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| W 000 | INITIAL COMMENTS<br><br>A recertification and complaint survey for intake # NC00235658 was completed on February 9 - 10, 2026. The complaint was substantiated. Deficiencies related to the complaint and the recertification survey were cited. | W 000 | | |
| W 104 | GOVERNING BODY<br>CFR(s): 483.410(a)(1)<br><br>The governing body must exercise general policy, budget, and operating direction over the facility.<br>This STANDARD is not met as evidenced by:<br>Based on reviews and interviews, the facility failed to monitor general operating direction over the facility. This affected 1 of 1 discharged clients (dc #1). The finding is:<br><br>Review on 2/9/26 of dc #1's hospital provider notes, dated 11/27/25, revealed she was admitted to the emergency room (ER) due to a behavioral episode after law enforcement and emergency medical staff (EMS) were called to the facility. She was transported to the hospital at approximately 7:30pm with no staff accompaniment. At 11:21pm, dc #1's guardians arrived at the hospital. No staff, medications, or medication list was provided by the facilty.<br><br>Review on 2/9/26 of facility case notes by the facility nurse, dated 11/27/25 at 6:45am, revealed dc #1 was combative, engaged in property destruction, scratched and kicked staff, engaged in self-injury, and attempted to elope. The medical provider was contacted, as well as the guardians, to inform them of the increase in behaviors. She then calmed. At 7:00pm, dc #1 began to exhibit self-injurious behavior and physically attack staff as she attempted to bite | W 104 | | |

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| W 104 | Continued From page 1 | W 104 | | |

and grab them. She then crawled underneath the nurses' desk and refused to come out. The local police and EMS were notified; they arrived at 7:20pm. The nurses station was taken apart to allow EMS closer to dc #1. During the process, a pole connecting the internet was torn loose, disabling any transmission of medical information or printing for EMS. The facility supplied EMS with written doctor orders and allergy information. Dc #1 was then taken to the emergency room via EMS. Facility staff did not accompany dc #1 with EMS. No facility staff went to the hospital to offer support or assist dc #1. A call was then placed to the guardians, who planned to arrive at the hospital on the following morning.

Review on 2/9/26 of facility case notes by the Qualified Intellectual Disabilities Professional (QIDP), dated 11/28/25, revealed a journal from dc #1's guardian, which detailed events on 11/27/25 and 11/28/25. At 7:38pm, the guardian was notified that dc #1 was on the way to the hospital due to behaviors. At 8:00pm, the hospital called the guardian to confirm her identify and obtain consent to treat. At 8:57pm, the hospital called the guardian out of concern because dc #1 was at the hospital alone, without facility staff. At 11:20pm, the guardians arrived at the hospital to find no facility staff had arrived and none of her medications had been brought to the hospital. At 12:03am, the facility nurse confirmed she was sent to the hospital without supervision of staff, medications, documentation, or means of communication with facility.

Review on 2/10/26 of the facility policy for staff emergency accompaniment to the hospital, dated 8/5/24, revealed if an emergency or the need for urgent care arises, staff should call 911, the home

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| W 104 | Continued From page 2<br>manager, the nurse, and administrator. If a client is transported to the hospital, staff should coordinate with the home manager to ensure the client 's records are sent to the hospital. Staff should remain with the client in the emergency room to provide information to the hospital and support or comfort for the client.<br><br>Interview on 2/9/26 with the facility Director revealed client #dc was admitted to the facilty on 11/24/25 and was in the process of being evaluated for her plans to be developed. On 11/27/25, her behavior led to a dangerous situation for other clients in the home, as well as staff. EMS and the police were called to transfer her to the hospital. However, the staff mistakenly did not go with dc #1. Staff did not think they were supposed to go once EMS left with her because it was due to behavior instead of a medical emergency. Staff should have gone to supervise her. | W 104 | | |
| W 125 | PROTECTION OF CLIENTS RIGHTS<br>CFR(s): 483.420(a)(3)<br><br>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.<br>This STANDARD is not met as evidenced by:<br>Based on observations, record reviews and interviews, the facility failed to ensure the rights of 1 of 11 audit clients (#13) by failing to assure client dignity related to the use of incontinence padding. The findings is:<br><br>During observations in the home throughout the | W 125 | | |

