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DAVIDSON #2	434 SHANNON DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint survey was completed on April 28, 2026. The complaint was substantiated (Intake #NC00236542). 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 6. The survey sample consisted of audits of 2 current clients.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their	V 108		

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equivalence for relieving airway obstruction.
(i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure staff were currently trained in general organizational orientation, client rights, confidentiality, infectious diseases and bloodborne pathogens affecting 1 of 2 audited staff (#2). The findings are:

Review on 4/23/26 of Executive Director's (ED) personnel record revealed:
-Hire date: 6/11/25;
-Job description: ED;
-No documentation was provided for training in general organizational orientation, client rights, confidentiality, infectious diseases and bloodborne pathogens.

Observation on 4/23/26 at approximately 1:45pm revealed:
-The ED was observed searching the drawers of the filing cabinet located in the Human Resource (HR) office, stating that her training record "should be in here."

Interviews on 4/23/26 and 4/28/26 with the ED revealed:
-Her personnel and training records were located

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in the HR's office;
-She was "unable to find" her training record;
-She completed required training upon hire but the record "must have magically disappeared."

Interview on 4/23/26 with the Human Resource revealed:
-He was hired approximately 2 weeks ago and was in the process of auditing employee records. He found the personnel and training records were "a mess;"
-The personnel records and training records were kept separately. He was able to locate the ED's personnel record but "could not locate the training record for the ED."

Interview on 4/23/26 with the Residential Programs Director revealed:
-"To my knowledge she (ED) has not had any training."
Based on record review, observation, and interview, the facility failed to ensure that the Executive Director (ED) had training as required. The findings are:

Review on 4/21/26 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

Observation on 4/21/26 revealed:
-The ED was observed searching the drawers of the vertical filing cabinet located in the Human Resource (HR) Manager's office, saying that her training record "should be in here"

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V 108	Continued From page 3 Interview on 4/21/26 with ED revealed: -Her personnel and training record was located in the HR office Interview on 4/28/26 with the ED revealed: -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 Interview on 4/21/26 with the HR Manager 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" ED was unable to provide documentation of required training prior to the survey exit on 4/28/26	V 108		
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.	V 109		

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V 109	Continued From page 4 (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 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 reviews and interviews, the Qualified Professional (QP) shall demonstrate competence by exhibiting skills in decision-making affecting 1 of 2 audited staff (#1). The findings are:	V 109		

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Review on 4/21/26 of the QP's personnel record revealed:
-Date of Hire: 9/10/08;
-Job Description: QP.

Review on 4/20/26 of client #1's record revealed:
-Admission date: 9/21/17;
-Diagnoses: Intellectual Developmental Disability, Mild; Intermittent Explosive Disorder; Mild Hypertension;
-Individual Support Plan (ISP) dated 3/11/26, had client #1's guardian/sister name on the plan.

Interview on 4/23/26 with the QP revealed:
-She signed the ISP plan for client #1 because she submitted the plan into, "[Local Management Entity/Managed Care Organization (LME/MCO)] system;"
-Other documents that needed the legal guardian's signature were, "consents, privacy, and the forms for client #1 to change from client #1's current day program to the Licensee's day program;"
-Client #1's guardian/sister mentioned during the ISP meeting on 3/24/26, "the signature was not hers (ISP dated 3/11/26);"
-"I did not forge [client #1's guardian's/sister] name;"
-"I do not think that [FS #3] or the [Medical Assistant] would do anything like that (forge client'1's guardian/sister name)."

Interview on 4/22/26 with client #1's guardian/sister revealed:
-During the ISP meeting on 3/24/26, she expressed not understanding what was happening (client #1's contract being terminated);
-She told the QP, "You did not tell me [Medical Assistant] was coming with paperwork from Licensee's day program;"

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-" ...Someone forged my signature (ISP dated 3/11/26) ..."
-The Care Manager (CM) provided her with the documentation she supposedly signed. "This form was not in there (original documentation);"
-"Clearly the two signatures don't match;"
-"Usually I would sign [client #1's] ISP via electronic signature through email."

