

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029-029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/28/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DAVIDSON #4	STREET ADDRESS, CITY, STATE, ZIP CODE 125 DELTA STREET LEXINGTON, NC 27295
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	<p>INITIAL COMMENTS</p> <p>A complaint survey was completed on 4/28/26. The complaint was substantiated (intake #NC00236544). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.</p> <p>This facility is licensed for 6 and has a current census of 6. The survey sample consisted of audits of 2 of 6 current clients.</p>	V 000		
V 108	<p>27G .0202 (F-I) Personnel Requirements</p> <p>10A NCAC 27G .0202 PERSONNEL REQUIREMENTS</p> <p>(f) Continuing education shall be documented.</p> <p>(g) Employee training programs shall be provided and, at a minimum, shall consist of the following:</p> <p>(1) general organizational orientation;</p> <p>(2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B;</p> <p>(3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and</p> <p>(4) training in infectious diseases and bloodborne pathogens.</p> <p>(h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their</p>	V 108		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029-029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/28/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DAVIDSON #4	STREET ADDRESS, CITY, STATE, ZIP CODE 125 DELTA STREET LEXINGTON, NC 27295
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 108	<p>Continued From page 1</p> <p>equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients.</p> <p>This Rule is not met as evidenced by: Based on record review, observation, and interviews, the facility failed to ensure that the Executive Director (ED) had training as required for 1 of 2 staff. The findings are:</p> <p>Review on 4/23/26 of ED's personnel record revealed: -Hire date 6/11/25; -Job description of ED; -No documentation of any training in general organizational orientation, client rights and confidentiality, or infectious diseases and bloodborne pathogens.</p> <p>Observation on 4/23/26 at approximately 1:45pm revealed: -The ED was observed searching the drawers of the vertical filing cabinet located in the Human Resource (HR) office, saying that her training record "should be in here."</p> <p>Interview on 4/23/26 with ED revealed: -Her personnel and training record was located in the HR office.</p> <p>Interview on 4/28/26 with the ED revealed:</p>	V 108		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029-029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/28/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DAVIDSON #4	STREET ADDRESS, CITY, STATE, ZIP CODE 125 DELTA STREET LEXINGTON, NC 27295
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 108	<p>Continued From page 2</p> <p>-She was "unable to find" her training record; -She had completed required training upon hire but the record "must have magically disappeared;" -She did not have any copies of training certificates to verify that general organizational orientation, client rights and confidentiality, or infectious diseases and bloodborne pathogens had been completed.</p> <p>Interview on 4/23/26 with the HR revealed: -He was hired approximately 2 weeks ago and was in the process of auditing employee records and has found that they (the personnel and training records) are "a mess" -The personnel record and training record are kept separately. He was able to locate the ED's personnel record but "could not locate the training record for the ED."</p> <p>ED was unable to provide documentation of required training prior to the survey exit on 4/28/26.</p>	V 108		
V 291	<p>27G .5603 Supervised Living - Operations</p> <p>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</p>	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029-029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/28/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DAVIDSON #4	STREET ADDRESS, CITY, STATE, ZIP CODE 125 DELTA STREET LEXINGTON, NC 27295
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 291	<p>Continued From page 3</p> <p>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.</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to coordinate services for 1 client (#2).</p> <p>Review on 4/20/26 of client #2's record revealed: -Admission date: 1/2/94; -Diagnoses included: moderate intellectual developmental disability; anxiety; hypertension; hyperlipidemia; Bell's Palsy; severe obesity; acne on face; -Individual Support Plan (ISP) date: 3/12/26 revealed that the client has attended her current day program since admission to the Licensee's residential program in 1994; -ISP had the legal guardian/brother electronic signature with no date.</p> <p>Interview with the Qualified Professional (QP) on</p>	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029-029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/28/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DAVIDSON #4	STREET ADDRESS, CITY, STATE, ZIP CODE 125 DELTA STREET LEXINGTON, NC 27295
