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
	MHL014-092	A. BUILDING: _____ B. WING _____	R 01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINE MCNAIRY GROUP HOME	713 SERVET CIRCLE LENOIR, NC 28645

(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 January 7, 2026. The complaint was substantiated (Intake #NC00235123). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 6 and has a current census of 5. The survey sample consisted of audits of 3 current clients.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross,	V 108	RECEIVED FEB 04 2026 DHSR-MH Licensure Sect	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ashley Jenny TITLE: Regional Manager (X6) DATE: 1/30/26

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V 108	Continued From page 1 the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 2 audited paraprofessionals (Staff #1 and the House Manager) received training to meet the MH/DD/SA needs of the clients. The findings are: Review on 12/23/25 of Client #3's record revealed: -Admit: 3/17/25. -Diagnoses: Intellectual Developmental Disability, Mild; Schizoaffective Disorder Bipolar Type; Cannabis Use Disorder; Stimulant Use Disorder, Amphetamine Type; and Thrombocytopenia. -Person Centered Plan (PCP) (treatment plan) dated 2/27/25 had no goals or strategies to address elopement. -No evidence of revisions to PCP to address the client needs. Review on 12/23/25 of Staff #1's personnel record revealed: -Date of Hire: 3/3/23. -No individual client specific training to address elopement behaviors. -No documentation that staff had been trained on intervention or strategies to prevent elopement.	V 108	**Issues noted: #1(V108)27G .0202 (F-1) Personnel Requirements:The Facility failed to ensure 2 of 2 audited paraprofessionals (Staff #1 and the House Manager) received training to meet the MH/DD/SA needs of the clients.** **Correction Action:** Response to Personnel Requirements: Orientation, client rights, confidentiality, client-specific training, and Bloodborne Pathogens (BBP) training were all completed and properly documented in personnel records as required by the rule. The identified area of noncompliance involved updated client specifics and the subsequent required training not being completed/documented in a timely manner. This issue has been addressed, and corrective actions are now in place to ensure that all updated client information is reviewed promptly and that corresponding staff updates and documentation occur without delay. A new client-specific training was completed on 1/9/2026 for Staff #1 and the House Manager that addresses elopement behaviors, reviews the Plan of Protection and covers all prevention and safety expectations, including the use of strategies to prevent elopement, required safety measures, the monitoring tools that have been implemented, and the PCP revision to include new goals that were implemented. These goals include demonstrating the appropriate response when an alarm sounds, remaining in designated safe areas during smoking breaks, using coping strategies when feeling anxious or wanting to leave the home, and reinforcing elopement prevention strategies. An employee supervision was also completed on 12/31/25 for House manager and on 1/1/2026 with Staff #1 to document that Staff #1 and the House Manager received training on elopement behaviors, the Plan of Protection, prevention strategies, required safety measures and monitoring tools. **Preventative Measures:** To prevent recurrence of this deficiency, a client specific training will be completed each time there is an annual plan update, any revisions to the client's PCP, or any change in the client's behavior and/or needs. This client specific training will be reviewed with all staff within the home who support this client to ensure they understand updated expectations, safety measures, and support strategies. Documentation of this training will be maintained in the staff record and monitored for ongoing compliance. **Audit Feedback Loop/Quality Assurance:** The QP will maintain a current client specific training summary in each staff's record and update it each time there is an annual plan update, a PCP revision, or any change in the client's behavior and/or needs. If such changes are needed, the QP will review the updated client specific training with all staff who support the client and obtain staff acknowledgment on the client specific training form. The QP will also complete quarterly face-to-face supervisions with the client and staff to assess understanding of support needs, ensure consistent implementation of elopement prevention strategies, and verify that updates to the PCP and safety expectations are being followed. **Timetable for Correction:** A new client specific training was completed for Staff #1 and the House Manager on 1/9/2026 addressing elopement behaviors, reviewing the Plan of Protection, and covering all prevention and safety expectations, including strategies to prevent elopement, required safety measures, monitoring tools that have been implemented, and the PCP revision to include the newly added goals. These goals include demonstrating the appropriate response when an alarm sounds, remaining in designated safe areas during smoking breaks, using coping strategies when feeling anxious or wanting to leave the home, and reinforcing elopement prevention strategies. An employee supervision was also completed with House Manager on 12/31/2026 and Staff #1 on 1/1/2026 to document that Staff #1 and the House Manager received training on elopement behaviors, the Plan of Protection, prevention strategies, required safety measures and monitoring tools. Additional alarms were installed on 12/31/2025, and the implementation of 15-minute visual check-in log was completed on 12/31/2025. A team meeting with the LRP, Care Manager, Residential Coordinator, RM, and SRM was held on 1/7/2026 to review short range goals, and the updated PCP was implemented on 1/9/2026. The outdoor camera was installed on 1/2/2026 to support visual monitoring during smoking times.	**All items associated with V108 have been confirmed completed on 1/29/2025**

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V 108	Continued From page 2 -No documentation of client specific training to address PCP revisions. Review on 12/23/25 of The House Manager's personnel record revealed: -Date of Hire: 2/14/22 -No individual client specific training to address elopement behaviors. -No documentation that staff had been trained on intervention or strategies to prevent elopement. -No documentation of client specific training to address PCP revisions. Review on 12/29/25 of an email from the Residential Coordinator to the Division of Health Services Regulation Surveyor on 12/29/25 revealed: -"So in looking back [Client #3]'s PCP was updated to reflect the issues of elopement, but not uploaded to her [electronic medical record], this update was completed at the time of the HRC (Human Rights Committee) (October 2025) approval to reflect the alarms. This should have been uploaded into her record at that time, and I only had the PCP you reviewed. I will put this in her record and share with Manager & DSP's (Direct Service Professional)." -An attachment to the email included an updated PCP signed by the Qualified Professional (QP) and dated 10/30/25. -The updated PCP identified an increase in elopements from the facility in the "safety and security" domain section; however, there were no goals with interventions or strategies to address elopement and safety. -No documentation staff had been trained on this updated PCP. Interview on 12/29/25 with Staff #1 revealed: -Would review client goals in the electronic	V 108	**Issue noted #1 Continued.** **Root Cause:** Failure to ensure 2 of 2 audited paraprofessionals received training to meet the MH/DD/SA needs of the client. **Disciplinary Action:** A coaching session was completed with the QP on 1/29/26 to address expectations related to clinical oversight, documentation, and client-specific training requirements. This coaching reinforced that client-specific trainings must be completed each time there is an annual plan update, any revision to the client's PCP, any change in the client's behaviors or support needs, or when the client's level of support changes. The QP is also expected to ensure that each updated client-specific training is reviewed with all staff who support the client so they clearly understand updated expectations, safety measures, and support strategies. This coaching is intended to support the QP in maintaining full compliance with agency policy and regulatory standards and to ensure timely and accurate implementation of all client-specific updates moving forward.	

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V 108	Continued From page 3 medical record. -Was unaware that there had been any updates to Client #3's treatment plan. Interview on 12/29/25 with the House Manager revealed: -"Everything (PCPs) is on the computer... I keep a spiral book for each client and their plans (PCPs)." -"Was not aware..." if the PCP had been updated to include treatment strategies to address elopements. Interview on 12/23/25 with the Residential Coordinator revealed: -There was no documentation that the treatment plan had been updated. Interviews on 12/29/25 and 1/5/26 with the Regional Manager revealed: -Had conversations with staff. -"We should have been doing that (documenting discussions about Client #3)."	V 108		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;	V 112		