Interviews on 4/20/26 and 4/23/26 with the Residential Program Director (RPD) revealed:
-"[QP] told her that she forged [client #1's guardian's/sister name]. 'I f****d up I forged her name, and I changed the date on the ISP;'"
-She was unsure of the date on the ISP;
-The QP disclosed the forgery to her, and she was unsure of the date;
-The Director of Quality and Compliance (DQC) came to her on 3/26/26 about the QP forging client #1's guardian/sister name. "I (DQC) was informed (forgery) on the night of 3/25/26, '[QP] went to [Executive Director (ED)] and disclosed she forged the name (client #1's guardian/sister name);'"
-"[ED] said be very nice to [client #1's guardian/sister] from now on and we f**ked up big time;"
-The ED told her and the DQC, "to keep it (forgery) a secret because the three of them don't want the state coming in and reviewing all their files;"
-"[FS #3)] just quit, and the plan was to throw [FS #3] under the bus. That she (FS #3) forged the plan (client #1's ISP)."

Interview on 4/21/26 with the DQC revealed:
-She reviewed client #1's ISP documentation as part of the internal investigation. "The signature was not [client #1's guardian/sister] and the name was misspelled;"

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V 109	Continued From page 7 - "[Client #1's guardian/sister] mentioned during the ISP meeting (3/24/26) the signature on the documentation was not her signature;" -To her knowledge FS #3 scanned the ISP documents to the QP. The QP uploaded the documents; -The QP did not report anything wrong with the documentation.	V 109		
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	V 291		

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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 interviews, the facility failed to coordinate services affecting 1 of 2 audited clients (#1). The findings are:

Review on 4/20/26 of client #1's record revealed:
-Admission date: 9/21/17;
-Diagnoses: Intellectual Developmental Disability, Mild; Intermittent Explosive Disorder; Mild Hypertension.

Interview on 4/24/26 with client #1 revealed:
-He made up his mind. "I prefer to remain at [client #1's current day program] because of my job, and friends;"
-Client #1 attended a day program operated by another agency. The Licensee identified client #1 as a potential client that may want to move to Licensee's day program;
-" ... I told her (client #1's guardian/sister) that I wanted to stay at client #1's current day program." He was unsure of the date;
-"I wish they (Licensee staff and his peers) would leave him the h**l alone. It's stressing him out (changing day programs)."

Interview with the Qualified Professional (QP) on 4/20/26 revealed:
-She is responsible for coordinating annual Individual Support Plan (ISP) meetings for the clients, including all providers of service;
-"[Client #1] is happy with the services he's receiving at [client #1's current day program];"
-She understood that all clients "have a choice of

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where they want to receive services."

Interviews on 4/22/26 and 4/23/26 with client #1's legal guardian/sister revealed:
-She had no knowledge of an individual contract;
-On 2/26/26, she and the Care Manager (CM) met with Licensee about their day program. She was unaware of whom she met with;
-The Licensee wanted client #1 to change from client #1's current day program to Licensee day program. Client #1's supported employment was also mentioned during this meeting;
-Client #1's current day program was not present for the meeting;
-There was an ISP meeting via zoom with Licensee on 3/11/26, "I forgot about the zoom meeting (did not attend):"
-The CM reminded her there needed to be another ISP meeting because client #1's current day program was not present during the meeting on 2/26/26;
-The ISP meeting on 3/12/26 was with the following individuals from Licensee, Former Staff (FS #3), Director of Quality and Compliance (DQC), and the Intake Coordinator/Supported Employment. Client #1's current day program the Executive Director (ED), the Assistant Director (AD), and client #1's supported employment worker;
-The ISP meeting on 3/12/26 was to clarify which day program client #1 would be attending, "[Client #1] stated I will stay at [client #1's current day program];"
-The entire team from the Licensee, "got up and walked out without saying a word;"
-3/13/26, the CM notified her that, "[client #1's] contract just got pulled." Client #1 would no longer be able to attend his current day program after 4/30/26;
-There was another meeting on 3/24/26 to

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discuss the termination of the contract between the Licensee and client #1's current day program. Client #1's guardian/sister reported the signature on the ISP dated 3/11/26, "was not her signature;"
-"[ED] stated, "if [client #1] did not choose Licensee day program they (client #1 and client #1's guardian/sister) will have to find a new residence (residential placement)." If client #1 comes to Licensee day program, "everything stays the same (residential placement);"
-The CM explained the only available residential placements for client #1 are outside of the County he currently resides;
-Client #1 could reside with her, but she worked multiple jobs and, "[client #1] would be home alone often."