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| W 125 | Continued From page 3<br>survey on 2/9 - 2/10/26, client #13 was positioned in her wheelchair. The client was noted to have an incontinence pad positioned underneath her and covering the seat of her wheelchair. The incontinence pad was visible to anyone in the home.<br><br>Interview on 2/10/26 with the Habilitation Specialist (HS) revealed the pad may have been put in place by third shift staff after getting client #13 up in the morning. The HS stated, "It's a dignity issue."<br><br>Review on 2/10/26 of client #13's Individual Program Plan (IPP) dated 4/16/25 revealed, "[Client #13] is physiologically continent for bowel and bladder and depends on staff to assist with her personal needs." Additional review of the IPP noted she cooperates with toileting procedures. The plan noted she is also "able to express her basic needs and interact effectively with others through verbal communication."<br><br>Interview on 2/10/26 with the QIDP indicated client #13 is continent of bowel and bladder and is assisted in the bathroom by staff to use the toilet. The QIDP noted the incontinence pad should not be placed in client #13's wheelchair and there "is no reason for it". | W 125 | | |
| W 202 | ADMISSIONS, TRANSFERS, DISCHARGE<br>CFR(s): 483.440(b)(4)(ii)<br><br>If a client is to be either transferred or discharged, the facility must provide a reasonable time to prepare the client and his or her parents or guardian for the transfer or discharge (except in emergencies).<br>This STANDARD is not met as evidenced by: | W 202 | | |

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Based on record review and interviews, the facility failed to assure reasonable time was given to prepare 1 client (#dc) and her guardian for discharge/transfer. The finding is:

Review on 2/9/26 of client #dc's hospital notes, dated 11/27/25, revealed she was transported and admitted to the emergency room due to behavioral episodes after the facilty contacted the local police department and emergency medical services (EMS). At 9:19pm, the facility notified the hospital that client #dc could no longer be cared for in the present placement. At 11:21pm, client #dc's guardians arrived at the hospital.

Review on 2/9/26 of facility case notes by the facility nurse, dated 11/27/25 at 6:45am, revealed client #dc was combative, engaged in property destruction, scratched and kicked staff, engaged in self-injury, and attempted to elope. The medical provider was contacted, as well as client #dc's guardians. At 7:00pm, client #dc once again began to exhibit self-injurious behavior and physically attacked staff, attempting to bite and grab them. She then crawled underneath the nurses' desk and refused to come out. The local police and EMS were notified; they arrived at 7:20pm. Client #dc was then taken to the emergency room via EMS. A call was placed to notify the guardians of the incident at 7:38pm. The facility Director of Nursing (DON) was then notified of the situation. The facility nurse was then made aware that "client #dc would not be allowed back into the facility and would need to be transferred by the hospital".

On 11/27/25 at 11:15pm, the facility nurse placed a call to the hospital to receive an update on client #dc. The hospital nurse reported that the

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guardians had arrived at the hospital, and were now on their way to the facility to pick up medications and items for her. Once at the facility, the guardian asked why client #dc was being discharged without notice. The facility nurse explained that while she is not currently discharged, client #dc would be transferred to another hospital or facility.

Review on 2/9/26 of facility case notes by the Qualified Intellectual Disabilities Professional (QIDP), dated 11/28/25, revealed a detailed account of the events on 11/27/25 and 11/28/25 from client #dc's guardian as follows:
-On 11/27/25 at 7:38pm, the guardian was notified that client #dc was on the way to the hospital due to behaviors.
-At 8:00pm, the hospital called the guardian to confirm identify and obtain consent to treat.
-At 8:57pm, the hospital called the guardian out of concern because client #dc was at the hospital alone, without facility staff.
-At 11:20pm, the guardians arrived at the hospital to find no facility staff had arrived or sent medication.
-At 12:03am, the facility nurse confirmed client #dc was sent to the hospital without supervision of staff, documentation, or means of communication with facility.
-At 12:04am, client #dc's guardian was notified she could not be detained in the hospital but could not return to the facility, per facility information. She would have to wait in the waiting room until another placement could be arranged.
-The hospital provider and guardians elected to discharge client #dc to the family home until arrangements could be made.
-On 11/28/25 at 12:41pm, the facility had still not contacted client #dc's guardians.

