

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-244	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/15/2025
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NAME OF PROVIDER OR SUPPLIER POA LIVING GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2510 LONG FERRY ROAD SALISBURY, NC 28146
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V 000	<p>INITIAL COMMENTS</p> <p>An annual, complaint and follow up survey was completed on 12/15/25. The complaints were substantiated (intakes #NC234152, #NC234566 and #NC234969). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.</p> <p>The facility is licensed for 4 and currently has a census of 4. The survey sample consisted of audits of 3 current clients and 1 former client.</p> <p>The initial exit date was 12/2/25. The survey was reopened due to a new complaint.</p>	V 000		
V 114	<p>27G .0207 Emergency Plans and Supplies</p> <p>10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES</p> <p>(a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes.</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>	V 114		

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

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V 114	<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 conduct disaster drills at least quarterly and repeated for each shift. The findings are:</p> <p>Review on 12/1/25 of the facility's disaster drills from 12/1/24-12/1/25 revealed: -There were no 2nd shift disaster drills recorded for the 1st quarter (January, February, March). -There were no disaster drills recorded for the 2nd quarter (April, May, June). -There were no disaster drills recorded for 3rd quarter (July, August, September). -There were no 3rd shift disaster drills recorded for the 4th quarter (October, November, December).</p> <p>Interview on 12/1/25 with the Associate Professional/Licensee/Director/Registered Nurse revealed: - The Qualified Professional (QP) was the staff who "oversees" the facility's disaster drills. The QP was not always present for every drill.</p>	V 114		
V 132	<p>G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection</p> <p>G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services</p>	V 132		

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V 132	<p>Continued From page 2</p> <p>as defined by G.S. 131E-201 are being provided.</p> <p>b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.</p> <p>c. Misappropriation of the property of a healthcare facility.</p> <p>d. Diversion of drugs belonging to a health care facility or to a patient or client.</p> <p>e. Fraud against a health care facility or against a patient or client for whom the employee is providing services).</p> <p>Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to protect clients from harm during an investigation. The findings are:</p> <p>Review on 11/17/25 of the North Carolina Incident Response and Reporting (IRIS) revealed:</p> <ul style="list-style-type: none"> - Date of Incident: 9/14/25 - Date reported: 9/17/25 - Name of Person Who Completed Form: Associate Professional/Licensee/Director/Registered Nurse (AP/L/D/RN) - "during a community outing at the Park [Former Client (FC) #5] became dysregulated after being informed by staff (staff #1) that he needed to use the restroom before returning to the facility. When staff attempted to escort him to the designated 	V 132		
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V 132	<p>Continued From page 3</p> <p>restroom area, [FC #5] refused, stating he would not make it in time, and instead relieved himself outside while under direct staff supervision. Upon returning to the group, another consumer (client #1) made laughing and mocking comments toward [FC #5] regarding the incident. [FC #5] became visibly upset and called the other consumer (client #1) the N word, began yelling, and attempted to strike the other consumer with a punch. He (FC #5) then ran toward a tree and started banging his head on the tree and scratching himself. Staff (staff #1) immediately followed and intervened implemented a therapeutic barrier to prevent [FC #5] from causing further harm to himself. After a few minutes, [FC #5] was able to calm down. [FC #5] sustained scratches to his face and neck and bruise to his left ear."</p> <p>- "Level of Incident: Level III"</p> <p>- "HCPR - Facility Allegation" reported on 9/17/25</p> <p>- "Choose the Type(s) of Allegations Being Made: Resident Abuse"</p> <p>- "Staff full name: [staff #1]"</p> <p>Review on 11/20/25 of the "5-Day Investigation Report-DHSR (Division of Health Services Regulation) Health Care Personnel Registry" revealed:</p> <p>- Date of Incident: 9/14/25</p> <p>- Date Initial Allegation Report Filed: 9/18/25</p> <p>- Date report was completed: 9/24/25</p> <p>Interview on 11/24/25 with the AP/L/D/RN revealed:</p> <p>- Staff #1 worked during the internal investigation on the following dates: 9/14/25-9/16/25; 9/18/25; 9/19/25; 9/22/25, and 9/24/25.</p> <p>- "We did provide her (staff #1) with emotional support because of all the investigation that was going on."</p>	V 132		

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V 293	<p>27G .1701 Residential Tx. Child/Adol - Scope</p> <p>10A NCAC 27G .1701 SCOPE</p> <p>(a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility.</p> <p>(b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section.</p> <p>(c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services.</p> <p>(d) The children or adolescents served shall require the following:</p> <p>(1) removal from home to a community-based residential setting in order to facilitate treatment; and</p> <p>(2) treatment in a staff secure setting.</p> <p>(e) Services shall be designed to:</p> <p>(1) include individualized supervision and structure of daily living;</p> <p>(2) minimize the occurrence of behaviors related to functional deficits;</p> <p>(3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint;</p> <p>(4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and</p> <p>(5) support the child or adolescent in gaining the skills needed to step-down to a less</p>	V 293		

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V 293	<p>Continued From page 5</p> <p>intensive treatment setting.</p> <p>(f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to provide individualized supervision; and coordinate with other individuals and agencies within the child or adolescent's system of care affecting 2 of 3 audited current clients (#2 and #3) and 1 of 1 audited former client (FC #5). The findings are:</p> <p>Review on 11/18/25 of Client #2's record revealed: -Date of Admission: 10/31/25 - Age: 11 years-old - Diagnoses: Oppositional Defiant Disorder; Attention Deficit Hyperactivity Disorder; and Major Depressive Disorder, Moderate</p> <p>Review on 11/18/25 of Client #3's record revealed: - Date of Admission: 10/9/25 - Age: 15 years-old - Diagnoses: Conduct Disorder; Oppositional Defiant Disorder; Attention Deficit Hyperactivity Disorder, Combined Type; Post-Traumatic Stress</p>	V 293		