Interview on 4/23/26 with FS #3 revealed:
-She "did not" invite client #1's current day program to the meetings on 2/26/26 or 3/11/26;
-She did not know when a guardian suggested something that you needed to get permission from the other service provider.

Interview on 4/21/26 with client #1's current day program Assistant Director (AD) revealed:
-She was not invited to the ISP meeting on 2/26/27 or 3/11/26;
-"There was never a conversation between the two agencies (transition plan);"
-There is no plan to have individual contracts for any of the clients;"
-She attended the ISP meeting on 3/12/26, "tensions were high between client #1's current day program and the Licensee's day program; The CM was unable to attend that meeting;
-"I believe The Licensee is not fully explaining the differences in the two programs (day programs);"
-The Licensee's QP (unidentified staff) told the AD that it was "not her job to notify them of

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meetings, and the Local Management Entity/Managed Care Organization (LME/MCO) was responsible for that."

Interview on 4/23/26 with the Local Management Entity/Managed Care Organization (LME/MCO) Unit Manager revealed:
-The Licensee needed more of a transition plan;
-She facilitated supported employment ISP meetings. The Licensee could attend "if they want too."

Interview on 4/21/26 with the DQC revealed:
-She provides supervision to the QPs, and they were responsible for coordinating the ISP meeting, "The QPs would reach out to client #1's current day program individually;"
-She identified a trend during an internal review that, "the QPs have not been reaching out to [client #1's current day program];"
-She reminded all the QPs this responsibility was, "part of their job description."

Interviews on 4/20/26 and 4/28/26 with the ED revealed:
-The Licensee notified guardians and some of the LME/MCO's about the contract dated 1/1/26 had been terminated effective 4/30/26;
-She was notified by email on 3/13/26 or 3/14/26 about a grievance filed by client #1's current day program with the President of Board of Directors (PBD);
-"[PBD] stated, 'we have to address this grievance prior to doing anything else;'"
-The PBD and Executive Board upheld her decision to terminate the contract. "Letters were sent out on 3/27/26 (guardians)."

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

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

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available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and
(3) immediately notifying the following:
(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;
(B) the LME where the client resides, if different;
(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;
(D) the Department;
(E) the client's legal guardian, as applicable; and
(F) any other authorities required by law.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to implement their policies governing how they would respond to level II incident reports as required. The findings are:

Review on 4/20/26 of client #1's record revealed:
-Admission date: 9/21/17;
-Diagnoses: Intellectual Developmental Disability, Mild; Intermittent Explosive Disorder; Mild Hypertension;
-Individual Support Plan (ISP) dated 3/11/26, had client #1's guardian/sister name on the plan;
-There was no documentation of an internal investigation provided.

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Attempted review on 4/21/26 of facility's internal investigation from 3/24/26 to 4/21/26 revealed:
-There was no report provided for the internal investigation.

Interview on 4/23/26 with the QP revealed:
-Client #1's guardian/sister mentioned during the ISP meeting on 3/24/26, "the signature was not hers (ISP dated 3/11/26");"
-"I did not forge [client #1's guardian's/sister] name;"
-"I do not think that [FS #3] or the [Medical Assistant] would do anything like that (forge client'1's guardian/sister name)."

Interview on 4/21/26 with the Director of Quality and Compliance (DQC) revealed:
-"The investigation is not documented (internal investigation)." I am attempting to wrap up the investigation, and she told the ED. She was unsure of the date;
-She is new to her position as DQC and considered the forgery to be a significant event in her new role. "I consulted my policy manual (not helpful) and went to [ED] ..."
-Within 24 hours she recommended to the Executive Director (ED) "that it would not be good to bill against a plan (Individual Support Plan (ISP) that the guardian (client #1's guardian/sister) questioned the signature on (dated 3/11/26). The ED made the decision not to bill against the ISP plan dated 3/11/26;
-"The investigation is inconclusive because no one took responsibility for the forged signature;"
-"Once I come to a determination of what I'm going to say (internal investigation). I will take my report to [ED];"
-"I'm learning about documentation as I go (documentation for internal investigations)."