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 291	<p>Continued From page 4</p> <p>4/20/26 revealed: -She is responsible for coordinating annual ISP meetings for the clients, including all providers of service. -She understood that all clients "have a choice of where they want to receive services."</p> <p>Interview with the former staff #3 on 4/23/26 revealed: -Her last day of employment with The ARC of Davidson County (Licensee) was 3/26/26; -She "did not contact [client #2's current day program provider] to invite them" to meetings.</p> <p>Interview with client #2's legal guardian/brother on 4/22/26 revealed: -A phone call was received in February 2026 (date unknown) from Licensee (unsure of name or staff) regarding scheduling a meeting to update ISP goals and to discuss changing day program services from the current day program to the day program that is managed by the Licensee; -On the day of the ISP meeting (date unknown), the legal guardian/brother requested the meeting be rescheduled due to family illness and an (unidentified staff) responded that the meeting could not be rescheduled; -He was told that the "goals were online" (sent to his email address) for his review and signature; -He "did not attend" the ISP meeting and "signed the plan through [electronic signature service];" -After the ISP meeting was held (date unknown), the Assistant Director (AD) of client #2's current day program contacted the legal guardian/brother by telephone; -She asked him about the ISP goals for Client #2's current day program because she was not invited to the ISP meeting; -AD told the legal guardian/brother that she had "tried to contact The ARC's (Licensee's) QP</p>	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029-029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/28/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DAVIDSON #4	STREET ADDRESS, CITY, STATE, ZIP CODE 125 DELTA STREET LEXINGTON, NC 27295
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 291	<p>Continued From page 5</p> <p>(unidentified staff) but had not gotten a response."</p> <p>-This was "confusing to me because the planning meetings had always included both agencies (Licensee and client #2's day program) for about 30 years."</p> <p>Interview with client #2's day program AD on 4/21/26 revealed:</p> <p>-Client #2 receives day programs at her agency Monday-Friday for 7 hours a day;</p> <p>-She had not been invited to attend client #2's ISP meeting;</p> <p>-She had several clients who attended her day program and received residential placement with the Licensee;</p> <p>-She had not been included in ISP planning meetings for other clients in the past few months;</p> <p>-AD had discussed this with the Licensee's QP (unidentified staff);</p> <p>-The Licensee QP (unidentified staff) had responded that it was "not their job to notify them of meetings," and that "the [LME/MCO] (Licensed Management Entity/Managed Care Organization) was "responsible for doing that;"</p> <p>-On several occasions, client #2's current day program staff had arrived at the Licensee's support office for meetings "about 5 times" only to learn that the meetings had been rescheduled;</p> <p>-She believed that day program options were not being fully explained to legal guardians, resulting in "7 clients being moved" from client #2's current day program to the day program managed by the Licensee.</p> <p>Interview with the Director of Quality Compliance (DQC) on 4/21/26 revealed:</p> <p>-She provides supervision to the QPs and they were responsible for coordinating ISP meetings;</p> <p>-"The QP would reach out to [client #2's current</p>	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029-029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/28/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DAVIDSON #4	STREET ADDRESS, CITY, STATE, ZIP CODE 125 DELTA STREET LEXINGTON, NC 27295
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 291	Continued From page 6 day program program] individually;" -She had identified a trend during an internal review that "the QPs have not been reaching out to [client #2's current day program program];" -She had addressed this with the all the QPs and identified it as "the disconnect between the Licensee and [client #2's current day program program];" -She had reminded all the QPs that this responsibility was "part of their job description."	V 291		
V 511	27D .0303 Client Rights - Informed Consent 10A NCAC 27D .0303 INFORMED CONSENT (a) Each client, or legally responsible person, shall be informed, in a manner that the client or legally responsible person can understand, about: (1) the alleged benefits, potential risks, and possible alternative methods of treatment/habilitation; and (2) the length of time for which the consent is valid and the procedures that are to be followed if he chooses to withdraw consent. The length of time for a consent for the planned use of a restrictive intervention shall not exceed six months. (b) A consent required in accordance with G.S. 122C-57(f) or for planned interventions specified by the rules in Subchapter 27E, Section .0100, shall be obtained in writing. Other procedures requiring written consent shall include, but are not limited to, the prescription or administration of the following drugs: (1) Antabuse; and (2) Depo-Provera when used for non-FDA approved uses. (c) Each voluntary client or legally responsible person has the right to consent or refuse	V 511		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029-029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/28/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DAVIDSON #4	STREET ADDRESS, CITY, STATE, ZIP CODE 125 DELTA STREET LEXINGTON, NC 27295