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V 293	<p>Continued From page 6</p> <p>Disorder and Cannabis Use Disorder</p> <p>Review on 11/18/25 of FC #5's record revealed:</p> <ul style="list-style-type: none"> - Date of Admission: 8/7/25 - Date of Discharge: 10/6/25 - Age: 9 years-old - Diagnosis: Disruptive Mood Dysregulation Disorder <p>Finding #1</p> <p>Review on 11/19/25 of the "DHHS (Department of Health and Human Services) Incident and Death Report" dated 11/2/25 revealed:</p> <ul style="list-style-type: none"> - Report was completed by the Qualified Professional (QP) - Date of Incident: 11/2/25 - "Upon returning to the facility from an outing at [local park] consumer [client #2] reported to the QP after reporting to [staff #1] that consumer [client #3] tried to ask him if he would let him 'F (f**k)' him in the 'butt.' QP separated the consumers (client #2, client #3, and FC #5) that had been at the park. Each consumer was questioned separately about the acquisition. Consumer [client #3] denied what consumer [client #2] said. Consumer [client #1] stated he didn't know what I was talking about the staff were questioned separately [staff #1] and [staff # 11], the two staff at the park with consumers reported that the two consumers ran ahead of the two staff and went into the bathroom- staff (staff #1 and staff #11) reported they noticed the consumers (client #2 and client #3) had mistakenly ran into the bathroom, the directed the consumers (client #2 and client #3) to come out of the bathroom. The consumers came out of the bathroom, then on the way walking through the park consumer [client #2] told the staff (staff #11) that [client #3] attempted to 'F' him in butt. After 	V 293		
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V 293	<p>Continued From page 7</p> <p>staff and consumers where questioned the QP sent a text alerting staff that the consumers where speaking sexually and we should keep [client #3] and [client #2] separated and monitored the behaviors of all consumers because of the increased sexual verbalization."</p> <ul style="list-style-type: none"> - "Abuse Allegation...alleged abuse of a consumer" - "Consumer Behavior...Inappropriate or illegal sexual behavior" <p>Interviews on 11/17/25 and 11/18/25 with client #2 revealed:</p> <ul style="list-style-type: none"> - He recalled the allegation of abuse incident had occurred on a "Sunday" (11/2/25). - He, client #3, and client #1 were taken to the park on 11/2/25 by staff #1 and staff #11. - He and client #3 told staff #1 they needed to go to the bathroom. - He and client #3 went to "the wrong bathroom" (women's restroom) in the park. - He went into a stall beside client # 3's stall. - "[Client #3] told me to come under the stall. By the time I got under [client #3] already had his p***s out and [client #3] said 'suck it' and I did it that time. I stopped and [client #3] said 'do it or I am going to go tell.' " - "I said (to client #3), 'I didn't do it you are the one who kept saying do it.' " - "I wasn't the one who wanted to do it, [client #3] told me 'to do it.' " - "[Client #3] put it (p***s) all the way in my mouth and it made me almost throw up." - "[Client #3] made me pull my pants down. So, I pulled them down and he put his p***s in my butt." - "[Client #3] started doing it doing it and it hurt and I kept on moving around because he told me to move around." - "My shorts were still down and I tried to pull 	V 293		
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V 293	<p>Continued From page 8</p> <p>them up and I said I was done and he pulled my pants back down."</p> <p>- "I was on the floor. [Client #3] was on the floor too. Then [client #3] did it again. [Client #3] put his p***s into my butt."</p> <p>- "[Staff #1] called out my name and I crawled under and went back to my stall and I hit my head on the toilet paper thing."</p> <p>- He and client #3 both came out of the bathroom stalls and washed their hands. "[Staff #1] asked why are you two in the women's bathroom and we both said we don't know."</p> <p>- While he and client #3 were in the women's bathroom, staff #1 was in the park area initially and then came into the women's restroom. "That's when she called my name and I went to the other stall (his original stall)."</p> <p>- While still at the park, he told staff #11 that client #3 "did something to me in the bathroom."</p> <p>- He did not go into details with staff #11 about what occurred in the bathroom stall with client #3 but staff #11 knew what he meant by "did something in the bathroom."</p> <p>- Staff #1 walked up and told staff #11 that he and client #3 were both in the same bathroom stall.</p> <p>- Staff #11 said to client #3 "why did you do that to him (client #2)?" Client #3 reported he never did anything to client #2.</p> <p>- When he got back to the facility from the park, he told the QP what client #3 did to him and pointed to his butt area when he told the QP what client #3 did to him.</p> <p>Interview on 11/18/25 with client #3 revealed:</p> <p>- On 11/2/25 he went to the park with client #1, client #2, staff #1 and staff #11.</p> <p>- When he arrived, he had to go to the restroom and "accidentally" went into the women's restroom because the door was open and he did not see the sign for the women's restroom.</p>	V 293		

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V 293	<p>Continued From page 9</p> <ul style="list-style-type: none"> - Client #2 came in behind him into the women's restroom. - "I went into the big handicap bathroom and I see [client #2's] hat come under the stall. [Client #2] tried to crawl under to my stall and I was using the restroom. I kicked at his face multiple times with my shoe. Then [client #2] tries to come in there I am trying to pull my pants up." - When "I clean myself up" client #2 was already out of the bathroom. - Client #2 ran to staff #11 and told staff #11, "that I shoved my privates in his mouth and I was trying to get him to come under the stall. None of that was true." - When he initially ran to the women's restroom, staff #1 was on "her phone" and "she was walking behind us slowly." - "[Staff #1] claimed she was in the restroom when I was in there but she was not in there until the last minute when [client #2] ran out. [Staff #11] was with [client #1] when I was in the bathroom." - "[Staff #1] only came to the doorway (of the women's restroom) and stood at the doorway when [client #2] ran out." <p>Interview on 11/19/25 with client #1 revealed:</p> <ul style="list-style-type: none"> - Denied that anyone in the facility had touched his genitals or showed him their genitals. - Did not know any details about the 11/2/25 allegation of abuse. <p>Interviews on 11/17/25 and 11/25/25 with staff #1 revealed:</p> <ul style="list-style-type: none"> - On 11/2/25, she and staff #11 took client #1, client #2 and client #3 to the park. - While at the park client #2 and client #3 had to use the restroom. - She and staff #11 walked down to the bathroom with all the clients. Client #1 did not have to use 	V 293		

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V 293	<p>Continued From page 10</p> <p>the restroom and stayed outside the bathroom with her and staff #11.</p> <ul style="list-style-type: none"> - "Three minutes later [client #2] came out, running out of the bathroom saying that [client #3] raped him in the bathroom. [Client #3] said the opposite that [client #2] tried to rape him." - "They (client #2 and client #3) were not in the bathroom three minutes at the most. Anything over 3 minutes, I would have sent [staff #11] inside the bathroom." - She called the QP who told her to bring the clients back to the facility and the QP talked to the clients at the facility. - "The QP said their stories didn't match up and that (abuse allegation) could not happen in 3 minutes." - She stayed outside of the park restroom because you could not tell the men's restroom from the women's restroom. - The clients (#2 and #3) went into the women's restroom. At the time of the allegation of abuse incident, she did not know the clients had gone into the women's restroom. - The only time she was on her cell phone at the park was when she contacted the QP. <p>Interview on 11/20/25 with staff #11 revealed:</p> <ul style="list-style-type: none"> - On 11/2/25, he and staff #1 took client #1, client #2, and client #3 to the park. - While at the park client #3 asked staff #1 to use the restroom. - Client #3 took off to the restroom and client #2 followed client #3. - He and client #1 went into the men's restroom to wash their hands. "I thought they (client #2 and #3) were in that restroom but they were not." - After he realized clients #2 and #3 were not in the men's restroom with, he started looking for them around the park. - About "ten minutes later", staff #1 came out of 	V 293		
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V 293	<p>Continued From page 11</p> <p>the women's restroom. He heard staff #1 calling out the 3 clients' names (#1, #2, and #3) because she was looking for the 3 clients.</p> <ul style="list-style-type: none"> - Staff #1 told him she was looking for him (staff #11) and client #1 because she thought client #2 and client #3 were with him. - "Five minutes" later client #2 and client #3 came out of the women's restroom. - "[Client #2] was yelling and crying and saying that [client #3] made him crawl under the stall. [Client #3] said [client #2] crawled under the stall himself. [Client #2] said that [client #3] made him suck his private parts." - Client #2 and client #3 were in the women's bathroom "about 10-15 minutes." - "I said let's leave the park, that was my first day (working) and let the QP manager handle this." <p>Observations on 11/25/25 and review on 12/1/25 of client #3's forensic interview conducted by the Forensic Interviewer revealed:</p> <ul style="list-style-type: none"> - At 00:10:15: - Forensic Interviewer: "What was that boy's name?" - Client #2: "[client #3's first name]" - Forensic Interviewer: "[client #3's first name?]" - Forensic Interviewer: "Do you know [client #3's] last name?" - Client #2: "Oh, [client #3's last name]" - Forensic Interviewer: "[client #3's first and last name]. Okay. And you said he did something to you? Tell me about that." - Client #2: "I can't tell you the whole thing, but I'm just going to say he did something inappropriate." - Forensic Interviewer: "Inappropriate. Ok" - At 00:15:38: - Forensic Interviewer: "And when you say inappropriate, tell me what parts of your body that involved?" - Client #2: "Like my butt and that's it. And for 	V 293		
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V 293	<p>Continued From page 12</p> <p>[client #3], He told me it's his p***s and that's it." - Forensic Interviewer: "Okay. So you said for [client #3] his p***s and that's it and for you your butt and that's it. Okay. So we have something inappropriate happening with your butt and [client #3's] p***s. Help me understand what that is?" - Client #2: "Basically, he just telling me to do something and he want me to do it because I don't know why, but I guess he's just dirty minded so he want me to do it." - Forensic Interviewer: "Okay, so you said he's dirty minded. So what did [client #3] ask you to do with his p***s?" - Client #2: "He told me to suck it." - Forensic Interviewer: "Okay. Did he ask you to do anything else besides suck it?" - Client #2: "No, that's it." - Forensic Interviewer: "That's it? Okay. And what did [client #3] do with your butt?" - Client #2: "He (client #3) put his p***s in my butt." - Forensic Interviewer: "He (client #3) put his p***s in your butt. How did that make your body feel?" - Client #2: "Bad." At 00:18:43: - Client #2: "I can't remember for all of them (incidents between him and client #3)." - Forensic Interviewer: "Okay. Did you ever tell a staff member?" - Client #2: "I told [staff #11], and that's it." - Forensic Interviewer: "And what did [staff #11] say?" - Client #2: "He said, 'why would you do that to an 11-year-old?' And was like [client #3] was like, 'no.' [Client #3] was like, 'no, because why would I do that?...'" - Forensic Interviewer: "That's what [client #3] said?" - Client #2: "Yes"</p>	V 293		