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V 366	Continued From page 16 Interviews on 4/22/26 and 4/23/26 with client #1's guardian revealed: -During a meeting on 3/24/26, she questioned her signature on the ISP dated 3/11/26. "Clearly the two signatures don't match;" -She was told by the DQC, "we (Licensee) will investigate;" -Approximately one day later the Licensee stated, "no one admitted to forging the document." She was unsure of who she spoke too; -The Licensee stated there was another person Former Staff #3 they could interview who was no longer employed with the company. Interview on 4/23/26 with the Local Management Entity/Managed Care Organization revealed: -On 3/26/26, she received follow up from the DQC and was informed, "No one admitted to the forgery."	V 366		
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,	V 511		

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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 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.
(d) Documentation of informed consent shall be placed in the client's record.

This Rule is not met as evidenced by:
Based on record review 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 audited clients (#1). The findings are:

Review on 4/20/26 of client #1's record revealed:
-Admission date: 9/21/17;
-Diagnoses: Intellectual Developmental Disability, Mild; Intermittent Explosive Disorder; Mild Hypertension.

Review on 4/24/26 of the signed contract between Licensee and client #1's current day program revealed:
-The contract was signed by The Licensee's

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V 511	Continued From page 18 Executive Director (ED) and client #1's current day program ED on 12/12/25 the duration of the contract was 1/1/26 -12/31/26; -"The contract may be terminated at the request of either involved party with 30 days written notice." Review on 4/22/26 of facility's 60-day notice addressed to client #1's guardian/sister dated 3/23/26 revealed: -"The allegation that your signature was forged has been reviewed in accordance with compliance and documentation standards ...; -Additionally, due to changes in provider contracts and service authorization limitations, returning to [client #1's current day program] is not an available option while [client #1] continues to receive residential services through our agency." Review on 4/24/26 of Director of Quality and Compliance (DQC's) meeting minutes dated 1/15/26 revealed: -Discussion held with the ED and Residential Program Director (RPD) to identify individuals currently residing in the residential program who may be appropriate for Licensee's day program; -Client #1 was identified on this list with next steps identified as contacting the guardian to determine interest in changing day programs. Interviews on 4/22/26 and 4/23/26 with client #1's guardian/sister revealed: -Client #1's guardian/sister reported during the meeting on 3/24/26, the Individual Support Plan (ISP) dated 3/11/26, "was not her signature:" -She did not authorize for client #1 to change from client #1's current day program to Licensee's day program; -On 3/24/26 "[ED] stated, "if [client #1] did not choose Licensee's day program they (client #1	V 511		

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and client #1's guardian/sister) will have to find a new residence (residential placement). If [client #1] comes to Licensee's day program, "everything stays the same (residential placement);"
-After the meeting on 3/24/26, the QP came to the city where client #1's guardian/sister resided. "The QP asked her to sign another plan (ISP dated 3/24/26);"
-The QP apologized for sending the medical assistant on 3/11/26 and he was in training. The QP was about to lose her job, and she was responsible for it (ISP). She refused to sign the ISP dated 3/24/26;
-She was concerned that anything she does Licensee, "will hold it against her and put her brother out;"
-Ten years of working with Licensee and she "never had issues like this (forced to do something);"
-She told client #1 that she loved him very much, and if there was something that she could do to keep him at client #1's current day program then she would;
-Client #1 told her that Licensee's day program would be fine.

Interview on 4/23/26 with the Residential Programs Director revealed:
-She was told by client #1's guardian/sister "[Executive Director] stated, "if [client #1] did not attend Licensee he would need to find some where to go (residential placement)."

Interview on 4/22/26 with client #1's current day program ED revealed:
-There were "ongoing issues" with Licensee;
-A meeting was held on 3/12/26 at client #1's current day program to discuss not being invited to attend ISP meetings;

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-" ...Tension was high (accusation of poaching)" at this meeting;
-After the meeting on 3/12/26, "within 30 minutes" she received an email from Licensee's ED stating the contract would be terminated effective 4/30/26;
-She had not received information from Licensee or President of Board of Directors about initiating individual contracts.

Interview on 4/23/26 with the Local Management Entity/Managed Care Organization (LME/MCO) Unit Manager revealed:
-If client #1's guardian/sister wanted client #1 to continue residing at Licensee, "we cannot combine that service (pay different agencies)." We would need to work with Licensee to develop an additional plan;
-During the meeting on 3/24/26. "Licensee made it clear" they would not be willing to submit a contract for day program for client #1 after 4/30/26;
-If there was another alternative to provide day programing;
-The Licensee needed more of a transition plan.