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 511	<p>Continued From page 7</p> <p>treatment/habilitation in accordance with G.S. 122C-57(d). A voluntary client's refusal of consent shall not be used as the sole grounds for termination or threat of termination of service unless the procedure is the only viable treatment/habilitation option available at the facility.</p> <p>(d) Documentation of informed consent shall be placed in the client's record.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure each client or legally responsible person had the right to consent or refuse services without threat of termination of service affecting 1 of 2 clients (#2). The findings are:</p> <p>Review on 4/20/26 of client #2's record revealed: -Admission date: 1/2/94; -Diagnoses included: moderate Intellectual and Developmental Disability; anxiety; hypertension; hyperlipidemia; Bell's Palsy; severe obesity; acne on face; -Individual Support Plan (ISP) date: 3/12/26 revealed that the client has attended her current day program since being admitted to the Licensee's residential program in 1994; -There was no documentation of a discussion in the ISP with client #2 and legal guardian/brother about day program service options while client #2 continued to reside in Davidson #4.</p> <p>Review on 4/24/26 of the signed contract between The ARC of Davidson County (Licensee) and client #2's current day program revealed: -The Licensee terminated the contract on 3/12/26</p>	V 511		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029-029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/28/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DAVIDSON #4	STREET ADDRESS, CITY, STATE, ZIP CODE 125 DELTA STREET LEXINGTON, NC 27295
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 511	<p>Continued From page 8</p> <p>with client #2's current day program, effective 4/30/26.</p> <p>Review on 4/24/26 of meeting minutes from 1/15/26 between the Executive Director (ED), Director of Quality and Compliance (DQC), and Residential Program Director (RPD) revealed: -Discussion held to identify individuals currently residing in their residential program who may be appropriate for the Licensee's day program; -Client #2 was identified on this list. Next steps documented as initiating contact with the guardian to determine interest in changing day programs.</p> <p>Review on 4/24/26 of an email sent on 3/12/26 at 12:02 pm from the Licensee's ED to the ED of client #2's current day program revealed: -"Hello [ED], As outlined in our contract with [client #2's current day program program], this email serves as formal 30-day written notice to terminate our agreement. Per the contract terms: 'The effective date of this agreement is January 1, 2025, and the termination date is December 31, 2026. This contract may be terminated at the request of either involved party with 30 days written notice.' Accordingly, [Licensee] is providing notice that it will terminate its contact with [client #2's current day program], effective April 30, 2026. Please contact me if you have any questions regarding this notice. A formal copy of this letter will also be sent via USPS (United States Postal Service)."</p> <p>Review on 4/23/26 of a letter mailed through USPS from Licensee to client #2's legal guardian/brother revealed: -3/27/26: "...we would like to meet with you and the care manager (Local Management Entity/Managed Care Organization (LME/MCO))</p>	V 511		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029-029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/28/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DAVIDSON #4	STREET ADDRESS, CITY, STATE, ZIP CODE 125 DELTA STREET LEXINGTON, NC 27295
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 511	<p>Continued From page 9</p> <p>assigned to your loved one to discuss the available options and next steps for your adult child while they continue to reside with [Licensee]."</p> <p>Interview on 4/24/26 with client #2 revealed: -"I want to stay here" (current day program); -"My friends are here (current day program) and I come to [current day program] every day...;" -She had not been told by Licensee what is going to happen after the contract ends on 4/30/26; -"The women (unidentified staff) at the office (Licensee) promised me more money if I come to [day program managed by Licensee]. I don't want to change though. I want to stay here.;" -"I would not be happy if I have to go."