

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL068-100</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>04/01/2026</b>
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NAME OF PROVIDER OR SUPPLIER  <b>RSI-WEST EPESUS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1400 EPHEBUS CHURCH ROAD CHAPEL HILL, NC 27517</b>
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V 000	<p><b>INITIAL COMMENTS</b></p> <p>An annual and follow up survey was completed on April 1, 2026. 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 4 and has a current census of 4. The survey sample consisted of audits of 3 current clients.</p>	V 000		5/20/2026
V 112	<p><b>27G .0205 (C-D) Assessment/Treatment/Habilitation Plan</b></p> <p>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN</p> <p>(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.</p> <p>(d) The plan shall include:</p> <p>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;</p> <p>(2) strategies;</p> <p>(3) staff responsible;</p> <p>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;</p> <p>(5) basis for evaluation or assessment of outcome achievement; and</p> <p>(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.</p>	V 112	<p>Further follow up found, legal guardian has been out of the country. An ISP meeting has been scheduled.</p>	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE **5/8/26**

STATE FORM 6899 KVE311 If continuation sheet 1 of 13

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V 112	Continued From page 1  This Rule is not met as evidenced by: Based on record review and interview, the facility failed to schedule a review of a plan at least annually affecting one of four audited clients (#1). The findings are:  Reviews on 3/31/26 and 4/1/26 of client #1's record revealed: -Admission date of 1/13/2009. -Diagnoses of Profound Intellectual Disability, Graves' Disease, Congenital Malformations of the brain, Hyperthyroidism, Epilepsy and Apraxia. -Individualized Support Plan was dated 6/1/24. -There was no documentation of a current plan.  Interview on 4/1/26 with the Supervisor of Support Services revealed: -"Didn't realize [client #1] PC Plan was outdated until just now." -"[Client #1] has private pay and his plan got overlooked." -"We dropped the ball on that one." -He confirmed there was no documentation of a current plan for client #1.	V 112		
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	V 114		

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V 114	<p>Continued From page 2</p> <p>these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes.</p> <p>(b) The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.</p> <p>(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.</p> <p>(d) Each facility shall have a first aid kit accessible for use.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure fire and disaster drills were conducted quarterly and on each shift. The findings are:</p> <p>Review on 4/1/26 of the facility's fire drill log from March 2025 through March 2026 revealed: -No fire drills conducted on 1st shift in the 2nd quarter (April, May, and June). -No fire drills were conducted on 2nd shift in the 3rd quarter (July, August, and September). -No fire drills were conducted on 1st shift in the 4th quarter (October, November, and December).</p> <p>Review on 4/1/26 of the facility's disaster drill log from March 2025 through March 2026 revealed: -No disaster drills conducted on 2nd shift in the 2nd quarter (April, May, and June). -No disaster drills conducted on 2nd shift in the 3rd quarter (July, August, and September).</p> <p>Interview on 4/1/26 with the Supervisor of Support</p>	V 114		

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V 114	Continued From page 3  Services revealed: -"The shift leader is responsible for completing the drills." -"Management is trying to put systems in place so they don't miss anymore drills." -He confirmed the facility failed to complete fire and disaster drills for each quarter and for each shift.  This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 114	DSC's received retraining on Fire and disaster drill training	4/15/2026
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	V 536		

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V 536	<p>Continued From page 4</p> <p>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"> <li>(1) knowledge and understanding of the people being served;</li> <li>(2) recognizing and interpreting human behavior;</li> <li>(3) recognizing the effect of internal and external stressors that may affect people with disabilities;</li> <li>(4) strategies for building positive relationships with persons with disabilities;</li> <li>(5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;</li> <li>(6) recognizing the importance of and assisting in the person's involvement in making decisions about their life;</li> <li>(7) skills in assessing individual risk for escalating behavior;</li> <li>(8) communication strategies for defusing and de-escalating potentially dangerous behavior; and</li> <li>(9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).</li> </ol> <p>(h) Service providers shall maintain documentation of initial and refresher training for at least three years.</p> <p>(1) Documentation shall include:</p>	V 536		

