

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL100-023	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 04/08/2026
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NAME OF PROVIDER OR SUPPLIER CALLOWAY COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 35 CELO STREET BURNSVILLE, NC 28714
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V 000	<p>INITIAL COMMENTS</p> <p>A complaint and limited follow up survey was completed on 4/8/26. This was a limited follow up survey, only 10A NCAC 27G .5601 Scope (V289), 10A NCAC 27G .0202 Personnel Requirements (V108), 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109), 10A NCAC 27G .0205 Assessment and Treatment/Habilitation Plan (V112), 10A NCAC 27G .0208 Client Services (V115), 10A NCAC 27G .5602 Staff (V290), 10A NCAC 27F .0103 Client Rights Health, Hygiene, Grooming (V540) were reviewed for compliance. The following were brought back into compliance: 10A NCAC 27G .0202 Personnel Requirements (V108), 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109), 10A NCAC 27G .0205 Assessment and Treatment/Habilitation Plan (V112), 10A NCAC 27G .0208 Client Services (V115), 10A NCAC 27F .0103 Client Rights-Health, Hygiene, Grooming (V540). Three complaints were substantiated (#NC00236203, #NC00236408, #NC00236427). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p> <p>The facility is licensed for 5 and has a current census of 4. The survey sample consisted of audits of 4 current clients.</p>	V 000		
V 132	<p>G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection</p> <p>G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the</p>	V 132		

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

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V 132	<p>Continued From page 1</p> <p>Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes:</p> <ul style="list-style-type: none"> a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). <p>Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the Health Care Personnel Registry (HCPR) was notified of all allegations of abuse against health care personnel and failed to protect the clients during an investigation. The findings are:</p> <p>Review on 3/23/26 of facility's internal investigation dated 3/9/26 and signed by the</p>	V 132		

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V 132	<p>Continued From page 2</p> <p>Regional Operations Manager (ROM) revealed: - "...Allegations: the reporter (anonymous) stated on March 1, 2026, he/she witnessed [Staff #1], direct support staff, verbally abuse [Client #4]. The caller stated [Staff #1] called [Client #4] an 'idiot' twice because she (Client #4) was picking at a sore on her (Client #4) foot. The caller stated no other forms of abuse occurred ...The caller stated he/she has never witnessed [Staff #1] behave this way before and he/she believes she experienced a 'momentary lapse in judgement' ..."</p> <p>- "Conclusions: Based on the above facts the accusation of [Staff #1] being verbally abusive towards [Client #4] is unsubstantiated."</p> <p>Review on 3/23/26 of the North Carolina Incident Response Improvement System (IRIS) revealed: - There was no IRIS report that alleged Staff #1 verbally abused Client #4 on 3/1/26 which would have included a report to the Health Care Personnel Registry (HCPR).</p> <p>Review on 4/2/26 of Staff #1's timesheets from 3/1/26-3/9/26 revealed: - 3/1/26: 6:31am-4:35pm - 3/3/26: 6:48am-3:30pm - 3/4/26: 6:50am-3:45pm - 3/5/26: 6:56am-3:38pm - 3/6/26: 6:51am-3:11pm</p> <p>Interview on 3/27/26 with Staff #1 revealed: - Did not call Client #4 an idiot. - "Never called any of these guys an idiot or stupid." - Had not been suspended nor received any disciplinary action regarding the allegation she verbally abused Client #4.</p> <p>Interview on 4/2/26 with Staff #2 revealed:</p>	V 132		

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V 132	<p>Continued From page 3</p> <p>-Primarily worked together with Staff #1, "she's my normal partner." -"...thought he heard [Staff #1] call [Client #4] and idiot..." -"...never heard [Staff #1] call a client names since then..."</p> <p>Interview on 4/2/26 with the former Qualified Professional (QP) revealed: -"I'm responsible for doing an investigation." -"I contacted my administrator [Regional Operations Manager (ROM)] to ask what to do I was told to do the investigation ... interview staff ...I did not interview [Client #4] because she would say yes to whatever I asked." -Was not aware of allegation reporting requirements. -"Didn't know [Staff #1] needed to be off the schedule."</p> <p>Interview on 4/2/26 with the ROM revealed: -"QP should have reported in IRIS." -"I didn't follow up to see that IRIS (including HCPR) was completed."</p>	V 132		
V 289	<p>27G .5601 Supervised Living - Scope</p> <p>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</p>	V 289		

