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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 3/30/26. The complaint was substantiated (Intake #NC00235991). 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 4. The survey sample consisted of audits of 3 current clients.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility	V 105		

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V 105	Continued From page 1 can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105		

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V 105	Continued From page 2	V 105		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to implement their admission policy regarding admission screenings affecting 1 of 3 audited clients (#2) and failed to delegate management authority for the operation of the facility. The findings are:

Finding #1
Review on 2/18/26 of Client #2's record revealed:
-No date of admission.
-Diagnoses: Unspecified Mood Disorder, Epilepsy, Post-Traumatic Stress Disorder, Mild Intellectual Developmental Disability, Dementia and Traumatic Brain Injury.
-No screening assessment.

Interview on 2/17/26 with Client #2 revealed:
-Admitted to the facility in November 2025 but the exact date was unknown.

Interviews on 2/17/26 and 2/26/26 with Staff #1 revealed:
-Client #2 was admitted to the facility about 2 1/2 months ago.
-She provided the telephone number to a Sister Facility Qualified Professional (QP) who would be able to obtain the client's admission screening.
-Executive Director (ED)/QP was responsible to conduct any assessments.

Interview on 2/26/26 with Sister Facility QP revealed:
-She was able to obtain Client #2's records and

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V 105	Continued From page 3 would "help in any way" she could. Attempted reviews of Client #2's facility records on 2/19/26, 2/20/26, 2/24/26 and 2/25/26 revealed: -No documentation of a screening assessment for Client #2. Multiple requests for Client #2's screening assessment were made to the ED/QP on 2/19/26, 2/20/26, 2/24/26 and 2/25/26. The documentation was not provided by the survey exit date 3/10/26. Review of the email correspondence on 2/24/26 from the ED/QP to the Division of Health Service Regulation (DHSR) surveyor dated 2/24/26 revealed: -"Here's the rest of [Client #3's] requested docs (documents). Sending [Client #2's] next..." -The screening assessment was not received prior to the survey exit on 3/10/26. Finding #2 Review on 2/25/26 of email correspondence from the DHSR surveyor and the ED/QP on 2/25/26 revealed: -DHSR: "...Is there a good time we can meet in the (licensee) office tomorrow?" -ED/QP: "I am happy to meet with you...I am available by phone tomorrow morning, and then will be out of working until next Wednesday, March 4." -"I (DHSR surveyor) would like to review [Client #2's] paperwork before we meet. If you can get that to me today, we could talk by phone tomorrow am? Do you have someone I can communicate with/someone who will be in charge during your absence?" -ED/QP: "Yes will do and phone interview tomorrow morning works for me, as well. I will	V 105		

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V 105	Continued From page 4	V 105		

send you the contact person in my email with additional requested docs (documents)..."
-No further documents were received prior to exit 3/10/26.

Attempted telephone interview on 2/26/26 with the ED/QP revealed:
-No response to the planned call, a message was left to return call.

Review of an email correspondence from the DHSR Team Leader to the ED/QP on 2/26/26 revealed:
-"[DHSR surveyor] advised me that she has been trying to speak with you today as you agreed upon in your email correspondence from yesterday, 2/25/26. [DHSR surveyor] has expressed concern to me that she has not been able to reach you and you may be unavailable until 3/4/26. Please contact [DHSR surveyor] at [phone number] or have the person who you have delegated with management authority contact [DHSR surveyor]."
-No response was received prior to the exit on 3/10/26.

Interview on 2/26/26 with Staff #1 revealed:
-She did not know the ED/QP was gone and did not know who was in charge in her absence.
-She would contact Sister Facility QP and the Finance Director to see if they could help with the needed documents.

Interview on 2/26/26 with the Finance Director revealed:
-She would contact the ED/QP to call the DHSR surveyor.

Interview on 2/26/26 with the ED/QP revealed:
-She had very limited time to interview due to

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V 105	Continued From page 5 being on vacation with her family. -She left the Finance Director in charge while she was gone. 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 105		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures	V 109		

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V 109	Continued From page 6 for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record review and interview, 1 of 1 Qualified Professionals (Executive Director/QP) failed to demonstrate the knowledge, skills and abilities to meet the needs of clients. The findings are: Review on 2/18/26 of the ED/QP's employee file revealed: -Date of hire: 3/11/04. Review on 3/2/26 of the ED/QP's job description which was not dated or signed by the ED/QP revealed: -"The primary purpose of this position is to provide support and clinical supervision to all team members regarding implementing an Individual Plan of Care...Develop plans of care for individuals supported. Ensure that the records of all individuals supported are maintained properly according to NC (North Carolina) licensure standards. Monitor the overall health and safety of the individuals served, including providing information to medical professionals (psychiatrists, general practitioners, specialists, etc.). Assuring that issues and concerns about	V 109		

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V 109	Continued From page 7	V 109		

health and safety are brought to team members' attention when they arise, and that direct care staff are communicated with regarding treatments and interventions. Accuracy is essential in all aspects of this work. Accuracy and timeliness in record keeping are critical to the agency..."

Refer to Tag 105 for the ED/QP's failure to implement their admission policy regarding admission screenings for Client #2 and delegate management authority for the operation of the facility.
-The facility did not conduct an admission screening for Client #2.
-Staff did not know who to contact in the absence of the ED/QP.

Refer to Tag 111 for the ED/QP's failure to ensure an assessment was completed prior to the delivery of services for Client #2.
-Client #2 had been at the facility for approximately 2 1/2 months and did not have an assessment completed prior to the delivery of services.

Refer to Tag 112 for the ED/QP's failure to develop and implement treatment goals and strategies to address the needs of Clients #1, #2, and #3.
-Clients #1, #2 and #3 all had expired treatment plans in their record.
-Staff had no access to any electronic files that may have contained updated treatment plans.
-Client #2's updated treatment plan was not received prior to survey exit on 3/10/26.

Refer to Tag 290 for the ED/QP's failure to maintain staffing to meet the individualized client needs.
-Client #1 had falls and Client #2 had seizures.

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V 109	Continued From page 8 -Staff reported not being able to meet the clients individualized needs. Refer to Tag 291 for the ED/QP's failure to maintain coordination between the facility operator and the professionals responsible for the client's treatment. -Client #1 had frequent falls and required hospital visits on 11/19/25, two times on 11/29/25 and on 2/13/26. -After each hospitalization it was recommended Client #1 follow up with his Primary Care Physician (PCP). -There was no documentation of any follow up visits with the client's PCP. Multiple requests for facility records were made to the ED/QP on 2/19/26, 2/20/26, 2/24/26 and 2/25/26. No records were received prior to survey exit on 3/10/26. Attempted telephone interview on 2/26/26 with the ED/QP revealed: -No response to the scheduled telephone interview, a message was left to return call. Interview on 2/26/26 with the Finance Director revealed: -She would contact the ED/QP to call the DHSR surveyor. Interview on 2/26/26 with the ED/QP revealed: -Apologized for missing the DHSR surveyor's call earlier, "I thought I would have time in the morning to talk..." -She had very limited time to interview due to being on vacation with her family. -"I am gathering items (client records) as fast as I can...now that all the agencies are involved (investigating), I'm having to get [Local	V 109		

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V 109	Continued From page 9 Management Entity/Managed Care Organization] and DSS (Department of Social Services) documents as well..." 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 109		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.	V 111		

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V 111	Continued From page 10	V 111		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure an assessment was completed prior to the delivery of services for 1 of 3 audited clients (#2). The findings are:

Review on 2/18/26 of Client #2's record revealed:
-No date of admission.
-Diagnoses: Unspecified Mood Disorder, Epilepsy, Post-Traumatic Stress Disorder, Mild Intellectual Developmental Disability, Dementia and Traumatic Brain Injury.
-No documentation of an assessment prior to the delivery of services.

Interview on 2/17/26 with Client #2 revealed:
-Admitted to the facility in November 2025 the exact date was unknown.

Interviews on 2/17/26 and 2/26/26 with Staff #1 revealed:
-Client #2 moved to the facility about 2 1/2 months ago.
-She provided the telephone number to another Sister Facility Qualified Professional (QP) in an attempt to obtain records.

Interview on 2/26/26 with Sister Facility QP revealed:
-She was able to obtain Client #2's records and

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V 111	Continued From page 11 would "help in any way" she could. Reviews on 2/19/26, 2/20/26, 2/24/26 and 2/25/26 for an assessment revealed: -No documentation of an assessment prior to the delivery of services for Client #2. Multiple requests for Client #2's assessment were made to the Executive Director(ED)/QP on 2/19/26, 2/20/26, 2/24/26 and 2/25/26. The documentation was not provided by the survey exit date 3/10/26. Review of the email correspondence on 2/24/26 from the ED/QP to the Division of Health Service Regulation (DHSR) surveyor dated 2/24/26 revealed: -"Here's the rest of [Client #3's] requested docs (documents). Sending [Client #2's] next..." -The assessment prior to the delivery of services was not received prior to the survey exit on 3/10/26. 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 111		
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.	V 112		

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V 112	Continued From page 12 (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; (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 review and interview, the facility failed to develop and implement treatment goals and strategies to address the needs of 3 of 3 audited clients (#1, #2 and #3). The findings are: Review on 2/18/26 of Client #1's record revealed: -Date of admission: 1/4/25. -Hospital admission: 12/3/25. -Returned to facility from a local rehabilitation facility: 2/6/26. -Diagnoses of Multiple Fractures, Spondylosis, Repeated Falls, Arthropathic Psoriasis, Schizoaffective Disorder, Autism Spectrum Disorder, Intellectual Developmental Disorder	V 112		

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V 112	Continued From page 13 (IDD), Hypertension (HTN), Gastroesophageal Reflux Disease (GERD), Coronary Artery Disease, Hyperlipidemia, Osteoarthritis, Chronic Pain, Diabetes Mellitus (DM) Type 2, and Vitamin D Deficiency. -No current treatment plan. Review of an email sent by the Executive Director/Qualified Professional (ED/QP) to the Division of Health Service Regulation (DHSR) surveyor dated 2/20/26 revealed: -An email with an attachment. -The attachment was Client #1's treatment plan dated 1/6/26. Review on 2/20/26 of Client #1's most recent treatment plan revealed: -1/6/26 - "...Safety and Security...He (Client #1) requires daily assistance and reminders from staff to use his walker, which helps increase his safety when walking...Healthy Living...[Client #1] has continued to have increased falls and needs support to decrease his falls...[Client #1] will utilize the use of all adaptive equipment to be safe in his home...Interventions...Staff will assist [Client #1] to utilize his walker when walking at all times. Staff will provide positive validation given for all attempts..." Review on 2/19/26 of the facility's incident reports regarding Client #1 from 11/1/25 through 2/19/26 revealed: -11/19/25 - 8:45 pm - Fall occurred outside - "...He (Client #1) started down the sidewalk. I (Staff #2) prompted [Client #1] 3 times to take his walker and (he) said 'Naugh' each time. I continued sweeping off the porch when I turned back around I saw [Client #1] lying on the ground..." -11/29/25 - 1:34 am - "Found [Client #1] on the	V 112		

