughout the week...He was fine...Nothing out of the usual except he saying his stomach hurt...He didn't feel good...I took it as a stomach bug for real...Everybody coughing;"
-"[The QP] told me what to do (purchase and administer COVID/Flu test and administer Pepto Bismol);"
-On 12/19/25, "when I got back from getting his COVID test and Pepto Bismol, I tested him personally;"
-"He was checked for COVID and Flu and it was negative;"

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V 512	Continued From page 19 -"I actually gave him [energy drink] personally;" -"When I left (the facility), he was in the bathroom. He was kind of confused. He wasn't sure if he needed to poop or throw up. He was sitting on the commode. He wanted to be comfortable. Well, when I got back there (facility), he was sitting on the floor. You don't have to sit on the floor. He was a thin man. I didn't want him on that floor. I couldn't help him up;" -"I told you wrong earlier. I didn't see him (DC #3) on the (bathroom) floor;" -"I saw him in the bathroom before I left the facility but I gave him privacy when he pulled his pants down. He said I got the runs;" -"When I got back to the facility, he asked me to take him to the hospital but I told him no;" -She was unable to remember where DC #3 and she were in the facility when he asked her to take him to the hospital; -"He (DC #3) got a phone. He can call 911;" -When Staff #3 administered DC #3 his medications at approximately 8:00pm, she encouraged him to take a shower, eat, drink fluids and take his Pepto Bismol; -She didn't check on DC #3 between 8:00pm and when she left the facility at the end of her shift at approximately 10:00pm; -As far as she was aware, DC #3's physician wasn't notified of his issues. Interview on 1/14/26 with Staff #3 revealed: -He worked at the facility on an as needed basis: -He worked at the facility on 12/19/25 - 12/20/25 from 6:00pm - 8:30am; -When he arrived at the facility, Staff #2 and #4 were working; -Staff #2 left the facility at approximately 8:00pm and Staff #4 left the facility at approximately 10:00pm; -DC #3 was sitting on the bathroom floor when he	V 512		

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V 512	Continued From page 20 arrived at the facility; -Staff #2 and #4 informed him that DC #3 was unable to get up by himself and they were unable to pick him up; -"He just looked so bad. He was complaining. He had shortness of breath from what I could see...there was a foul odor. He was sick and he was vomiting...His hands was real cold. His hands were ice cold;" -"They (Staff #2 and #4) said he had been sick throwing up the last few hours;" -"He asked me to take him to the hospital;" -According to Staff #2, she had assisted DC #3 with calling the QP when she arrived at the facility at 3:00pm; -The QP had informed DC #3 he needed to go to urgent care rather than the hospital because he didn't have an emergency and staff was going to transport him after he had taken a shower and gotten ready; -DC #3 didn't want to take a shower because he felt so bad, -The QP determined since it was probably a stomach virus, he would take Pepto Bismol, drink fluids, rest and see how he was feeling the following day and DC #3 agreed; -Staff #4 administered Pepto Bismol to DC #3, "and he threw that up;" -"I picked him up (carried him to his room) and set him in his bed" at approximately 7:30pm;" -He administered DC #3 his medications at approximately 8:00pm with, "...a sip of bottled water. I don't know if they (medications) came up after;" -He informed Staff #4 before she left if DC #3 looked the same the next day, he was, "...going to call 911 my d**n self;" -"The next time I saw [DC #3] was when EMS arrived at the residence...He was sitting in the living room. He looked worse...He was colder.	V 512		

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V 512	Continued From page 21 Even EMS said they couldn't take his vitals from his hands because they were too cold;" -DC #3 was transported to the local hospital; -"If I had it to do over, I would have called 911 (when DC #3 asked) and just took the consequences." Interview on 1/13/26 with DC #3's legal guardian revealed: -On 12/19/25, he had talked with DC #3 on the telephone while he was at the facility by himself; -DC #3 informed him that he had, "...thrown up...he said he was throwing up;" -"I made the comment if you really aren't feeling good at some point, call 911;" -"I had talked to the people (the QP on 12/19/25) there (the facility) and they hadn't seen any evidence of him throwing up;" -"They (facility staff) had tried to get him to go to the doctor one day and he had laid on the floor;" -He was unsure when facility staff had attempted to take DC #3 to the doctor; -"I hate that it (death of DC #3) happened. It seemed like it was a series of events that went fast." Interviews on 1/13/26 and 1/14/26 with the QP revealed: -Facility staff had not informed her of DC #3 having a change in appetite beginning 12/9/25: -DC #3's teacher from the day program informed her on 12/16/25 between 1:00pm - 1:30pm that he wasn't feeling well and wanted to return to the facility; -The day program ended for the day at 3:00pm; -She instructed the day program teacher, "...to move him to a quiet area so he could rest until time to leave for the day that way we avoided the back and forth." -She wasn't sure if DC #3 was sick or if he	V 512		