Interview on 4/28/26 with the ED revealed:
-"With client #1's guardian/sister we may need to look at making some changes. I love [Client #1], we all love [Client #1], the issue is the guardian/sister."
-"[ED] denied that client #1 was in jeopardy of losing residential housing;"
-"No one in the organization had a conversation about [client #1] leaving the agency (loosing residential placement)."

Interviews on 4/22/26 and 4/24/26 with the PBD revealed:
-He was going to contact client #1's current day

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program PBD to follow up about individual contracts;
-"I don't know why client #1's current day program had not initiated individual contracts. [ED] would know the problem better than me (initiating the contracts);"
-"I know nothing about", guardians being told if they don't change to Licensee's day program the clients could lose their residential placement;
-As of 4/28/26, an individual contract had not been initiated for client #1.

Review on 4/28/26 of the Plan of Protection signed and dated 4/28/26 by the Licensee revealed:
"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 system]. Guardian notifications related to medication changes are being initiated and will be documented. Identified concerns are being 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:
Client Rights

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Coordination of Care
Case Management
Documentation requirements, including crisis documentation, medical appointments, and communication with guardians.
The agency will explore coordination with client #1's current day program to review individual service arrangements and ensure services are clearly defined and appropriately documented.

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."

Client #1 is an adult with Intellectual and Developmental Disability who has resided in the Licensee's group home since 2017 and had continuously attended the same day program operated by a different agency. On 3/12/26, the Licensee unilaterally terminated the day program contract agreement effective 4/30/26. The legal guardian/sister was informed client #1 needed to transition to Licensee's day program or seek another residential placement. Client #1 would no longer be allowed to attend his chosen day program after 4/30/26. Client #1 and his legal

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V 511	Continued From page 23 guardian did not agree to any change in service providers prior to the termination of the contract. This action disregards the client's and legal guardian's right to refuse treatment planning/habilitation without the threat of termination of services. 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.	V 511		
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, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the	V 536		

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V 536	Continued From page 24 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 documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the	V 536		

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V 536	Continued From page 25 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 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	V 536		

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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, observation, and interviews, the facility failed to ensure the Executive Director (ED) had training in alternatives to restrictive interventions affecting 1 of 2 audited staff (#2). The findings are:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL029-027	A. BUILDING: ______ B. WING ______	C 04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIDSON #2	434 SHANNON DRIVE LEXINGTON, NC 27292

(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
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Attempted review on 4/23/26 of the ED's training record revealed:
-Hire date 6/11/25;
-Job description: ED;
-No documentation of training in alternatives to restrictive interventions.

Observation on 4/23/26 at approximately 1:45pm revealed:
-The ED was observed searching the drawers of the filing cabinet located in the Human Resource (HR) Manager's office, saying that her training record "should be in here."

Interviews on 4/23/26 and 4/28/26 with the ED revealed:
-Her personnel and training record were located in the HR office;
-She was "unable to find" her training record;
-She had completed required training upon hire but the record "must have magically disappeared."

Interview on 4/23/26 with the Director of Residential Programs revealed:
-"To my knowledge she (ED) has not had any training;"
-She is the agency's trainer for alternatives to restrictive intervention. "I scheduled the ED for the training and the ED declined. She would take the training (alternative to restrictive intervention) another time."

Interview on 4/21/26 with the HR Manager revealed:
-He was hired approximately 2 weeks ago and was in the process of auditing employee records and found the personnel and training records were "a mess;"
-The personnel record and training record are

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V 536	Continued From page 28	V 536		

kept separately. He was able to locate the ED's personnel record but "could not locate the training record for the ED."
Based on record review, observation, and interview, the facility failed to ensure that the Executive Director (ED) had training in alternatives to restrictive interventions as required. The findings are:

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

Observation on 4/21/26 revealed:
-The ED was observed searching the drawers of the vertical filing cabinet located in the Human Resource (HR) Manager's office, saying that her training record "should be in here"

Interview on 4/21/26 with ED revealed:
-Her personnel and training record was located in the HR office

Interview on 4/28/26 with the ED revealed:
-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 documentation to show that training in alternatives to restrictive interventions had been completed

Interview on 4/21/26 with the HR Manager 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"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL029-027	A. BUILDING: ______ B. WING ______	C 04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIDSON #2	**434 SHANNON DRIVE LEXINGTON, NC 27292**

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-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"

ED was unable to provide documentation of the required training prior to the survey exit on 4/28/26