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V 293	<p>Continued From page 13</p> <ul style="list-style-type: none"> - At 00:32:48: - Forensic Interviewer: "Okay. And the park, [local park], was that day or night?" - Client #2: "Day." - Forensic Interviewer: "Do you remember the staff that took you to the park?" - Client #2: "[Staff #1] and [staff #11]." - Forensic Interviewer: "And when you were at the park, where did the inappropriate stuff happen at?" - Client #2: "In the Women's bathroom" - Forensic Interviewer: "Okay, did anyone see?" - Client #2: "[staff #1] heard me and him (client #3)." - Forensic Interviewer: "[Staff #1] heard, and what did she do?" - Client #2: "She, um, she called, first she stand there at the men's bathroom called my name, then she came in after she used the bathroom she came to the woman's bathroom calling my name and I said 'I am coming,' and I went back under the stall and I hit my head on the toilet tissue thing." - Forensic Interviewer: "Okay. And you said that you told [staff #11]. Did you tell him that day or another time?" - Client #2: "I told him that day." - Forensic Interviewer: "Okay. And he (staff #11) said (to client #3), 'why would you do that?' " - Client #2 agreed to meet on another date to provide further details. <p>Interview on 12/1/25 with client #2's school administration revealed:</p> <ul style="list-style-type: none"> - On client #2's second day of attending their school (11/6/25) he told his teacher that he wanted to talk to someone. - She had already talked to client #2 on his first day and agreed to talk to him. - Client #2 told her that "someone" touched him 	V 293		

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V 293	<p>Continued From page 14</p> <p>inappropriately and kept saying "it wasn't right." - Client #2 told her it happened in the bathroom stall at the park. - Client #2 told her the other person came into his stall and wanted to touch him. Client #2 did not want to touch the other person. - Client #2 told her he told "the worker." The worker told client #2 that they would keep the other boy away from him. - Client #2 never provided the name of the other client nor the worker's name. - Client #2 did not tell her where the worker was located when the allegation of abuse incident occurred.</p> <p>Interview on 11/21/25 with the QP revealed: - On 11/2/25, she was at the facility when Staff #1 and staff #11 took clients (#1- #3) to the park. - When the staff and clients returned to the facility she talked to client #2 outside. - "Basically [client #2] said that another consumer [client #3] asked him to let him f him in the butt. [Client #2] said it happened in the bathroom. They (client #2 and client #3) were in the women's bathroom." - "From the report [staff #1] was in the bathroom because she was a woman using the (women's) bathroom. She realized they (clients #2 and #3) were in the wrong bathroom and told them to get out of the bathroom and the other [staff #11] was standing outside the bathroom. This was my understanding."</p> <p>Interview on 11/21/25 with the QP revealed: - She did not take client #2 to be evaluated by a medical doctor after the 11/2/25 allegation of abuse incident occurred. - "I was not told any penetration occurred. I was told he (client #2) was asked to do it (sexual acts)."</p>	V 293		

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V 293	<p>Continued From page 15</p> <p>Interview on 11/21/25 with the AP/L/D/RN (Associate Professional/Licensee/Director/Registered Nurse) revealed:</p> <ul style="list-style-type: none"> - After the 11/2/25 allegation of abuse incident she did not have client #2 evaluated by a medical provider. <p>Finding #2</p> <p>Review on 11/17/25 of the North Carolina Incident Response and Reporting (IRIS) revealed:</p> <ul style="list-style-type: none"> - Date of Incident: 9/14/25 - Date reported: 9/17/25 - Name of Person Who Completed Form: Associate Professional/Licensee/Director/Registered Nurse (AP/L/D/RN) - "during a community outing at the Park [FC #5] became dysregulated after being informed by staff (staff #1) that he needed to use the restroom before returning to the facility. When staff attempted to escort him to the designated restroom area, [FC #5] refused, stating he would not make it in time, and instead relieved himself outside while under direct staff supervision. Upon returning to the group, another consumer (client #1) made laughing and mocking comments toward [FC #5] regarding the incident. [FC #5] became visibly upset and called the other consumer (client #1) the N word, began yelling, and attempted to strike the other consumer with a punch. He (FC #5) then ran toward a tree and started banging his head on the tree and scratching himself. Staff (staff #1) immediately followed and intervened implemented a therapeutic barrier to prevent [FC #5] from causing further harm to himself. After a few minutes, [FC #5] was able to calm down.[FC #5] 	V 293		

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V 293	<p>Continued From page 16</p> <p>sustained scratches to his face and neck and bruise to his left ear." - "Level of Incident: Level III" - "HCPR - Facility Allegation" reported on 9/17/25 - "Choose the Type(s) of Allegations Being Made: Resident Abuse" - "Staff full name: [staff #1]"</p> <p>Review on 11/20/25 of FC #5's medical records from local urgent care revealed: - Date of Service: 9/16/25 - "Your Diagnoses for today's visit are: 1. Abrasion of other part of head, initial encounter 2. Abrasion of left ear, initial encounter." - "Reason for Visit: Post altercation leaving scratches and bruises on him (FC #5)."</p> <p>Interview on 11/24/25 with the AP/L/D/RN revealed: - She did not take FC #5 immediately to be evaluated by a medical provider on 9/14/25 because "I just thought it was the end of the day and the house manager was coming the next day. I asked if it hurt and he said it didn't so I knew it (FC #5's skull/face) wasn't fractured."</p> <p>Review on 12/2/25 of the Plan of Protection dated 12/2/25 written by the AP/L/D/RN revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? The facility will implement the following safety measures immediately: Enhanced Supervision. oStaff will maintain continuous line-of-sight supervision of all awake consumers at all times. oConsumers will remain a minimum of 2 feet apart when seated on furniture and in common areas. Sleeping Checks oStaff will complete bedroom checks every 15</p>	V 293		

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V 293	<p>Continued From page 17</p> <p>minutes throughout the night while consumers are sleeping.</p> <p>Staff Training (Immediate)</p> <p>Staff involved will receive immediate retraining in:</p> <ul style="list-style-type: none"> Supervision expectations Line-of-sight Bathroom supervision Incident reporting Crisis intervention Trauma-informed care Clinical Review <p>A Licensed Clinical Mental Health Counselor will provide immediate supervision skill-building to staff involved in the incidents.</p> <p>Crisis Plan Updates- Crisis plans for consumers involved will be updated immediately to address self-injury risk, environmental triggers, and safety precautions.</p> <p>Coordination of Care - Effective immediately All youth involved in an incident will receive immediate documented physical assessments. Provider and guardian will be contacted immediately to determine whether urgent medical evaluation is required.</p> <p>Clinical Coordination</p> <p>The therapist and DSS (Department of Social Services) will be notified immediately of any incident involving allegations, self-harm, or unsafe peer interactions.</p> <p>A Coordination of Care Log will be used for every incident to document:</p> <ul style="list-style-type: none"> All provider/guardian contacts Clinical decisions Describe Your Plans to Make Sure This Happens. Staff Retraining Immediate retraining on Supervision expectations Line-of-sight Bathroom supervision Crisis intervention 	V 293		