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V 512	Continued From page 22 wanted to return to the facility because there was another client there during the day most of the time; -Staff #1 informed her on 12/17/25 that DC #3 wasn't felling well and didn't want to go to the day program so she gave permission for him to remain at the facility with 1st shift staff; -On 12/17/25, DC #3 ate breakfast but refused lunch; -DC #3 went with the other clients to the recreation center on 12/17/25 so she thought he might have been feeling a little better; -Staff #1 informed her on 12/18/25 that DC #3 wasn't feeling well and didn't want to attend the day program so she gave permission for him to remain at the facility with 1st shift staff; -On 12/18/25, DC #3 didn't eat breakfast, ate a snack, refused lunch and refused dinner at first because he felt like he was going to vomit; -DC #3 did eat some soup and applesauce before going to bed but continued to complain of not feeling well; -Staff #1 informed her on 12/19/25 that DC #3 wasn't feeling well and didn't want to attend the day program; -Staff #5 called in sick on 12/19/25 so she had nobody to work at the facility; -DC #3 had approved unsupervised time so he was allowed to stay at the facility by himself from approximately 9:00am - 3:00pm. -Staff #2 called her on 12/19/25 when she arrived at approximately 3:00pm and said DC #3 had thrown up and that was the first time anyone had informed her of that; -DC #3 requested to go to the hospital but she informed him that wasn't appropriate since it wasn't an emergency; -She informed DC #3 after he took a shower, he would be transported to urgent care; -Since DC #3 didn't want to go, she instructed	V 512		

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	MHL034-361	A. BUILDING: _____ B. WING _____	R 01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGWELL NETWORK, INC-EBERT STREET GROU	3830 EBERT STREET WINSTON-SALEM, NC 27127

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V 512	Continued From page 23 Staff #2 to purchase a COVID test and Pepto Bismol and administer them; -She wasn't notified by facility staff on 12/19/25 that DC #3 had shortness of breath and was too weak to get off the bathroom floor and to his bedroom by himself; -Facility staff should have informed her of the appetite change, vomiting, shortness of breath, and weakness; -DC #3's physician wasn't notified that he was sick; -"What was I going to tell them...He doesn't feel well?" -"There's nothing I would have done differently...I even asked one of the nurses at the hospital and she said there was nothing I could have done differently." Interviews on 1/13/25 and 1/20/25 with the Executive Director (ED) revealed: -"We were aware he (DC #3) said he was sick, and he said he didn't want to come to the day program...They never got to see what the throw up looked like;" -"I know the staff were encouraging him to eat;" -"[The QP] was there (the facility) every day;" -If DC #3 had informed the QP that he wanted to go to the hospital, "she would have called 911;" -Staff #1, #2, #3 and #4 should have communicated clearly with the QP about DC #3's symptoms (change of eating habits, throwing up, shortness of breath); -Staff #2, #3 and #4 should have called 911 for DC #3 on 12/19/25 when he asked to go to the hospital; -"We do emergency medical drills all the time so they (Staff #3) had no reason to say they didn't know what to do (when DC #3 asked to be taken to the hospital)."	V 512		