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V 112	Continued From page 4 (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews, the facility failed to develop and implement treatment goals and strategies to address the needs of 1 of 3 audited clients (Client #3). The findings are: Review on 12/23/25 of Client #3's record revealed: -Admit: 3/17/25. -Diagnoses: Intellectual Developmental Disability, Mild; Schizoaffective Disorder Bipolar Type; Cannabis Use Disorder; Stimulant Use Disorder, Amphetamine Type; and Thrombocytopenia. -Person Centered Plan (PCP) (treatment plan) dated 2/27/25 had no goals or strategies to address elopement. -No updates to the PCP after 2/27/25.	V 112	**Issues noted: #2(V112)27G .0205 (C-D) Assessment/Treatment/ Habilitation Plan: The facility failed to develop and implement treatment goals and strategies to address the needs of 1 of 3 audited clients (Client #3).** **Correction Action:** A revision to the Person-Centered Plan (PCP) was completed and implemented effective 1/9/2026 for Client #3, and new goals and support strategies were implemented to address the client's identified needs. These goals include demonstrating the appropriate response when an alarm sounds, remaining in designated safe areas during smoking breaks, using coping strategies when experiencing anxiety or urges to leave the home, and consistently applying elopement prevention strategies. In addition to the newly added goals, Abound Health implemented structured Safety Strategies for Daily Check-Ins to reinforce consistent support and promote client safety. These strategies include reviewing house rules and boundaries, reinforcing alarm awareness and the required response when an alarm sounds, identifying designated safe outdoor areas, encouraging appropriate self-advocacy statements, reviewing coping skills, role-playing scenarios related to anxiety or urges to leave, providing positive reinforcement for safe decision making, and using visual supports such as a "Stay Safe" card to assist with quick reminders during daily check-ins. **Preventative Measures:** To prevent recurrence of this issue, the client's Person-Centered Plan (PCP) will be updated any time the client's needs change or when the level of support required changes. As part of this process, the QP will develop and implement treatment goals and support strategies that directly address the client's updated needs. All staff who support the client will be informed of these changes through a client-specific training to ensure consistent understanding and implementation of the revised goals and strategies. **Audit Feedback Loop/Quality Assurance:** To ensure ongoing compliance, the QP will review each client's status during quarterly supervisory checks to determine whether the client's needs or level of support have changed and whether updates to the PCP are required. The QP will also utilize quarterly progress summaries to assess the client's ongoing goals, support needs, and any emerging behavioral or clinical changes that may require revisions to the PCP. When a change is identified, the QP will make the necessary changes and ensure that new treatment goals and support strategies have been developed and implemented as needed. All staff who support the client will be informed of these changes through client-specific training to ensure consistent understanding and implementation of the revised goals and strategies. In addition, quarterly face-to-face supervisions with the client and staff will be completed by the QP to ensure that staff understand and are consistently implementing the updated goals and strategies. Any discrepancies noted during audits or supervisions will result in immediate correction and retraining, with follow-up monitoring to ensure sustained compliance. **Timetable for Correction:** A revision to the Person-Centered Plan (PCP) was completed for Client #3, and new goals and support strategies were implemented to address the client's identified needs. Updates to the PCP were implemented effective 1/9/2026. These goals include demonstrating the appropriate response when an alarm sounds, remaining in designated safe areas during smoking breaks, using coping strategies when experiencing anxiety or urges to leave the home, and consistently applying elopement prevention strategies. In addition to the newly added goals, Abound Health implemented structured Safety Strategies for Daily Check-Ins to reinforce consistent support and promote client safety. These strategies include reviewing house rules and boundaries, reinforcing alarm awareness and the required response when an alarm sounds, identifying designated safe outdoor areas, encouraging appropriate self-advocacy statements, reviewing coping skills, role-playing scenarios related to anxiety or urges to leave, providing positive reinforcement for safe decision making, and using visual supports such as a "Stay Safe" card to assist with quick reminders during daily check-ins.	**All items associated with V111 have been confirmed completed on 1/29/2025**

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V 112	Continued From page 5 Review on 12/23/25 of the facility incident reports for Client #3 revealed: -Client #3 eloped from the facility on the following dates: 4/26/25, 6/25/25, 9/21/25, 10/12/25, 10/20/25, 11/22/25, and 12/14/25. -Client #3 eloped to a neighboring county at least 20 miles from the facility on at least 3 of the 7 elopement dates. -Local law enforcement was called each time Client #3 eloped from the facility. Observations on 12/23/25 at approximately 8:35 am and 1/5/26 at approximately 11 am of the surrounding area near the facility revealed: -The facility was located approximately 2 miles off of a 5-lane highway (2 lanes of traffic for each direction separated by a shared a middle turn lane). -The posted speed limit was 45 miles per hour (mph). -This 5-lane highway was located approximately 0.25 miles from a 4-way stop light intersection with another 5-lane highway. -Turning left at that intersection toward the neighboring county where Client #3 eloped to, that 5-lane highway initially had a concrete median for about 0.5 miles with a posted 45 mph speed limit. -After approximately 0.5 miles, the speed limit increased to 50 mph and the median became a grassy median but still remained a 4-lane highway. -The neighboring county/city where Client #3 went when she eloped was located at least 20 miles away. Review on 12/29/25 of an email from the Residential Coordinator to the Division of Health Services Regulation Surveyor on 12/29/25 revealed:	V 112	**Issues noted: #2 Continued** **Root Cause:** Failure to develop and implement treatment goals and strategies to address the needs of 1 of 3 audited clients. **Disciplinary Action:** Group Home QP and Residential Coordinator will complete a live virtual SME Short Range Goal Person-Centered Training with Senior Regional Manager by 2/6/26 and Microsoft Teams attendance will be uploaded to their personnel charts. Coaching was completed with the QP on 1/29/2026 to reinforce expectations related to Person-Centered Plan (PCP) management and clinical oversight. This coaching focused on ensuring that the client's PCP is updated any time the client's needs change or when the level of support required changes. Additionally, the coaching emphasized the QP's responsibility to develop and implement treatment goals and support strategies that directly address the client's needs and reflect any updates to their required supports. This coaching is intended to strengthen the QP's understanding of timely PCP revisions, alignment of goals with the client's current needs, and consistent implementation of effective support strategies across the team.	

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V 112	Continued From page 6 -"So in looking back [Client #3]'s PCP was updated to reflect the issues of elopement, but not uploaded to her [electronic medical record], this update was completed at the time of the HRC (Human Rights Committee) (october 2025) approval to reflect the alarms. This should have been uploaded into her record at that time, and I only had the PCP you reviewed. I will put this in her record and share with Manager & DSP's (Direct Service Professional)." -An attachment to the email included an updated PCP signed by the Qualified Professional (QP) and dated 10/30/25. -The updated PCP identified an increase in elopements from the facility in the "safety and security" domain section; however, there were no goals with interventions or strategies to address elopement and safety. Interviews on 12/23/25 and 1/5/26 with Client #3 revealed: -"I left (the facility) a few times...because I wanted to go see my friend (ex-boyfriend)...I used to live with him..." -"They (facility staff) caught me the first time (tried to elope) and brought me back. The second time I left through the kitchen door and went around (back of the house). -"I left 6 times." -Walked halfway to the neighboring county and ask for rides from strangers. "...find someone to give me a ride." -"I stayed with him (ex-boyfriend) the whole night (one incident of elopement on 12/14/25)..." -"I just ask people for rides (at a local gas station)." -"I would go to [city in neighboring county] and go see [ex-boyfriend]..." Interview on 12/29/25 with Staff #1 revealed:	V 112		

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V 112	Continued From page 7 -Would review client goals in the electronic medical record. -Was unaware that there had been any updates to Client #3's treatment plan. -Had conversations with the House Manager about Client #3's elopement behaviors but did not think there was documentation of strategies. Interview on 12/29/25 with the House Manager revealed: -"Everything (PCPs) is on the computer... I keep a spiral book for each client and their plans (PCPs)." -"Was not aware..." if the PCP had been updated to include treatment strategies to address elopements. -"We are trying to do the best we can (to prevent elopements)..." Interviews on 12/23/25 and 12/29/25 with the QP revealed: -Was responsible for the development and implementation of treatment strategies and the PCP. -Client #3's PCP had not been updated to include treatment strategies to address elopements. -Was "new...only been a QP for about a year and just didn't know." Interview on 12/23/25 with the Residential Coordinator revealed: -"...typically (the QP) update them (PCPs) annually..." -There was no documentation that the treatment plan had been updated. -There had been a treatment team meeting in October 2025, "...we (Licensee) have to come up with a solution or we can't care for her (Client #3)."	V 112		

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V 112	Continued From page 8 Interview on 1/5/26 with the Regional Manager revealed: -"I will say as she (Client #3) has done the elopements, we should have done the goals...we should have incorporated them." -"Developing strategies (regarding elopement), we don't have documentation..." This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 112		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally	V 113		