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V 293	<p>Continued From page 18</p> <p>Incident reporting Protection from harm Consumer separation Documentation standards The QP will begin daily safety briefings, covering: High-risk consumer assignments Bathroom monitoring Peer separation Supervision adjustments Staff Reintegration Monitoring Ongoing supervised reintegration plan starting today, overseen by the LP (Licensed Professional), QP and AP. Ensuring Ongoing Compliance Weekly supervision audits conducted by leadership. 24-hour review of all incidents by the QP. Weekly clinical safety meetings reviewing supervision patterns, bathroom compliance, and peer dynamics. Corrective action issued immediately if any staff fail to follow supervision or bathroom policy."</p> <p>This facility served clients with diagnoses of Conduct Disorder; Post-Traumatic Stress Disorder; Attention Deficit Hyperactivity Disorder, Combined Type; Other Persistent Mood Disorder; Impulse Control Disorder; Oppositional Defiant Disorder; Major Depressive Disorder, Moderate; Disruptive Mood Dysregulation Disorder; and Cannabis Use Disorder. During an outing at a local park on 11/2/25 with staff #1 and staff #11, client #2 and client #3 went to the women's restroom alone and had no staff supervision. Client #2 reported to staff, his school administration and during a forensic interview that while he and client #3 were in the park restroom alone, inappropriate sexual behavior occurred. The age difference of client #2 and client #3 was more than four years. Client #2 who had reported</p>	V 293		

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V 293	<p>Continued From page 19</p> <p>being sexually assaulted by client #3 was not evaluated by a medical provider. On 9/14/25, after FC #5 had his head pushed into a tree by staff #1, FC #5 had bruising to his left ear and face along with scratches on his face and neck. FC #5 was not evaluated for 2 days by a medical provider.</p> <p>This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.</p> <p>This deficiency constitutes a re-cited deficiency.</p>	V 293		
V 318	<p>130 .0102 HCPR - 24 Hour Reporting</p> <p>10A NCAC 130 .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g).</p> <p>This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to report an allegation of neglect to</p>	V 318		

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V 318	<p>Continued From page 20</p> <p>the Health Care Personnel Registry (HCPR) within 24 hours of becoming aware of the allegation(s). The findings are:</p> <p>Review on 11/17/25 of the North Carolina Incident Response and Reporting (IRIS) revealed:</p> <ul style="list-style-type: none"> - Date of Incident: 9/14/25 - Date reported: 9/17/25 - Name of Person Who Completed Form: Associate Professional/Licensee/Director/Registered Nurse (AP/L/D/RN) - "during a community outing at the Park [Former Client (FC) #5] became dysregulated after being informed by staff (staff #1) that he needed to use the restroom before returning to the facility. When staff attempted to escort him to the designated restroom area, [FC #5] refused, stating he would not make it in time, and instead relieved himself outside while under direct staff supervision. Upon returning to the group, another consumer (client #1) made laughing and mocking comments toward [FC #5] regarding the incident. [FC #5] became visibly upset and called the other consumer (client #1) the N word, began yelling, and attempted to strike the other consumer with a punch. He (FC #5) then ran toward a tree and started banging his head on the tree and scratching himself. Staff (staff #1) immediately followed and intervened implemented a therapeutic barrier to prevent [FC #5] from causing further harm to himself. After a few minutes, [FC #5] was able to calm down. [FC #5] sustained scratches to his face and neck and bruise to his left ear." - "Level of Incident: Level III" - "HCPR - Facility Allegation" reported on 9/17/25 - "Choose the Type(s) of Allegations Being Made: Resident Abuse" - "Staff full name: [staff #1]" 	V 318		

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V 318	Continued From page 21 Interview on 11/21/25 with the AP/L/D/RN revealed: - She completed the notification of client abuse to HCPR on 9/17/25.	V 318		
V 364	G.S. 122C- 62 Additional Rights in 24 Hour Facilities § 122C-62. Additional Rights in 24-Hour Facilities. (a) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-61, each adult client who is receiving treatment or habilitation in a 24-hour facility keeps the right to: (1) Send and receive sealed mail and have access to writing material, postage, and staff assistance when necessary; (2) Contact and consult with, at his own expense and at no cost to the facility, legal counsel, private physicians, and private mental health, developmental disabilities, or substance abuse professionals of his choice; and (3) Contact and consult with a client advocate if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each adult client may exercise these rights at all reasonable times. (b) Except as provided in subsections (e) and (h) of this section, each adult client who is receiving treatment or habilitation in a 24-hour facility at all times keeps the right to: (1) Make and receive confidential telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00	V 364		

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V 364	<p>Continued From page 22</p> <p>p.m.; however visiting shall not take precedence over therapies;</p> <p>(3) Communicate and meet under appropriate supervision with individuals of his own choice upon the consent of the individuals;</p> <p>(4) Make visits outside the custody of the facility unless:</p> <p>a. Commitment proceedings were initiated as the result of the client's being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found not guilty by reason of insanity or incapable of proceeding;</p> <p>b. The client was voluntarily admitted or committed to the facility while under order of commitment to a correctional facility of the Division of Adult Correction of the Department of Public Safety; or</p> <p>c. The client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; A court order may expressly authorize visits otherwise prohibited by the existence of the conditions prescribed by this subdivision;</p> <p>(5) Be out of doors daily and have access to facilities and equipment for physical exercise several times a week;</p> <p>(6) Except as prohibited by law, keep and use personal clothing and possessions, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002;</p> <p>(7) Participate in religious worship;</p> <p>(8) Keep and spend a reasonable sum of his own money;</p> <p>(9) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes; and</p> <p>(10) Have access to individual storage space for his private use.</p> <p>(c) In addition to the rights enumerated in G.S.</p>	V 364		

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V 364	<p>Continued From page 23</p> <p>122C-51 through G.S. 122C-57 and G.S. 122C-59 through G.S. 122C-61, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to have access to proper adult supervision and guidance. In recognition of the minor's status as a developing individual, the minor shall be provided opportunities to enable him to mature physically, emotionally, intellectually, socially, and vocationally. In view of the physical, emotional, and intellectual immaturity of the minor, the 24-hour facility shall provide appropriate structure, supervision and control consistent with the rights given to the minor pursuant to this Part. The facility shall also, where practical, make reasonable efforts to ensure that each minor client receives treatment apart and separate from adult clients unless the treatment needs of the minor client dictate otherwise.</p> <p>Each minor client who is receiving treatment or habilitation from a 24-hour facility has the right to:</p> <p>(1) Communicate and consult with his parents or guardian or the agency or individual having legal custody of him;</p> <p>(2) Contact and consult with, at his own expense or that of his legally responsible person and at no cost to the facility, legal counsel, private physicians, private mental health, developmental disabilities, or substance abuse professionals, of his or his legally responsible person's choice; and</p> <p>(3) Contact and consult with a client advocate, if there is a client advocate.</p> <p>The rights specified in this subsection may not be restricted by the facility and each minor client may exercise these rights at all reasonable times.</p> <p>(d) Except as provided in subsections (e) and (h) of this section, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to:</p>	V 364		

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NAME OF PROVIDER OR SUPPLIER POA LIVING GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2510 LONG FERRY ROAD SALISBURY, NC 28146
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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 364	<p>Continued From page 24</p> <p>(1) Make and receive telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party;</p> <p>(2) Send and receive mail and have access to writing materials, postage, and staff assistance when necessary;</p> <p>(3) Under appropriate supervision, receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over school or therapies;</p> <p>(4) Receive special education and vocational training in accordance with federal and State law;</p> <p>(5) Be out of doors daily and participate in play, recreation, and physical exercise on a regular basis in accordance with his needs;</p> <p>(6) Except as prohibited by law, keep and use personal clothing and possessions under appropriate supervision, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002;</p> <p>(7) Participate in religious worship;</p> <p>(8) Have access to individual storage space for the safekeeping of personal belongings;</p> <p>(9) Have access to and spend a reasonable sum of his own money; and</p> <p>(10) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes.</p> <p>(e) No right enumerated in subsections (b) or (d) of this section may be limited or restricted except by the qualified professional responsible for the formulation of the client's treatment or habilitation plan. A written statement shall be placed in the client's record that indicates the detailed reason for the restriction. The restriction shall be reasonable and related to the client's treatment or habilitation needs. A restriction is effective for a</p>	V 364		