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V 289	<p>Continued From page 4</p> <p>(2) two or more adult clients. Minor and adult clients shall not reside in the same facility.</p> <p>(c) Each supervised living facility shall be licensed to serve a specific population as designated below:</p> <p>(1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses;</p> <p>(2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses;</p> <p>(3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses;</p> <p>(4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses;</p> <p>(5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or</p> <p>(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</p>	V 289		

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V 289	<p>Continued From page 5</p> <p>(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).</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to operate within the scope of their license affecting 4 of 4 clients (#1,#2,#3,#4). The findings are:</p> <p>Cross Reference: 10A NCAC 27G .5602 Staff (V290) Based on record reviews and interviews, the facility failed to maintain staffing to meet the individualized client needs of 4 of 4 audited clients (#1,#2,#3,#4).</p> <p>Review on 3/30/26 of Plan of Protection dated 3/30/26 and signed on 3/30/26 by the Senior Vice President (SVP) of Operations revealed: -" What immediate action will the facility take to ensure the safety of the consumers in your care? The clinical team and supervisory staff will be trained on RHA (Licensee)-established workforce management processes to ensure Operational Workforce Continuity. These processes include standardized scheduling protocols and defined procedures for reviewing, adjusting, and supplementing staffing coverage in the event of an unanticipated reduction in workforce availability. To ensure consistent implementation and</p>	V 289		

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V 289	<p>Continued From page 6</p> <p>oversight of this plan, RHA will conduct ongoing workforce monitoring, including:</p> <ol style="list-style-type: none"> 1. Weekly workforce review meetings to assess scheduled staffing coverage, identified vacancies, availability of relief staff, and the status of recruitment and hiring efforts. These reviews will be documented on the Weekly Workforce Status & Plan document. 2. Formal evaluation of the outcomes of each weekly review to determine whether conditions meet the criteria for activation of the Emergency Operational Workforce Continuity Plan. In the event that a relocation is required, the Clinical and Management teams will utilize the Emergency Operational Workforce Continuity Plan, in collaboration with Executive Leadership. <p>Describe your plans to make sure the above happens.</p> <ol style="list-style-type: none"> 1. The weekly review will be monitored by the VP and Sr. (senior) VP of Operations no later than Friday of each week for a period of one month, then on a routine basis, thereafter. 2. In the event the Emergency Operational Workforce Continuity Plan is implemented, it will be reviewed with the VP and/or Sr. VP of Operations. This review will ensure that all feasible workforce options have been exhausted while maintaining the health, safety, protection of rights, and overall well-being of the people supported." <p>The facility served clients who are diagnosed with Mild and Moderate Intellectual and Developmental Disabilities, Autism Disorder, Cerebral Palsy, Anxiety Disorder, Schizoaffective Disorder, Epilepsy, Attention Deficit Hyperactivity Disorder and including 1 non-ambulatory client. Client #1 had hernia surgery on 3/12/26 and returned to the facility on 3/17/26. One staff was</p> 	V 289		

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V 289	Continued From page 7 required to attend to Client #1's needs while at the same time monitor Clients #2 and #3's sexual inappropriate interactions and monitor Client #2's stealing food and possible choking risk. Additionally, Staff also reported restricting Client #2 and #3's movement by sending them to their respective rooms while assisting Client #1. Furthermore, Staff #2 and #3 reported being unable to transfer Client #1 alone and required calling in an additional staff to assist. There continued to be only 1 direct care staff on 2nd shift from 3pm-11pm for 6 of 29 days (from 2/22/26-3/23/26). On Sunday 3/22/26, the 4 residents at this facility as well as 5 residents at a sister facility were moved to the vocational center from approximately 10am to 7pm due to a lack of staffing. The House Manager and Program Director provided the coverage at the vocational center for 9 hours. This deficiency constitutes a continuing Type A1 rule violation originally cited for serious neglect for failure to correct 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	V 290		