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V 113	Continued From page 9 responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain the required documentation in the client's record affecting 1 of 3 clients (Client #3). The findings are: Review on 12/23/25 of Client #3's record revealed: -Admit: 3/17/25. -Diagnoses: Intellectual Developmental Disability, Mild; Schizoaffective Disorder Bipolar Type; Cannabis Use Disorder; Stimulant Use Disorder, Amphetamine Type; and Thrombocytopenia. -Person Centered Plan (PCP) (treatment plan) dated 2/27/25 with no updates. -No documentation of services provided or progress toward outcomes.	V 113	**Issues noted: #3(V113)27G .0206 Client Records: The Facility failed to maintain the required documentation in the client's record affecting 1 of 3 clients (Client #3).** **Correction Action:** A Q-note for coordination of care was completed on 1/26/2026 to document all internal and team meetings held regarding the client, including discussion of the strategies and safety measures that were implemented. These Q-notes have been entered into the client's electronic medical record. Enhanced supervision was initiated on 12/31/2025, and staff began completing documented 15-minute check-ins. A daily log of these check-ins is being maintained and uploaded into the client's electronic medical record. A revision to the PCP was completed and implemented effective 1/9/2026, which included new goals focused on intervention and prevention of elopement, and this updated PCP has been uploaded into the client's electronic medical record. In addition, the client's quarterly progress summaries are uploaded into the electronic medical record. **Preventative Measures:** To prevent recurrence of this issue, notes will be taken during all internal and team meetings and used to complete a Q-note that documents the purpose of the meeting, any changes that need to be made, and any additional outcomes. Q-notes will also be completed whenever an incident occurs that requires changes or updates to the client's support needs, including the specific measures and interventions that must be implemented. Staff will continue conducting 15-minute check-ins with the client and will document these on their logs, which will be reviewed and uploaded into the client's electronic record. When an annual PCP update or revision is required, the QP will complete the revision and upload the signed plan into the client's medical record. The QP will also complete quarterly progress summaries, and these will be uploaded into the client's record to ensure ongoing documentation of goal progression and support needs. **Audit Feedback Loop/Quality Assurance:** To ensure ongoing compliance, the QP will take detailed notes during all internal and team meetings and will use these notes to complete Q-notes documenting the purpose of the meeting, any identified changes, and resulting outcomes. The QP will also complete Q-notes any time an incident occurs that requires updates to the client's support needs, including the specific measures and interventions that must be implemented. Staff will continue conducting 15-minute check-ins with the client and documenting them on their logs. As part of the monitoring structure, the Residential Coordinator will collect signed logs daily on weekdays, the Group Home Manager will submit check-in logs daily (with weekend logs submitted on Monday mornings), and the Regional Manager will complete a weekly review of all logs to ensure accuracy and completion. The QP will review these logs for compliance and will upload them into the client's electronic record. The QP will also complete and upload PCP revisions and annual updates whenever the client's needs or level of support change. In addition, the QP will complete quarterly progress summaries and upload them into the client's record to ensure ongoing evaluation of goal progression, intervention effectiveness, and alignment of supports with the client's needs. **Timetable for Correction:** A Q-note for coordination of care has been completed on 1/26/26 to document all internal and team meetings held regarding the client, including discussion of the strategies and safety measures that were implemented. These Q-notes have been entered into the client's electronic medical record. Enhanced supervision was initiated on 12/31/2025, and staff began completing documented 15-minute visual check-ins. A daily log of these check-ins is being maintained and uploaded into the client's electronic medical record. A revision to the PCP was completed and implemented effective 1/9/2026, which included new goals focused on intervention and prevention of elopement, and this updated PCP has been uploaded into the client's electronic medical record. In addition, the client's quarterly progress summaries are uploaded into the electronic medical record.	**All items associated with V113 have been confirmed completed on 1/29/2025**

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	MHL014-092	A. BUILDING: _____ B. WING _____	R 01/07/2026

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V 113	Continued From page 10 Interview on 12/22/25 with the Department of Social Services legal guardian revealed: -"After each elopement, we have had treatment team meetings (with the facility)." Interview on 11/29/25 with the House Manager revealed: -Had verbally been instructed to complete 15 minute checks. -"We try to check every 10 to 15 minutes..." -"No. I can't say that they are. (documenting preventative measures for Client #3). I wasn't directed to do that." Interview on 12/23/25 with the Residential Coordinator revealed: -"There was no other documentation (outside of what was documented in IRIS)." -There was no documentation of any meetings with the legal guardian. -No documentation of increased visuals check. -There had been a treatment team meeting in October and wasn't sure who was responsible for taking notes. -There had been discussion about the incidents and prevention, "...For my part, didn't think about notes (of the meetings)." -Acknowleged that there was not any documentation from any meetings that had taken place. Interviews on 12/29/25 and 1/5/26 with the Regional Manager revealed: -Staff had verbally been instructed to do 15 minute checks but here was no documentation. -Would have monthly meetings at the facility but did not have documentation. -"...and we (management staff) highly preach to new hires..." to document everything.	V 113	**Issues Noted #3 Continued:** **Root Cause:** Failure to maintain the required documentation in the client's record affecting 1 of 3 clients (Client #3). **Disciplinary Action:** A coaching session was completed on 1/29/2026 with the QP to ensure they understand and follow expectations for documentation and clinical oversight. This coaching addressed the requirement to take notes during all internal and team meetings and to document those notes as Q-notes in the client's chart, including details of the meeting, any changes discussed, and updates that need to be made. The coaching also covered the expectation that Q-notes must be completed at the time of an annual plan update or whenever revisions to the PCP are needed, as well as when a client experiences issues outside of their typical daily routine or when there is an increase in health or safety concerns. In addition, the coaching reinforced the QP's responsibility to update PCPs promptly by adding or revising goals and strategies when there are changes in the client's support needs.	

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V 113	Continued From page 11 -"Developing strategies, we don't have documentation. That is where it lacks..." -"We don't have anything (documentation) showing we follow through."	V 113		
V 289	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have	V 289		

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V 289	Continued From page 12 other diagnoses; (5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7)(A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1)(i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e)(1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL). This Rule is not met as evidenced by: Based on record reviews, observations and interviews, the facility failed to provide supervision while in the residence affecting 1 of 3 audited clients (Client #3). The findings are: CROSS REFERENCE: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or	V 289		

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V 289	Continued From page 13 Service Plan (V112). Based on record reviews, observations, and interviews, the facility failed to develop and implement treatment goals and strategies to address the needs of 1 of 3 audited clients (Client #3). CROSS REFERENCE: 10A NCAC 27G .5602 Staff (V290). Based on record reviews, observations, and interviews, the facility failed to maintain staffing to respond to meet the individualized client needs of 1 of 3 audited clients (Client #3). Review on 12/31/25 of the Plan of Protection signed and dated 12/31/25 by the Regional Manager revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? Please see the attached Plan of Protection Describe your plans to make sure the above happens. Please see the attached Plan of Protection -Immediate Actions to Ensure Client Safety Prevent Elopement for Client with Recent History -Continue use of HRC (Human Rights Committee)-approved alarms on common area doors, client's bedroom door, and window. -By COB (Close of Business) 12/31/25: Install alarms purchased locally for ALL facility windows. -Order high-quality, state-of-the-art alarms from [retail provider] with superior loudness for maximum effectiveness. (To be delivered 1/4/26) -RM (Regional Manager) to submit emergency approval request to Human Rights Committee by COB 1/2/26. -Residential Coordinator will notify all LRPs (Legally Responsible Person) in the home of installation and request approval for state-of-the-art alarms (for health and safety, not monitoring purposes for all clients).	V 289	**Issues noted: #4(V289)27G .5601 Supervised Living-Scope: The Facility failed to provide supervision while in the residence affecting 1 of 3 audited clients (client #3). Cross Referenced Service Plan (V112)The Facility Failed to develop and implement treatment goals and strategies to address the needs of 1 of 3 audited clients (Client #3). Cross Referenced Staff(V290) The Facility failed to maintain staffing to respond to meet the individualized client needs of 1 of 3 audited clients (Client #3).** **Correction Action:** The facility acknowledges the state's concern regarding the level of supervision provided to client #3. At all times, there was at least one staff member physically present in the group home, consistent with the requirements for supervised living settings. The client did not have a documented or verbal history of elopement prior to admission, nor any behavioral indicators that suggested enhanced supervision was clinically indicated at the time of placement. Client #3 had lived independently in the community for approximately 15 years before joining the group home, and based on available information, awake overnight staffing was not assessed initially as necessary. The facility's supervision approach followed the client's known functional level, prior residential history, and the absence of safety related concerns at that time. We acknowledge the finding related to the need for more clearly defined treatment goals and strategies. While the existing plan addressed general support needs, it did not explicitly integrate individualized risk-based supervision considerations for Client #3. The facility has reviewed and updated the service plan to include: Individualized supervision requirements based on current assessment. Person centered goals that reflect both the client's strengths and any areas requiring enhanced support. Specific strategies and staff responsibilities related to proactive monitoring and risk mitigation. These updates ensure that the service plan fully reflects the client's needs and aligns with regulatory expectations. Although a staff member was present in the home at all times, we acknowledge the need to reassess staffing patterns when new information about Client #3's needs emerges during service delivery. We recognize the need for implementation of additional technology. Corrective tech implemented: 1 camera installed in outdoor common area that is monitored via tablet by staff. There are 4 door alarms on the exterior doors of the home. The total number of window alarms was increase to a total of 9 to include every home egress. A revision to the Person-Centered Plan (PCP) was completed and implemented effective 1/9/2026 for Client #3, and new goals and support strategies were implemented to address the client's identified needs. These goals include demonstrating the appropriate response when an alarm sounds, remaining in designated safe areas during smoking breaks, using coping strategies when experiencing anxiety or urges to leave the home, and consistently applying elopement prevention strategies. In addition to these newly added goals, Abound Health implemented structured Safety Strategies for Daily Check-Ins to reinforce consistent support and promote client safety. These strategies include reviewing house rules and boundaries, reinforcing alarm awareness and the required response when an alarm sounds, identifying designated safe outdoor areas, encouraging appropriate self advocacy statements, reviewing coping skills, role playing scenarios related to anxiety or urges to leave, providing positive reinforcement for safe decision making, and using visual tools such as a "Stay Safe" card during daily check-ins. A Plan of Protection was also implemented on 12/31/2025, and multiple corrective measures were put into place to prevent elopement and ensure the safety of the client and others in the home. The facility continued the use of Human Rights Committee (HRC) approved alarms on all common area doors, the client's bedroom door, and the window, and additional alarms were installed on all remaining facility windows. An emergency approval request was submitted to the HRC, and all LRPs for clients in the home were notified of the alarm installation and provided consent for the upgraded alarms.	**All items associated with V289 have been confirmed completed on 1/29/2025**