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V 364	<p>Continued From page 25</p> <p>period not to exceed 30 days. An evaluation of each restriction shall be conducted by the qualified professional at least every seven days, at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's record. Restrictions on rights may be renewed only by a written statement entered by the qualified professional in the client's record that states the reason for the renewal of the restriction. In the case of an adult client who has not been adjudicated incompetent, in each instance of an initial restriction or renewal of a restriction of rights, an individual designated by the client shall, upon the consent of the client, be notified of the restriction and of the reason for it. In the case of a minor client or an incompetent adult client, the legally responsible person shall be notified of each instance of an initial restriction or renewal of a restriction of rights and of the reason for it. Notification of the designated individual or legally responsible person shall be documented in writing in the client's record.</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure privacy during telephone calls affecting 3 of 4 audited clients (#1- #3) and 1 of 1 non-audited client, (NAC #4). The findings are:</p> <p>Reviews on 11/18/25 and 12/1/25 of Client #1's record revealed: - Date of Admission: 2/13/25 - Age: 7 years-old - Diagnoses: Post-Traumatic Stress Disorder;</p>	V 364		

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V 364	<p>Continued From page 26</p> <p>Oppositional Defiant Disorder; Attention Deficit Hyperactivity Disorder, Combined Type; Other Persistent Mood Disorder; and Impulse Control Disorder</p> <ul style="list-style-type: none"> - No documentation of approval from the Human Rights Committee for restriction of client telephone calls. <p>Review on 11/18/25 of Client #2's record revealed:</p> <ul style="list-style-type: none"> -Date of Admission: 10/31/25 - Age: 11 years-old - Diagnoses: Oppositional Defiant Disorder; Attention Deficit Hyperactivity Disorder; Major Depressive Disorder, Moderate - No documentation of approval from the Human Rights Committee for restriction of client telephone calls. <p>Review on 11/18/25 of Client #3's record revealed:</p> <ul style="list-style-type: none"> - Date of Admission: 10/9/25 - Age: 15 years-old - Diagnoses: Conduct Disorder; Oppositional Defiant Disorder; Attention Deficit Hyperactivity Disorder, Combined Type; Post-Traumatic Stress Disorder and Cannabis Use Disorder - No documentation of approval from the Human Rights Committee for restriction of client telephone calls. <p>Interview on 11/19/25 with client #1 revealed:</p> <ul style="list-style-type: none"> - He made his telephone calls to his Legal Guardian (LG) "on the couch (in the living room)." - Staff listened to his telephone calls. <p>Interview on 11/19/25 with client #2 revealed:</p> <ul style="list-style-type: none"> - When he made telephone calls staff listened to his calls. - His telephone calls took place in the living room. 	V 364		

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V 364	<p>Continued From page 27</p> <p>Interview on 11/18/25 with client #3 revealed: - Last night he tried to talk to his LG and staff #9 told him to "speak up." - He and staff #9 were in the staff office when he made his telephone call to his LG.</p> <p>Interview on 11/18/25 with client #3's LG revealed: - When she was on the phone with client #3 the phone was on speaker phone. - Staff listened to her telephone calls with client #3.</p> <p>Interview on 11/20/25 with staff #10 revealed: - Client phone calls were put on speaker phone so that staff could listen to the calls. - Staff listened when clients talked to their LGs on the telephone.</p> <p>Interview on 11/20/25 with staff #7 revealed: - "Yes, we do have to be present during (clients') phone calls." - The telephone calls made by clients took place in their bedrooms and staff were present. - Staff were present when clients talked to their LGs on the telephone.</p> <p>Interview on 11/20/25 with staff #11 revealed: - Staff listened in when clients made telephone calls to their LGs.</p> <p>Interview on 11/21/25 with the Associate Professional/Licensee/Director/Registered Nurse revealed: - All telephone calls made by the clients took place in the staff office on a speaker phone. - A staff member was present during all client telephone calls.</p>	V 364		

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V 366	Continued From page 28	V 366		
V 366	<p>27G .0603 Incident Response Requirements</p> <p>10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS</p> <p>(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:</p> <p>(1) attending to the health and safety needs of individuals involved in the incident;</p> <p>(2) determining the cause of the incident;</p> <p>(3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;</p> <p>(4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;</p> <p>(5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;</p> <p>(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</p> <p>(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.</p> <p>(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.</p> <p>(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</p>	V 366		

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V 366	<p>Continued From page 29</p> <p>by:</p> <p>(1) immediately securing the client record</p> <p>by:</p> <p>(A) obtaining the client record;</p> <p>(B) making a photocopy;</p> <p>(C) certifying the copy's completeness; and</p> <p>(D) transferring the copy to an internal review team;</p> <p>(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:</p> <p>(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;</p> <p>(B) gather other information needed;</p> <p>(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</p> <p>(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</p>	V 366		

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V 366	<p>Continued From page 30</p> <p>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</p> <p>(3) immediately notifying the following:</p> <p>(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;</p> <p>(B) the LME where the client resides, if different;</p> <p>(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;</p> <p>(D) the Department;</p> <p>(E) the client's legal guardian, as applicable; and</p> <p>(F) any other authorities required by law.</p> <p>This Rule is not met as evidenced by: Based in interviews and record reviews, the facility failed to report a Level III incident to other authorities (Law Enforcement) required by law. The findings are:</p> <p>Review on 11/19/25 of the "DHHS (Department of Health and Human Services) Incident and Death Report" dated 11/2/25 revealed:</p> <ul style="list-style-type: none"> - Report was completed by the Qualified Professional (QP) - Date of Incident: 11/2/25 - "Upon returning to the facility from an outing at [local park] consumer [client #2] reported to the QP after reporting to [staff #1] that consumer [client #3] tried to ask him if he would let him 'F 	V 366		

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V 366	<p>Continued From page 31</p> <p>(f**k)' him in the 'butt.' QP separated the consumers (client #2, client #3, and Former Client (FC) #5) that had been at the park. Each consumer was questioned separately about the acquisition. Consumer [client #3] denied what consumer [client #2] said. Consumer [client #1] stated he didn't know what I was talking about the staff were questioned separately [staff #1] and [staff # 11], the two staff at the park with consumers reported that the two consumers ran ahead of the two staff and went into the bathroom- staff (staff #1 and staff #11) reported they noticed the consumers (client #2 and client #3) had mistakenly ran into the bathroom, the directed the consumers (client #2 and client #3) to come out of the bathroom. The consumers came out of the bathroom, then on the way walking through the park consumer [client #2] told the staff that [client #3] attempted to 'F' him in butt. After staff and consumers where questioned the QP sent a text alerting staff that the consumers where speaking sexually and we should keep [client #3] and [client #2] separated and monitored the behaviors of all consumers because of the increased sexual verbalization."</p> <p>- "Abuse Allegation...alleged abuse of a consumer"</p> <p>- "Consumer Behavior...Inappropriate or illegal sexual behavior"</p> <p>Review on 11/18/25 of Client #2's record revealed:</p> <ul style="list-style-type: none"> -Date of Admission: 10/31/25 - Age: 11 years-old - Diagnoses: Oppositional Defiant Disorder; Attention Deficit Hyperactivity Disorder; Major Depressive Disorder, Moderate <p>Review on 11/18/25 of Client #3's record revealed:</p>	V 366		

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V 366	<p>Continued From page 32</p> <ul style="list-style-type: none"> - Date of Admission: 10/9/25 - Age: 15 years-old - Diagnoses: Conduct Disorder; Oppositional Defiant Disorder; Attention Deficit Hyperactivity Disorder, Combined Type; Post-Traumatic Stress Disorder and Cannabis Use Disorder <p>Review on 11/25/25 of NC State Statute 14-27.29. First-Degree Statutory Sexual Offense Revealed:</p> <ul style="list-style-type: none"> - "(a) A person is guilty of first-degree statutory sexual offense if the person engages in a sexual act with a victim who is a child under the age of 13 years and the defendant is at least 12 years old and is at least four years older than the victim." <p>Interview on 11/21/25 with the Associate Professional/Licensee/Director/Registered Nurse revealed:</p> <ul style="list-style-type: none"> - The 11/2/25 incident was not reported to law enforcement. - "The reason we didn't report to police...is because he (client #2) said he (client #3) tried to f me in the butt". If he went to school and reported something different, we didn't know about it." 	V 366		
V 367	<p>27G .0604 Incident Reporting Requirements</p> <p>10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS</p> <p>(a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where</p>	V 367		