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V 112	Continued From page 14 floor in his bedroom..." -11/29/25 - 12:18 pm - "...heard a loud bump, went to look found [Client #1] in hallway on floor..." Review on 2/19/26 of Client #1's medical records from a local hospital dated 2/13/26 revealed: -2/13/26 - "Chief Complaint...FALL...presents via EMS (emergency medical services) from group home after fall...States that he hit the back of his head on the door after rolling out of bed...Diagnosis/Disposition 1. Fall from bed 2. Low back pain...Thankfully, no new fractures were noted seen... Review on 2/18/26 of Client #2's record revealed: -No date of admission documented. -Diagnoses: Unspecified Mood Disorder, Epilepsy, Post-Traumatic Stress Disorder, Mild IDD, Dementia and Traumatic Brain Injury. -Safety Plan - updated 1/27/23 - " ...continued to leave the group home (previous placement) to walk to the store for cigarettes and sometimes soda. She would leave the home when DSPs (Direct Support Professionals) were distracted and walk, primarily to the [local gas station] at the end of her road ...[Client #2] has had seizures while walking down the road and has fallen ... [Client #2] also approaches people she doesn't know in the community for cigarettes, money, or request for a ride home ...[Client #2] is at high risk for seizure activity while out in the community and staff should maintain a visual on her ...[Client #2] will not leave the group home premises without staff or approved peer supports accompanying her ...While in the house, staff must lay eyes on [Client #2] every 10 minutes, except when asleep ..." -No current treatment plan. The last treatment plan was implemented on 1/31/24 and expired	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 112	Continued From page 15 1/31/25. Interview on 2/17/26 with Staff #1 revealed: -Client #2 was admitted to the facility about 2 1/2 months ago. Review on 2/18/26 of Client #3's record revealed: -Date of admission: 5/14/09. -Diagnoses of Anxiety Disorder, Severe IDD, Cerebral Palsy, HTN, Hyperlipidemia, Acid Reflux, Gingivitis, Generalized Anxiety Disorder, Obsessive Compulsive Disorder and Intermittent Explosive Disorder. -10/21/25 - "Client Specific" training signed by staff "...support to increase his ADLs (Activities of Daily Living), communication, coping and safety skills and needs support to assure his hygiene/personal care and medical needs are met..." -No current treatment plan. The last treatment plan was implemented on 8/13/20 and expired 8/13/21. Interviews on 2/17/26 and 2/18/26 with Client #2 revealed: -She had a seizure "a couple of weeks ago" and "got 4 staples in my head." -"Walked down there (local gas station)...a (unknown) man came up and walked with me the rest of the way...[Staff #1] knew I left..." Interviews on 2/17/26, 2/20/26 and 2/24/26 with Staff #1 revealed: -Client #1 fell during her shift on 2/9/26 and she completed an incident report for this. -Was not aware of any updated goals or interventions to reduce Client #1's falls. -His goals were to "make sure he is not falling...using his walker...he used to be allowed to walk to the end of (street) approximately 0.2	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 112	Continued From page 16 miles one-way), and [Client #2] too...I don't know if he is allowed to anymore...He has been falling for the last 4-5 months...he is not stable on his feet anymore...[Executive Director/Qualified Professional (ED/QP)] said every time you hear him move you got to move...I can't watch them (clients) all the time...I may be cooking, changing [Client #4]. Sometimes when [Client #2] is out smoking she may have a seizure..." -"I can't lift [Client #1]...told [Human Resources (HR) Director] and [ED/QP] this...was told to call for assistance...[HR Director] said 'To tell him [Client #1] to roll over onto his knees' in order to assist in lifting him...he won't do this...EMS (emergency medical services) said 'we can't keep calling' them just to get him off the floor...so call [one male who previously worked at facility or another male staff who worked weekends]...they always come for me...(to help get Client #1 up)." -"[Client #2]...if you don't give her what she wants (soda or cigarette) she wanders off...has seizures often back-to-back...has VNS (Vagus Nerve Stimulator)...[Client #1] been here maybe going on 2 months. Didn't know what her needs were...no one ever told us she walks off...have to keep an eye on her...they (administration) don't tell you nothing...I made the decision to look on her more often...allowed a cigarette every 2 hours...that's what she was doing at (sister facility) and QP at that facility said to continue this..." -"When she (Client #2) first moved here...no one ever told me she walks off...[Staff #2] picked her up...she made it to the stop sign (at the end of Marne (street)...[Staff #2] took her to the store and brought her back...I did my rounds and looked around and calling everyone (administration) saying she was gone... (approximately 2/3/26) she walked to the end of the road (Marne street)...did an incident report	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 112	Continued From page 17 and called [ED/QP]. [ED/QP] went to get her. She had a seizure while at [local gas station where she walked to]...hit concrete and got staples in her head...I was changing [Client #4]. I didn't know she was gone..." -"Can't see treatment plans" in the electronic record. "Another Q (QP) was supposed to update the books (client records kept in the facility)..." Interviews on 2/18/26 and 2/20/26 with Staff #2 revealed: -When first started working at facility (8/27/25), "[Client #1] fell in the bathroom...first time I knew he had issues with falling..." -Goals "...I work with him [Client #1] to say thank you when given something...he is not working on nothing...so stubborn....he started falling a lot around Halloween (2025)." -Goals for Client #2 "trying to work on closing the bathroom door when uses the bathroom...can change some things...like washing face and hands before go to the kitchen and get a soda and ice...[Client #2] is workable...like not being so rude and disrespectful when she can't get a cigarette...I don't think it's in her plan...gets upset with (not getting) soda and cigarettes...will walk off property...got off work one morning (date unknown) and went back to house (facility) for pocket book, by time got back (to facility) [Client #2] was sitting up on the curb of the road..." Attempted review on 2/19/26, 2/20/26, 2/24/26 and 2/25/26 of Client #2 and Client #3's current treatment plans was unsuccessful as no documentation of the updated treatment plans were in the client records. Multiple requests for Client #2 and Client #3's treatment plans were made to the ED/QP on 2/19/26, 2/20/26, 2/24/26 and 2/25/26.	V 112		

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V 112	Continued From page 18 Review of the email correspondence on 2/24/26 from the ED/QP to the Division of Health Service Regulation surveyor revealed: -"Here's the rest of [Client #3's] requested docs (documents). Sending [Client #2's] next..." -The attachment on the email was Client #3's treatment plan dated 10/1/25. -Client #2's treatment plan was not received prior to survey exit on 3/10/26. 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	V 113		

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V 113	Continued From page 19 and telephone number of the client's preferred physician; (6) a signed statement from the client or legally 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 review and interview, the facility failed to maintain complete client records affecting 3 of 3 audited clients (#1, #2 and #3). The findings are: Review on 2/18/26 of Client #1's record revealed: -Incorrect address on the face sheet. -Incorrect telephone contact number for family member. -No current treatment plan. Review on 2/18/26 of Client #2's record revealed: -No date of admission documented.	V 113		

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V 113	Continued From page 20 -Incorrect address on the face sheet. -No current treatment plan. Review on 2/18/26 of Client #3's record revealed: -No current treatment plan. Attempted telephone interview on 2/24/26 with Client #1's brother revealed: -No answer and a message was left to return the call but no call was received prior to the end of the survey. Interview on 2/24/26 with Staff #1 revealed: -The number on the face sheet, which the Division of Health Service Regulation (DHSR) surveyor called, was no longer a valid phone number for Client #1's brother. -Staff #1 provided the correct number for Client #1's brother. Interview on 2/24/26 with Client #1's brother revealed: -He did not receive a missed call from the DHSR surveyor and the number on the face sheet was old. Multiple requests for Client #1, Client #2 and Client #3's treatment plans were made to the Executive Director/Qualified Professional on 2/19/26, 2/20/26, 2/24/26 and 2/25/26, but no updated treatment plans were provided prior to the exit of the survey for Client #2 and Client #3. Client #1's treatment plan was provided by the ED/QP via email on 2/20/26. There was no current copy of Client #1's treatment plan in the facility for staff reference. Review of the email correspondence on 2/24/26 from the ED/QP to the DHSR surveyor revealed: -"Here's the rest of [Client #3's] requested docs	V 113		

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V 113	Continued From page 21 (documents). Sending [Client #2's] next..." -The attachment on the email was Client #3's treatment plan dated 10/1/25. -Client #2's treatment plan was not received prior to survey exit on 3/10/26.	V 113		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes. (b) The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate the facility's response to fire emergencies. (d) Each facility shall have a first aid kit accessible for use. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure disaster drills were held quarterly and repeated on each shift. The findings are: Review on 2/17/26 of the facility's fire and disaster drill log from January 2025 through December 2025 revealed: -No disaster drills were conducted for 2025.	V 114		

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V 114	Continued From page 22 Interview on 2/17/26 with Client #1 revealed: -"Yeah," practiced disaster drills. Interview on 2/17/26 with Client #2 revealed: -"Say...I don't know..." about whether or not there were disaster drills conducted at the facility. Interview on 2/17/26 with Staff #1 revealed: -Worked 12 hour shifts, 7:00 am to 7:00 pm, for "almost 4 years." -Have not done disaster drills with the clients. -"To be honest with you...no...just fire drills...but they (facility) need to..." practice disaster drills with the clients. Interview on 2/26/26 with the ED/QP revealed: -She had very limited time to interview due to being on vacation with her family. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 114		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications.	V 118		

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V 118	Continued From page 23 (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure medications were administered on the written order of a physician, and failed to keep the MARs current affecting 3 of 3 audited clients (#1, #2, and #3). The findings are: Cross Reference: 10A NCAC 27G .0209 (V121). Based on record review and interview, the facility failed to obtain a pharmacist's or physician's review of medications every 6 months for clients who were administered psychotropic medications for 1 of 3 audited clients (#1). Cross Reference: 10A NCAC 27G .0209 (V123). Based on record review and interview, the facility failed to ensure medication errors were reported	V 118		

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V 118	Continued From page 24 immediately to a physician or pharmacist affecting 3 of 3 audited clients (#1, #2, and #3). Review on 2/18/26 of Client #1's record revealed: -Date of admission: 1/4/25. -Hospital admission: 12/3/25. -Returned to facility from local rehabilitation facility 2/6/26. -Diagnoses of Multiple Fractures, Spondylosis, Repeated Falls, Arthropathic Psoriasis, Schizoaffective Disorder, Autism Spectrum Disorder, Intellectual Developmental Disorder (IDD), Hypertension (HTN), Gastroesophageal Reflux Disease (GERD), Coronary Artery Disease, Hyperlipidemia, Osteoarthritis, Chronic Pain, Diabetes Mellitus (DM) Type 2, and Vitamin D Deficiency. Review on 2/18/26 of Client #1's physician orders revealed: -Dated 10/14/25: -Metformin (Diabetes Mellitus) 500 milligrams (mg) - 1 tablet twice daily - no discontinue order. -Dated 2/6/26: -Midodrine 5 mg - 1 tablet 3 times a day - hold for BP systolic greater than 100 and diastolic less than 60. -Valproic Acid Oral Solution (mood symptoms) 500mg/10ml (millimeters) - 30 ml every morning. -No orders: -Vitamin D3 5000 IU (International Units) (supplement) - 1 capsule every day- no discontinue order. Review on 2/18/26 of Client #1's MAR from 2/6/26 through 2/18/26 revealed: -Metformin 500 mg - 1 tablet twice daily - "DC'd (discontinued)" with no date - last initialed as administered 8:00 am on 2/11/26.	V 118		