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V 290	<p>Continued From page 8</p> <p>the home or community without supervision for specified periods of time.</p> <p>(c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present:</p> <p>(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</p> <p>(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.</p> <p>(d) In facilities which serve clients whose primary diagnosis is substance abuse dependency:</p> <p>(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</p> <p>(2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain staffing to meet the individualized client needs of 4 of 4 clients (#1,#2,#3,#4). The findings are:</p>	V 290		

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V 290	<p>Continued From page 9</p> <p>Review on 3/23/26 of Client #1's record revealed: -Date of admission: 7/1/15 -Diagnoses: Mild Intellectual Developmental Disability (IDD), Cerebral Palsy, Osteoporosis, Sleep Apnea, Gastroesophageal Reflux Disease, Spasmodic Torticollis, Major Depressive Disorder, Adjustment Disorder, Psychotic Disorder, Quadriplegia. -Review of hospital discharge summary revealed, Client #1 admitted on 3/12/26, "underwent elective robotic assisted laparoscopic paraoesophageal hernia repair with concurrent cholecystectomy (gall bladder removal)." Discharged 3/17/26 on full liquid diet for 1 week slowly moving to pureed foods then soft foods.</p> <p>Review on 3/23/26 of Client #2's record revealed: -Date of admission: 6/9/21 -Diagnoses: Fetal Alcohol Syndrome (FAS), Moderate IDD, Attention Deficit Hyperactivity Disorder (ADHD). -Positive Behavior Support Plan (PBSP) dated 7/16/25 included target behaviors of, engaging in incest with twin brother (Client #3), touching self inappropriately in public..."staff will consistently maintain [Client #2] within their line of sight or within earshot ...especially during transitions or periods of less structured time ..."</p> <p>Review on 3/23/26 of Client #3's record revealed: -Date of admission: 6/9/21 -Diagnoses: FAS, Mild IDD. -PBSP dated 7/16/25 included target behaviors of, engaging in incest with twin brother (Client #2), touching self inappropriately in public, inappropriate behaviors towards children, aggression ..."staff should maintain a line of sight or within earshot proximity to [Client #3] whenever possible particularly during transitions or</p>	V 290		

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V 290	<p>Continued From page 10</p> <p>unstructured time ...Rely heavily on door alarms and other monitoring technology to alert staff if [Client #3] attempts to access other resident's rooms, especially his brother's ..."</p> <p>Review on 3/23/26 of Client #4's record revealed: -Date of admission: 7/1/15 -Diagnoses: Moderate IDD, Tremors, Nightmare Disorder, Pseudobulbar Affect, Anxiety Disorder, Mood Disorder, White Matter Disease, Leukemia in remission, ADHD, Sleep Apnea. -Treatment plan dated 3/17/25 revealed, "White matter disease is progressive ...requiring hand over hand assistance with toileting (wiping), both verbal prompts and hand over hand assistance washing her hair and body ...continuing loss of vision and balance ..."</p> <p>Review on 3/26/26 of incident reports from 2/22/26-3/23/26 revealed: -"On 3/20/26 [Client #2] was assisting carrying in groceries, while peers and staff continued (bringing in groceries), he removed food items and hid them in his closet. When staff went to assist him fold a blanket it was discovered that he had several empty food containers (a box of brownies and large bag of cereal) as well as a new box of soft cookies."</p> <p>Review on 3/26/26 of staffing schedule from 2/22/26 to 3/23/26 revealed: -There was only 1 staff on 2nd shift from 3pm-11pm on: 2/24/26, 2/26/26, 3/3/26, 3/10/26, 3/20/26 and on 3/21/26 from 8pm-11pm.</p> <p>Review on 3/24/26 of all staff in-service training dated 2/11/26 regarding "supervision on person supported in Calloway (facility)" revealed: -" ...Proximity Control, the only moment that staff are not in 'line of sight' or 'within earshot' (of</p>	V 290		