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V 289	Continued From page 14 Enhanced Supervision -RM will create a log for GH (Group Home) (facility) DSPs (Direct Service Professionals) to initial every 15 minutes while client is at home and awake (client attends PSR (Psychosocial Rehabilitation Program) (part of the day) and deliver to GH staff 12/31/25. Team Coordination -Team meeting scheduled 1/7/26 with LRP, Care Manager, Residential Coordinator, RM, and SRM (Senior Regional Manager) to review short-range goals and update Provider Plan for signature by COB 1/9/26. Other Consumers -Safety of the other four clients in the home has been assessed; no immediate modifications required. Responsible Parties -Residential Coordinator: Collect signed logs daily on weekdays. -GH Manager: Submit logs daily except weekends and those will be on Monday mornings. -RM: Weekly review of logs. -RM: Lead team meeting on 1/7/26 and issue 60-day discharge notice by COB 12/31/25 due to unresolved safety concerns and funding limitations. Staff Coaching -By COB 1/6/26: Residential Coordinator will provide coaching to all DSPs and GH Managers on: -What to do if an alarm goes off: 'If the client forgets the rules and attempts to exit the facility during typical sleeping hours, staff will be alerted by alarms (additional alarms are being installed as outlined in the POP) and will redirect the client, reminding her that she is unable to leave the facility. Staff will remain with her until she returns to bed and the alarm is re-secured.' -How to redirect the client as noted in the	V 289	**Issues Noted #4 Continued.** **Corrective action continued:** Enhanced supervision was initiated, including the use of a 15-minute check-in log created by the Regional Manager for DSPs to initial while the client is at home and awake. A team meeting with the LRP, Care Manager, Residential Coordinator, RM, and SRM was held on 1/7/2026 to review short range goals, and these updates to the PCP were implemented on 1/9/2026. The safety of the four other clients in the home was assessed, with no immediate modifications required. Additional measures to support safety included installing an outdoor camera on 1/2/2026 for visual monitoring during scheduled smoking times. Immediate reporting expectations were reinforced with DSPs to ensure timely communication and coordinated response during any elopement concern. **Preventative Measures:** To prevent recurrence of this deficiency, the client's Person-Centered Plan (PCP) will be updated any time the client's needs change or when the level of support required changes. As part of this process, the QP will develop and implement treatment goals and support strategies that directly address the client's updated needs, and all staff who support the client will receive client specific training to ensure consistent understanding and implementation of the revised goals and strategies. To prevent future occurrences, all corrective measures implemented through the Plan of Protection will be maintained and monitored on an ongoing basis. The continued use of HRC approved alarms on common area doors, the client's bedroom door, and windows and the additional alarms installed throughout the home will ensure staff are immediately alerted to any unsafe exits. Enhanced supervision, including 15 minute documented check-ins while the client is at home and awake, provides continuous monitoring and allows staff to respond quickly to any signs of elopement risk. The team meeting held on 1/7/2026 and the PCP updates implemented on 1/9/2026 established clear, individualized strategies and goals to address elopement behaviors. The installation of an outdoor camera adds an additional layer of monitoring during smoking times. Reinforcing immediate reporting expectations with DSPs helps ensure staff respond consistently and promptly during any incident. Together, these measures create a structured, multi layered prevention system designed to support timely intervention, enhance client safety, and promote consistent implementation of elopement prevention practices moving forward. **Audit Feedback Loop/Quality Assurance:** To ensure ongoing compliance, the QP will review the client's status during quarterly supervisory checks to determine whether the client's needs or level of support have changed and whether updates to the PCP are required. The QP will also utilize quarterly progress summaries to assess goal progression, support needs, and any emerging behavioral or clinical changes that may require revisions to the PCP. When changes are identified, the QP will make the necessary updates and ensure new treatment goals and support strategies are developed and implemented. All staff who support the client will be informed of these updates through client specific training to ensure consistent understanding and implementation of revised goals and strategies. In addition, the QP will complete quarterly face-to-face supervisions with the client and staff to verify that staff understand and are consistently applying elopement prevention expectations, safety procedures, and client specific strategies. As part of the ongoing monitoring structure, DSPs will continue completing 15 minute check-in logs while the client is at home and awake to provide continuous oversight of safety, location, and behavioral changes. To ensure accuracy and accountability, the Residential Coordinator will collect signed logs daily on weekdays, the GH Manager will submit the logs daily (with weekend logs submitted Monday mornings), and the Regional Manager will complete a weekly review of all logs to verify proper documentation and follow through. This quality assurance process ensures that supervision, PCP updates, behavioral monitoring, and safety procedures are consistently implemented, reviewed, and adjusted as needed to maintain client safety and prevent future incidents.	

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V 289	Continued From page 15 Crisis Plan (to be reviewed at team meeting on 1/7/26). -When to contact police (per Executive Director: police will only be contacted if client refuses redirection and is out of staff's sight). -Immediate steps: DSP will notify supervisor, who will notify QP (Qualified Professional) of elopement. -After 30 minutes, LRP, RM and SRM will be notified by Residential Coordinator. Additional Measures -Install outdoor camera for visual monitoring during scheduled smoking times by COB 1/2/26. -Review Smoking schedule during Team Meeting 1/7/26 Additional Comment on Monitoring Options -GPS (Global Positioning System) and other monitoring options were previously attempted and failed. Elopement was not initially considered due to the client's history of living independently for over 15 years. Discharge Reason -We are concerned about the ability to ensure one client's safety as all available options have been exhausted. Additionally, we are concerned about the wellbeing and rights of four other individuals in the home over the long term. We are also hopeful the client will not elope again yet if she does, we will take her to ER (Emergency Room) for evaluation regardless of feedback from police." The facility served clients with diagnoses that included but not limited to Mild Intellectual Developmental Disability, Schizoaffective Disorder Bipolar Type, Cannabis Use Disorder, and Stimulant Use Disorder, Amphetamine Type. Client #3 was admitted to the facility in March 2025 and within 9 months she eloped from the facility 7 times. Three of those elopements she	V 289	**Incident Noted #4 Continued.** **Timetable for Correction:** A revision to the Person-Centered Plan (PCP) was completed for Client #3, and new goals and support strategies were implemented to address the client's identified needs, including demonstrating the appropriate response when an alarm sounds, remaining in designated safe areas during smoking breaks, using coping strategies when experiencing anxiety or urges to leave the home, and consistently applying elopement-prevention strategies. In addition, Abound Health implemented structured Safety Strategies for Daily Check-Ins—such as reviewing house rules and boundaries, reinforcing alarm awareness, identifying designated safe outdoor areas, encouraging self advocacy, reviewing coping skills, role playing scenarios, providing positive reinforcement, and using visual supports like the "Stay Safe" card to promote consistent safety practices. These updates and strategies were confirmed completed by 1/9/2026. The facility continued the use of HRC approved alarms on all common area doors, the client's bedroom door, and the window, and by 12/31/2025, alarms were installed on all remaining facility windows, and 15-minute check-in logs were created and implemented for DSPs to use while the client is at home and awake. On 1/2/2026, an outdoor camera was installed to support visual monitoring during scheduled smoking times. A team meeting with the LRP, Care Manager, Residential Coordinator, RM, and SRM was held on 1/7/2026 to review short range goals and determine necessary updates to the PCP, and all PCP updates including new goals addressing elopement and intervention strategies were implemented on 1/9/2026. **Root Cause:** The Facility failed to provide supervision while in the residence affecting 1 of 3 audited clients (client #3). The Facility Failed to develop and implement treatment goals and strategies to address the needs of 1 of 3 audited clients (Client #3). The Facility failed to maintain staffing to respond to meet the individualized client needs of 1 of 3 audited clients (Client #3). **Disciplinary Action:** Coaching was completed on 1/29/26 with the QP to reinforce expectations related to Person-Centered Plan (PCP) management and clinical oversight. This coaching focused on ensuring that the client's PCP is updated any time the client's needs change or when the level of support required changes. It also emphasize the QP's responsibility to develop and implement treatment goals and support strategies that directly address the client's needs and accurately reflect any updates to their required supports. This coaching is intended to strengthen the QP's understanding of timely PCP revisions, alignment of goals with the client's current needs, and consistent implementation of effective support strategies across the team. In addition, coaching was provided by the Residential Coordinator to Staff #1 on 1/1/2026 and House Manager on 12/31/2025 to ensure they fully understand and consistently implement required safety procedures. This coaching included instruction on what to do if an alarm goes off, the immediate safety steps and staff response expectations, and how to redirect the client in accordance with the Crisis Plan reviewed during the team meeting held on 1/7/2026. Guidance was also provided on when to contact police, following the directive that law enforcement should only be contacted if the client refuses redirection and is out of staff's sight. Immediate reporting expectations were reinforced, including DSPs notifying their supervisor as soon as an elopement occurs, the supervisor notifying the QP, and the Residential Coordinator notifying the LRP, RM, and SRM after 30 minutes. This combined coaching ensures that the QP, DSPs, and GH Managers are aligned with safety procedures, escalation protocols, documentation expectations, and the timely communication required during any elopement related event.	