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V 536	<p>Continued From page 5</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> <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</p>	V 536		

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V 536	<p>Continued From page 6</p> <p>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> <p> </p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure two of three audited staff (Supervisor of Support Services and staff #2) had training on the use of alternatives to restrictive interventions. The findings are:</p>	V 536	Employees were recertified.	Completed on 4/7/2026

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V 536	Continued From page 7  Review on 4/1/26 of a personnel record for staff#2 revealed: -Hire date of 5/14/23. -Hired as a Direct Support Paraprofessional. -Nonviolent Crisis Intervention training was completed on 2/27/25. -No documentation of current training on the use of alternatives to restrictive interventions.  Review on 4/1/26 of a personnel record for Supervisor of Support Services revealed: -Hire date of 8/30/20. -Hired as a Supervisor of Support Services. -Nonviolent Crisis Intervention training was completed on 9/18/24. -No documentation of current training on the use of alternatives to restrictive interventions.  Interview on 4/1/26 with the Supervisor of Support Services revealed: -"[The Supervisor of Support Services] was scheduled for NCI training but missed due to having to work." -"We were short of staff and we needed the [Supervisor of Support Services] to worked and ended up missing the training." -He confirmed staff #2 and Supervisor of Support Services had no documentation of current training on the use of alternatives to restrictive interventions.	V 536		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO  10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation	V 537		

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V 537	<p>Continued From page 8</p> <p>time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually.</p> <p>(b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated.</p> <p>(c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions.</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 plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.</p> <p>(g) Acceptable training programs shall include, but are not limited to, presentation of:</p> <p>(1) refresher information on alternatives to the use of restrictive interventions;</p> <p>(2) guidelines on when to intervene (understanding imminent danger to self and</p>	V 537		

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V 537	<p>Continued From page 9</p> <p>others);</p> <p>(3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention);</p> <p>(4) strategies for the safe implementation of restrictive interventions;</p> <p>(5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention;</p> <p>(6) prohibited procedures;</p> <p>(7) debriefing strategies, including their importance and purpose; and</p> <p>(8) documentation methods/procedures.</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 Qualification 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 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out.</p> <p>(3) Trainers shall demonstrate competence by scoring a passing grade on testing in an</p>	V 537		

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V 537	<p>Continued From page 10</p> <p>instructor training program.</p> <p>(4) 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>(5) 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 (j)(6) of this Rule.</p> <p>(6) Acceptable instructor training programs shall include, but not be limited to, presentation of:</p> <p>(A) understanding the adult learner;</p> <p>(B) methods for teaching content of the course;</p> <p>(C) evaluation of trainee performance; and</p> <p>(D) documentation procedures.</p> <p>(7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule.</p> <p>(8) Trainers shall be currently trained in CPR.</p> <p>(9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach.</p> <p>(10) Trainers shall teach a program on the use of restrictive interventions at least once annually.</p> <p>(11) Trainers shall complete a refresher instructor training at least every two years.</p> <p>(k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.</p> <p>(1) Documentation shall include:</p>	V 537		

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V 537	<p>Continued From page 11</p> <p>(A) who participated in the training and the outcome (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.            (l) 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.            (m) Documentation shall be the same preparation as for trainers.</p> <p>This Rule is not met as evidenced by:            Based on record review and interviews, the facility failed to ensure one of four audited staff Supervisor of Support Services and staff #2) had training in the use of seclusion, physical restraints and isolation time-out training on the use of alternatives to restrictive interventions. The findings are:</p> <p>Review on 4/1/26 of a personnel record for staff#2 revealed:            -Hire date of 5/14/23.            -Hired as a Direct Support Paraprofessional.            -Nonviolent Crisis Intervention training was completed on 2/27/25.            -There was no documentation of current training in the use of seclusion, physical restraints and isolation time-out.</p>	V 537		