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Review on 2/10/26 of facility meeting calendar notes revealed a team meeting was held on 11/28/25 with team members. Guardians were not present. No further details were listed.

Review on 2/10/26 of case notes, dated 11/28/25 at 10:52am revealed the psychologist notes of a team meeting to discuss the recent event. The team validated that client #dc's guardians discharged her from the hospital back to the guardian's home. The team agreed she needs increased interventions and 1:1 staffing put into place.

Review on 2/10/26 of facility emails, dated 11/28/25 at 12:15pm, revealed the home manager had notified the guardian that she was aware client #dc was in crisis, which "warranted the need to be sent out to the hospital and was discharged from the hospital to you". Per staff, there was property damage, and staff were injured due to the episode, which "contributed to a staffing shortage for the remainder of the weekend". The team is planning a meeting sometime next week.

Review on 2/10/26 of client #dc's guardian's emails to the facility, dated 12/1/25, revealed "I think a meeting with all parties, including the MCO, is necessary before making decisions" for transfers.

Review on 2/10/26 of client #dc's psychology evaluation, dated 12/15/25, revealed she returned to the facility on 12/15/25 from being discharged to home, following the incident and brief hospital stay on 11/27/25.

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| W 202 | Continued From page 7<br>Review on 2/10/26 of case notes, dated 12/28/25, revealed an evening meeting was conducted by the facility and client #dc's guardians to discuss the situation. The guardians agreed to visit a sister facility for more appropriate placement.<br><br>Review on 2/10/26 of a facility email, dated 12/29/25, revealed client #dc was transferred to a sister facility.<br><br>Interview on 2/9/26 with the Director revealed client #dc was not officially discharged from the facility as a lengthy process and plan would have been required. She is unaware of anyone telling the guardians, or hospital, that client #dc could not return to the home. The staff and nurses were concerned with the safety of other clients after witnessing the behaviors on 11/27/25. When the facility staff attempted to contact the hospital on 11/28/25, they found that the guardian had discharged client #dc to her home. | W 202 | | |
| W 210 | INDIVIDUAL PROGRAM PLAN<br>CFR(s): 483.440(c)(3)<br><br>Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.<br>This STANDARD is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to ensure assessments for 1 of 3 newly admitted clients (#18) was completed within 30 days after admission. The finding is:<br><br>Review on 2/9/26 of client #18's record revealed he was admitted to the facility on 11/24/25. Additional review of the record did not include | W 210 | | |

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| W 210 | Continued From page 8<br>Speech Language, Independent Living Skills and dental evaluations for client #18.<br><br>Interview on 2/10/26 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed no Speech Language evaluation, Independent Living Skills assessment and dental examination were available for review for client #18. | W 210 | | |
| W 247 | INDIVIDUAL PROGRAM PLAN<br>CFR(s): 483.440(c)(6)(vi)<br><br>The individual program plan must include opportunities for client choice and self-management.<br>This STANDARD is not met as evidenced by:<br>Based on observations, record reviews, and interviews, the facility failed to ensure the individual program plan (IPP) for 1 of 4 audit clients (#7) included opportunities for independence and self-management. The finding is:<br><br>During observations in the facility from 02/09/26 to 02/10/26, several instances were revealed in which staff were observed several times pushing client #7 from one area of the facility to another.<br><br>Review on 02/09/26 of client #7's IPP dated 9/25/25 revealed that client #7 can independently maneuver her wheelchair.<br><br>Interview on 02/10/26 with the Qualified Intellectual Disabilities Professional (QIDP) revealed that client #7 is independent in maneuvering her wheelchair. | W 247 | | |
| W 249 | PROGRAM IMPLEMENTATION<br>CFR(s): 483.440(d)(1) | W 249 | | |