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V 367	<p>Continued From page 33</p> <p>services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:</p> <p>(1) reporting provider contact and identification information;</p> <p>(2) client identification information;</p> <p>(3) type of incident;</p> <p>(4) description of incident;</p> <p>(5) status of the effort to determine the cause of the incident; and</p> <p>(6) other individuals or authorities notified or responding.</p> <p>(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:</p> <p>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or</p> <p>(2) the provider obtains information required on the incident form that was previously unavailable.</p> <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <p>(1) hospital records including confidential information;</p> <p>(2) reports by other authorities; and</p> <p>(3) the provider's response to the incident.</p> <p>(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A</p>	V 367		

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V 367	<p>Continued From page 34</p> <p>providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).</p> <p>(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:</p> <ol style="list-style-type: none"> (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to report all level II incidents in the</p>	V 367		

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V 367	<p>Continued From page 35</p> <p>North Carolina Incident Response Improvement System (IRIS) within 72 hours of becoming aware of the incident. The findings are:</p> <p>Finding #1</p> <p>Review on 11/17/25 of the North Carolina Incident Response and Reporting (IRIS) revealed:</p> <ul style="list-style-type: none"> - Date of Incident: 9/14/25 - Date reported: 9/17/25 - Name of Person Who Completed Form: Associate Professional/Licensee/Director/Registered Nurse (AP/L/D/RN) - "during a community outing at the Park [Former Client (FC) #5] became dysregulated after being informed by staff (staff #1) that he needed to use the restroom before returning to the facility. When staff attempted to escort him to the designated restroom area, [FC #5] refused, stating he would not make it in time, and instead relieved himself outside while under direct staff supervision. Upon returning to the group, another consumer (client #1) made laughing and mocking comments toward [FC #5] regarding the incident. [FC #5] became visibly upset and called the other consumer (client #1) the N word, began yelling, and attempted to strike the other consumer with a punch. He (FC #5) then ran toward a tree and started banging his head on the tree and scratching himself. Staff (staff #1) immediately followed and intervened implemented a therapeutic barrier to prevent [FC #5] from causing further harm to himself. After a few minutes, [FC #5] was able to calm down.[FC #5] sustained scratches to his face and neck and bruise to his left ear." - "Level of Incident: Level III" - "HCPR - Facility Allegation" reported on 9/17/25 - "Choose the Type(s) of Allegations Being Made: 	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-244	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/15/2025
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NAME OF PROVIDER OR SUPPLIER POA LIVING GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2510 LONG FERRY ROAD SALISBURY, NC 28146
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V 367	<p>Continued From page 36</p> <p>Resident Abuse" - "Staff full name: [staff #1]"</p> <p>Interview on 11/21/25 with the AP/L/D/RN revealed: - She completed the 9/14/25 IRIS incident report of FC #5 being abused by staff #1 on 9/17/25.</p> <p>Finding #2</p> <p>Review on 11/19/25 of the "DHHS (Department of Health and Human Services) Incident and Death Report" dated 11/2/25 revealed: - Report was completed by the Qualified Professional (QP) - Date of Incident: 11/2/25 - "Upon returning to the facility from an outing at [local park] consumer [client #2] reported to the QP after reporting to [staff #1] that consumer [client #3] tried to ask him if he would let him 'F (**k)' him in the 'butt.' QP separated the consumers (client #2, client #3, and FC #5) that had been at the park. Each consumer was questioned separately about the acquisition. Consumer [client #3] denied what consumer [client #2] said. Consumer [client #1] stated he didn't know what I was talking about the staff were questioned separately [staff #1] and [staff # 11], the two staff at the park with consumers reported that the two consumers ran ahead of the two staff and went into the bathroom- staff (staff #1 and staff #11) reported they noticed the consumers (client #2 and client #3) had mistakenly ran into the bathroom, the directed the consumers (client #2 and client #3) to come out of the bathroom. The consumers came out of the bathroom, then on the way walking through the park consumer [client #2] told the staff that [client #3] attempted to 'F' him in butt. After staff and consumers where questioned the QP sent a text</p>	V 367		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-244	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/15/2025
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NAME OF PROVIDER OR SUPPLIER POA LIVING GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2510 LONG FERRY ROAD SALISBURY, NC 28146
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V 367	Continued From page 37 alerting staff that the consumers where speaking sexually and we should keep [client #3] and [client #2] separated and monitored the behaviors of all consumers because of the increased sexual verbalization." - "Abuse Allegation...alleged abuse of a consumer" - "Consumer Behavior...Inappropriate or illegal sexual behavior" Interview on 11/21/25 with the Qualified Professional revealed: - She did not report the 11/2/25 incident to IRIS. - "[Client #3] denied anything happening and the staff did not see anything happen. It was one child (client #2) saying it happened."	V 367		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of	V 500		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-244	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/15/2025
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V 500	<p>Continued From page 38</p> <p>each facility shall develop and implement policy that identifies:</p> <p>(1) any restrictive intervention that is prohibited from use within the facility; and</p> <p>(2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client.</p> <p>(d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify:</p> <p>(1) the permitted restrictive interventions or allowed restrictions;</p> <p>(2) the individual responsible for informing the client; and</p> <p>(3) the due process procedures for an involuntary client who refuses the use of restrictive interventions.</p> <p>(e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes:</p> <p>(1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E);</p> <p>(2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and</p> <p>(3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention.</p>	V 500		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-244	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/15/2025
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V 500	<p>Continued From page 39</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure all instances of allegations of abuse were reported to the County Department of Social Services (DSS) affecting 1 of 4 current clients (client #2) and 1 of 1 audited former client (FC) (#5). The findings are:</p> <p>Finding #1</p> <p>Review on 11/17/25 of the North Carolina Incident Response and Reporting (IRIS) revealed:</p> <ul style="list-style-type: none"> - Date of Incident: 9/14/25 - Date reported: 9/17/25 - Name of Person Who Completed Form: Associate Professional/Licensee/Director/Registered Nurse (AP/L/D/RN) - "during a community outing at the Park [FC #5] became dysregulated after being informed by staff (staff #1) that he needed to use the restroom before returning to the facility. When staff attempted to escort him to the designated restroom area, [FC #5] refused, stating he would not make it in time, and instead relieved himself outside while under direct staff supervision. Upon returning to the group, another consumer (client #1) made laughing and mocking comments toward [FC #5] regarding the incident. [FC #5] became visibly upset and called the other consumer (client #1) the N word, began yelling, and attempted to strike the other consumer with a punch. He (FC #5) then ran toward a tree and started banging his head on the tree and scratching himself. Staff (staff #1) immediately followed and intervened implemented a therapeutic barrier to prevent [FC #5] from 	V 500		

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V 500	<p>Continued From page 40</p> <p>causing further harm to himself. After a few minutes, [FC #5] was able to calm down.[FC #5] sustained scratches to his face and neck and bruise to his left ear."</p> <ul style="list-style-type: none"> - "Level of Incident: Level III" - "HCPR - Facility Allegation" reported on 9/17/25 - "Choose the Type(s) of Allegations Being Made: Resident Abuse" - "Staff full name: [staff #1]" <p>Interview on 11/21/25 with Child Protective Services (CPS) Social Worker:</p> <ul style="list-style-type: none"> - The facility staff did not report the 9/14/25 incident to Department of Social Services (DSS). <p>Interview on 11/21/25 with the AP/L/D/RN revealed:</p> <ul style="list-style-type: none"> - She did not report the 9/14/25 incident to DSS. <p>Finding #2</p> <p>Review on 11/19/25 of the "DHHS (Department of Health and Human Services) Incident and Death Report" dated 11/2/25 revealed:</p> <ul style="list-style-type: none"> - Report was completed by the Qualified Professional (QP) - Date of Incident: 11/2/25 - "Upon returning to the facility from an outing at [local park] consumer [client #2] reported to the QP after reporting to [staff #1] that consumer [client #3] tried to ask him if he would let him 'F (f**k)' him in the 'butt.' QP separated the consumers (client #2, client #3, and FC #5) that had been at the park. Each consumer was questioned separately about the acquisition. Consumer [client #3] denied what consumer [client #2] said. Consumer [client #1] stated he didn't know what I was talking about the staff were questioned separately [staff #1] and [staff # 11], the two staff at the park with consumers 	V 500		