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V 290	<p>Continued From page 11</p> <p>Clients #2, #3) is if the staff are assisting in changing. To make sure that staff are still keeping line of sight and within earshot, staff will be trained in the following steps to make sure that supervision is being given.</p> <p>-One staff working: When getting ready to change [Client #1], staff will explain to [Client #1] that they are going to change her now and make sure that her privacy and safety are their first priority, however that they will have to stop after each step to check on the twins (Clients #2, #3) ..."</p> <p>-Two staff working: Staff will explain to [Client #1] that they are going to change her now, if she is okay with it to have the door cracked until she is lifted onto her bed. Once [Client #1] is on the bed, the second staff will leave the room to check on the twins, while the other gives [Client #1] the care she needs. If the second staff is needed, they will come back in and stop after each step of the changing process to ensure the safety of the twins ..."</p> <p>Interview on 3/24/26 with Client #1 revealed: -Had been in the hospital from 3/12/26-3/17/26 to get a hernia fixed and her gall bladder out. -"This weekend (3/20/26-3/22/26) we just sort of hanged out at the house (facility)...had to come to the voc (vocational) center on Sunday (3/22/26) cause we were out of ratio (at the facility) ...only 1 staff at [sister facility] too." -"We watched cartoon movies and sat outside ...the weather was nice ...had dinner down here (vocational center) ...pizza ...we got back (to the facility) after 7 o'clock then just got ready for bed." -"I would rather stay at home (facility)...we may not like it but we have to do some things we don't want to ...that's life." -"No choice ...there was only 1 staff." -"2 staff have to get me in the bed ...don't</p>	V 290		

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V 290	<p>Continued From page 12</p> <p>remember having to wait for staff to change me ...they're pretty good when I tell them I need to be changed."</p> <p>Interview on 3/24/26 with Client #2 revealed: -On Sunday (3/22/26) "we came to the voc center. We watched a few movies, sat outside at the picnic tables ...staff told us we were short staffed ...I was happy I could see my friends but sad I couldn't watch my tv at home (facility) ...came down (to vocational center) about 10(am) something and at 5 o'clock we had pizza ...stayed till about 7(pm) ..."</p> <p>Interview on 3/24/26 with Client #3 revealed: -"Sunday (3/22/26) we came here (vocational center) because we didn't have enough staff ...it was ok ...we watched movies, hung out outside ...they (staff) brought my 2 o'clock med (medication) down here (vocational center) for me to take ...[HM] and [PM] worked." -"Usually just have 1 (staff) person at home (facility on 2nd shift)."</p> <p>Interview on 3/24/26 with Client #4 revealed: -"...we (facility and sister facility) came down here (vocational center) and had pizza." -"we just wanted to, on Sunday (3/22/26)."</p> <p>Interviews on 3/24/26 and 3/27/26 with Staff #1 revealed: -Typically worked 1st shift. She had not worked the weekend (3/20-3/22/26). -"Second shift is the hardest and we only have 1 staff ...med times 3pm, 4pm, 8pm ...prepare dinner, 2 (clients) are assisted in shower, prepare [Client #1]'s meal, [Client #4] and [Client #2] have special forks, plates and have to watch for eating too fast, [Client #3] has to have plastic utensils, go back and forth to observe [Client #2] and</p>	V 290		

