

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/19/2026
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G109	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/17/2026
NAME OF PROVIDER OR SUPPLIER PENNY LANE II			STREET ADDRESS, CITY, STATE, ZIP CODE 2830 HIGHWAY 70 EAST CLAREMONT, NC 28610		
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W 000	INITIAL COMMENTS	W 000			
W 154	<p>A complaint survey was completed on 2/17/26 for intake #NC00235983. The complaint was unsubstantiated; however, a Condition of Participation in Active Treatment and standard level deficiencies were cited.</p> <p>STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3)</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on observations, document/record review and interviews, the facility failed to ensure all allegations of potential abuse or neglect were thoroughly investigated. This affected 1 of 1 audit client (#1). The finding is:</p> <p>Review on 2/17/26 of the facility's behavior data documentation dated 2/9/26 revealed that on that date, client #1 ran into the living room after taking her medications. She stood over staff, who asked if she wanted to go to her bedroom. Client #1 proceeded to run into her bedroom, and slam her bedroom door. Staff then asked client #1 to go sit in the living room. After going into the living room, client #1 began attacking staff by hitting and kicking them, spitting on them, and pulling their hair. Further review of the behavior data documentation revealed that client #1 sustained bruising on her back and side from where she was attacking staff and where she slammed herself on the chair that staff were directing her to sit in. Continued review of the incident report revealed that client #1 also sustained scratches to her neck as a result of a staff scratching client #1 when attempting to have client #1 release hold of the staff's hair.</p>	W 154			

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 154	Continued From page 1 Review on 2/17/26 of the facility's incident report dated 2/9/26 revealed that following the above behavior incident, staff were getting exhausted; therefore, 911 was called for assistance. Review on 2/17/26 of an email sent by the facility administrator to several of the facility team members revealed that staff restrained client #1 for approximately one hour, rotating off and on in 15 minute increments, per client #1's behavior support plan (BSP). Review on 2/17/26 of client #1's behavior support plan (BSP) dated 9/30/25 revealed "No restraint or hold should last more than 15 minutes. If the restraint required to calm [client #1] lasts for 5 minutes, nursing should be called for crisis medication. Should [client #1] require restraint after 10 minutes, staff should contact 911 for backup support, and then reach out to the qualified professional (QP) or administrator. Interview on 2/17/26 with Staff B revealed she was working on 2/9/26 at the time the behavior event occurred. Staff B stated she administered client #1 her medication, and client #1 ran out into the living room, and then ran to her bedroom and slammed her door. Staff B revealed that client #1 became aggressive and had another staff member held down by her hair, and that staff scratched client #1 multiple times to try to get client #1 to release her hair, and revealed client #1 slammed herself into the restraint chair while staff were trying to restrain her. Continued interview with Staff B revealed that staff called 911 for assistance after restraining client #1 for one hour. Further interview with Staff B revealed staff have been trained to call 911 for assistance	W 154			

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W 154	Continued From page 2 only after client #1 has been put into restraint 15 or more times.	W 154			
W 195	Interview on 2/17/26 with the facility administrator revealed no investigation was completed as this incident was all related to client #1's normal behaviors. The facility administrator confirmed no investigation was completed to investigate the inconsistencies in restraint procedures as written in the BSP and what was reported during the client's 2/9/26 behavioral intervention. ACTIVE TREATMENT SERVICES CFR(s): 483.440 The facility must ensure that specific active treatment services requirements are met.	W 195			
W 196	This CONDITION is not met as evidenced by: The facility failed to: ensure an active treatment program was provided to each client (W196); and ensure that each client received a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training and treatment directed towards the acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible (W249). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated active treatment services to the clients. ACTIVE TREATMENT CFR(s): 483.440(a)(1)	W 196			

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W 196	Continued From page 3 Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 1 audit client (#1) received continuous services in the area of behavior support program (BSP) implementation. The findings are: A. Cross reference W249. The facility failed to ensure 1 of 1 audit client (#1) received a continuous active treatment program consisting of needed interventions and services as identified in the individual program plan (IPP) and BSP.	W 196			
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) 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.	W 249			

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W 249	Continued From page 4 This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 1 audit client (#1) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) by failing to implement behavior support plan (BSP) as prescribed.. The finding is: Review on 2/17/26 of the facility's behavior data documentation revealed on 2/9/26, client #1 ran into the living room after taking her medications. She stood over staff, who asked if she wanted to go to her bedroom. Client #1 proceeded to run into her bedroom, and slam her bedroom door. Staff then asked client #1 to go sit in the living room. After going into the living room, client #1 began attacking staff by hitting and kicking them, spitting on them, and pulling their hair. Review on 2/17/26 of the facility's incident report dated 2/9/26 revealed that following the above behavior incident, staff were getting exhausted; therefore, 911 was called for assistance. Review on 2/17/26 of an email sent by the facility administrator to several of the facility team members revealed that staff restrained client #1 for approximately one hour, rotating off and on in 15 minute increments, per client #1's BSP. Review on 2/17/26 of client #1's BSP dated 9/30/25 revealed "No restraint or hold should last more than 15 minutes. If the restraint required to calm [client #1] lasts for 5 minutes, nursing should be called for crisis medication. Should [client #1] require restraint after 10 minutes, staff should contact 911 for backup support, and then	W 249			