</p> <p>Interview with client #2's legal guardian/brother on 4/22/26 revealed: -" ...I am fearful that if we don't do this (change day programs) [client #2] will lose her spot at the house. It's been on my mind that I need to do this;" -He asked client #2 about the potential change and she did not want to leave her current day program; -Licensee's QP confirmed that client #2 would no longer be able to attend her current day program after 4/30/26. "This is what's going to happen." The date of this conversation was unknown; -Licensee's QP told the legal guardian/brother that client #2 "could go to [current day program] if she could pay for it;" -Client #2 does not have the money to pay for her current day program expenses. "It's not even an option;" -He was notified by client #2's current day program "about 3 weeks ago" about her changing day programs after 4/30/26. "There is a lack of communication between [Licensee] and us."</p>	V 511		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029-029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/28/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DAVIDSON #4	STREET ADDRESS, CITY, STATE, ZIP CODE 125 DELTA STREET LEXINGTON, NC 27295
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 511	<p>Continued From page 10</p> <p>Interview on 4/22/26 with client #2's current day program ED revealed: -There were "ongoing issues" with the Licensee; -A meeting was held on 3/12/26 at client #2's current day program to discuss not being invited to attend meetings; -She admitted that "tension was high" at this meeting; -She believed that the Licensee was "poaching clients from our program;" -After the 3/12/26 meeting between the two providers, "within 30 minutes" she received an email from the Licensee's ED stating that the contract would be cancelled effective 4/30/26; -On 3/16/26, the ED of client #2's current day program contacted the Licensee's PBD via email to file a grievance due to behavior that she felt was "unethical;" -In the email to the Licensee's PBD, she asked about establishing individual contracts for clients that did not want to change to the day program managed by the Licensee; -She has not received information from the Licensee to initiate the individual contracts.</p> <p>Interview on 4/22/26 and 4/24/26 with the Licensee's PBD revealed: -He received an email (unknown date) from the ED of client #2's current day program regarding the termination of the contract -He agreed that the Licensee should terminate the contract because "it did not make sense to pay money to [client #2's current day program]..." -"[Licensee ED] terminated the contract prior to consulting with the Board of Directors." -The Board of Directors agreed with the decision to terminate the "blanket" contract but still offer individual contracts with client #2's current day</p>	V 511		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029-029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/28/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DAVIDSON #4	STREET ADDRESS, CITY, STATE, ZIP CODE 125 DELTA STREET LEXINGTON, NC 27295
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 511	<p>Continued From page 11</p> <p>program for clients who do not want to attend the Licensee's day program.</p> <p>-He believed that client #2's current day program should be responsible for initiating the individual contracts and "someone needs to make it happen"</p> <p>-He was unsure why individual contracts had not been initiated and he was going to contact client #2's current day program ED to follow-up;</p> <p>-He was unaware of any conversations with legal guardians or clients that threatened losing current residential placement if clients did not switch to the Licensee's day program;</p> <p>-As of 4/24/26, PBD had not spoken with client #2's current day program ED to follow-up with the individual contracts;</p> <p>-As of 4/28/26, an individual contract had not been initiated for client #2.</p> <p>Interview on 4/20/26 with the QP revealed:</p> <p>-All clients "have a choice of where they want to receive services"</p> <p>-A meeting was held on 3/12/26 between the Licensee management and client #2's current day program provider that resulted in the day program contract being terminated effective 4/30/26;</p> <p>-She was not present during the meeting on 3/12/26, but "something happened in the meeting and words were said on both sides. The next thing I knew, the contract was terminated."</p> <p>Interview on 4/20/26 and 4/25/26 with the Licensee's ED revealed:</p> <p>-The LME/MCO pays the Licensee for Long-Term Community Support services and the Licensee had been subcontracting this service with client #2's current day program since before she was hired;</p> <p>-The invoices received from the client #2's current</p>	V 511		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029-029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/28/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DAVIDSON #4	STREET ADDRESS, CITY, STATE, ZIP CODE 125 DELTA STREET LEXINGTON, NC 27295