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V 290	<p>Continued From page 13</p> <p>[Client #4] ...[Staff #3] is too small to change [Client #1] by herself ...[Staff #4] will come in at night to help get [Client #1] in the bed." -"Behavior plans (for Clients #2,#3) don't have consequences ...very inconsistent guidance." -Haven't had to follow steps (proximity control) with Client #1. "...told to take [Client #1] into her room, unbuckle her feet (from wheelchair), get sling behind her and secured (to lift) so she won't fall forward, then go check on the twins (Clients #2,#3) ...come back, get her (client #1) to the bed, rails up then check on the twins again ...pants down, diaper off, clean her (client #1), replace diaper and go check on twins again." -"Never had to use steps because I have another staff with me." -"Twins look for opportunities to touch each other ...[Client #2] will go sneak food too." -Client #2 had to be monitored at meal time because he could choke due to overstuffing his mouth with food .</p> <p>Interview on 3/26/26 with Staff #2 revealed: -Just began working at the facility 2/11/26 "mostly 3rd shift but had worked two 2nd shifts." -Had "always worked by myself". -"[Client #1] really needs 2 people ...I can't get her up and out of bed by myself ...will wait for 3rd shift ...I can change her when she's in the bed, rolling her back and forth ..." -" ...I can't watch the twins and help [Client #1] ...when I have to change [Client #1] I have the twins go to their rooms ...following the steps, make sure [Client #1] is in the bed and situated then check on the twins to make sure they are in their rooms ..."</p> <p>Interview on 3/27/26 with Staff #3 revealed: -Started in January working 2nd shift mostly alone. " ...dinner, showers, cleaning, snacks,</p>	V 290		

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V 290	<p>Continued From page 14</p> <p>laundry.."</p> <p>-Did not work the weekend of 3/20/-3/22/26.</p> <p>-"I have to get help putting [Client #1] in the bed; [HM] or [Staff #4] will come in (facility) to help me ...takes 20-30 minutes (to get into bed).</p> <p>-Client #1 was generally changed when arriving home from vocational center (2-3pm) and not again until bedtime around 8pm. She had not had any accidents during that time.</p> <p>-Client #1 had surgery in March so "we take extra time" due to her surgical sensitivity.</p> <p>-"We're (staff) supposed to step out in the hallway between changing steps ...I've asked the boys (Clients #2, #3) to go to their rooms ...sometimes the (bedroom door) alarms don't work."</p> <p>-"I told [HM], if [Client #4] is in the shower, I just hope [Client #2] doesn't get anything out of the frig (refrigerator) cause he could get choked."</p> <p>-The relief team (Licensee's out of town staff) had helped sometimes filling in staffing gaps; generally had 2 staff on the weekends. "During the week, it's just me."</p> <p>-"It's not easy by myself ...I don't feel it's a 1 person (staff) house."</p> <p>Interview on 3/26/26 with Staff #4 revealed:</p> <p>-Started in January and worked at both facility and sister facility on 1st shift. "Will go back to the facility to help put [Client #1] in the bed on the nights when [Staff #3] worked. It would take 30-45 minutes since her surgery to get [Client #1] comfortably in the bed. [Staff #3] is short and doesn't have the strength to get [Client #1] up."</p> <p>-"Supposed to stop after each step ...[Client #1] has muscle twitches/jerks, hard to get the sling behind her ...can't watch the twins ...sometimes the alarm won't go off if the twins' door opened."</p> <p>-"Always someone else (a 2nd staff) there on 1st shift ...2nd and 3rd shifts are by themselves."</p>	V 290		