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V 118	Continued From page 25 -Valproic Acid Oral Solution 500mg/10ml - 30 ml every morning - was not listed. -Vitamin D3 5000 IU - 1 cap every day- "DC'd" with no date - initialed as administered 2/7/26, 2/8/26, 2/9/26, 2/10/26 and 2/11/26. -Midodrine (Orthostatic Hypotension) 5 mg - 1 tablet 3 times a day - hold for blood pressure (BP) systolic (top number) greater than 100 - diastolic (bottom number) less than 60: -8:00 am - no BP readings 2/7/26, 2/8/26, 2/9/26, 2/10/26, 2/11/26, 2/12/26 - initialed as administered 2/8/26, 2/9/26, 2/11/26, 2/12/26 (with no BP readings). BP readings of systolic over 100 and initialed as administered 2/13/26 - 120/90, 2/15/26 -140/62, 2/16/26 - 107/77. -12:00 pm - no BP readings 2/7/26, 2/8/26, 2/9/26, 2/10/26, 2/11/26 - initialed as administered 2/7/26, 2/8/26, 2/9/26, 2/10/26 (with no BP readings). BP readings of systolic over 100 and initialed as administered 2/12/26 - 120/90, 2/13/26 - 121/80, 2/14/26 - 142/62, 2/16/26- 110/80. -8:00 pm - no BP readings 2/7/26, 2/8/26, 2/9/26, 2/10/26, 2/11/26 - initialed as administered 2/9/26, 2/10/26, 2/11/26 (with no BP readings). BP readings of systolic over 100 and initialed as administered 2/12/26 - 119/80, 2/13/26 - 122/80, 2/14/26- 140/60, 2/15/26- 101/76, 2/16/26- 120/80. Review on 2/18/26 of Client #2's record revealed: -No date of admission documented. -Diagnoses: Unspecified Mood Disorder, Epilepsy, Post-Traumatic Stress Disorder (PTSD), Mild IDD, Dementia and Traumatic Brain Injury. Review on 2/18/26 of Client #2's physician orders revealed: -No orders:	V 118		

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V 118	Continued From page 26 -Perampanel (Epilepsy) 6 mg - 1 tablet every day. -Ciclopirox 8% Solution (Onychodystrophy) - apply thick film daily. Review on 2/18/26 of Client #2's MARs for 12/1/25 through 2/17/26 revealed: -Perampanel 6 mg - 1 tablet every day - initialed as administered daily. -Ciclopirox 8% Solution - apply thick film daily - initialed as administered daily. Review on 2/18/26 of Client #3's record revealed: -Date of admission: 5/14/09. -Diagnoses: Severe IDD, Anxiety Disorder, Cerebral Palsy, HTN, Hyperlipidemia, Acid Reflux, Gingivitis, General Anxiety Disorder, Obsessive Compulsive Disorder (OCD) and Intermittent Explosive Disorder. Review on 2/18/26 of Client #3's physician orders revealed: -Dated 10/24/22: Ciclopirox 8% Solution (fungus) - apply to affected nails every day. -Dated 7/7/22: Tavaborole 5% Topical Solution (fungus) - apply to affected area daily. Observation on 2/17/26 of Client #3's medications revealed: -Ciclopirox 8% solution - was not available. -Tavaborole 5% Topical Solution - was not available. Interview on 3/2/26 with the dispensing pharmacist regarding Client #1's medications revealed: -Asperflex Lido 4% Patch and Lidocaine 4% topical film were the same medication. -Humira Pen 40 mg/0.4 ml - was for Client #1's arthritis; when not given as ordered "potentially symptoms may not be managed as well as they	V 118		

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could be...which is why they (physician) increased it...now it (Humira) needs to be (administered) every other week instead of 1 time a month."
-Midodrine 5 mg - hold for BP systolic greater than 100 - diastolic less than 60 - "We are waiting on clarification on that (from the physician)...he (Client #1) gets it (Midodrine) for lower blood pressure...if given (administered for systolic greater than 100) it would increase it (BP) further which we don't want to give it. Will cause high BP. Want to keep systolic around 120...I see a note here (electronic record)...less than 60 (dystolic)...waiting for them to reach out...prescriber...meantime we removed "less than 60," this is not a hold parameter that's valid...needs to be if greater than 60 (for dystolic) or less than 80 (for systolic) because it's going increase his blood pressure, which his what we would want in his case."
-Valproic Acid Oral Solution 250mg/5ml - 30 ml every day; Valproic Acid Oral Solution 250mg/5 ml - 15 ml 2 x day and Valproic Acid Oral Solution 500mg/10ml - 30 ml every morning "is the same thing...it's equal...don't see (in electronic record) 250mg/5ml - see the order for 500mg/10 ml... should be 30 ml...it's all the same concentration. He used to get the dose split, now the order is to have one time a day...but it's all the same concentration."

Attempted interviews on 2/25/26 and 3/2/26 with Client #1 and #2's physician were unsuccessful as a return call was not received prior to survey exit on 3/10/26.

Interviews on 2/17/26 and 2/18/26 with Staff #1 revealed:
-Client #1's February 2026 MAR "is all messed up since he got back from rehab (rehabilitation)...they got it all messed up...I have

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been working with his physicians to try and get it worked out."
-"They (pharmacy) do the MARs each month...I can discontinue medications (duplications on electronic MAR), but then the pharmacy has to approve it and then I have to click it (electronic medication entry) to get it off (the MAR)."
-Did not administer Client #1's duplicated entries of medications twice, had to put initials in each box "to be able to move to the next" medication; I can guarantee you he did not get his medications twice."
-Did not know what the Asperflex Lido patch was for Client #1, "he only gets 1 patch, Lidocaine, for his pain."
-Humira - "I give that...always been every 30 days. I have never given it every other week."
-Midodrine - "I check his blood pressure 3 times a day. You can't move to the next step if you don't enter a blood pressure, so I don't know why they are blank. No.." the BPs were not documented in any other place.
-Did not know why Client #2's medications on 2/10/26 were not initialed as administered.
-Client #3's Ciclopirox solution "...expired...the pharmacy hasn't sent a new one yet...I think that's discontinued because his nails are beautiful."
-Client #3's Tavaborole solution "...the doctor discontinued it...it hasn't been taken off the MAR yet..."
-Not aware Client #3 had initials circled without an exception noted on 12/26/25 and 2/8/26.

Review on 2/25/26 of email correspondence from the Executive Director/Qualified Professional (ED/QP) to the Division of Health Service Regulation surveyor dated 2/25/26 revealed:
-Person responsible for monitoring MARs and physician orders was "the QP...who is currently me...our lead staff assists with medication

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oversight as well. Right now, [Staff #1] has been assisting with the coordination of medications at Marne..."

Interview on 2/26/25 with the ED/QP revealed:
-"Okay." regarding medication administration concerns for Client's #1, #2 and #3.
-"She (Staff #1) didn't document that (BP checks for Client #1) anywhere else?"

Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician.

Review on 2/27/26 of the Plan of Protection dated 2/27/26 written by the ED/QP and the Finance Director revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care?
1. Resident Monitoring
Staff will conduct safety checks every 15 minutes while residents are awake and every hour while residents are asleep.
All checks will be documented in accordance with agency policy.
2. Individual Resident Safety Supports
[Client #1]: A bed pad will be purchased and installed to support his identified safety needs.
[Client #2]: Safety alarms will be put in place to ensure proper supervision and reduce risk of elopement or injury.
3. Medication Oversight
[Sister Facility QP] will provide full medication oversight until a new Qualified Professional (QP) is hired.
This includes medication administration record review, documentation accuracy, and ensuring adherence to physician orders.
4. Medical Monitoring & Blood Pressure Protocol

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V 118	Continued From page 30 Staff will be retrained on: Proper procedures for taking blood pressure reading Recording readings either in [Electronic Record] or on a paper log as a backup Retraining will be completed and documented for all direct care staff. Describe your plans to make sure the above happens. Oversight & Monitoring These corrective actions will be discussed weekly during the Team Consultation Meeting. Issues, trends, or necessary adjustments will be reviewed and addressed at that time. Weekly monitoring of all corrective actions will be completed by the QP or Quality Assurance (QA) Coordinator. Executive Director (ED/QP) will provide oversight to ensure accountability and follow-through. All findings or concerns will be documented and addressed promptly. " Review on 3/2/26 of the addendum to the Plan of Protection dated 3/2/26 written by the Finance Director revealed: "1...[QP] reviewed the [Electronic Record] for Marne on Friday, February 27 (2026). Going forward, [QP] will provide full medication oversight...This includes...ensuring adherence to physician orders on a weekly basis. 2...Retraining will be provided by an RN [Licensee RN] on the actual medicine administration. [QP] will provide retraining on the correct use of [Electronic Record]. Retraining will be completed...no later than Friday, March 13, 2026. Describe your plans...Oversight & Monitoring...This meeting includes the Executive	V 118		

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V 118	Continued From page 31 Director, Finance Director, QPs, and Quality Assurance Coordinator...The Quality Assurance Coordinator and the Finance Director will provide oversight to ensure accountability and follow-through...and addressed promptly by the QA Coordinator and/or the Finance Director." This facility served adults with Developmental Disabilities with diagnoses which included Multiple Fractures, Spondylosis, Arthropathic Psoriasis, Schizoaffective Disorder, Autism Spectrum Disorder, IDD, HTN, GERD, Coronary Artery Disease, Hyperlipidemia, Osteoarthritis, Chronic Pain, DM Type 2, Vitamin D Deficiency, Unspecified Mood Disorder, Epilepsy, PTSD, Dementia, Traumatic Brain Injury, Anxiety Disorder, Cerebral Palsy, Gingivitis, General Anxiety Disorder, OCD and Intermittent Explosive Disorder. Client #1's Lidocaine patches were not initialed as applied for 10 of 12 days. Humira was not administred for at least 1 dose when it was ordered on 2/12/26. Both of these medications were prescribed to relieve his pain. Blood pressure parameters were required prior to administering Midodrine. From 2/7/26 through 2/12/26 there were 16 occurrences where his BP was not documented and he was administered Midodrine 14 of those days. From 2/12/26 through 2/16/26 there were 5 days Client #1's systolic BP was greater than 100, outside of the physician ordered parameter, and he was administered the Midodrine. Pantoprazole, Haloperidol, Olanzapine, Trazodone and Valproic Acid had duplicate and/or conflicting entries on the MAR, with staff initialing some of these as administered more than once on the same day. He had 6 routine psychotropic medications that had not been reviewed by a pharmacist or physician within the last 6 months. Four medications indicated discontinued on the MAR	V 118		

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V 118	Continued From page 32 without corresponding discontinue physician orders. Client #2 had 8 morning medications that were not initialed as administered on 2/10/26 to include medications for epilepsy, anxiety and PTSD. Client #3 had 10 morning medications that were not initialed as administered on 12/25/25 and 2/8/26 some of which were for HTN, OCD and anxiety. Two of Client #3's topical solutions were not available for administration. The physician or pharmacist was not notified of Client #1, #2 or #3's medication errors. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 118		
V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain a pharmacist's or physician's review of medications every 6 months for clients	V 121		

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V 121	Continued From page 33 who were administered psychotropic medications for 1 of 3 audited clients (#1). The findings are: Review on 2/18/26 of Client #1's record revealed: -No psychotropic medication review. Review on 2/23/26 of an email from the Executive Director/Qualified Professional (ED/QP) to the Department of Health Service Regulation (DHSR) surveyor dated 2/23/26 revealed: -an attached document titled "Consultant Pharmacist's Progress Notes" of medication regimen reviews conducted between 12/1/25 and 12/30/25 for the licensee's current residents. -12/29/25 - "Resident (Client #1) is in the hospital. Full chart review deferred until next time..." Review on 2/18/26 of the most recent physician orders for Client #1's drug regimen review dated 2/6/26 revealed: -The psychotropic medication orders were written by the Family Nurse Practitioner from the rehabilitation facility the day of the client's return to the facility. -Psychotropic medication orders: -Haloperidol (Schizoaffective Mood Disorder) 5 milligrams (mg) - 1 tablet at HS (hour of sleep). -Olanzapine (Schizoaffective Mood Disorder) 20 mg - 1 tablet at HS. -Oxycodone HCl (hydrochloride) (pain) 5 mg - 1 tablet every 6 hours as needed for pain. -Trazodone HCl (Insomnia) 50 mg - 2 tablets at HS. -Valproic Acid Oral Solution (mood symptoms) 250mg/5ml (milliliters)- 30 ml- every morning -Clonazepam (anxiety/agitation) 0.5 mg - 1 tablet 2 times a day. -Citalopram (mood symptoms) 20 mg - 1 tablet at HS.	V 121		