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 511	<p>Continued From page 12</p> <p>day program were "very expensive;"</p> <ul style="list-style-type: none"> -It was in the Licensee's best interest to terminate the contract in order to "keep this money in house;" -Legal Guardians and "some" LME/MCOs were contacted after initiating the termination of the contract with client #2's current day program; -She was unaware that client #2 did not want to attend the Licensee's day program; -She denied that the termination of the contract was in retaliation; -She denied telling the legal guardian/brother that if client #2 did not attend Licensee's day program that client #2 would have to move from her residential placement; -The issue for client #2's current day program was not client rights, but that "they would be losing \$15,000 each quarter." <p>Review on 4/28/26 of the Plan of Protection signed and dated 4/28/26 by the Licensee revealed:</p> <p>"What immediate action will the facility take to ensure the safety of the consumers in your care? The agency is initiating immediate actions to ensure the safety of all individuals served. Individual supervision requirements are reviewed and verified, and all direct care staff are being informed of person-specific restrictions to ensure appropriate supervision. Required staff training has been identified and is being scheduled to address identified gaps. Director-level documentation, including job description and training file, is being completed and verified. Documentation is being reviewed and corrected to ensure the use of approved signature methods, limited to wet signature and [electronic signature service]. Guardian notifications related to medication changes are being initiated and will be documented. Identified concerns are being</p>	V 511		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029-029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/28/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DAVIDSON #4	STREET ADDRESS, CITY, STATE, ZIP CODE 125 DELTA STREET LEXINGTON, NC 27295
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 511	<p>Continued From page 13</p> <p>evaluated and will be documented in accordance with incident reporting requirements to ensure appropriate follow-up. Targeted staff training will be completed within 30 days based on job responsibilities and will include, but is not limited to:</p> <ul style="list-style-type: none"> Client Rights Coordination of Care Case Management Documentation requirements, including crisis documentation, medical appointments, and communication with guardians <p>The agency will explore coordination with the [client #2's current day program] to review individual service arrangements and ensure services are clearly defined and appropriately documented.</p> <p>Describe your plans to make sure the above happens. The agency will implement structured corrective actions to ensure sustained compliance. This includes staff training on supervision requirements, documentation standards, incident reporting criteria, and guardian notification procedures. Further training will be sought regarding the investigation procedure and proper completion of documentation of investigations. Standardized processes will be implemented to ensure consistent documentation and communication across all locations. A system-wide audit will be conducted to verify compliance, and supervisory oversight and routine monitoring will be implemented to ensure continued adherence to regulatory requirements."</p> <p>Client #2 is an adult with Intellectual and Developmental Disabilities who has resided in the Licensee's group home since 1994 and has continuously attended the same day program</p>	V 511		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029-029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/28/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DAVIDSON #4	STREET ADDRESS, CITY, STATE, ZIP CODE 125 DELTA STREET LEXINGTON, NC 27295
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 511	<p>Continued From page 14</p> <p>operated by a different agency. On 3/12/26, the Licensee unilaterally terminated the day program contract agreement effective 4/30/26. The Licensee informed the legal guardian/brother that client #2 would no longer be allowed to attend her chosen program after that date. Client #2 and her legal guardian/brother did not agree to any change in service providers prior to the termination of this subcontract. The Licensee failed to notify and consult the client's legal guardian/brother regarding available day program options. The Licensee proceeded to initiate a change in client #2's day program without obtaining consent. This action disregards the client's right to refuse treatment planning/habilitation and violated the guardian's legal authority to make informed decisions. The legal guardian/brother interpreted the contract being terminated as an ultimatum and not a choice that may potentially impact client #2's residential placement at Davidson #4.</p> <p>This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients and must be corrected within 45 days.</p>	V 511		
V 536	<p>27E .0107 Client Rights - Training on Alt to Rest. Int.</p> <p>10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS</p> <p>(a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions.</p> <p>(b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall</p>	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029-029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/28/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DAVIDSON #4	STREET ADDRESS, CITY, STATE, ZIP CODE 125 DELTA STREET LEXINGTON, NC 27295