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V 290	<p>Continued From page 15</p> <p>Interviews on 3/23/26 and 3/27/26 with the HM revealed:</p> <ul style="list-style-type: none"> -Had been HM for 1 ½ months. " ...have 1 staff at Calloway on 2nd shift ...have a 2nd staff coming in to help put [Client #1] to bed." -Client #2 will steal food from the pantry (drinks, cereal, cookies) and/or the refrigerator (drinks, juice, fruit), "will chug milk and stuff his mouth full ...choking concern." -On 3/20/26, found a whole box of brownies and large bag of cereal in his closet under a blanket. "Told him he didn't have to hoard food but just ask if he was hungry." -"Had 3 staff call out for yesterday (3/22/26) for both houses (facility and sister facility) ...had to drive all the way back from (town about 300 miles away) ...me and [Program Manager(PM)] had both houses (10 clients) at the voc (vocational) center all day." <p>Interview on 3/24/26 with the former Qualified Professional (QP) revealed:</p> <ul style="list-style-type: none"> -Had moved to human resources position on 3/8/26. -The PM was the acting QP for the facility since 3/8/26. -The vocational center hours were 9am-5pm Monday -Friday. -The HM was responsible for staff scheduling. The HM and QP would have to fill in staffing gaps. <p>Interview on 3/24/26 with the PM revealed:</p> <ul style="list-style-type: none"> -The HM and PM worked at the vocational center on 3/22/26 from around 10am till 7pm with both facility and sister facility clients. "I worked at 4 different houses (facilities operated by Licensee) this weekend (because of gaps in staffing)." -"We're in crisis stabilization meetings 3 times weekly and go through staffing weekly to fill gaps" 	V 290		

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V 290	<p>Continued From page 16</p> <p>if needed ...it's a collective decision to fill holes with relief staff." -HM was responsible for scheduling staff. -"The Senior Vice President (SVP) made the decision to go to the voc center on Sunday (3/22/26) ...I told her we had 3 call outs; 'It's me and [HM]'; she said just for today you all merge at voc center ...better in ratio at voc center ..." -"Yes, clients have a choice but if they refuse, we'd have a big problem ...we can't force them in the van ...We're in survival mode."</p> <p>Interview on 3/24/26 with Regional Operations Manager revealed: -"had 3 call outs over the weekend (on 3/22/26 for the 2 residential facilities) ...had 2 relief staff...we had staff for the weekend ...what are we supposed to do?" -"Health and safety is the first thing we think about ...we'd go to the voc center to have a meaningful day ..."</p> <p>Interview on 3/27/26 with the SVP revealed: -"We were staffed for the weekend (3/20/26-3/22/26). Relief staff (2) had gone back home since they had been there (at facility and sister facility) for 2 weeks. Given the circumstances (3 call outs and no relief staff), worst-case scenario, in this situation we needed 2 staff togetherbetter to have 2 people (staff) monitoring engaging activities, socializing rather than having 1 staff." -The facility had developed a worst-case scenario plan (staffing plan when facility and sister facility were short staffed) for each home during the pandemic (2020-2022) although it had not been updated since then. That plan included moving clients to the vocational center in the event of reduced staffing. -"We were burning both ends of the candle</p>	V 290		

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V 290	Continued From page 17 ...fighting an uphill battle ...this is reality." -"We have put systems in place; hired more people, have relief staff filling in, and available clinical staff filling in when needed ...this was only 1 day since December (2025)." This deficiency is cross referenced into 10A NCAC 27G.5601 Scope (V298) for a failure to correct Type A1 rule violation.	V 290		
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; (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.	V 367		

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V 367	<p>Continued From page 18</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 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> <p>(1) medication errors that do not meet the definition of a level II or level III incident;</p>	V 367		

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V 367	<p>Continued From page 19</p> <p>(2) restrictive interventions that do not meet the definition of a level II or level III incident;</p> <p>(3) searches of a client or his living area;</p> <p>(4) seizures of client property or property in the possession of a client;</p> <p>(5) the total number of level II and level III incidents that occurred; and</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to report Level II incidents in the Incident Response Improvement System (IRIS) and notify the Local Management Entity/Managed Care Organization (LME/MCO) responsible for the catchment area where services were provided within 72 hours of becoming aware of the incident. The findings are:</p> <p>Review on 3/23/26 of Client #4's record revealed: -Date of admission: 7/1/15 -Diagnoses: Moderate Intellectual Developmental Disability, Tremors, Nightmare Disorder, Pseudobulbar Affect, Anxiety Disorder, Mood Disorder, White Matter Disease, Leukemia in remission, Attention Deficit Hyperactivity Disorder, Sleep Apnea.</p>	V 367		