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V 121	Continued From page 34 Interview on 3/2/26 with Staff #1 revealed: -Client #1 had seen the psychiatric physician since he returned to the facility (date unknown) who reviewed his psychotropic medications. -Was not given any paperwork from the psychiatric physician regarding this visit. Requested via email from the DHSR surveyor to the ED/QP dated 2/19/26, 2/20/26 and 2/24/26 for any physician visits, including any physician specialist revealed: -"I believe his most recent Report of Health svcs (services) are at the group home. I will get those and send them over this afternoon." Attempted review on 2/19/26, 2/20/26 and 2/24/26 of Client #1's 6 month drug regimen review was unsuccessful as the document was not present. No further documents were received prior to exit on 3/10/26. This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type A1 rule violation and must be corrected within 23 days.	V 121		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. .	V 123		

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V 123	Continued From page 35 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure medication errors were reported immediately to a physician or pharmacist affecting 3 of 3 audited clients (#1, #2, and #3). The findings are: Review on 2/19/26 of facility records revealed: -No contact to a physician or pharmacist for medication errors for Clients #1, #2 and #3 for period 11/1/25 through 2/19/26. Review on 2/18/26 of Client #1's MAR from 2/6/26 through 2/18/26 revealed: -Amlactin (Arthropathic Psoriasis) 12% Lotion - apply topically to affected area twice daily - same entries were duplicated. -Asperflex Lido (Lidocaine) (Pain) 4% Patch - apply 1 patch topically once daily -2/7/26, 2/8/26, 2/9/26, 2/10/26, 2/11/26, 2/12/26, 2/13/26, 2/14/26, 2/15/26 and 2/16/26 - 10 of 12 days not initialed as administered. -Asperflex Lido 4% Patch - remove at HS (bedtime) - 2/7/26, 2/8/26, 2/9/26, 2/10/26, 2/11/26, 2/12/26, 2/13/26, 2/14/26, 2/15/26 and 2/16/26 - 10 of 12 days not initialed as removed. -Atorvastatin (Cholesterol) 40 milligrams (mg) - 1 tablet daily - duplicate entries - one entry "DC'd (discontinued)" and last initialed as administered on 2/11/26. Second entry also initialed on 2/11/26. -Haloperidol (Schizoaffective Mood Disorder) 5 mg - 1 tablet at HS - duplicate entries - one entry "DC'd;" both entries were initialed as administered: 2/6/26, 2/7/26, 2/8/26, 2/9/26 and	V 123		

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V 123	Continued From page 36 2/10/26. -Humira Pen (Arthritis) 40 mg/0.4 ml (milliliters) - 1 injection every other week - no initials to indicate administered. -Lidocaine 4% Pain Relief Patch - apply 1 patch daily and remove at HS - no initials as applied and removed on the 2/7/26, 2/8/26, 2/9/26, 2/10/26, 2/11/26, 2/12/26, 2/13/26, 2/14/26, 2/15/26. -Olanzapine (Schizoaffective Mood Disorder) 20 mg - 1 tablet at HS - duplicate entries - bottom entry "DC'd" - initialed as administered in both entries on 2/6/26. -Pantoprazole (Gastroesophageal Reflux Disease) 40 mg - 1 tablet daily - 3 entries - 2 entries marked as "DC'd" - 2/7/26, 2/8/26, 2/9/26, 2/11/26, 2/12/26, 2/13/26; 2/15/26, 2/16/26 - initialed as administered twice a day. -Simlandi (CF (citrate-free)) (AI (Autoinjector)) (Osteoarthritis) 40 mg/0.4 ml - inject SQ (subcutaneous) 1 x (time) month - "DC'd." No initials to indicate it was administered. -Trazodone (Insomnia) 50 mg - 2 tablets at HS - duplicate entries - top entry "DC'd" 2/6/26, 2/7/26, 2/8/26, 2/9/26, 2/10/26 - initialed as administered twice a day. -Valproic Acid Oral Solution (mood symptoms) 250mg/5ml - 30 ml- every morning - initialed as administered 2/15/26, 2/16/26, 2/17/26. -Valproic Acid Oral Solution 250mg/5ml - 30 ml every day - marked at "DC'd" - initialed as administered 2/15/26, 2/16/26. -Valproic Acid Oral Solution 250/5 ml - 15 ml 2 x day - initialed as administered 8:00 am - 2/15/26 and 2/16/26; 8:00 pm - 2/14/26 and 2/15/26. -Vitamin D2 (supplement) 1.25 mg (50,000 unit) - 1 capsule every Monday - "DC'd" - initialed with a circle on 2/2/26. Review on 2/18/26 of Client #1's physician orders	V 123		

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revealed:
-Dated 2/6/26:
-Haloperidol 5 mg - 1 tablet at HS.
-Olanzapine 20 mg - 1 tablet at HS.
-Trazodone HCl 50 mg - 2 tablets at HS.
-Valproic Acid Oral Solution 250mg/5ml - 30 ml every morning.
-Dated 2/9/26:
-Pantoprazole 40 mg - 1 tablet daily.
-Atorvastatin 40 mg - 1 tablet daily.
-Lidocaine (Asperflex Lido) 4% topical film - 1 patch apply daily and remove at HS.
-Dated 2/12/26:
-Amlactin 12% Lotion - apply topically to affected area twice daily.
-Humira Pen 40 mg/0.4 ml - 1 injection subcutaneous every other week.
-No orders:
- Simlandi 40 mg/0.4 ml - inject SQ 1 x month - no discontinue order.
-Vitamin D2 1.25 mg (50,000 unit) - 1 capsule every Monday - no discontinue order.

Review on 2/18/26 of Client #2's MARs for 2/1/26 through 2/17/26 revealed:
-The following 8:00 am medications were not initialed as administered on 2/10/26:
-Ammonium Lactate (skin condition) 12% Lotion - apply to affected area topically every shift.
-Briviact (partial epilepsy) 100 mg - 1 tablet 2 x day.
-Fluticasone (Allergies) 50 mcg (micrograms) - 1 spray in each nostril daily.
-Lamotrigine (Anxiety/PTSD) (100 mg - 2 1/2 tablets 2 times a day.
-Methenamine (Urinary Tract Infection (UTI)) 1 gram - 1 tablet 2 times a day.
-Multivitamin (UTI) - 1 tablet day.
-Topiramate (Partial Epilepsy) 50 mg - 1

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tablet 2 times a day.
-Vitamin D3 (supplement) 1000 IU (International Units) - 2 tablets every day.

Review on 2/18/26 of Client #2's physician orders revealed:
-Dated: 2/3/25: Topiramate 50 mg - 1 tablet 2 times a day.
-Dated: 3/19/25:
-Methenamine 1 gram - 1 tablet 2 times a day.
-Multivitamin - 1 tablet day.
-Dated: 7/18/25: Briviact 100 mg - 1 tablet 2 x day.
-Dated: 3/28/23: Fluticasone 50 mcg - 1 spray in each nostril daily.
-Dated 3/22/19: Ammonium Lactate 12% Lotion - apply to affected area topically every shift.
-Dated 2/8/18: Lamotrigine 100 mg - 2 1/2 tablets 2 times a day.
-Dated 2/18/18: Vitamin D3 1000 IU - 2 tablets every day.

Review on 2/18/26 of Client #3's MARs from 12/1/25 through 2/17/26 revealed:
-The following 8:00 am medications were circled and initialed to indicate they were not administered on 12/26/25 and 2/8/26 with no exception documented:
-Amlodipine (Hypertension (HTN)) 5 mg - 1 tablet twice daily.
-Atenolol (HTN) 50 mg - 1 tablet twice daily.
-Ciclopirox (fungal infection) 8% Solution - apply to affected nails every day.
-Divalproex ER (extended release) (Anxiety Disorder) 500 mg - 1 tablet twice daily.
-Lisinopril (HTN) 30 mg - 1 tablet daily
-Omega-3 Fish Oil (supplement) 1,200 mg - 1 capsule every day.
-Omeprazole DR (delayed release) (Acid

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Reflux) 40 mg - 1 capsule twice daily.
-Sertraline (OCD) 50 mg - 1 tablet every day.
-Vitamin D3 (supplement) 2000 IU -1 capsule every day.
-Tavaborole (fungal infection) 5% Topical Solution - apply to affected area daily.

Review on 2/19/26 of Client #3's physician orders revealed:
-Dated 1/28/26: Vitamin D3 2000 IU -1 capsule every day.
-Dated 8/18/25: Omeprazole DR 40 mg - 1 capsule twice daily.
-Dated 7/23/25:
-Amlodipine 5 mg - 1 tablet twice daily.
-Atenolol 50 mg - 1 tablet twice daily.
-Divalproex ER (extended release) 500 mg - 1 tablet twice daily.
-Lisinopril 30 mg - 1 tablet daily
-Sertraline 50 mg - 1 tablet every day.
-Dated 7/3/23: Omega-3 Fish Oil 1,200 mg - 1 capsule every day.
-Dated 10/24/22: Ciclopirox 8% Solution (fungus) - apply to affected nails every day.
-Dated 7/7/22: Tavaborole 5% Topical Solution (fungus) - apply to affected area daily.

Interview on 2/18/26 with Staff #1 revealed:
-Client #1 refused his Lidocaine patch this morning (2/18/26).
-This was not documented on the MAR.
-Client #1's medications were not administered twice. "I can guarantee you he did not get his medications twice."

This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type A1 rule violation and must be corrected within 23 days.

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V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the 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: 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). 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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to investigate all allegations of abuse	V 132		

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against health care personnel by conducting an internal investigation and reporting the findings of the investigation to Health Care Personnel Registry (HCPR) within 5 working days as required. The findings are:

Review on 2/18/26 of Staff #2's record revealed:
-Date of hire: 8/27/25.
-Date of termination: 2/27/26.

Review on 2/18/26 of Client #1's record revealed:
-Date of admission: 1/4/25.
-Date of hospital admission: 12/3/25.
-Returned to facility from a local rehabilitation facility: 2/6/26.
-Diagnoses of Multiple Fractures, Spondylosis, Repeated Falls, Arthropathic Psoriasis, Schizoaffective Disorder, Autism Spectrum Disorder, Intellectual Developmental Disorder (IDD), Hypertension (HTN), Gastroesophageal Reflux Disease (GERD), Coronary Artery Disease, Hyperlipidemia, Osteoarthritis, Chronic Pain, Diabetes Mellitus (DM) Type 2, and Vitamin D Deficiency.

Review on 2/19/26 of the local hospital medical records for Client #1 from 11/1/25 through 2/19/26 revealed:
-2/13/26 - "Chief Complaint...FALL...presents via EMS (Emergency Medical Services) from group home after fall...States that he hit the back of his head on the door after rolling out of bed..."

Reviews on 2/17/26 and 2/24/26 of the North Carolina Incident Response Improvement System (IRIS) revealed:
-No IRIS report for Client #1 which would have included a report to the HCPR.