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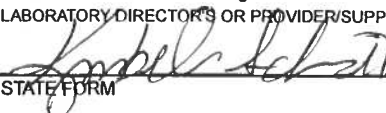
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 537	<p>Continued From page 12</p> <p>Review on 4/1/26 of a personnel record for Supervisor of Support Services revealed: -Hire date of 8/30/20. -Hired as a Supervisor of Support Services. -Nonviolent Crisis Intervention training was completed on 9/18/24. -There was no documentation of current training in the use of seclusion, physical restraints and isolation time-out.</p> <p>Interview on 4/1/26 with the Supervisor of Support Services revealed: -"[The Supervisor of Support Services] was scheduled for NCI training but missed due to having to work." -"We were short of staff and we needed the [Supervisor of Support Services] to worked and ended up missing the training." -He confirmed staff #2 and Supervisor of Support Services had no documentation of current training in the use of seclusion, physical restraints and isolation time-out.</p>	V 537	Employees were recertified	4/7/2026

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL068-102</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>04/02/2026</b>
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NAME OF PROVIDER OR SUPPLIER  <b>RSI-PUREFOY ROAD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>102 PUREFOY ROAD</b> <b>CHAPEL HILL, NC 27514</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	<p><b>INITIAL COMMENTS</b></p> <p>An annual and follow up survey was completed on April 2, 2026. A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.</p> <p>This facility is licensed for 6 and has a current census of 6. The survey sample consisted of audits of 3 current clients.</p>	V 000		
V 112	<p><b>27G .0205 (C-D)</b> <b>Assessment/Treatment/Habilitation Plan</b></p> <p>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN</p> <p>(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.</p> <p>(d) The plan shall include:</p> <p>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;</p> <p>(2) strategies;</p> <p>(3) staff responsible;</p> <p>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;</p> <p>(5) basis for evaluation or assessment of outcome achievement; and</p> <p>(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.</p>	V 112		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Director of Adult Services	(X6) DATE 5/8/26
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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL068-102</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>04/02/2026</b>
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NAME OF PROVIDER OR SUPPLIER  <b>RSI-PUREFOY ROAD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>102 PUREFOY ROAD</b> <b>CHAPEL HILL, NC 27514</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to schedule a review of a plan at least annually affecting one of four audited clients (#1). The findings are:</p> <p>Reviews on 4/1/26 and 4/2/26 of client #1's record revealed: -Admission date of 4/17/2017. -Diagnoses of Obsessive Compulsive Disorder unspecified, Mild Intellectual disabilities, and Autistic Disorder. -Individualized Support Plan was dated 11/1/24. -There was no documentation of a current plan.</p> <p>Interview on 4/2/26 with the Supervisor of Support Services revealed: -"Didn't realize [client #1] PC Plan was outdated until just now." -"[Client #1] plan got overlooked." -"We dropped the ball on that one." -He confirmed there was no documentation of a current plan for client #1.</p>	V 112	Plan completed on 8.1.25. Copy obtained and on file.	5/6/2026



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[www.rsi-nc.org](http://www.rsi-nc.org)  
Scott A. Keller, Executive Director

05.08.26

Catrice Horton  
Mental Health Licensure & Certification Section  
Division of Health Service Regulation  
2718 Mail Service Center  
Raleigh, NC 27699-2718

Dear Ms. Horton,  
Please find the enclosed Plan of Correction for deficiencies cited during the April 1, 2026, survey of RSI – West Ephesus Group Home, MHL #068-100. Please let me know if you have any questions or need any additional information.

Sincerely,



Kymberlei Schmidt  
Director of Autism Services  
RSI Community  
*(previously known as Residential Services, Inc.)*  
Address: 111 Providence Road, Chapel Hill, NC 27514  
[kschmidt@rsi-nc.org](mailto:kschmidt@rsi-nc.org)  
919-864-9904  
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