

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-471</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/08/2026</b>
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NAME OF PROVIDER OR SUPPLIER  <b>EASTER SEALS UCP NC RALEIGH GROUP HC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1529 BEN LLOYD DRIVE RALEIGH, NC 27604</b>
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V 000	<p><b>INITIAL COMMENTS</b></p> <p>An annual and complaint survey was completed on 4/8/26. The complaint was substantiated (intake #NC00236470). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.</p> <p>This facility is licensed for 6 and has a current census of 6. The survey sample consisted of audits of 3 current clients.</p>	V 000		
V 318	<p><b>130 .0102 HCPR - 24 Hour Reporting</b></p> <p>10A NCAC 130 .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g).</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report an allegation of abuse to the Health Care Personnel Registry (HCPR) within 24 hours for 1 of 1 audited former staff (FS #4). The</p>	V 318		

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

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V 318	<p>Continued From page 1</p> <p>findings are:</p> <p>Review on 3/19/26 of the Incident Response Improvement System (IRIS) revealed:</p> <ul style="list-style-type: none"> <li>- A level II incident report submitted on 12/22/25 for an allegation of abuse for FS #4 against client #1</li> <li>- The incident of abuse occurred on 12/19/25 and facility management became aware of it on 12/19/25</li> <li>- HCPR was notified on 12/22/25</li> <li>- FS #4 was terminated on 12/23/25</li> </ul> <p>Review on of FS #4's record revealed:</p> <ul style="list-style-type: none"> <li>- Date of Hire: 5/19/23</li> <li>- Date of Administrative Leave: 12/19/25</li> <li>- Termination Date: 12/23/25</li> </ul> <p>Interview on 3/23/26 with a representative for the Health Care Personnel Investigation reported:</p> <ul style="list-style-type: none"> <li>- The HCPR received an allegation of abuse report for FS #4 on 12/22/25</li> </ul> <p>Interview on 3/19/26 the Group Home Manager/Qualified Professional (GHM/QP) reported:</p> <ul style="list-style-type: none"> <li>- She submitted the IRIS report for the allegation of abuse on 12/19/25</li> <li>- She was responsible for submitting reports to HCPR</li> <li>- She submitted the HCPR for FS #4 on 12/22/25 via the IRIS report</li> </ul> <p>Interview on 3/19/26 the Regional Manager reported:</p> <ul style="list-style-type: none"> <li>- He was notified of the allegation of abuse for FS #4 on 12/19/25</li> <li>- The 5 day HCPR report should have been completed but he would have to check on the 24 hour report</li> </ul>	V 318		

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V 318	Continued From page 2  - The GHM/QP was responsible for HCPR reports  Interview on 3/27/26 Quality Assurance Manager reported: - She received an email from the GHM/QP about the allegation of abuse for FS #4 on 12/19/25 - FS #4 was suspended immediately and internal investigation was started - Would have to check IRIS report to see when HCPR was notified - HCPR was notified of the result of the internal investigation on 12/23/25 - The GHM/QP was responsible for all reporting	V 318		
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: (1) reporting provider contact and identification information;	V 367		

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V 367	<p>Continued From page 3</p> <p>(2) client identification information;</p> <p>(3) type of incident;</p> <p>(4) description of incident;</p> <p>(5) status of the effort to determine the cause of the incident; and</p> <p>(6) other individuals or authorities notified or responding.</p> <p>(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:</p> <p>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or</p> <p>(2) the provider obtains information required on the incident form that was previously unavailable.</p> <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <p>(1) hospital records including confidential information;</p> <p>(2) reports by other authorities; and</p> <p>(3) the provider's response to the incident.</p> <p>(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).</p> <p>(e) Category A and B providers shall send a</p>	V 367		

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V 367	<p>Continued From page 4</p> <p>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:</p> <ol style="list-style-type: none"> <li>(1) medication errors that do not meet the definition of a level II or level III incident;</li> <li>(2) restrictive interventions that do not meet the definition of a level II or level III incident;</li> <li>(3) searches of a client or his living area;</li> <li>(4) seizures of client property or property in the possession of a client;</li> <li>(5) the total number of level II and level III incidents that occurred; and</li> <li>(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.</li> </ol> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to notify the Local Management Entity (LME)/Managed Care Organization (MCO) responsible for the catchment area where services were provided of level II incidents within the required time frames. The findings are:</p> <p>Review on 3/19/26 of the Incident Response Improvement System (IRIS) revealed: - A level II incident report submitted on 12/22/25:</p>	V 367		

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V 367	<p>Continued From page 5</p> <ul style="list-style-type: none"> <li>- Incident was an allegation of abuse for former staff (FS #4) against client #1</li> <li>- The incident of abuse occurred on 12/19/25 and facility management became aware of it on 12/19/25</li> <li>- The LME/MCO was notified on 12/22/25</li> <li>- A level II incident reported submitted on 3/13/26: <ul style="list-style-type: none"> <li>- Incident was a fall for client #1 that resulted in a brain hemorrhage and required emergency surgery</li> <li>- The fall occurred on 3/6/26 and facility management became aware of it on 3/6/26</li> </ul> </li> </ul> <p>Interview on 3/19/26 the Group Home Manager/Qualified Professional (GHM/QP) reported:</p> <ul style="list-style-type: none"> <li>- She was responsible for submitting IRIS reports</li> <li>- She submitted the 12/22/25 IRIS report for the allegation of abuse that occurred on 12/19/25</li> <li>- She thought it was required to be submitted within 72 hours and did not know an abuse allegation was supposed to be submitted at the time of the allegation being discovered</li> <li>- She submitted the IRIS for the fall on 3/6/26 on 3/6/26</li> <li>- She was not sure why the IRIS system showed that it was submitted on 3/13/26</li> </ul> <p>Interview on 3/19/26 the Regional Manager reported:</p> <ul style="list-style-type: none"> <li>- The GHM/QP was responsible for IRIS reports</li> <li>- He was notified of the allegation of abuse for FS #4 on 12/19/25 and thought that IRIS was submitted on time</li> <li>- The QHM/QP told him that she had not originally been able to submit the report for the fall on 3/6/26 because the IRIS system was</li> </ul>	V 367		

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V 367	Continued From page 6  down, but he thought it had still been submitted on time  Interview on 3/27/26 Quality Assurance Manager reported: - The GHM/QP was responsible for all reporting - She received an email from the GHM/QP about the allegation of abuse for FS #4 on 12/19/25 - The GHM/QP notified her on 3/6/26 of client #1's fall and surgery - The GHM/QP was responsible for timely submission of those IRIS reports	V 367		