Interview on 2/19/26 with the Department of

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V 132	Continued From page 42 Social Services (DSS) social worker revealed: -He initiated an abuse investigation at the facility on 2/16/26. -The allegation involved Client #1 and occurred 2/13/26 which was observed by EMS. -The staff member involved in the allegation of abuse against Client #1 was Staff #2. -He met Qualified Professional (QP) #2 and Staff #1 while at the facility and notified them of the allegation. Interview on 2/20/26 with Staff #1 revealed: -A DSS worker came to the facility on 2/16/26. -"He read the allegation (of abuse) of what the fire department observed (2/13/26)" regarding Client #1. -"I called [Executive Director/Qualified Professional (ED/QP)]...she was sick so she sent [Finance Director] out (to facility)." -The Finance Director and DSS worker "went outside and talked." Interviews on 2/19/26 and 2/26/26 with the ED/QP revealed: -She became aware of the allegation of abuse against Staff #2 when the DSS social worker came to the facility on 2/16/26. -Staff #2 "was suspended today (2/19/26) and we'll probably eventually term (terminate) her..." -"[Finance Director] is pulling the term (termination) letter today (2/26/26) (regarding Staff #2)..we wanted to make sure we had our ducks in a row (before termination)." -Told the Finance Director on 2/26/26 the IRIS report needed to "happen (be submitted) today...Then we have the 5-day report to make sure it gets in (to IRIS)..." Multiple requests for the internal investigation documentation were made to the ED/QP on	V 132		

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V 132	Continued From page 43 2/19/26, 2/20/26, 2/24/26 and 2/25/26. No documentation was received prior to the survey exit on 3/10/26.	V 132		
V 133	G.S. 122C-80 Criminal History Record Check G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT. (a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter. (b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this	V 133		

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section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency.
(c) Action. - If an applicant's criminal history

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V 133	Continued From page 45 record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant: (1) The level and seriousness of the crime. (2) The date of the crime. (3) The age of the person at the time of the conviction. (4) The circumstances surrounding the commission of the crime, if known. (5) The nexus between the criminal conduct of the person and the job duties of the position to be filled. (6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed. (7) The subsequent commission by the person of a relevant offense. The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant. (d) Limited Immunity. - A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for: (1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual. (2) Failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section.	V 133		

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V 133	Continued From page 46 (e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related	V 133		

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V 133	Continued From page 47 offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5. (f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor. (g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met: (1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10. (2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.) This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a national criminal history record check was requested within five business days of making the conditional offer of employment affecting 1 of 3 audited staff (#1). The findings are:	V 133		

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V 133	Continued From page 48 Review on 2/18/26 of Staff #1's record revealed: -Date of hire: 3/20/23. -No criminal history check. Interview on 2/19/26 with the Executive Director/Qualified Professional (ED/QP) revealed: -Staff #1's criminal history check was not in the employee file. -She would ensure the criminal history check was received. Multiple requests for Staff #1's criminal history check were made to the ED/QP on 2/20/26, 2/24/26 and 2/25/26. No documentation of Staff #1's criminal history check was received prior to the survey exit on 3/10/26.	V 133		
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	V 289		

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V 289	Continued From page 49 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 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).	V 289		

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This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to provide care, habilitation, or rehabilitation services for 3 or 3 audited clients (#1, #2 and #3). The findings are:

Cross Reference: 10A NCAC 27G.0201 Governing Body Policies (V105): Based on record review and interview, the facility failed to implement their admission policy regarding admission screenings affecting 1 of 3 audited clients (#2) and failed to delegate management authority for the operation of the facility.

Cross Reference: 10A NCAC 27G.0203 Competencies of Qualified Professionals and Associate Professionals (V109): Based on record review and interview, 1 of 1 Qualified Professionals (Executive Director/QP) failed to demonstrate the knowledge, skills and abilities to meet the needs of clients.

Cross Reference: 10A NCAC 27G.0205 Assessment and Treatment/Habilitation or Service Plan (V111): Based on record review and interview, the facility failed to ensure an assessment was completed prior to the delivery of services for 1 of 3 audited clients (#2).

Cross Reference: 10A NCAC 27G.0205 Assessment and Treatment/Habilitation or Service Plan (V112): Based on record review and interview, the facility failed to develop and implement treatment goals and strategies to address the needs of 3 of 3 audited clients (#1,

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V 289	Continued From page 51 #2 and #3). Cross Reference: 10A NCAC 27G.5602 Staff (V290): Based on record review and interview, the facility failed to maintain staffing to meet the individualized client needs. Cross Reference: 10A NCAC 27G.5603 Operations (V291): Based on record review and interview, the facility failed to maintain coordination between the facility operator and the professionals responsible for the client's treatment affecting 1 of 3 audited clients (#1). Review on 2/27/26 of the Plan of Protection dated 2/27/26 written by the ED/QP and the Finance Director revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? Corrective Action Steps 1. Immediate QP Supervision Effective immediately, all required QP supervision will be provided by the existing QP team. This includes: Ongoing oversight of service delivery Documentation review Compliance with regulatory and organizational standards 2. Team Lead Reassignment and Retraining The current Team Lead will be reassigned and scheduled for retraining. Retraining will include: supervisory expectations, documentation standards, compliance requirements, and workflow protocols. Completion Deadline: March 7, 2026. 3. Interim Supervision Coverage Until the Team Lead position is permanently filled, QP supervision and oversight responsibilities will be divided among	V 289		

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V 289	Continued From page 52 members of the QP team to ensure uninterrupted support and compliance. Each QP will be assigned specific staff or caseloads to oversee Weekly internal check-ins will be conducted to ensure consistent communication and quality monitoring 4. Medical Appointments & Follow-up Care All medical appointments-including scheduling, transportation coordination, and follow-up recommendations-will be managed by the Team Lead. Oversight will be provided by the QP team and QA Coordinator/Director team to ensure timely completion and documentation. Describe your plans to make sure the above happens. The QP Supervisor will conduct biweekly reviews for 60 days to ensure supervision is occurring as required. Documentation of supervisory activities will be maintained and audited monthly. Any gaps in coverage will be addressed immediately through reassignment within the QP team." Review on 3/2/26 of the addendum to the Plan of Protection dated 3/2/26 written by the Finance Director revealed: "1. Resident Monitoring Staff will conduct safety checks every 15 minutes while residents are awake and every hour while residents are asleep. All checks will be documented in accordance with agency policy. 2. Individual Resident Safety Supports [Client #1]: A bed pad has been purchased and will be installed to support his identified safety needs no later than Friday, March 6, 2026.	V 289		

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V 289	Continued From page 53 [Client #2]: Safety alarms will be put in place to ensure proper supervision and reduce risk of elopement or injury, not later than Friday, March 6, 2026. 3. Immediate QP Supervision [name,[QP], and [name], Quality Assurance Coordinator, will take on interim QP responsibilities for this location, effective immediately. [Quality Assurance Coordinator] will review the files, including treatment plans, incident reports, and staff training, to determine what may be missing and/or what may need further retraining. This will be completed no later than Friday, March 20, 2026. [QP] will review the service delivery by weekday check-ins with the staff. This will begin immediately and continue until March 31, 2026. At that point, the check-ins will move to weekly and on an as-needed basis until a new QP is hired specifically for this location. Compliance with regulatory and organizational standards will be reviewed by March 20, 2026, and retraining for direct care staff and QPs will be provided as needed,, based on the results of the internal review. Hiring efforts for a new QP will be increased and will be focused on having a new QP in place no later than March 27, 2026, or as soon as possible. New hire training for the new QP will be provided by the Finance Director [name], [QP] and QA Coordinator. 4...Oversight will be provided by [name], QA Coordinator to ensure timely completion and documentation... Describe your plans...The Finance Director will conduct biweekly reviews for 60 days to ensure supervision is taking place as required. Any issues of concern will be documented and	V 289		

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V 289	Continued From page 54 addressed by the Finance Director." Review on 3/3/26 of the second addendum to the Plan of Protection dated 3/3/26 written by the Finance Director revealed: "..[Quality Assurance Coordinator] will review the files...This will be completed no later than Friday, March 13, 2026...Compliance with regulatory and organizational standards will be reviewed by March 13, 2026 This facility served adults with Developmental Disabilities with diagnoses of Multiple Fractures, Spondylosis, Arthropathic Psoriasis, Schizoaffective Disorder, Autism Spectrum Disorder, Intellectual Developmental Disability, Hypertension, Gastroesophageal Reflux Disease, Coronary Artery Disease, Hyperlipidemia, Osteoarthritis, Chronic Pain, Diabetes Mellitus Type 2, Vitamin D Deficiency, Unspecified Mood Disorder, Epilepsy, Post Traumatic Stress Disorder, Dementia, Traumatic Brain Injury, Anxiety Disorder, Cerebral Palsy, Gingivitis, General Anxiety Disorder, Obsessive Compulsive Disorder and Intermittent Explosive Disorder. Client #2 had an unknown transfer date to the current facility, approximately 2 months ago, and no initial screening assessment and no assessment prior to the delivery of services was documented. The treatment plans in the facility file for Client #1 expired 12/1/23, Client #2's treatment plan expired 1/31/25, and Client #3 treatment plan expired 8/13/21. Staff interviews confirmed lack of access to current PCPs and were unaware of any updated goals or interventions. Client #1 had multiple falls from 11/19/25 through 2/13/26. One fall resulted in fractures to his face. After returning from the rehabilitation facility, he continued to fall. Staff were not aware of any updated interventions to	V 289		

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V 289	Continued From page 55 help reduce falls. After each hospital visit relating to falls, 11/19/25, two times on 11/29/25, 12/3/25 and 2/13/26, the discharge recommendations were to follow up with his Primary Care Physician. Client #1 had not been to his Primary Care Physician since 11/20/25. Client #2 had a history of seizures and leaving the facility without staff knowledge. The most recent incident was on 2/4/26 when she left without staff knowledge, and while in the community, had a seizure and hit her head on the concrete. This resulted in a hospital visit to apply staples to her scalp to repair a laceration. One staff reported being unaware of any updated supervision requirements to maintain the safety of clients. One staff felt the expectation of supervision was not reasonable due to the inability to consistently monitor the needs of Clients #1 and #2. Staff reported being instructed to not lift Client #1 after a fall. This resulted in repeated calls to emergency responders without a medical need, calling a previous staff member or a staff off duty and using inappropriate measures to lift the client by pulling him up by his jacket. Multiple requests for client records and critical incidents were made to the ED/QP between 2/19/26 and 2/26/26. The ED/QP was unresponsive to a scheduled interview and did not provide requested documents prior to exiting the survey. During her scheduled absence there was no delegation of management authority as nobody knew what to do or who to call. 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	V 290		

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V 290	Continued From page 56 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: (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	V 290		

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V 290	Continued From page 57 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 review and interview, the facility failed to maintain staffing to meet the individualized client needs. The findings are: Review on 2/18/26 of Client #1's record revealed: -Date of admission: 1/4/25. -Hospital admission: 12/3/25. -Returned to facility from a local rehabilitation facility 2/6/26. -Diagnoses: Multiple Fractures, Spondylosis, Repeated Falls, Arthropathic Psoriasis, Schizoaffective Disorder, Autism Spectrum Disorder, Intellectual Developmental Disorder (IDD), Hypertension, Gastroesophageal Reflux Disease, Coronary Artery Disease, Hyperlipidemia, Osteoarthritis, Chronic Pain, Diabetes Mellitus Type 2, and Vitamin D Deficiency. Review on 2/19/26 of facility incident reports regarding Client #1 from 11/1/25 through 2/19/26 revealed: -Falls on 11/19/25, 11/29/25 at 1:34 am and 11/29/25 12:18 pm. Review on 2/19/26 of Client #1's medical records from a local hospital dated 2/13/26 revealed: -"ER (Emergency Room) Report...Chief Complaint...FALL...presents via EMS (Emergency	V 290		