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	<p>Continued From page 15</p> <p>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.</p> <p>(c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered.</p> <p>(d) 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.</p> <p>(e) Formal refresher training must be completed by each service provider periodically (minimum annually).</p> <p>(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.</p> <p>(g) Staff shall demonstrate competence in the following core areas:</p> <ol style="list-style-type: none"> (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 	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029-029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/28/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DAVIDSON #4	STREET ADDRESS, CITY, STATE, ZIP CODE 125 DELTA STREET LEXINGTON, NC 27295
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	<p>Continued From page 16</p> <p>decisions about their life;</p> <p>(7) skills in assessing individual risk for escalating behavior;</p> <p>(8) communication strategies for defusing and de-escalating potentially dangerous behavior; and</p> <p>(9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).</p> <p>(h) Service providers shall maintain documentation of initial and refresher training for at least three years.</p> <p>(1) Documentation shall include:</p> <p>(A) who participated in the training and the outcomes (pass/fail);</p> <p>(B) when and where they attended; and</p> <p>(C) instructor's name;</p> <p>(2) The Division of MH/DD/SAS may review/request this documentation at any time.</p> <p>(i) Instructor Qualifications and Training Requirements:</p> <p>(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.</p> <p>(2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.</p> <p>(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.</p> <p>(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.</p>	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029-029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/28/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DAVIDSON #4	STREET ADDRESS, CITY, STATE, ZIP CODE 125 DELTA STREET LEXINGTON, NC 27295
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	<p>Continued From page 17</p> <p>(5) Acceptable instructor training programs shall include but are not limited to presentation of:</p> <p>(A) understanding the adult learner;</p> <p>(B) methods for teaching content of the course;</p> <p>(C) methods for evaluating trainee performance; and</p> <p>(D) documentation procedures.</p> <p>(6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach.</p> <p>(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.</p> <p>(8) Trainers shall complete a refresher instructor training at least every two years.</p> <p>(j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.</p> <p>(1) Documentation shall include:</p> <p>(A) who participated in the training and the outcomes (pass/fail);</p> <p>(B) when and where attended; and</p> <p>(C) instructor's name.</p> <p>(2) The Division of MH/DD/SAS may request and review this documentation any time.</p> <p>(k) Qualifications of Coaches:</p> <p>(1) Coaches shall meet all preparation requirements as a trainer.</p> <p>(2) Coaches shall teach at least three times the course which is being coached.</p> <p>(3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.</p> <p>(l) Documentation shall be the same preparation as for trainers.</p>	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029-029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/28/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DAVIDSON #4	STREET ADDRESS, CITY, STATE, ZIP CODE 125 DELTA STREET LEXINGTON, NC 27295
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	<p>Continued From page 18</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the Executive Director (ED) had training in alternatives to restrictive interventions as required for 1 of 2 staff. The findings are:</p> <p>Review on 4/21/26 of ED's personnel record revealed: -Hire date 6/11/25; -Job description of ED; -No documentation of training in alternatives to restrictive interventions.</p> <p>Interview on 4/21/26 with ED revealed: -Her personnel and training record was located in the Human Resources (HR) office.</p> <p>Interview on 4/21/26 with the HR revealed: -He was hired approximately 2 weeks ago and was in the process of auditing personnel records; -He could not locate the training record for the ED.</p> <p>Interview on 4/28/26 with the ED revealed: -She was unable to locate her training record. The training record "must have magically disappeared."</p> <p>ED was unable to provide documentation of required training prior to the survey exit on</p>	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029-029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/28/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DAVIDSON #4	STREET ADDRESS, CITY, STATE, ZIP CODE 125 DELTA STREET LEXINGTON, NC 27295
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	Continued From page 19 4/28/26.	V 536		