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V 289	Continued From page 16 was located in a neighboring county at least 20 miles away from the facility. Local law enforcement was called for each incident to report a missing person and for assistance in locating Client #3. While this was not a presenting problem upon admission, Client #3's treatment plan was not updated to include goals, interventions, or strategies to address her elopement behaviors. The facility maintained one staff to supervise, monitor and meet the needs of all clients, including increased supervision to prevent Client #3 from eloping. The one staff slept at night and as the facility did not provide 24-hour awake supervision despite Client #3 from eloping during overnight hours. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 289		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present:	V 290		

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V 290	Continued From page 17 (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews, the facility failed to maintain staffing to respond to meet the individualized client needs of 1 of 3 audited clients (Client #3). The findings are: Review on 12/23/25 of Client #3's record revealed: -Admit: 3/17/25. -Diagnoses: Intellectual Developmental Disability,	V 290	**Issues noted: #5(V290) 27.5602 Supervised Living-Staff: The Facility failed to maintain staffing to respond to meet the individualized client needs of 1 of 3 audited clients (Client #3).** **Correction Action:** A Plan of Protection was implemented on 12/31/25, and multiple corrective measures were put into place to prevent elopement and ensure the safety of the client and others in the home. The facility continued the use of Human Rights Committee (HRC) approved alarms on all common area doors, the client's bedroom door, and the window. Additional alarms were installed on all remaining facility windows, and an emergency approval request was submitted to the HRC. All LRPs for clients in the home were notified of the alarm installation and provided consent for the upgraded alarms for health and safety purposes. Enhanced supervision was initiated, including a log created by the Regional Manager for DSPs to initial every 15 minutes while the client is at home and awake. There was a team meeting on 1/7/2026 with the LRP, Care Manager, Residential Coordinator, RM, and SRM to review short range goals, and these updates to the PCP were implemented on 1/9/2026. The safety of the four other clients in the home was assessed, with no immediate modifications required. Additional measures included installing an outdoor camera for visual monitoring during scheduled smoking times. Immediate reporting expectations were reinforced with DSPs. **Preventative Measures:** To prevent future occurrences, all corrective measures implemented through the Plan of Protection will be maintained and monitored on an ongoing basis. The continued use of HRC approved alarms on common area doors, the client's bedroom door, and windows—along with the additional alarms installed throughout the home—will ensure that staff are immediately alerted to unsafe exits. Enhanced supervision, including 15-minute documented check-ins while the client is at home and awake, provides ongoing monitoring and allows staff to respond promptly to any signs of elopement risk. The team meeting held on 1/7/2026 and the PCP updates implemented on 1/9/2026 established clear, individualized strategies and goals to address elopement behaviors. The installation of an outdoor camera adds another level of monitoring and supports staff during scheduled smoking times, when elopement risk may increase. Reinforcing immediate reporting expectations with DSPs ensures staff respond consistently and quickly during any incident. Together, these measures create a structured, multi-layered prevention system designed to support timely intervention, enhance client safety, and promote consistent implementation of elopement prevention practices moving forward. **Audit Feedback Loop/Quality Assurance:** To ensure ongoing compliance and continued effectiveness of the safety measures put into place, the QP will complete quarterly face-to-face supervisions with staff to assess their understanding of elopement prevention expectations, required safety procedures, and updated client specific strategies. The QP will also complete quarterly progress summaries to evaluate the client's goals, review behavioral trends, and determine whether any revisions to the PCP or support strategies are needed. Any necessary updates identified during quarterly supervision or progress summary review will be completed promptly to ensure the PCP remains current and reflective of the client's needs. As part of the ongoing monitoring structure, DSPs will continue completing 15-minute check-in logs while the client is at home and awake. These logs provide continuous oversight of safety, location, and behavioral changes that may indicate elopement risk. To ensure accuracy and accountability, the Residential Coordinator will collect signed 15-minute logs daily on weekdays, the GH Manager will submit the logs daily (with weekend logs submitted Monday mornings), and the Regional Manager will complete a weekly review of all logs to ensure proper documentation and follow through. This quality assurance process ensures that supervision, PCP updates, behavioral monitoring, and safety procedures are consistently implemented, reviewed, and updated as needed to maintain client safety and prevent future incidents.	**All items associated with V290 have been confirmed completed on 1/29/2025**

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V 290	Continued From page 18 Mild; Schizoaffective Disorder Bipolar Type; Cannabis Use Disorder; Stimulant Use Disorder, Amphetamine Type; and Thrombocytopenia. -Seven elopements from the facility on the following dates: 4/26/25, 6/25/25, 9/21/25, 10/12/25, 10/20/25, 11/22/25, and 12/14/25. Review on 12/23/25 of the facility incident reports for Client #3 revealed: -Elopements from the facility on the following dates: 4/26/25, 6/25/25, 9/21/25, 10/12/25, 10/20/25, 11/22/25, and 12/14/25. -One incident, dated 10/20/25, Client #3 left the facility at an unidentified time in the middle of the night. -Client #3 eloped to a neighboring county at least 20 miles away from the facility on at least 3 of the 7 elopement dates. -Local law enforcement had been called each time Client #3 eloped from the facility. Observations on 12/23/25 at approximately 8:35 am and 1/5/26 at approximately 11 am of the surrounding area near the facility revealed: -The facility was located approximately 2 miles off of a 5-lane highway (2 lanes of traffic for each direction separated by a shared a middle turn lane). -The posted speed limit was 45 miles per hour (mph). -This 5-lane highway was located approximately 0.25 miles from a 4-way stop light intersection with another 5-lane highway. -Turning left at that intersection toward the neighboring county where Client #3 eloped to, that 5-lane highway initially had a concrete median for about 0.5 miles with a posted 45 mph speed limit. -After approximately 0.5 miles, the speed limit increased to 50 mph and the median became a	V 290	**Issue Noted#5 Continued** **Timetable for Correction:** The facility continued the use of HRC approved alarms on all common area doors, the client's bedroom door, and the window. By 12/31/2025, alarms were installed on all remaining facility windows, and 15-minute check-in logs were created and implemented on 12/31/25 for DSPs to document while the client is at home and awake. On 1/2/2026, an outdoor camera was installed to support visual monitoring during scheduled smoking times. A team meeting with the LRP, Care Manager, Residential Coordinator, RM, and SRM was held on 1/7/2026 to review short range goals and determine necessary updates to the PCP, and all updates including new goals to address elopement and intervention strategies. These PCP updates were implemented on 1/9/2026. **Root Cause:** The Facility failed to maintain staffing to respond to meet the individualized client needs of 1 of 3 audited clients (Client #3). **Disciplinary Action:** Coaching was provided by the Residential Coordinator to Staff#1 on 1/1/2026 and House Manager on 12/31/2025 to ensure they fully understand and consistently implement required safety procedures. This coaching included instruction on what to do if an alarm goes off, including the immediate safety steps and staff response expectations. Staff were also coached on how to redirect the client in accordance with the Crisis Plan, which was reviewed during the team meeting held on 1/7/2026. Guidance was provided on when to contact police, following the directive that law enforcement should only be contacted if the client refuses redirection and is out of staff's sight. Immediate reporting expectations were reinforced. DSPs must notify their supervisor as soon as an elopement occurs, the supervisor will notify the QP, and after 30 minutes the Residential Coordinator will notify the LRP, RM, and SRM. This coaching ensures that all staff are aligned with safety procedures, escalation protocols, and the expectations for timely communication during any elopement related event.	