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V 290	Continued From page 58 Medical Services) from group home after fall..." Review on 2/18/26 of Client #2's record revealed: -No date of admission documented. -Diagnoses: Unspecified Mood Disorder, Epilepsy, Post-Traumatic Stress Disorder, Mild IDD, Dementia and Traumatic Brain Injury. -Safety Plan - updated 1/27/23 - " ...continued to leave the group home (previous placement) to walk to the store for cigarettes and sometimes soda. She would leave the home when DSPs (Direct Support Professionals) were distracted and walk...[Client #2] has had seizures while walking down the road and has fallen ...While in the house, staff must lay eyes on [Client #2] every 10 minutes, except when asleep ..." Interviews on 2/17/26 and 2/18/26 with Client #2 revealed: -She had a seizure "a couple of weeks ago" and "got 4 staples in my head." -"Walked down there (local gas station)...a (unknown) man came up and walked with me the rest of the way...[Staff #1] knew I left..." Review on 2/18/26 of Client #3's record revealed: -Date of admission: 5/14/09. -Diagnoses: Anxiety Disorder, Severe IDD, Cerebral Palsy, HTN, Hyperlipidemia, Acid Reflux, Gingivitis, Generalized Anxiety Disorder, Obsessive Compulsive Disorder and Intermittent Explosive Disorder. Review on 3/3/26 of Client #4's record revealed: -Date of admission: "06/2018." -Diagnoses: Severe IDD, Seizure Disorder, Vagus Nerve Stimulant, Oppositional Deviant Disorder, Chronic Constipation and Ataxia (loss of muscle control.)	V 290		

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V 290	Continued From page 59 Interviews on 2/17/26, 2/20/26 and 2/24/26 with Staff #1 revealed: -Client #1 fell during her shift on 2/9/26 and she completed an incident report for this...I was in the kitchen cooking when this happened...He has been falling for the last 4-5 months...he is not stable on his feet anymore...[Executive Director/Qualified Professional (ED/QP)] said every time you hear him move you got to move...I can't watch them (clients) all the time...I may be cooking, changing [Client #4]. Sometimes when [Client #2] is out smoking she may have a seizure...so I need to watch her...we need a second person (staff) here...at least until 2:00 pm - 4:00 pm...that would help..." -"I can't lift [Client #1]...told [Human Resources (HR) Director[and [ED/QP] this...was told to call for assistance...[HR Director] said 'To tell him [Client #1] to roll over onto his knees' in order to assist in lifting him...he won't do this...EMS said 'we can't keep calling' them just to get him off the floor...so call [one male who previously worked at facility or another male staff who worked weekends]...they always come for me...(to help get Client #1 up)." -"[Client #2]...if you don't give her what she wants (soda or cigarette) she wanders off...I made the decision to look on her more often...When she (Client #2) first moved here...no one ever told me she walks off...[Staff #2] picked her up...she made it to the stop sign (at the end of facility street)...she is used to going everyday and now she is not...[Client #1] is used to going with his mom. If get a second person can get all of them out..." -"I have been asking for a second person (staff)...before [Client #2] came, because [Client #1] had been falling a lot." Interviews on 2/18/26 and 2/20/26 with Staff #2	V 290		

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V 290	Continued From page 60 revealed: -Denied being told to check on Client #1 any certain amount of time "would check on [Client #1] more often - asked him to leave his door open so could hear him...Was told never to lift [Client #1], to always get help...by [Staff #1] and then [HR Director] told me this...Started calling the Fire Department and they said 'We can't keep coming out to get him off the floor.' That's when I started getting him up by myself. When there at nighttime can't call anyone else...what else do I do when the Fire Department told me not to call...pulling him up by his jacket, that's how I have to do it now..." -Client #2 "...gets upset with (not getting) soda and cigarettes...will walk off property...got off work one morning (date unknown) and went back to house (facility) for pocket book, by time got back (to facility) [Client #2] was sitting up on the curb of the road...got her in the car and took her to the store and got her a drink..." Interview on 2/19/26 with the ED/QP revealed: -Aware Client #1 fell 11/19/26 and "a couple more times in a row...this was staffed with the treatment team as well as DSPs to assist [Client #1] or be with him when he is ambulating...and to check on him more frequently..." -Aware Client #2 left the facility (2/4/26). "I'm the one that went to get her at the gas station...I couldn't see that she had injured her head that bad due to her hair...but she ended up getting like 3 staples..." -Working on getting more staff for the facility. 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 291	Continued From page 61	V 291		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain coordination between the facility	V 291		

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V 291	Continued From page 62 operator and the professionals responsible for the client's treatment affecting 1 of 3 audited clients (#1). The findings are: Review on 2/18/26 of Client #1's record revealed: -Date of admission: 1/4/25. -Hospital admission: 12/3/25. -Returned to facility from a local rehabilitation facility 2/6/26. Review on 2/19/26 of the local hospital medical records for Client #1's Emergency Room (ER) Reports from 11/1/25 through 2/19/26 revealed: -11/19/25 - "Chief Complaint..FALL...70-year-old male with history of autism residing in group home here for evaluation after a fall. Per report, he was standing on a porch at his group home facility and tripped while walking following several feet landing on the ground. Did strike the right side of his head sustaining a laceration to his right eyebrow...Assessment/Plan 1. Orbital floor fracture 2. Eyebrow laceration 3. Fall...Repair: Simple, 1 layer, 5-0 Vicryl (synthetic absorbable) suture, running. 6 total sutures...Please follow closely with ophthalmology for further evaluation..." -11/29/25 - 2:30 am - "...70-year-old male presenting to the emergency department via EMS (emergency medical services) for fall out of bed. Patient has a history of recurrent falls with recent facial injuries...Patient subsequently discharge home (facility) with plan to follow-up with PCP (Primary Care Physician) outpatient..." -11/29/25 - 1:46 pm - "...Chief Complaint...Fall...lives in adult group home and is known to the ER (emergency room) for frequent falls. He was actually seen this morning...Upon returning to the facility he had another fall. He did hit his head...He has bruising to the face and left temporal region all at different stages of	V 291		

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V 291	Continued From page 63	V 291		

healing...He does have known existing orbital fractures...Patient is discharged back to facility...Your ED (emergency department) Physician recommends that you follow up with: Your Primary Care Provider."
-12/3/25 - "...recurrent falls who presented initially due to chest discomfort...he was also noted to have multiple recent falls...Regarding the falls, patient was identified to have orthostatic hypotension. All of his antihypertensive regimen was discontinued...At this time, patient is medically stable for discharge to postacute rehab with followup...All antihypertensives were held on discharge (12/7/25)."
-2/13/26 - "Chief Complaint...FALL...presents via EMS from group home after fall...States that he hit the back of his head on the door after rolling out of bed...Diagnosis/Disposition 1. Fall from bed 2. Low back pain...Thankfully, no new fractures were noted seen...Follow-up with a primary care doctor in the next 2-3 days to discuss your emergency department visit, follow up pending studies, and for continued evaluation and management of your long-term health..."

Interview on 2/23/26 with Staff #1 revealed:
-Client #1's most recent visits to his PCP were 11/7/25 (office visit) and 11/20/25 (video visit).
-Client #1's next appointment was scheduled for 3/12/26.
-Had not been back to his PCP since being discharged from rehabilitation facility.

Attempted interviews on 2/25/26 and 3/2/26 with Client #1's PCP were unsuccessful as a return call was not received prior to survey exit.

Attempted reviews on 2/19/26, 2/20/26, 2/24/26 and 2/25/26 of Client #1's medical appointments was unsuccessful as no documentation was

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V 291	Continued From page 64 provided prior to exit on 3/10/26. Multiple requests for Client #1's medical appointments were made to the Executive Director/Qualified Professional (ED/QP) on 2/19/26, 2/20/26, 2/24/26 and 2/25/26. The documentation was not provided by the survey exit date 3/10/26. Review of the email correspondence on 2/24/26 from the ED/QP to the Division of Health Service Regulation surveyor dated 2/24/26 revealed: -"I believe his (Client #1's) most recent Report of Health svcs (services) are at the group home. I will get those and send them over this afternoon." -No further documentation was received prior to exit of the survey on 3/10/26. 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 291		
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	V 366		

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V 366	Continued From page 65 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 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	V 366		

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V 366	Continued From page 66 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 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	V 366		

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V 366	Continued From page 67 (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement written policies governing their response to Level II and Level III incidents. The finding are: Review on 2/19/26 of the local hospital medical records for Client #1 from 11/1/25 through 2/19/26 revealed: -11/19/25 - Client #1 -"Chief Complaint..FALL...Did strike the right side of his head sustaining a laceration to his right eyebrow...Orbital floor fracture 2. Eyebrow laceration...Vicryl (synthetic absorbable) suture, running. 6 total sutures..." -2/4/26 - Client #2 - "...Patient (Client #2) had a witnessed seizure at a gas station she had walked there to get cigarettes...She fell and struck her head and has a right septal scalp hematoma...scalp laceration...staples..." -2/13/26 - Client #1 -"Chief Complaint...FALL...presents via EMS (emergency medical services) from group home after fall..." Review on 3/2/26 of the local Fire Department incident report for Client #1 dated 2/13/26 revealed: -Responded to a fall at "Residential - Group Home...Investigation; Forcible Entry...Upon entering the main lobby area...could hear a woman's (Staff #2) voice screaming and cursing saying 'get up now, get your a*s up'...when	V 366		

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V 366	Continued From page 68 entered the room, a health care worker (Staff #2) was violently dragging a resident (the caller (Client #1)), across the floor by his arm while yelling at him and while the resident moaned in pain because the arm was twisted. The health care worker would not let go of the resident and kept jerking his arm even after [Fire Department responder] told her to 'stop and step back...'" Review on 2/19/26 of the facility's incident reports regarding Clients #1 and #2 from 11/1/25 through 2/19/26 revealed: -11/19/25 - 8:45 pm - Fall occurred outside - "...He (Client #1) started down the sidewalk. I (Staff #2) prompted [Client #1] 3 times to take his walker and (he) said 'Naugh' each time. I continued sweeping off the porch when I turned back around I saw [Client #1] lying on the ground. I ran over to him to help get him up and saw that his eye was bleeding so I got him up and walked him back to the chair on the porch...I called the EMS to check him out. I got peroxide and cleaned his face free of the blood held pressure to stop the flow waited on EMS..." -2/4/26 - no incident report for Client #2 who left the facility without staff knowledge, had a seizure while in the community, requiring staples to her scalp. -2/13/26 - no incident report for an abuse allegation of Staff #2 against Client #1 after a fall in his bedroom. Reviews on 2/17/26 and 2/24/26 of the North Carolina Incident Response Improvement System (IRIS) revealed: -Level II incident for Client #1 dated 11/20/25 "...While going outside, [Client #1] was walking without his walker. Staff redirected him on 3 occasions to get his walker. [Client #1] fell on the ground outside and fell face forward and injuring	V 366		

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V 366	Continued From page 69 his eye. [Client #1] was transported by EMS to the [local hospital]." -No attachments to Client #1's level II incident to determine the facts and causes of the incident, no recommendations to minimize future occurrences, no internal review within 24 hours of the incident, no 5 day written report of preliminary findings, and no notification to the client's legal guardian. -2/4/26 -No IRIS report for Client #2 who required medical treatment. -2/13/26 -No IRIS report for Client #1 which would have included a referral to the Health Care Personnel Registry for Staff #2 due to an abuse allegation. Interview on 3/3/26 with Client #1 and Staff #1 revealed: -Client #1 was comfortable with Staff #1's presence during the follow up interview. -11/19/25 - before he fell he was "trying to take the trash out...[Staff #2] told me to do it...I told her I wasn't capable of walking over the rocks (at the end of the driveway)...Tried to take it (trash) out and fell down on cement on driveway..." -2/13/26 - "I fell out of bed on my own...I called 911...She (Staff #2) tried to pull me up on my bed...by my hands...I volunteered to go to the hospital...hurt my lower back..." Interviews on 2/17/26 and 2/18/26 with Client #2 revealed: -She had a seizure "a couple of weeks ago" and "got 4 staples in my head." -"Walked down there (local gas station)...a (unknown) man came up and walked with me the rest of the way...[Staff #1] knew I left..." Interviews on 2/17/26, 2/20/26 and 2/24/26 with Staff #1 revealed:	V 366		

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V 366	Continued From page 70	V 366		

-Client #1 fell during her shift on 2/9/26 and she completed an incident report for this..."
-"[Client #2]...if you don't give her what she wants (soda or cigarette) she wanders off...[Staff #2] picked her up (unknown date)...she made it to the stop sign (at the end of Marne street)..."