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As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

This STANDARD is not met as evidenced by:
Based on observations, record review and interviews, the facility failed to ensure 9 of 11 audit clients ( #7, #10, #13, #14, #22, #24, #25, #27, and #29) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of leisure activities and opportunities for independence. The findings are:

A. During observations in the facility on 2/9/26 and 2/10/26, clients in Classroom #3 sat for long periods of time with no leisure activity offered. On 2/9/26 from 4:10pm to 5:30pm, clients #10, #14, #22, #24, #25, and #29 sat on one side of the room with their wheelchair surrounding a small, round, activity table that was too small for more than two clients to pull up to for activities. Staff E and Staff F alternated sitting at the table to color pictures. Clients were not observed to color or participate in any other Actviity. Staff did not interact with clients or offer a choice of activity. On 2/10/26 from 7:00am to 8:00am at the same side of Classroom #3, clients #25 and #27 sat with no activity offered by staff and looked around the room or slept. At 7:40am, client #25 groaned and attempted to turn in her wheelchair to look

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around the room. Staff did not respond, and no activity or interaction was offered.

Interview on 2/10/26 with Staff E revealed the emphasis in the morning is getting everyone fed and changed to prepare for the day.

Interview on 2/10/26 with Staff F revealed clients can normally watch television while medication administration and dining is taking place, but the internet is not working. Therefore the clients cannot watch television.

Interview on 2/10/26 with the qualified intellectual disabilities professional (QIDP) indicated there were activities for the clients to be involved in. Staff should be interacting with clients and offering choices of activities.
B. During observations of dinner and breakfast meals in the home on 2/9 - 2/10/26, various staff poured drinks for client #13 and cleared her dishes from the table at the end of the meal. At the meals, client #13 was not prompted or assisted to use a napkin to wipe her mouth. Although client #13 was noted to feed herself at all meals, use a small paint brush during an art activity and utilize a spray bottle to water various plants, the client was not prompted or assisted to be as independent as possible at meals.

Interview on 2/10/26 with the Habilitation Specialist (HS) revealed client #13 is capable of pouring and clearing her dishes with assistance depending on which hand she is using.

Review on 2/10/26 of client #13's IPP dated 4/16/25 revealed staff should "encourage independence in all activities..." The plan indicated, "[Client #13] is very independent and

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| W 249 | Continued From page 11<br>works best with people who allow her to be as independent as possible." The IPP identified a need to encourage client #13's active participation in personal ADLs. Further review of the IPP revealed an objective to use a napkin to wipe her mouth at mealtime given verbal prompts.<br><br>Interview on 2/10/26 with the QIDP confirmed client #13 needs assistance with pouring and has the ability to clear her dishes after meals. The QIDP confirmed the client also has a current objective to wipe her mouth at meals.<br><br>C. During observations of dinner and breakfast meals in the home on 2/9 - 2/10/26, various staff members poured drinks for client #7 and cleared her dishes from the table at the end of the meal. At the meals, client #7 was not prompted or assisted to clean up her space.<br><br>Review on 2/10/26 of client #7 IPP dated 9/25/25 revealed staff should allow client #7 to be as independent as possible while dining.<br><br>Interview on 2/10/26 with QIDP revealed the facility never tried to allow client #7 to clean up her space. QIDP stated she can assist in clean up and pour her drinks. | W 249 | | |
| W 340 | NURSING SERVICES<br>CFR(s): 483.460(c)(5)(i)<br><br>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate | W 340 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G009 | A. BUILDING ______ B. WING ______ | C 02/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| W 340 | Continued From page 12<br>health and hygiene methods.<br>This STANDARD is not met as evidenced by:<br>Based on observations, document review and interviews, the facility failed to ensure all staff were effectively trained to were latex gloves appropriately. This affected 1 of 11 audit clients (#18). The finding is:<br><br>During dinner and breakfast observations in the home on 2/9 - 2/10/26, Staff D and Staff G wore latex gloves while feeding client #18.<br><br>Interview on 2/10/26 with Staff D revealed she had not been trained to wear gloves while feeding client #18.<br><br>Review on 2/10/26 of the facility's Standard Precautions policy (Revised March 2017) revealed, "Wear gloves when touching blood, body fluids, secretions, and contaminated items. Put on clean gloves, just before touching mucus membranes or non-intact skin..." Additional review of the policy did not indicate staff were required to wear gloves while feeding clients.<br><br>Interview on 2/10/26 with the facility's nurse revealed staff should be wearing latex gloves as indicated in the Standard Precautions policy for Personal Protective Equipment (PPE) use.<br><br>Interview on 2/10/26 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed latex gloves should be worn as indicated per facility policy unless the staff has to finger feed food items to a client or has to cover a wound on their hand. | W 340 | | |
| W 445 | EVACUATION DRILLS<br>CFR(s): 483.470(i)(2)(i) | W 445 | | |