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V 290	Continued From page 19 grassy median but still remained a 4-lane highway. -The neighboring county/city where Client #3 went when she eloped was located at least 20 miles away. Interviews on 12/23/25 and 1/5/26 with Client #3 revealed: -Only one staff member worked in the facility at a time. -"I left (the facility) a few times...because I wanted to go see my friend (ex-boyfriend)...I used to live with him..." -"They (facility staff) caught me the first time (tried to elope) and brought me back. The second time I left through the kitchen door and went around (back of the house). -"I left 6 times." -Walked halfway to the neighboring county and ask for rides from strangers. "...find someone to give me a ride." -"I stayed with him (ex-boyfriend) the whole night (one incident of elopement on 12/14/25)..." -"I would go to [city in neighboring county] and go see [ex-boyfriend]..." Interview on 12/29/25 with Staff #1 revealed: -Worked in the facility by herself. -"Doing the best I can with that (working alone in the facility)...would it be easier if someone else? Yes. But that isn't how it works...there is no funding to have someone else (working) in the house (group home)..." -"I am always doing my best to check on her (Client #3)." Interview on 12/29/25 with the House Manager revealed: -Only one staff working at a time and staff sleep at night.	V 290		

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V 290	Continued From page 20 -Client #3 did not have unsupervised time in the community. -Left Client #3 alone at the hospital after she had been admitted. -Worked in the facility alone on her shift. -"We are trying to do the best we can (to prevent elopements)..." Interview on 12/23/25 with the Qualified Professional (QP) revealed: -Staff "try to keep eyes on as much as possible...hard to do with 1 staff and 5 clients." Interview on 12/23/25 with the Residential Coordinator revealed: -"Not our license typeThere really is no one that could be available to sit up all night with her (Client #3). I just don't really know how that would go. We are not set up for that and don't have the funding...but to have that extra staff, so many dynamics to it." -Staff in the facility sleep at night as they are not 24 hour awake staff. Interview on 1/5/26 with the Regional Manager revealed: -"At night, staff do sleep. They are not awake all night with clients..." -"One of the times she (Client#3) left really early in the morning..." -"If she (Client #3) walks out...we can't follow. We have other clients. We would have to put them in the van to follow her." This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 290		

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V 366	Continued From page 21	V 366		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond	V 366		

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V 366	Continued From page 22 by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not	V 366		

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V 366	Continued From page 23 available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement policies governing their response to level II incidents. Review on 12/23/25 of Client #3's record revealed: -Admit: 3/17/25. -Diagnoses: Intellectual Developmental Disability, Mild; Schizoaffective Disorder Bipolar Type; Cannabis Use Disorder; Stimulant Use Disorder, Amphetamine Type; and Thrombocytopenia. Reviews on 12/22/25 and 12/23/25 of the North Carolina Incident Response Improvement System (IRIS) revealed:	V 366	**Issues noted: #6 (V366)27G .0603 Incident Response Requirements: The Facility failed to develop and implement policies governing their response to level II incidents.** **Correction Action:** The company does have established written policies governing the reporting, documentation, and follow-up of Level I, Level II, and Level III incidents. These policies were in place at the time of review; however, we acknowledge that staff adherence to Level II documentation and procedural expectations did not occur consistently. The Regional Manager conducted targeted coaching with both the Residential Coordinator and the Qualified Professional (QP) regarding: proper incident categorization, required documentation steps, the importance of maintaining complete and auditable records in the OTC system. Verbal coaching occurred immediately following the most recent incident, however, formal documented coaching occurred on 1/29/2026. This coaching was documented on 1/29/2026, with evidence retained in supervisory notes and uploaded accordingly. Although team meetings and routine staff discussions had been occurring regularly, we recognize that formal minutes and documentation were not consistently maintained. As part of corrective action: All team meetings, treatment related discussions, and incident related reviews will now be formally documented. Meeting minutes and training records will be uploaded into OTC for verification and audit readiness. A quarterly audit process has been ongoing and will continue to ensure ongoing compliance. A revision to the Person-Centered Plan (PCP) was completed and implemented effective 1/9/2026 for Client #3, and new goals and support strategies were implemented to address the client's identified needs. These goals include demonstrating the appropriate response when an alarm sounds, remaining in designated safe areas during smoking breaks, using coping strategies when experiencing anxiety or urges to leave the home, and consistently applying elopement prevention strategies. In addition to these newly added goals, Abound Health implemented structured Safety Strategies for Daily Check-Ins to reinforce consistent support and promote client safety. These strategies include reviewing house rules and boundaries, reinforcing alarm awareness and the required response when an alarm sounds, identifying designated safe outdoor areas, encouraging appropriate self advocacy statements, reviewing coping skills, role playing scenarios related to anxiety or urges to leave, providing positive reinforcement for safe decision making, and using visual supports such as a "Stay Safe" card to assist with quick reminders during daily check-ins. A Q-note for coordination of care was completed on 1/26/2026 to document all internal and team meetings held regarding the client, including discussions of the strategies and safety measures implemented, and these Q-notes have been entered into the client's electronic medical record. Enhanced supervision was initiated, and staff began completing documented 15-minute check-ins, with daily logs maintained and uploaded into the client's electronic medical record. A PCP revision was completed and implemented effective 1/9/2026, that included new goals focused on intervention and prevention of elopement, and this updated plan has been uploaded into the client's electronic medical record. In addition, the client's quarterly progress summaries are completed and uploaded to ensure ongoing documentation of progress and support needs.	**All items associated with V366 have been confirmed completed on 1/29/2025**