Interviews on 2/18/26 and 2/20/26 with Staff #2 revealed:
-Client #2 "...gets upset with (not getting) soda and cigarettes...will walk off property...got off work one morning (date unknown) and went back to house (facility) for pocket book, by time got back (to facility) [Client #2] was sitting up on the curb of the road...got her in the car and took her to the store and got her a drink...[Staff #1] did the incident report..."

Interview on 2/19/26 with the Executive Director/Qualified Professional (ED/QP) revealed:
-Incident with Client #1 on 11/19/25 was reviewed as a "critical incident" and reviewed by the treatment team.
-Was not aware Client #1 fell on 2/9/26.
-"Yes," there was an incident report for Client #2 on 2/4/26. "...I'm the one that went to get her (Client #2) at the gas station. She had fallen and EMS was already there...I couldn't see that she had injured her head that bad due to her hair...But she ended up getting like 3 staples..."
-She would obtain the critical incident review for Client #1 and the incident report for Client #2 for the Division of Health Service Regulation (DHSR) surveyor.
-Became aware of the allegation of abuse by Staff #1 against Client #1 when the Department of Social Services arrived at the facility on 2/16/26.

Multiple requests for the incident reports were

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V 366	Continued From page 71 made to the ED/QP on 2/19/26, 2/20/26, 2/24/26 and 2/25/26. No further incident reports or risk-cause analysis of incidents were received prior to the survey exit on 3/10/26.	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: (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:	V 367		

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V 367	Continued From page 72 (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 .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;	V 367		

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V 367	Continued From page 73 (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 review and interview, the facility failed to report all level II and Level III incidents in the Incident Response Improvement System (IRIS) and failed to notify the Local Management Entity (LME)/ Managed Care Organization (MCO) responsible for the catchment area where services are provided within the required time frames. The findings are: Review on 2/19/26 of facility incident reports regarding Clients #1 and #2 from 11/1/25 through 2/19/26 revealed: -2/4/26 - no incident report for Client #2 who had a seizure requiring staples to her scalp. -2/13/26 - no incident report for an abuse allegation of Staff #2 against Client #1 after a fall in his bedroom. Reviews on 2/17/26 and 2/24/26 of the North Carolina Incident Response Improvement System (IRIS) revealed: -2/4/26 -No IRIS report for Client #2 who required medical treatment after a seizure.	V 367		

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V 367	Continued From page 74 -2/13/26 -No IRIS report for Client #1 for an abuse allegation regarding Staff #2 that the facility learned about on 2/16/26. Interviews on 2/19/26 and 2/26/26 with the Executive Director/Qualified Professional (ED/QP) revealed: -"Yes," there was an incident report for Client #2 on 2/4/26. "...I'm the one that went to get her (Client #2) at the gas station. She had fallen and EMS (emergency medical services) was already there...I couldn't see that she had injured her head that bad due to her hair...But she ended up getting like 3 staples..." -She was already aware of the abuse allegation against Staff #2 when the Department of Social Services came to the facility on 2/16/26. -Told the Finance Director on 2/26/26 the IRIS report needed to "happen (be submitted) today...Then we have the 5-day report to make sure it gets in (to IRIS)..." Multiple requests for the incident reports were made to the ED/QP on 2/19/26, 2/20/26, 2/24/26 and 2/25/26. No further incidents reports were received prior to the survey exit on 3/10/26.	V 367		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (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. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social	V 500		

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V 500	Continued From page 75 Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (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. (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: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (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: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (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: (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	V 500		

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V 500	Continued From page 76 renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure all allegations of abuse were reported to the local Department of Social Services (DSS) affecting 1 of 3 audited clients (#1). The findings are: Review on 2/18/26 of Client #1's record revealed: -Date of admission: 1/4/25. -Date of hospital admission: 12/3/25. -Returned to facility from a local rehabilitation facility: 2/6/26. -Diagnoses of Multiple Fractures, Spondylosis, Repeated Falls, Arthropathic Psoriasis, Schizoaffective Disorder, Autism Spectrum Disorder, Intellectual Developmental Disorder (IDD), Hypertension (HTN), Gastroesophageal Reflux Disease (GERD), Coronary Artery Disease, Hyperlipidemia, Osteoarthritis, Chronic Pain, Diabetes Mellitus (DM) Type 2, and Vitamin D Deficiency. Review on 2/19/26 of facility incident reports regarding Client #1 from 11/1/25 through 2/19/26 revealed: -2/13/26 - no incident report for an abuse allegation of Staff #2 against Client #1 after a fall	V 500		

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V 500	Continued From page 77 in his bedroom. Reviews on 2/17/26 and 2/24/26 of the North Carolina Incident Response Improvement System (IRIS) revealed: -2/13/26 - no IRIS report for an abuse allegation of Staff #2 against Client #1. Interview on 2/17/26 with Staff #1 revealed: -DSS came to the facility on 2/16/26 and spoke to her and the Finance Director about an allegation of abuse against Client #1. Interview on 2/19/26 with the Executive Director/Qualified Professional (ED/QP) revealed: -Became aware of the allegation of abuse by Staff #2 against Client #1 when DSS arrived at the facility on 2/16/26. -Would obtain required incident reports which would include notifications to DSS regarding the abuse allegation involving Staff #2 and Client #1 on 2/13/26. Multiple requests for documentation of notification to DSS for the abuse allegation involving Staff #2 and Client #1 on 2/13/26 was requested from the ED/QP on 2/19/26, 2/20/26, 2/24/26 and 2/25/26. No documentation was received prior to the survey exit on 3/10/26.	V 500		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC	V 512		

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V 512	Continued From page 78 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on observation, record review and interview, 1 of 2 paraprofessional staff (#2) abused 1 of 3 audited clients (#1). The findings are: Observations on 2/18/26 at 1:55 pm and 2/24/26 at 2:23 pm revealed: -A concrete porch area that was covered by the roof of the facility, and level when exiting from inside the facility. -Extended evenly from the porch was a sidewalk approximately 40 feet long and 5 feet wide. -The sidewalk had a slight decline down toward the driveway. -At the end of the sidewalk, there was a step down, approximately 3 inches, before reaching the 2 larger steps that were approximately 3 feet wide and 2 feet long each.	V 512		

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V 512	Continued From page 79 -The steps led to the paved driveway, which was at a slight decline. -As descending the driveway the decline became steeper. -From the steps to the end of the driveway, where the trash cans were located, was approximately 30 feet. -At the end of the driveway, the pavement ended into a rock area, where the trash cans were positioned. There was a gap between the pavement and rocks that was approximately 3 inches deep. Review on 2/18/26 of Staff #2's record revealed: -Date of hire: 8/27/25. -Date of termination: 2/27/26. -Job title: Direct Support Professional. -"Overview of Abuse and Neglect of Individuals with IDD (Intellectual Developmental Disability)" training completed 8/28/25. -Client Rights training acknowledged and signed 8/26/25. Review on 2/18/26 of Client #1's record revealed: -Age: 70 years old. -Date of admission: 1/4/25. -Hospital admission: 12/3/25. -Returned to facility (from local rehabilitation facility): 2/6/26. -Diagnoses of Multiple Fractures, Spondylosis, Repeated Falls, Arthropathic Psoriasis, Schizoaffective Disorder, Autism Spectrum Disorder, IDD, Hypertension, Gastroesophageal Reflux Disease, Coronary Artery Disease, Hyperlipidemia, Osteoarthritis, Chronic Pain, Diabetes Mellitus Type 2, and Vitamin D Deficiency. -1/6/26 - Person-Centered Plan - "...Safety and Security...He (Client #1) requires daily assistance and reminders from staff to use his walker, which	V 512		

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V 512	Continued From page 80 helps increase his safety when walking...Healthy Living...[Client #1] has continued to have increased falls and needs support to decrease his falls...[Client #1] will utilize the use of all adaptive equipment to be safe in his home...Interventions...Staff will assist [Client #1] to utilize his walker when walking at all times..." Review on 2/19/26 of facility incident reports regarding Client #1 from 11/1/25 through 2/19/26 revealed: -11/19/25 - 8:45 pm - Fall occurred outside - "...He (Client #1) started down the sidewalk. I (Staff #2) prompted [Client #1] 3 times to take his walker and (he) said 'Naugh' each time. I continued sweeping off the porch when I turned back around I saw [Client #1] lying on the ground. I ran over to him to help get him up and saw that his eye was bleeding so I got him up and walked him back to the chair on the porch...I called the EMS (Emergency Medical Services) to check him out. I got peroxide and cleaned his face free of the blood held pressure to stop the flow waited on EMS..." -2/13/26 - no incident report for a fall. Review on 2/17/26 of the North Carolina Incident Response Improvement System (IRIS) revealed: -Level II incident for Client #1 dated 11/20/25 completed by the Human Resources/Program Director. -"Incident Comments...While going outside, [Client #1] was walking without his walker. Staff redirected him on 3 occasions to get his walker. [Client #1] fell on the ground outside and fell face forward and injuring his eye. [Client #1] was transported by EMS to the [local hospital]." Review on 2/19/26 of the local hospital medical records for Client #1 from 11/1/25 through	V 512		

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V 512	Continued From page 81 2/19/26 revealed: -11/19/25 - "Chief Complaint..FALL...70-year-old male with history of autism residing in group home here for evaluation after a fall. Per report, he was standing on a porch at his group home facility and tripped while walking following several feet landing on the ground. Did strike the right side of his head sustaining a laceration to his right eyebrow...Assessment/Plan 1. Orbital floor fracture 2. Eyebrow laceration 3. Fall...Repair: Simple, 1 layer, 5-0 Vicryl (synthetic absorbable) suture, running. 6 total sutures...Please follow closely with ophthalmology for further evaluation..." -2/13/26 - "Chief Complaint...FALL...presents via EMS from group home after fall...States that he hit the back of his head on the door after rolling out of bed...Diagnosis/Disposition 1. Fall from bed 2. Low back pain...Thankfully, no new fractures were noted seen...Follow-up with a primary care doctor in the next 2-3 days to discuss your emergency department visit, follow up pending studies, and for continued evaluation and management of your long-term health..." Review on 3/2/26 of the local Fire Department incident report for Client #1 dated 2/13/26 revealed: -Responded to a fall at "Residential - Group Home...Investigation; Forcible Entry; EMS-Patient (Client #1) Assessment...Primary Narrative:...arrived on scene to Marne mental health facility for a call regarding a fall that was made by a resident (Client #1)...arrived at the front door that was locked and after knocking several times with no answer, was able to jimmy the door open. Upon entering the main lobby area...could hear a woman's (Staff #2) voice screaming and cursing saying 'get up now, get your a*s up'...when entered the room, a health	V 512		

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V 512	Continued From page 82 care worker (Staff #2) was violently dragging a resident (the caller (Client #1)), across the floor by his arm while yelling at him and while the resident moaned in pain because the arm was twisted. The health care worker would not let go of the resident and kept jerking his arm even after [Fire Department responder] told her to 'stop and step back.' The worker asked 'how the h**l' we got in and that nobody told us we could come in...told her that 'a resident had called 911' and that she 'should have let us in instead of dragging the elderly and mentally ill patient around his room.' She then told us to 'leave,' and we said 'no' that we were going to check on the patient (Client #1). The patient advised that he was hurt and wanted to go to the hospital. The health care worker told us 'no, he will not be going'...advised the worker that it was not her decision and to leave the room...went to the office in an attempt to obtain a medical jacket (record) for the patient. The worker was unable to print any information for the patient, so we took it out of the file to send with EMS..." Interview on 2/17/26 with Client #1 revealed: -"I want to move to another place...don't get along with her (Staff #2)...she acts mean..." -Denied Staff #2 touched him or dragged him across the floor. Interview on 3/3/26 with Client #1 and Staff #1 revealed: -Client #1 was comfortable with Staff #1's presence during the follow up interview. -11/19/25 - before he fell he was "trying to take the trash out...[Staff #2] told me to do it...I told her I wasn't capable of walking over the rocks (at the end of the driveway)...I don't remember what she (Staff #2) said after that...Tried to take it (trash) out and fell down on cement on driveway...yeah	V 512		