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| W 445 | Continued From page 13<br><br>The facility must actually evacuate clients during at least one drill each year on each shift.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure the clients' were actually evacuated for drills on second and third shifts at least once a year. This potentially affects all the clients residing in the facility. The finding is:<br><br>The second and third shift drills were not conducted to include the client's participation in the evacuation(s).<br><br>Review on 02/09/26 of the fire drill logs revealed serveral fire drills were referred as tabletop and test of the equipment with no actual evacuation completed.<br><br>During an interview on 02/10/26, the Program Manager (PM) confirmed the clients were only evacuated once annually. The clients are to participate in at least one drill on each shift annually. Further interview revealed the documentation did not show the client's participation in the drills. | W 445 | | |
| W 473 | MEAL SERVICES<br>CFR(s): 483.480(b)(2)(ii)<br><br>Food must be served at appropriate temperature.<br>This STANDARD is not met as evidenced by:<br>Based on observations, record review, the facility failed to ensure all food was served at an appropriate temperature. This affected 1 of 11 audit clients (#13). The finding is:<br><br>During dinner observations in classroom #2 in the home on 2/9//26, client #13's pureed food arrived | W 473 | | |

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| W 473 | Continued From page 14<br>on a plate covered with aluminum foil at 5:10pm. The temperature of the food was taken prior to serving and then given to client #13. The client consumed her food at a slow and steady pace until 5:51pm (41 minutes). During breakfast observations on 2/10/26 at 7:34am, client #13's plate of pureed food was presented to her at the table with the temperature taken by staff. The client again consumed her food at a slow pace until 8:31am (57 minutes). During both mealtime observations, no additional food temperatures were taken and client #13's food was not reheated.<br><br>During additional dinner observations in classroom #1 in the home on 2/10/26 at 5:10pm, prepared plates of food covered in aluminum foil arrived to the classroom. After one of the plates remained on a nearby cart until 5:40pm, Staff G took the temperature of the food. Two of three food items on the plate measured a temperature of 50 degrees (mashed potatoes) and 80 degrees (meat loaf), respectively. Staff G proceeded to serve the food, which was consumed at the measured temperature, at 5:45pm. The food was not reheated.<br><br>Interview on 2/10/26 with Staff G revealed food temperatures should be served between 80 - 110 degrees.<br><br>Review on 2/10/26 of client #14's Individual Program Plan (IPP) dated 4/16/25 revealed, "[Client #14] may take her time to savor her food and eat slowly. Continue to monitor to ensure that her food doesn't get cold when she is eating slowly. Do not rush her. Reheat if needed."<br><br>Interview on 2/10/26 with the Qualified Intellectual | W 473 | | |

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| W 473 | Continued From page 15<br>Disabilities Professional (QIDP) indicated hot foods should be served at 110 degrees and cold foods at 40 degrees. | W 473 | | |