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V 366	Continued From page 24 -4/26/25; Client #3 left the facility at 4:55pm. Local law enforcement was called. Client #3 was located and returned to the facility at 5:46 pm. -5/17/25; Client #3 was experiencing hallucinations at 9:38 am. Client #3 called 911. "[Client #3] was experiencing hallucinations and called 911 using to report that there were people in room, messing up her room and her belongings, were shooting her phone and at her and were going to shave her head. She also walked through the group home and stated that she saw people smoking meth with a pipe." Local law enforcement was dispatched. -6/25/25; Client #3 was outside smoking while staff was inside the facility with the other clients. After about 10 minutes, staff went to check on Client #3 and the back gate was open. Local law enforcement was called. Client #3 was located at a nearby school. -9/21/25; Client #3 left the facility without notifying staff and was found less than 3 hours after being reported missing to local law enforcement. There was no time indicated of the elopement. -10/12/25; Client #3 left the facility at 4:03 pm. Local law enforcement was called. Client #3 was found at 4:30pm. -10/20/25; Client #3 was discovered missing from the facility at 6:30am. Local law enforcement was called. Client #3 was found in a neighboring county at 1 pm. Local law enforcement estimated her elopement to be about 4am-5am per K9 search. -11/22/25; Client #3 left the facility at 7:20pm. Local law enforcement was called. Client #3 was located and returned to the facility at 9:45 pm. Client #3 reported that she went to a city in the neighboring county. -12/14/25; Client #3 left the facility at 5:45pm. Local law enforcement was called. Client #3 was located the next day at 6:58am in a neighboring	V 366	**Issue note #6 Continued.** **Preventative Measures:** To prevent recurrence of this deficiency, the client's Person-Centered Plan (PCP) will be updated any time the client's needs change or when the level of support required changes. As part of this process, the QP will develop and implement treatment goals and support strategies that directly address the client's updated needs, and all staff who support the client will receive client specific training to ensure consistent understanding and implementation of the revised goals and strategies. To further prevent recurrence, notes will be taken during all internal and team meetings and used to complete a Q-note that documents the purpose of the meeting, any changes that need to be made, and any additional outcomes. Q-notes will also be completed whenever an incident occurs that requires changes or updates to the client's support needs, including the specific measures and interventions that must be implemented. Staff will continue conducting 15-minute check-ins with the client and will document these on their logs, which will be reviewed and uploaded into the client's electronic record. When an annual PCP update or revision is required, the QP will complete the revision and upload the signed plan into the client's medical record. The QP will also complete quarterly progress summaries, and these will be uploaded into the client's record to ensure ongoing documentation of goal progression and support needs. **Audit Feedback Loop/Quality Assurance:** To ensure ongoing compliance, the QP will review each client's status during quarterly supervisory checks to determine whether the client's needs or level of support have changed and whether updates to the PCP are required. The QP will also utilize quarterly progress summaries to assess goal progression, support needs, and any emerging behavioral or clinical changes that may require revisions to the PCP. When changes are identified, the QP will make the necessary updates and ensure new treatment goals and support strategies are developed and implemented. All staff who support the client will be informed of these updates through client specific training to ensure consistent understanding and implementation of revised goals and strategies. The QP will also complete quarterly face-to-face supervisions with the client and staff to verify that staff understand and are consistently applying the updated expectations, safety procedures, and client specific strategies. In addition, the QP will take detailed notes during all internal and team meetings and use these notes to complete Q- notes that document the meeting purpose, identified changes, and outcomes. Q-notes will also be completed any time an incident occurs that requires updates to the client's support needs. Staff will continue completing 15-minute check-in logs while the client is at home and awake. As part of the monitoring structure, the Residential Coordinator will collect signed logs daily on weekdays, the Group Home Manager will submit logs daily (with weekend logs submitted Monday mornings), and the Regional Manager will complete a weekly review of all logs to ensure accuracy and completion. The QP will review these logs for compliance and upload them into the client's electronic record. The QP will also complete and upload PCP revisions and annual updates whenever the client's needs or level of support change, and quarterly progress summaries will be uploaded to ensure ongoing evaluation of goal progression, intervention effectiveness, and alignment of supports with the client's needs.	

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V 366	Continued From page 25 county by the law enforcement agency of that county. -For all incidents submitted, there was no documentation of: -attending to the health and safety needs of individuals involved in the incident; -determining the cause of the incident; -developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; -developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; or -assigning person(s) to be responsible for implementation of the corrections and preventive measures. Review on 12/23/25 of the facility's incident reports revealed: -No other documentation related to incidents outside of the IRIS reports. Interview on 12/23/25 with the Vice President of Clinical Compliance for North Carolina revealed: -"Incident reports are not to be shared but we can give a summary of incident reports." -Could provide a better summary of the incidents if needed. -"[The Residential Coordinator] can print them out for you to view." Interviews on 12/23/25 and 12/29/25 with Residential Coordinator revealed: -"Was involved in every single one of these (incidents being put into IRIS)." -There had been no documentation of the meetings related to the incidents. -"There was no other documentation (outside of what was documented in IRIS)." -There had been discussion about the incidents	V 366	**Issue Noted #6 Continued.** **Timetable for Correction:** A revision to the Person-Centered Plan (PCP) was completed and implemented effective 1/9/2026 for Client #3, and new goals and support strategies were implemented to address the client's identified needs. These goals include demonstrating the appropriate response when an alarm sounds, remaining in designated safe areas during smoking breaks, using coping strategies when experiencing anxiety or urges to leave the home, and consistently applying elopement prevention strategies. In addition, Abound Health implemented structured Safety Strategies for Daily Check-Ins including reviewing house rules and boundaries, reinforcing alarm awareness, identifying designated safe outdoor areas, encouraging self advocacy, reviewing coping skills, role playing scenarios, providing positive reinforcement, and using visual supports such as the "Stay Safe" card and this was confirmed completed by 1/9/2026. A Q-note for coordination of care was completed on 1/26/26 to document all internal and team meetings regarding the client, including discussions of strategies and safety measures, and these notes were entered into the client's electronic medical record. Enhanced supervision was initiated on 12/31/2025, with DSPs completing documented 15-minute check-ins, and daily logs continue to be maintained and uploaded into the client's electronic medical record. A PCP revision that included new goals focused on intervention and prevention of elopement was completed and implemented effective 1/9/2026 and uploaded to the client's electronic medical record, and the client's quarterly progress summaries were also uploaded. **Root Cause:** The Facility failed to develop and implement policies governing their response to level II incidents. There was no documentation to show follow through to responses on level II incidents regarding any additional supervision, strategies, etc. **Disciplinary Action:** A coaching session was completed with the QP on 1/29/26 to reinforce expectations related to Person-Centered Plan (PCP) management, documentation, and clinical oversight. This coaching focused on ensuring that the client's PCP is updated any time the client's needs change or when the level of support required changes, and will emphasize the QP's responsibility to develop and implement treatment goals and support strategies that directly address the client's needs and accurately reflect any updates to their required supports. The coaching also addressed the requirement to take detailed notes during all internal and team meetings and to document those notes as Q-notes in the client's chart, including the purpose of the meeting, changes discussed, and updates that need to be made. Additionally, the coaching covered the expectation that Q-notes must be completed at the time of an annual plan update, whenever revisions to the PCP are required, or when a client experiences issues outside of their typical daily routine or demonstrates increased health or safety concerns. Finally, the coaching reinforced the QP's responsibility to promptly update PCPs by adding or revising goals and strategies to reflect any changes in the client's support needs. This coaching is intended to strengthen the QP's understanding of timely PCP revisions, accurate documentation practices, alignment of goals with current client needs, and consistent implementation of effective support strategies across the team.	

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V 366	Continued From page 26 and prevention, "...For my part, didn't think about notes (of the meetings)." Interviews on 12/29/25 and 1/5/26 with Regional Manager revealed: -There was a place in their electronic medical record where staff could document information outside of the IRIS reports. -"We should have been doing that (documentation)." -"Each time we (staff) meet, we should be documenting." -"I will ensure we have that (documentation) moving forward." -"...don't have documentation but our group homes (facilities) have monthly meetings...we don't have documentation, that is where it lacks..."	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:	V 367		

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V 367	Continued From page 27 (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that 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	V 367		

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V 367	Continued From page 28 .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 incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report level II incidents appropriately. The findings are: Review on 12/23/25 of Client #3's record revealed: -Admit: 3/17/25. -Diagnoses: Intellectual Developmental Disability, Mild; Schizoaffective Disorder Bipolar Type;	V 367	**Issues noted: #7(V367)27G .0604 Incident Reporting Requirements: The Facility failed to report level II incidents appropriately.** **Correction Action:** A Level II incident involving Client #3 was reported timely through IRIS by the Qualified Professional, and the incident report was reviewed and approved by the supervising manager as required. However, we acknowledge that additional internal documentation reflecting follow-up actions, post incident monitoring, and team communication was not maintained electronically within our internal record system. To address this lapse, the following steps have been taken: Coaching was completed on 1/29/26 with the Qualified Professional and supervising manager to reinforce expectations for maintaining comprehensive internal follow-up documentation in addition to timely IRIS reporting. Coaching was conducted by [redacted] Regional Manager and documentation of this coaching is on file. Staff were re-educated on requirements for: Recording follow-up actions, documenting supervisory review, uploading all incident related materials into the electronic system (OTC). A revision to the Person-Centered Plan (PCP) was completed for Client #3, and new goals and support strategies were implemented on 1/9/2026 to address the client's identified needs. These goals include demonstrating the appropriate response when an alarm sounds, remaining in designated safe areas during smoking breaks, using coping strategies when experiencing anxiety or urges to leave the home, and consistently applying elopement prevention strategies. In addition to these newly added goals, Abound Health implemented structured Safety Strategies for Daily Check-Ins to reinforce consistent support and promote client safety. These strategies include reviewing house rules and boundaries, reinforcing alarm awareness and the required response when an alarm sounds, identifying designated safe outdoor areas, encouraging appropriate self advocacy statements, reviewing coping skills, role playing scenarios related to anxiety or urges to leave, providing positive reinforcement for safe decision making, and using visual supports such as a "Stay Safe" card to assist with quick reminders during daily check-ins. A Q-note for coordination of care was completed on 1/26/2026 to document all internal and team meetings held regarding the client, including discussions of the strategies and safety measures implemented, and these Q-notes have been entered into the client's electronic medical record. Enhanced supervision was initiated on 12/31/2025, and staff began completing documented 15-minute check-ins, with daily logs maintained and uploaded into the client's electronic medical record. A PCP revision was completed that included new goals focused on intervention and prevention of elopement, and this updated plan has been uploaded into the client's electronic medical record. In addition, the client's quarterly progress summaries are completed and uploaded to ensure ongoing documentation of progress and support needs. **Preventative Measures:** To prevent recurrence of this deficiency, the client's Person-Centered Plan (PCP) will be updated any time the client's needs change or when the level of support required changes. As part of this process, the QP will develop and implement treatment goals and support strategies that directly address the client's updated needs, and all staff who support the client will receive client specific training to ensure consistent understanding and implementation of the revised goals and strategies. To further prevent recurrence, notes will be taken during all internal and team meetings and used to complete a Q-note that documents the purpose of the meeting, any changes that need to be made, and any additional outcomes. Q-notes will also be completed whenever an incident occurs that requires changes or updates to the client's support needs, including the specific measures and interventions that must be implemented. Staff will continue conducting 15-minute check-ins with the client and will document these on their logs, which will be reviewed and uploaded into the client's electronic record. When an annual PCP update or revision is required, the QP will complete the revision and upload the signed plan into the client's medical record. The QP will also complete quarterly progress summaries, and these will be uploaded into the client's record to ensure ongoing documentation of goal progression and support needs.	**All items associated with V367 have been confirmed completed on 1/29/2025**