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V 512	Continued From page 83 (was scared of Staff #2)...you know...(scared of) her temper..." -Staff #1 stated she was leaving her shift at 8:00 pm (11/19/25), and Staff #2 "was already talking to [Client #1] about taking his trash out of the room...I said, 'Don't take it now, it's dark outside, we will get it tomorrow...I left...as soon as I got home (10 minutes later), [Staff #2] called and said he (Client #1) fell taking out the trash and was 'bleeding so bad...'" -Client #1 confirmed Staff #2 instructed him take out the trash that evening. -He did not remember where Staff #2 was while he was taking the trash out or after he fell. -2/13/26 - "I fell out of bed on my own...I called 911...She (Staff #2) tried to pull me up on my bed...by my hands...I volunteered to go to the hospital...hurt my lower back..." -Denied Staff #2 grabbed him anywhere other than his hands. Interviews on 2/17/26 and 2/18/26 with Client #2 revealed: -Staff #2 was "really mean and rude...she grabbed my jacket the other day...she grabbed [Client #1] by the arm and was pulling him...she made [Client #3] cry the other day...no, did not see [Client #1] when he fell" at the end of the driveway. -Has told the Executive Director/Qualified Professional (ED/QP) how mean and rude Staff #2 was. -The ED/QP told her they were going to hire new staff. Attempted interview on 2/17/26 with Client #3 was unsuccessful as he said, "yeah" or "no" and pointed to items in the room. Interview on 2/24/26 with Client #1's brother	V 512		

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V 512	Continued From page 84 revealed: -On 2/13/26, "EMS called me to tell me what he had witnessed...it was surprising...he (unknown name of Fire Department responder) called to say he saw [Client #1] what looked like being dragged and kicked (by unknown staff member)...He said he was transporting him (to emergency room) because concern of what he saw staff (Staff #2) do and didn't want to bring him back (to the facility). EMS said he felt the 'staff was treating him (Client #1) cruelly.'" Interviews on 2/17/26, 2/20/26 and 2/24/26 with Staff #1 revealed: -On 2/13/26, she had just gotten home from her shift and Client #1's brother called her. He stated that Client #1 had just called him and said, "'He (Client #1) was on the floor in his bedroom.' I said let me call [Staff #2]. Said can you go in and see if [Client #1] is on the floor. She said '[Client #1] fell in front of his bedroom door'...She (Staff #2) had to push it (the door) open a little...said 'Come on. Come on.' Heard him (Client #1) say, 'I can't do it. I can't do it.' I was still on the phone when she was yelling at him telling him to get up off the floor, you know I can't pick you up. She has a loud voice...she was yelling at him so loud she couldn't hear the Fire Department at the door...the Fire Department said, 'Don't yell at him.' [Staff #2] said, 'Who let you in here? I didn't let you in here'...she said, 'You can't just come in here'...The man (Fire Department responder) said, 'Don't holler at him. We'll take over from here'..." Interviews on 2/18/26 and 2/20/26 with Staff #2 revealed: -She was working when Client #1 fell on 11/19/25 and 2/13/26. -Was told, by Staff #1 and the Human	V 512		

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V 512	Continued From page 85 Resources/Program Director "never to lift [Client #1]...to always get help..." -Supervision expectation was to "make sure they (clients) don't hurt self...to redirect them...always meeting them where they are at." -11/19/25 - "I was sweeping off the porch. [Client #1] came from the door with trash in his hand. I said, 'leave it there and I'll take it out.' I'm sweeping the porch off. I said, 'I've got the trash.' He (Client #1) persisted...he tried to do it anyway...'Don't move without that walker [Client #1].' Stopped him at the steps...'Don't go down the steps...Don't go off the sideway'...and he still trying to get down the steps. 'I'll take the trash out.' So, I kept sweeping the porch. He had a walker all the way to the steps and wouldn't use it. So, I turned around and he was on his way down (falling)...That scared me. He was constantly bleeding from his eye and from his nose...it was steady bleeding..." -2/13/26 - "The last time [Client #1] supposedly had fallen...think he slid to the floor...feet slipped from under him. He was in the bed and then trying to pull himself up and the wheels on the walker moved and made him slip. [Client #1] was sitting in front of the door...took me a minute to get in...he had called 911...and his brother...His brother called [Staff #1] and [Staff #1] called me. I had just did the hourly check. He wasn't bleeding...I asked him to roll over on his side and try to get on his knees where I could squeeze through the door...I had a hold of his jacket...trying to get him up on the bed...I was telling him (Client #1), frantically, to 'help me, help me [Client #1]'...then a fireman came in and it really startled me...I raised my voice at them, 'Who are you? How did you get in here.' They never knocked. The way they came in it startled me and I could have dropped him. (Client #1) never yelled out I was hurting his arm...he never	V 512		

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V 512	Continued From page 86	V 512		

yelled out in pain. I would never do anything to harm anyone in that position. It is bothering me they forced their way into the house. EMS saw me pulling him up..."
-Denied grabbing, dragging or twisting Client #1 by the arm.

Requested via email to the Executive Director/Qualified Professional (ED/QP) on 2/19/26, 2/20/26, 2/24/26 and 2/25/26 the Critical Incident report and any disciplinary action against Staff #2. The requested documents were not received prior to the survey exit on 3/10/26.

Review of the email correspondence from the ED/QP to the Division of Health Service Regulation surveyor dated 2/24/26 revealed:
-"Here's the rest of [Client #3's] requested docs (documents). Sending [Client #2's] next. Then will send the critical inc. (incident) reviews for [Client #1]."

Interview on 2/19/26 with the ED/QP revealed:
-The Human Resources/Program Director was on leave and unavailable.
-The incident on 11/19/25 was reviewed as a "Critical Incident."
-Would locate the documentation for the critical review.
-Staff #2 "was suspended today (2/19/26) and we'll probably eventually term (terminate) her..."
Received complaints about Staff #2, "but it wasn't ever anything specific..."
-Would look for any disciplinary actions against Staff #2, but "I don't think there are any."

Attempted telephone interview on 2/26/26 with the ED/QP revealed:
-No response to the scheduled telephone interview, a message was left to please return

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V 512	Continued From page 87 call. Interview on 2/26/26 with the Finance Director revealed: -She would contact the ED/QP to call the DHSR surveyor. Interview on 2/26/26 with the ED/QP revealed: -"[Finance Director] is pulling the term (termination) letter today (2/26/26) (regarding Staff #2)..we wanted to make sure we had our ducks in a row (before termination)." Review on 2/27/26 of the Plan of Protection dated 2/27/26 written by the ED/QP and the Finance Director revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? Immediate Personnel Action The staff responsible for the deficiencies was suspended immediately. The staff has since been terminated. An IRIS/HCR (Health Care Registry) report will be completed and submitted per regulatory requirements. Describe your plans to make sure the above happens. Termination is complete." Review on 3/2/26 of the addendum to the Plan of Protection dated 3/2/26 written by the Finance Director revealed: -"The director team [ED/QP and Finance Director] was notified of the incident on February 16, 2026. The staff responsible for the deficiencies was suspended immediately (February 19, 2026), pending investigation. The staff has since been terminated (effective February 27, 2026). An IRIS/HCR report will be completed.... These will	V 512		

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V 512	Continued From page 88	V 512		

be completed no later than March 4, 2026.
-The finance director [Finance Director] will confirm that the IRIS/HCR reports are completed no later than end of business on Wednesday, March 4, 2026."

This facility served adults with Developmental Disabilities. Client #1 had diagnoses of Multiple Fractures, Other Fall, Spondylosis, Repeated Falls, Arthropathic Psoriasis, Schizoaffective Disorder, Autism Spectrum Disorder, IDD, Hypertension, Gastroesophageal Reflux Disease, Coronary Artery Disease, Hyperlipidemia, Osteoarthritis, Chronic Pain, Diabetes Mellitus Type 2, and Vitamin D Deficiency. Client #1, a 70-year-old individual with multiple medical conditions and a history of repeated falls, had a person-centered plan requiring staff assistance and reminders to use a walker at all times to increase safety and reduce falls. On 11/19/25 Client #1 fell outside while attempting to take trash to the end of the driveway and sustained an orbital floor fracture and eyebrow laceration requiring sutures. Client #1 later reported that Staff #2 had instructed him to take the trash out despite his concerns about walking over the rocks. Staff #2 stated while Client #1 was standing at the steps on the sidewalk, she turned around and continued to sweep the porch. Staff #2 left Client #1 alone while standing at the top of the steps that he later went down and fell. On 2/13/26 Client #1 fell in his bedroom and called 911. Fire Department responders forced entry after receiving no answer at the door and observed Staff #2 yelling at Client #1 and violently dragging him across the floor by his arm while he moaned in pain. Staff #2 reportedly continued jerking his arm until instructed to stop and initially attempted to prevent responders from transporting him to the hospital. Client #1 was

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V 512	Continued From page 89 transported for medical evaluation and treated for a fall and low back pain. Client #1 reported that Staff #2 was often rude and had previously grabbed Client #1 by the arm. Client #1's brother reported that EMS personnel informed him they observed the client being dragged and expressed concern about the staff member's treatment of him. The ED/QP reported prior complaints about Staff #2 and stated the staff member, as a result of the survey investigation, would be suspended and likely terminated. This deficiency constitutes a Type A1 rule violation for serious abuse and must be corrected within 23 days.	V 512		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based,	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-096	A. BUILDING: _____ B. WING _____	R 03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARNE	62 MARNE ROAD ASHEVILLE, NC 28803

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V 536	Continued From page 90	V 536		

include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
(e) Formal refresher training must be completed by each service provider periodically (minimum annually).
(f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.
(g) Staff shall demonstrate competence in the following core areas:
(1) knowledge and understanding of the people being served;
(2) recognizing and interpreting human behavior;
(3) recognizing the effect of internal and external stressors that may affect people with disabilities;
(4) strategies for building positive relationships with persons with disabilities;
(5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;
(6) recognizing the importance of and assisting in the person's involvement in making decisions about their life;
(7) skills in assessing individual risk for escalating behavior;
(8) communication strategies for defusing and de-escalating potentially dangerous behavior; and
(9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).
(h) Service providers shall maintain

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V 536	Continued From page 91 documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive	V 536		

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V 536	Continued From page 92 interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 3 audited staff (Staff #2)	V 536		

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V 536	Continued From page 93 received initial competency based training in alternatives to restrictive interventions prior to the provision of services. The findings are: Review on 2/18/26 of Staff #2's record revealed: -Date of hire: 8/27/25. -Date of termination: 2/27/26. -No initial training in alternatives to restrictive interventions. Interview on 2/18/26 with Staff #2 revealed: -She had Nonviolent Crisis Intervention (NCI) training when she was first hired. Interview on 2/18/26 with the Executive Director/Qualified Professional (ED/QP) revealed: -She would obtain Staff #2's NCI certificate. Multiple requests for Staff #2's NCI certificate were made to the ED/QP on 2/19/26, 2/20/26, 2/24/26 and 2/25/26. No documentation of Staff #2's NCI training was ever provided prior to the survey exit on 3/10/26.	V 536		