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V 512	Continued From page 24 Review on 1/20/26 of the Plan of Protection signed and dated 1/20/26 by the ED revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? Medical emergency training is the main focus on equipping support staff who work with IDD adults. We will learn to focus on communication strategies of medical crises by using tools such as crisis plans, visual aids and involving first responders for better preparedness and response. The staff will receive information training within the next 30 days that will be required for all employees and informational flyers with medical emergency procedures will be posted at all locations. Medical Emergency drill process will be posted at each location for guidance for employees to ensure they have reminders. We will be using the following resources: [Website that provides information for the primary care of adults with intellectual and developmental disabilities.] Winston Salem Forsyth County Emergency Management Team -Describe you plans to make sure the above happens. We will have an agency wide training with all staff to ensure everyone gets the same information. All staff will be required to complete Medical Emergency Training drills which will be recorded in Therap. The Qualified Professionals will review the drill data and ensure that drills were completed accurately. All data will be shared with the QI/QA (Quality Improvement/Quality Assurance) team for trends and barriers and recommendations for improvement will be discussed just in case they are needed." DC #3 had been diagnosed with Mild/Moderate Intellectual Developmental Disability, Depressive	V 512		

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V 512	Continued From page 25 Disorder, Anxiety Disorder, Seizure Disorder, Mitral Regurgitation, Hyperlipidemia, Calcium Deficiency and had a history of Small Bowel Obstruction. Starting around 12/9/25, facility staff noticed a decrease in appetite in DC #3 that lasted about 1 week. The facility staff did not notify the facility management of DC #3's change in appetite. On 12/16/25 DC #3 started complaining of stomach pain while at his day program. DC #3 had asked day program staff if he could return to the facility due to not feeling well. The QP denied DC #3's request to return to the facility early due to not feeling well. Upon returning to the facility, DC #3 continued to complain of stomach pain and not feeling well. On 12/17/25, DC #3 complained of stomach pain and vomiting and facility staff contacted the QP and informed her of DC #3's condition. On this day the QP instructed staff to allow DC #3 to remain at the facility instead of going to the day program. The QP arrived at the facility around lunch time and had DC #3 to get out of bed and instructed facility staff to not allow him to return to bed for the rest of the day. The QP nor the facility staff sought a medical evaluation or medical treatment for DC #3. On 12/18/25, DC #3 continued to complain of stomach pain and had at least 2 incidents of vomiting. The QP nor staff sought medical attention for DC#3. On the morning of 12/19/25, the 1st shift called out and the QP instructed the 3rd shift staff to clock out and leave DC #3 alone in the facility because he was approved for unsupervised time. DC #3 was left alone in the facility without staff monitoring and supervision despite complaints from DC #3 about not feeling well, having stomach pain and vomiting the night before. DC #3 was left alone in the facility for approximately 6 hours. On 12/19/25 DC #3 called his legal guardian and told him that he was not feeling well and had vomited. His legal	V 512		

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V 512	Continued From page 26	V 512		

guardian called and spoke with the QP and was informed that they were monitoring DC #3 but there was no indication that he had vomited despite it being documented in the facility's Communication Log. DC #3 asked 2nd shift staff to call the QP to ask if he could go to the hospital. The QP told staff to tell DC #3 since he was not experiencing a medical emergency he could not go to the hospital, but facility staff could transport him to Urgent Care to be seen. DC #3 told staff he didn't want to go to Urgent Care because he didn't want to take a shower. The QP had staff go to the store to purchase a COVID test and Pepto Bismol. Facility staff returned from the store around 3:45pm and administered the COVID test and gave DC #3 the Pepto Bismol which he vomited. The 3rd shift staff arrived around 6:00pm and DC #3 was still on the bathroom floor. The 3rd shift staff picked DC #3 up off the floor and carried him to his bedroom and placed him in his bed at approximately 7:30pm. DC #3 asked 2nd and 3rd staff again to transport him to the hospital, but they refused. The 3rd shift staff administered DC #3 his medicine at approximately 8:00pm and DC #3 was not checked on again until the staff heard an ambulance back into the facility driveway at approximately 2:00am, after DC #3 had called 911 on his personal cell phone. DC #3 was transported to the local hospital on 12/20/25 and was diagnosed with Small Bowel Obstruction, Septic Shock secondary to Bilateral PNA, Rhinovirus/Enterovirus, Acute Hypoxic Respiratory failure, and MODS. DC #3 passed away on 12/25/25. The facility management and staff did not respond to the medical concerns for DC #3 for at least 12 days and did not seek a medical evaluation or medical treatment for DC #3. This deficiency constitutes a Type A1 rule violation for neglect and must be corrected within

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V 512	Continued From page 27 23 days.	V 512		