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V 367	Continued From page 29 Cannabis Use Disorder; Stimulant Use Disorder, Amphetamine Type; and Thrombocytopenia. Review on 12/22/25 and 12/23/25 of the North Carolina Incident Response Improvement System (IRIS) revealed: -4/26/25; Client #3 left the facility at 4:55pm. Local law enforcement was called. Client #3 was located and returned to the facility at 5:46 pm. -5/17/25; Client #3 was experiencing hallucinations at 9:38 am. Client #3 called 911. "[Client #3] was experiencing hallucinations and called 911 using to report that there were people in room, messing up her room and her belongings, were shooting her phone and at her and were going to shave her head. She also walked through the group home and stated that she saw people smoking meth with a pipe." Local law enforcement was dispatched. -6/25/25; Client #3 was outside smoking while staff was inside the facility with the other clients. After about 10 minutes, staff went to check on Client #3 and the back gate was open. Local law enforcement was called. Client #3 was located at a nearby school. -9/21/25; Client #3 left the facility without notifying staff and was found less than 3 hours after being reported missing to local law enforcement. There was no time indicated of the elopement. -10/12/25; Client #3 left the facility at 4:03 pm. Local law enforcement was called. Client #3 was found at 4:30pm. -10/20/25; Client #3 was discovered missing from the facility at 6:30am. Local law enforcement was called. Client #3 was found in a neighboring county at 1 pm. Local law enforcement estimated her elopement to be about 4am-5am per K9 search. -11/22/25; Client #3 left the facility at 7:20pm. Local law enforcement was called. Client #3 was	V 367	**Issue note #7 Continued.** **Audit Feedback Loop/Quality Assurance:** To ensure ongoing compliance, the QP will review each client's status during quarterly supervisory checks to determine whether the client's needs or level of support have changed and whether updates to the PCP are required. The QP will also utilize quarterly progress summaries to assess goal progression, support needs, and any emerging behavioral or clinical changes that may require revisions to the PCP. When changes are identified, the QP will make the necessary updates and ensure new treatment goals and support strategies are developed and implemented. All staff who support the client will be informed of these updates through client specific training to ensure consistent understanding and implementation of revised goals and strategies. The QP will also complete quarterly face-to-face supervisions with the client and staff to verify that staff understand and are consistently applying the updated expectations, safety procedures, and client specific strategies. In addition, the QP will take detailed notes during all internal and team meetings and use these notes to complete Q-notes that document the meeting purpose, identified changes, and outcomes. Q-notes will also be completed any time an incident occurs that requires updates to the client's support needs. Staff will continue completing 15-minute check-in logs while the client is at home and awake. As part of the monitoring structure, the Residential Coordinator will collect signed logs daily on weekdays, the Group Home Manager will submit logs daily (with weekend logs submitted Monday mornings), and the Regional Manager will complete a weekly review of all logs to ensure accuracy and completion. The QP will review these logs for compliance and upload them into the client's electronic record. The QP will also complete and upload PCP revisions and annual updates whenever the client's needs or level of support change, and quarterly progress summaries will be uploaded to ensure ongoing evaluation of goal progression, intervention effectiveness, and alignment of supports with the client's needs. **Timetable for Correction:** A revision to the Person-Centered Plan (PCP) was completed and implemented effective 1/9/2026 for Client #3, and new goals and support strategies were implemented to address the client's identified needs. These goals include demonstrating the appropriate response when an alarm sounds, remaining in designated safe areas during smoking breaks, using coping strategies when experiencing anxiety or urges to leave the home, and consistently applying elopement prevention strategies. Updated PCP has uploaded to the client's electronic medical record in OTC. The client's quarterly progress summaries are also uploaded to the client's record in OTC. I n addition, Abound Health implemented structured Safety Strategies for Daily Check-Ins including reviewing house rules and boundaries, reinforcing alarm awareness, identifying designated safe outdoor areas, encouraging self advocacy, reviewing coping skills, role playing scenarios, providing positive reinforcement, and using visual supports such as the "Stay Safe" card and this was confirmed completed by 1/9/2026. A Q-note for coordination of care was completed on 1/26/26 to document all internal and team meetings regarding the client, including discussions of strategies and safety measures, and these notes were entered into the client's electronic medical record. Enhanced supervision was initiated, with DSPs completing documented 15-minute visual check-ins, and daily logs continue to be maintained and uploaded into the client's electronic medical record.	

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V 367	Continued From page 30 located and returned to the facility at 9:45 pm. Client #3 reported that she went to a city in the neighboring county. -12/14/25; Client #3 left the facility at 5:45pm. Local law enforcement was called. Client #3 was located the next day at 6:58am in a neighboring county by the law enforcement agency of that county. -For the incidents submitted, there was no documentation of: -status of the effort to determine the cause of the incident; and -other individuals or authorities notified or responding. Review on 12/23/25 of the facility's incident reports revealed: -No other documentation related to incidents outside of the IRIS reports. Interviews on 12/23/25 and 12/29/25 with Residential Coordinator revealed: -"There was no other documentation (outside of what was documented in IRIS)." -There had been discussion about the incidents and prevention, "...For my part, didn't think about notes (of the meetings)." Interviews on 12/29/25 and 1/5/26 with Regional Manager revealed: -Understood the follow up to the IRIS reporting to determine the cause of incidents. -"...don't have documentation but our group homes (facilities) have monthly meetings...we don't have documentation, that is where it lacks..."	V 367	**Issue Noted #7 Continued.** **Root Cause:** The Facility failed to report level II incidents appropriately. There was no supporting documentation showing efforts to determined the cause of incident, no documentation of notes, or meeting that were held and no documentation related to the incidents outside of the IRIS reports, **Disciplinary Action:** Coaching was completed on 1/29/26 with the Qualified Professional and supervising manager to reinforce expectations for maintaining comprehensive internal follow-up documentation in addition to timely IRIS reporting. Coaching was conducted by Ashley [redacted], Regional Manager and documentation of this coaching is on file. Staff were re-educated on requirements for: Recording follow-up actions, documenting supervisory review, uploading all incident related materials into the electronic system (OTC). Coaching session was completed on 1/29/26 with the QP to reinforce expectations related to Person-Centered Plan (PCP) management, documentation, and clinical oversight. The coaching focused on ensuring that the client's PCP is updated any time the client's needs change or when the level of support required changes, and will emphasize the QP's responsibility to develop and implement treatment goals and support strategies that directly address the client's needs and accurately reflect any updates to their required supports. The coaching also address the requirement to take detailed notes during all internal and team meetings and to document those notes as Q-notes in the client's chart, including the purpose of the meeting, changes discussed, and updates that need to be made. Additionally, the coaching covered the expectation that Q-notes must be completed at the time of an annual plan update, whenever revisions to the PCP are required, or when a client experiences issues outside of their typical daily routine or demonstrates increased health or safety concerns. Finally, the coaching reinforced the QP's responsibility to promptly update PCPs by adding or revising goals and strategies to reflect any changes in the client's support needs. This coaching is intended to strengthen the QP's understanding of timely PCP revisions, accurate documentation practices, alignment of goals with current client needs, and consistent implementation of effective support strategies across the team.	