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V 500	<p>Continued From page 41</p> <p>reported that the two consumers ran ahead of the two staff and went into the bathroom- staff (staff #1 and staff #11) reported they noticed the consumers (client #2 and client #3) had mistakenly ran into the bathroom, the directed the consumers (client #2 and client #3) to come out of the bathroom. The consumers came out of the bathroom, then on the way walking through the park consumer [client #2] told the staff that [client #3] attempted to 'F' him in butt. After staff and consumers where questioned the QP sent a text alerting staff that the consumers where speaking sexually and we should keep [client #3] and [client #2] separated and monitored the behaviors of all consumers because of the increased sexual verbalization."</p> <p>- "Abuse Allegation...alleged abuse of a consumer"</p> <p>- "Consumer Behavior...Inappropriate or illegal sexual behavior"</p> <p>Interview on 11/21/25 with CPS Social Worker: - The facility staff did not report the 11/2/25 incident to DSS.</p> <p>Interview on 11/21/25 with the AP/L/D/RN revealed: - She did not report the 11/2/25 incident to DSS.</p>	V 500		
V 512	<p>27D .0304 Client Rights - Harm, Abuse, Neglect</p> <p>10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION</p> <p>(a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66.</p> <p>(b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter.</p>	V 512		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-244	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/15/2025
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V 512	<p>Continued From page 42</p> <p>(c) Goods or services shall not be sold to or purchased from a client except through established governing body policy.</p> <p>(d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter.</p> <p>(e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.</p> <p>This Rule is not met as evidenced by: Based on interviews, observations, and record reviews 1 of 3 audited staff (#1) abused and harmed 1 of 1 audited former client (FC) (#5). The findings are:</p> <p>Review on 11/18/25 of FC #5's record revealed: - Date of Admission: 8/7/25 - Date of Discharge: 10/6/25 - Age: 9 years-old - Diagnosis: Disruptive Mood Dysregulation Disorder</p> <p>Review on 11/19/25 of Staff #1's record revealed: - Title: Direct Care Staff/Paraprofessional - Hire date: 10/31/24 - Completed training on Seclusion, Physical Restraint, and Isolation Time Out on 11/5/25.</p> <p>Review on 11/19/25 of the internal "DHHS</p>	V 512		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-244	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/15/2025
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V 512	<p>Continued From page 43</p> <p>(Department of Health and Human Services) Incident and Death Report" dated 9/14/25 revealed:</p> <ul style="list-style-type: none"> - Report was completed by staff #1 - Date of Incident: 9/14/25 - "During a community outing at [the local park], [FC #5] informed staff that he needed to use the restroom. Staff attempted to escort him to the designated rest area. [FC #5] stated that he wouldn't make it in time and instead went to the outskirts of nearby while under direct staff monitoring. Upon returning [FC #5] had a small amount of urine on the front of his pants. Staff reassured him that they were about to go back to the facility where he could change. At that time, another consumer (client #1) began laughing and making comments towards [FC #5], stating he urinated on himself. [FC #5] became upset began using racial slurs towards the other consumer (client #1) and then initiated physical aggression by throwing a punch (at client #1), [FC #5] ran to a tree and started banging his head and scratching himself. Staff (staff #1) used a therapeutic barrier to prevent [FC #5] from causing anymore harm to himself. Staff maintained safety and continued monitoring until [FC #5] was able to calm down. We gets back to the facility. I clean his (FC #5's) face up and clipped his finger nails. I notified my QP (Qualified Professional)." - "Injury: On the figures below, circle the location of any bruises, cuts, scratches, injuries, or other marks that occurred as a result of the incident" There were no circles to show where the injuries occurred. <p>Review on 11/17/25 of the North Carolina Incident Response and Reporting (IRIS) revealed:</p> <ul style="list-style-type: none"> - Date of Incident: 9/14/25 - Date reported: 9/17/25 	V 512		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-244	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/15/2025
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V 512	<p>Continued From page 44</p> <ul style="list-style-type: none"> - Name of Person Who Completed Form: Associate Professional/Licensee/Director/Registered Nurse (AP/L/D/RN) - "during a community outing at the Park [FC #5] became dysregulated after being informed by staff (staff #1) that he needed to use the restroom before returning to the facility. When staff attempted to escort him to the designated restroom area, [FC #5] refused, stating he would not make it in time, and instead relieved himself outside while under direct staff supervision. Upon returning to the group, another consumer (client #1) made laughing and mocking comments toward [FC #5] regarding the incident. [FC #5] became visibly upset and called the other consumer (client #1) the N word, began yelling, and attempted to strike the other consumer with a punch. He (FC #5) then ran toward a tree and started banging his head on the tree and scratching himself. Staff (staff #1) immediately followed and intervened implemented a therapeutic barrier to prevent [FC #5] from causing further harm to himself. After a few minutes, [FC #5] was able to calm down.[FC #5] sustained scratches to his face and neck and bruise to his left ear." - "Level of Incident: Level III" - "HCPR - Facility Allegation" reported on 9/17/25 - "Choose the Type(s) of Allegations Being Made: Resident Abuse" - "Staff full name: [staff #1]" <p>Review on 11/19/25 of pictures taken on 9/14/25 by staff #1 of FC #5 revealed:</p> <ul style="list-style-type: none"> - FC #5's neck on his left side had a scratch mark approximately 1/2 inch wide and approximately 4-5 inches long. - FC #5's left ear had red and purple bruising on his upper ear. 	V 512		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-244	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/15/2025
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V 512	<p>Continued From page 45</p> <ul style="list-style-type: none"> - FC #5's left side of face had several scratches and bruising beside his ear. The scratches were various sizes. <p>Review on 11/20/25 of pictures taken on 9/15/25 by school personnel of FC #5 revealed:</p> <ul style="list-style-type: none"> - The injuries were consistent with those shown in the photographs taken on 9/14/25; however, the bruising covered more area on the back of FC #5's ear and was dark purple. <p>Interview and observations at approximately 1:52 pm on 11/17/25 with FC #5 revealed:</p> <ul style="list-style-type: none"> - On 9/14/25, staff #1 and staff #7 took him, client #1, client #4, and FC #6 to the park. - On 9/14/25, he got into a fight with client #1 after client #1 laughed at him. Client #1 had laughed at him "because I accidently got urine on myself because I was in the woods using the bathroom." - Staff #1 restrained him and held his arms behind his back. - "[Staff #1] hold my arms like this and pushed me on the tree." He demonstrated his arms being held behind his back. - "The bark of the tree scratched me." - "My ear felt like a vein popped. It wasn't that I hit my head on the tree she (staff #1) just pushed my head on the tree..." - Staff #1 held him up against the tree "maybe 9 minutes." - "I had scratches on my chin and scratches on the side of my face and my ear had a vein pop." - "I tried to say something but I couldn't because I was screaming and crying too much." - He did not feel safe in the facility. - "That place sucks because it was rough for me." <p>Interview on 11/19/25 with FC #6 revealed:</p> <ul style="list-style-type: none"> - On 9/14/25, He, FC #5, client 1, and client #4 	V 512		