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W 249	<p>Continued From page 5</p> <p>reach out to the qualified professional (QP) or administrator." Continued review of the BSP revealed that during an episode of aggression, property destruction and self-injury, staff are to have immediate access to foam pads to use as protective shields. Further review of the BSP revealed that all interventions require two or more staff.</p> <p>Review on 2/17/26 of the facility's behavior data documentation from 9/2025 to 2/2026 revealed the following behavior incidents:</p> <p>9/7/25 - Shrieking out loud, redirected to bedroom.</p> <p>9/21/25 - Spitting on housemates, pulled housemates hair. Put into restraint and escorted to her room.</p> <p>9/19/25 - Spitting at dental staff during appointment.</p> <p>10/10/25 - Pulling others hair.</p> <p>10/11/25 - Spitting on peer.</p> <p>10/18/25 - Spitting at staff.</p> <p>10/23/25 - Had staff pinned against the wall by their hair.</p> <p>11/1/25 - Exposing herself, spitting at staff, tore staff shirt off, put into restraint.</p> <p>11/5/25 - Screaming at staff, slapped peer across the face, escorted to therapeutic room.</p> <p>11/9/25 - Grabbed peer by hair, tried to pull staffs hair.</p> <p>11/9/25 - Pulled clients hair.</p> <p>11/21/25 - Tried grabbing peers' tablet, started screaming at staff, grabs a white board and starts hitting a peer in the head.</p> <p>11/24/25 - Tried grabbing staffs' hair, staff held her hands down to her side. Two staff did a walk back to classroom. She dropped to the floor and tried to kick, scratch and grab staff.</p> <p>11/24/25 - Attacked nurse at vocational center.</p>	W 249			

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W 249	<p>Continued From page 6</p> <p>12/1/25 - Pulled staff hair, grabbed staff by chain and pulled, then hit self on shower chair. Grabbed another staff by hair and pulled wig off and fell onto the floor.</p> <p>12/8/25 - Kept yelling at staff and wouldn't calm down.</p> <p>12/19/25 - Spit at peer.</p> <p>1/4/26 - Got mad because staff tried to get her to put clean clothes on, began slamming door and fighting with staff.</p> <p>1/16/26 - Screaming at staff, threw magnets at staff, assisted to therapeutic room.</p> <p>1/22/26 - Screaming at staff.</p> <p>1/24/26 - Slamming bedroom door.</p> <p>2/9/26 - Hitting, kicking and spitting at staff.</p> <p>2/16/26 - Spitting at staff.</p> <p>Interview on 2/17/26 with Staff A revealed that staff have been trained to call 911 for assistance after client #1 has hit, bit or spit on staff 10 or more times in any given period of time. Staff A stated the facility administrator and behavior specialist trained them on this information the week following the incident on 2/9/26.</p> <p>Interview on 2/17/26 with Staff B revealed she was working on 2/9/26 at the time the behavior event occurred. Staff B stated she administered client #1 her medication, and client #1 ran out into the living room, and then ran to her bedroom and slammed her door. Staff B revealed that client #1 became aggressive and had another staff member held down by her hair, and that staff scratched client #1 multiple times to try to get client #1 to release her hair, and revealed client #1 slammed herself into the restraint chair while staff were trying to restrain her. Continued interview with Staff B revealed that staff called 911 for assistance after restraining client #1 for</p>	W 249			

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W 249	<p>Continued From page 7</p> <p>one hour. Further interview with Staff B revealed staff have been trained to call 911 for assistance only after client #1 has been put into restraint 15 or more times as stated in her BSP.</p> <p>Interview on 2/17/26 with Staff C revealed that staff have been trained to give client #1 verbal warnings when she becomes physically aggressive. Staff C stated that staff give client #1 more verbal warnings than they should to keep from having to restrain her. Staff C revealed staff have been trained to do a "2 man walk" to take client #1 to her bedroom. Staff C stated that staff are supposed to call 911 if client #1 comes out of her bedroom 10 or more times after staff "walk" her to her bedroom.</p> <p>Interview on 2/17/26 with the behavior specialist revealed staff have been trained to call 911 for assistance immediately if they feel unsafe. The behavior specialist confirmed staff should not have waited 60 minutes to call for assistance. Further interview with the behavior specialist revealed a concern that all behaviors are not documented by staff to show the true rate of behaviors.</p> <p>Interview on 2/17/26 with the facility administrator revealed staff have been trained on client #1's BSP, but confirmed staff could benefit from additional training.</p> <p>Based on review of records, the findings indicate that the facility failed to ensure behavior program implementation was consistent with what is prescribed in the BSP. In addition, based on interviews, the facility failed to ensure staff were adequately trained on client #1's behavior interventions.</p>	W 249			

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