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V 367	<p>Continued From page 20</p> <p>Review on 3/23/26 of facility's internal investigation dated 3/9/26 and signed by the Regional Operations Manager (ROM) revealed: -" ...Allegations: the reporter (anonymous) stated on March 1, 2026, he/she witnessed [Staff #1], direct support staff, verbally abuse [Client #4]. The caller stated [Staff #1] called [Client #4] an 'idiot' twice because she (Client #4) was picking at a sore on her (Client #4) foot. The caller stated no other forms of abuse occurred ...The caller stated he/she has never witnessed [Staff #1] behave this way before and he/she believes she experienced a 'momentary lapse in judgement' ..." -"Conclusions: Based on the above facts the accusation of [Staff #1] being verbally abusive towards [Client #4] is unsubstantiated."</p> <p>Review on 3/19/26 of the North Carolina Incident Response Improvement System (IRIS) from 2/22/26 to 3/19/26 revealed: -No level II incident report regarding alleged verbal abuse of Client #4. -No documentation the LME/MCO was notified of the allegation.</p> <p>Interview on 4/2/26 with the former Qualified Professional (QP) revealed: -"I'm responsible for doing an investigation." -"I contacted my administrator [ROM] to ask what to do I was told to do the investigation ... interview staff ...I did not interview [Client #4] because she would say yes to whatever I asked." -Was not aware of allegation reporting requirements.</p> <p>Interview on 4/2/26 with the ROM revealed: -"The (former) QP should have reported in IRIS ...I didn't investigate." -"I didn't follow up to see that an IRIS was</p>	V 367		

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V 367	Continued From page 21 completed."	V 367		
V 500	<p>27D .0101(a-e) Client Rights - Policy on Rights</p> <p>10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS</p> <p>(a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66.</p> <p>(b) The governing body shall develop and implement policy to assure that:</p> <p>(1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and</p> <p>(2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications.</p> <p>(c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies:</p> <p>(1) any restrictive intervention that is prohibited from use within the facility; and</p> <p>(2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client.</p> <p>(d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify:</p> <p>(1) the permitted restrictive interventions or allowed restrictions;</p> <p>(2) the individual responsible for informing</p>	V 500		

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V 500	<p>Continued From page 22</p> <p>the client; and</p> <p>(3) the due process procedures for an involuntary client who refuses the use of restrictive interventions.</p> <p>(e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes:</p> <p>(1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E);</p> <p>(2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and</p> <p>(3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure all incidences of alleged abuse, neglect, or exploitation was reported to the county's Department of Social Services (DSS). The findings are:</p> <p>Review on 3/23/26 of facility's internal investigation dated 3/9/26 and signed by the Regional Operations Manager (ROM) revealed: -" ...Allegations: the reporter (anonymous) stated on March 1, 2026, he/she witnessed [Staff #1], direct support staff, verbally abuse [Client #4].</p>	V 500		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL100-023	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 04/08/2026
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NAME OF PROVIDER OR SUPPLIER CALLOWAY COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 35 CELO STREET BURNSVILLE, NC 28714
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(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 500	<p>Continued From page 23</p> <p>The caller stated [Staff #1] called [Client #4] an 'idiot' twice because she (Client #4) was picking at a sore on her (Client #4) foot. The caller stated no other forms of abuse occurred ...The caller stated he/she has never witnessed [Staff #1] behave this way before and he/she believes she experienced a 'momentary lapse in judgement' ..."</p> <p>- "Conclusions: Based on the above facts the accusation of [Staff #1] being verbally abusive towards [Client #4] is unsubstantiated."</p> <p>Interview on 4/2/26 with the former Qualified Professional (QP) revealed: -Was QP until 3/8/26. -Learned of the 3/1/26 allegation of verbal abuse of CLient #4 by Staff #1 on 3/2/26. -Was responsible for completing investigation and reporting. -Was not aware of the reporting requirements to DSS for allegations of abuse.</p>	V 500		