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V 512	<p>Continued From page 46</p> <p>were in the park with staff #1 and staff #7.</p> <ul style="list-style-type: none"> - Client #1 and FC #5 got into a physical fight. - Staff #1 had to "restrain" FC #5. - "[Staff #1] had to push him to the tree. Just to get [FC #5] off of [client #1]." - FC #5 was facing the tree with staff #1 behind him. - "She (staff #1) grabbed his arms off the trees and she had his hands pulled together. She had to put her weight up against [FC #5] because [FC #5] was trying to get away." - "His (FC #5) ear was being pushed up to the tree. He kept complaining he could not hear out the ear. [Staff #1] was pushing her body against [FC #5's] body up against the tree. She was standing behind him. That is how his (FC #5's) ear got purple." - He recalled seeing a "bruise right beside of his (FC #5's) ear." - He saw bruising on both FC #5's left ear and left side of his face. - FC #5 told staff #1 "let me the f**k go." - Staff #1 pushed FC #5's body up against the tree for "about 10 minutes." <p>Interview on 11/17/25 with client #4 revealed:</p> <ul style="list-style-type: none"> - On 9/14/25 he recalled client #1 and FC #5 got in a fight at the park. - Staff #7 broke up the fight. - Then staff #1 held FC #5 "from behind and shoved [FC #5] toward the tree and pushed [FC #5's] head up against the tree." - FC #5's hands were behind his back. - Staff #1 "had one hand on his (FC #5's) hand and then her other hand was pushing his head up against the tree." - FC #5's face was "sideways on the tree when [staff #1] was pushing up against him (FC #5)." - "[FC #5] was yelling and screaming. [Staff #7] was talking to [client #1] to calm him down." 	V 512		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-244	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/15/2025
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NAME OF PROVIDER OR SUPPLIER POA LIVING GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2510 LONG FERRY ROAD SALISBURY, NC 28146
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V 512	<p>Continued From page 47</p> <ul style="list-style-type: none"> - Staff #1 held FC #5's up against the tree "for like 15 minutes." - Afterwards he saw that FC #5 had bruising and scratching on one side of his face. He could not recall which side. <p>Interview on 11/17/25 with client #1 revealed:</p> <ul style="list-style-type: none"> - Did not recall an allegation of abuse in the park where any of the clients were restrained. - Did not recall having a fight with FC #5 in the park. <p>Interview on 11/20/25 with staff #7 revealed:</p> <ul style="list-style-type: none"> - On 9/14/25 he and staff #1 were at the park with FC #5, FC #6, client #1 and client #4. - The clients wanted to fish in the area where the picnic tables were located. - Client #1 and FC #5 were arguing. - He was with FC #6 and client #4. - Staff #1, client #1 and FC #5 were close by. - He heard staff #1 state that client #1 and FC #5 were fighting. - He got client #1 out of the way. He did not put his hands on client #1 and told him "to chill out." - Staff #1 "had to hold or grab" FC #5 because FC #5 was trying to get at client #1. - "She (staff #1) had basically put her body up against him (FC #5) against the tree. He (FC #5) tried to get her (staff #1) off of him." - Staff #1's body was behind FC #5's body. FC #5 was facing the tree. - Staff #1 "did have one hand on his (FC #5's) head and she had one hand on his (FC #5's) back where she was basically trying to hold him (FC #5) against the tree. [FC #5's] hands were trying to push off the tree." - FC #5's face was on the tree. "His face was turned right and his left side of his face was on the tree. [Staff #1] held him against the tree nothing less or more than 8-10 minutes." 	V 512		

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V 512	<p>Continued From page 48</p> <ul style="list-style-type: none"> - When they returned to the facility he saw a mark on FC #5's left ear. "His ear looked purple." - FC #5 also had a mark on his lower left cheek. - "I felt putting him (FC #5) on the tree, she (staff #1) could have moved him somewhere else during that 8-10 minutes instead of him being pinned against the tree. She (staff #1) could have sat on the ground and just held him (FC #5)." - "He would have never gotten those marks if she used a different way to hold him." - He reported what occurred to the QP. "I told her (the QP) everything I told you." <p>Interview on 11/26/25 with FC #5's school administration revealed:</p> <ul style="list-style-type: none"> - FC #5 talked to her about the 9/14/25 allegation of abuse incident. - FC #5 told her that he was at a park. - FC #5 told her that staff #1 "did it to him" - FC #5 said that staff #1 "shoved his head up against the tree" and that's how the bruising got on his ear and the scratches on his face. <p>Interview on 11/17/25 with staff #1 revealed:</p> <ul style="list-style-type: none"> - On 9/14/25 while she and staff #7 were at the park, client #1 and FC #5 got into a fight. - She got between client #1 and FC #5. - FC #5 "started banging his head up against the tree and he started grabbing his ear screaming and scratching his face and saying the n word." - She did a "therapeutic barrier to stop him (FC #5)." - "I had a barrier against him (FC #5) and the tree so he would not get loose and bang his head." - She held her arms out on either side of FC #5 while FC #5 banged his head up against the tree. "But I did not touch him." - "When I tried to get hold of [FC #5], he finally stopped banging his head on the tree and scratching and that's when I notified my QP." 	V 512		

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V 512	<p>Continued From page 49</p> <ul style="list-style-type: none"> - FC #5 had a scratch on his face . "It was red and puffy." FC #5 had a scratch on his ear but she could not remember which ear had a scratch. <p>Interview on 11/21/25 with the QP revealed:</p> <ul style="list-style-type: none"> - She talked to the clients about the 9/14/25 allegation of abuse incident on 9/15/25. - Client #4 did not want to talk about the incident. - Client #1 would not answer questions. - FC #6 told her that he remembered FC #5 was acting "wild and crazy." FC #6 further told her that staff #1 had to keep FC #5 from hitting his head on the tree. - FC #5 told her that he and client #1 were fighting. He also told her that he banged his head and that staff #1 tried to stop him from banging his head. - Staff #7 told her during the allegation of abuse incident he was trying to keep FC #6 and client #4 calm. Did not remember staff #7 describing the restraint that staff #1 did on FC #5. - Staff #1 was put on leave because the facility did an internal investigation. - She did not do an internal investigation because staff #1 "did anything wrong it was making sure she had a mental health break." - FC #5 had scratches and abrasions on his face afterwards. - She did not know how the bruise got on FC #5's ear. <p>Review on 12/2/25 of the Plan of Protection dated 12/2/25 written by the AP/L/D/RN revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Staff member [staff #1] was on Approved Leave of Absence (ALOA) through 11/15/2025. Upon her return on 11/15/2025, she was permitted to work only under direct, continuous supervision by the Assistant Program Director , Qualified</p>	V 512		

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V 512	<p>Continued From page 50</p> <p>Professional (QP), and Group Home Manager at all times. She was not permitted to work independently and was never alone with any consumer.</p> <p>Following the State Exit on 12/1/2025 with a substantiated Protection from Harm citation, POA Living Group Home immediately removed [staff #1] from all direct and indirect consumer contact effective 12/2/2025.</p> <p>Effective immediately:</p> <ul style="list-style-type: none"> o [Staff #1] is not scheduled for any shifts o She (staff #1) has no access to consumers, the facility, or documentation systems o All consumers will continue to be supervised by fully trained staff o Enhanced line-of-sight supervision is in effect for all consumers <p>There is no current consumer contact between [staff#1] and any resident of the facility.</p> <p>Describe Your Plans to Make Sure This Happens.</p> <p>Minimum staffing ratios strictly enforced at all times</p> <p>Weekly QP supervision and documentation review</p> <p>Staff Training & Accountability</p> <p>Immediate refresher training provided on:</p> <ul style="list-style-type: none"> - Protection from Harm - Supervision standards - Mandatory reporting - Incident documentation <p>Weekly safety audits by the QP</p> <p>Random management supervision checks"</p> <p>This facility served clients with diagnoses of Conduct Disorder; Post-Traumatic Stress Disorder; Attention Deficit Hyperactivity Disorder, Combined Type; Other Persistent Mood Disorder; Impulse Control Disorder; Oppositional Defiant Disorder; Major Depressive Disorder, Moderate; Disruptive Mood Dysregulation Disorder; and</p>	V 512		

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V 512	<p>Continued From page 51</p> <p>Cannabis Use Disorder. During an outing at a local park on 9/14/25, client #1 and FC #5 got into a fight. Staff #1 intervened. Staff #1 pushed her body against FC #5's body and face against a tree in a local park. Staff #1 pushed FC #5 up against the tree somewhere between 8 to 15 minutes. This resulted in FC #5 having bruising on the top outer rim of his left ear to just above the earlobe, a large scratch to his neck and bruising along with scratches to the left side of his face.</p> <p>This deficiency constitutes a Type A1 rule violation for serious abuse and harm and must be corrected within 23 days.</p>	V 512		