Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			-		
		MHL029-006	B. WING		11/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
PATH OF I	НОРЕ		T CENTER STR ON, NC 27292	EET EXTENSION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 000	00 INITIAL COMMENTS		V 000		
	22, 2024. Deficiencies This facility is licensed categories: 10A NCAG Treatment/Rehabilitat	d for the following service C 27G .3400 Residential ion for Individuals with			
	Substance Abuse Disorders, 10A NCAC 27G .3700 Day Treatment Facilities for Individuals with Substance Abuse Disorders, 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program, and 10A NCAC 27G .4500 Substance Abuse Comprehensive Outpatient Treatment Program.				
	This facility is licensed for 12 and has a current census of 12. The 10A NCAC 27G .3400 Residential Treatment/Rehabilitation for Individuals with Substance Abuse Disorders has a current census of 12, the 10A NCAC 27G .3700 Day Treatment Facilities for Individuals with Substance Abuse Disorders has a current census of 0, the 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program (SAIOP) has a current census of 0, and the 10A NCAC 27G .4500 Substance Abuse Comprehensive Outpatient Treatment Program (SACOT) has a current census of 0.				
	current clients and 1 f NCAC 27G .3400 Res	ion for Individuals with			
V 110	27G .0204 Training/S Paraprofessionals	upervision	V 110		
		4 COMPETENCIES AND ARAPROFESSIONALS			

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) D			
		MHL029-006	B. WING		11	/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	ZIP CODE		
PATH OF	HOPE		ST CENTER STREE ON, NC 27292	ET EXTENSION		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG			PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 110	paraprofessionals. (b) Paraprofessional associate professional as speci Subchapter. (c) Paraprofessionals knowledge, skills and population served. (d) At such time as a employment system is then qualified professionals shall de (e) Competence sha exhibiting core skills is (1) technical knowle (2) cultural awarene (3) analytical skills; (4) decision-making; (5) interpersonal skills (6) communication side (7) clinical skills. (f) The governing bodevelop and implements	s shall be supervised by an all or by a qualified fied in Rule .0104 of this is shall demonstrate abilities required by the competency-based is established by rulemaking, sionals and associate emonstrate competence. If be demonstrated by including: dge; ss; is kills; and dy for each facility shall ent policies and procedures individualized supervision	V 110			
	competency in interposition skills with clients. The	ew and interview, a aff #4) did not demonstrate ersonal and communication				

Division of Health Service Regulation

STATE FORM Q2IF11 If continuation sheet 2 of 12

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SU COMPLE	
7410 1 2741	or dorate of the transfer of t	IDEITH IOMION NOMBER.	A. BUILDING: _		J JOHN EE	125
		MHL029-006	B. WING		11/22	2/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PATH OF	НОРЕ		CENTER STR N, NC 27292	EET EXTENSION		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETE DATE
V 110	Continued From page 2		V 110			
	Client #2 revealed:					
	-He identified 11 com	plaint items against Staff #4				
	in his grievance, which					
	,	ff #4) makes inappropriate uests in a demeaning way				
	_	Client (FC#5)) last night				
	'You ain't s**t.'"	eneria (i. e., e.,), i.e.e. i.i.g.i.i				
		Staff #4) referred to us as				
	children to houseguestsand [Client #4] wasn't					
	there to defend himself." -#11 stated " He (Staff #4) cusses just as much					
	as we do or worse."					
	Review on 11/22/24 or revealed:	of Client #2's record				
	-Admission date of 11	1/8/24.				
	Review on 11/24/24 or revealed:	of Client #4's record				
	-Admission date of 11	1/14/24.				
	Review on 11/22/24 o	of FC #5's record revealed:				
	-Admission date of 10					
	-Discharge date of 11	/20/24.				
	Review on 11/22/24 of revealed:	of Staff #4's personnel record				
	-Hire date of 5/5/23.					
	-Position as Substand	ce Abuse Residential				
	Technician.					
		with Client #2 revealed:				
	-"When he (Staff #4)					
		s and everyone is uptight." s inappropriate gestures to				
	, ,	lients) like he (Staff #4)				
		wn like a piece of meat."				
		C #5] 'You ain't s**t' while				
		IA (Narcotics Anonymous)				

Division of Health Service Regulation

STATE FORM Q2IF11 If continuation sheet 3 of 12

Division of Health Service Regulation

Division	of Health Service Regu	liation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		MHL029-006	B. WING		11/2	22/2024
					1 11/2	.2/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
PATH OF	HOPE			REET EXTENSION		
	-	LEXINGT	ON, NC 27292			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETE DATE
IAG		,	IAG	DEFICIENCY)		
V 110	O	- 0	V 110			
V 110	Continued From page	e 3	V 110			
	-"He (Staff #4) had a	confrontation with [Client #4]				
	and told him we were	all children. None of us				
	(clients) want to be re	eferred to as children."				
	-Staff #3 and Staff #4	told him "Staff should start				
	disciplining us (clients	s) for using profanity." He did				
	not know what the dis	scipline would be. He stated,				
		ouldn't use profane language				
	when [Staff #4] still us					
		ten grievance, Staff #4				
	"insinuated I would be	-				
		ready for a new roommate				
	_	about the kitchen chores				
		ot being in the right spot. He				
	makes me angry."					
	Interview on 11/22/24	with Client #4 revealed:				
		e in treatment at the facility				
	and he chose to retur	-				
		ering back and forth" with				
	Staff #4 was because					
	personalities."	,				
	•	e female house manager				
		one day 'Don't waste your				
	breath on him, meani	ng me.' [Staff #4] was telling				
	her (the female house	e manager) some things				
	about me and its not	up to him to share our				
	information without or	ur agreeing to it."				
		Staff #4] made some indirect				
	•	but he didn't give me the				
	_	nt #2] he was not going to				
		if he didn't quit aggravating				
	him (Staff #4)."					
	-" It might be a power					
	•	between [Staff #4] and				
	[Client #2]."					
		uses profanity when he				
	talks to us (clients)."					
		ent to earlier in the week				
		outside the meeting like we				
	usually do before goil	ng in and [Staff #4] told one				

Division of Health Service Regulation

STATE FORM 6899 Q2IF11 If continuation sheet 4 of 12

Division of Health Service Regulation

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE Co		(X3) DATE :	
		MHL029-006	B. WING		11/	22/2024
		WII 12023-000			11/2	22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
PATH OF	HOPE		ST CENTER STREI	ET EXTENSION		
	I	LEXINGT	ON, NC 27292			1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 110	V 110 Continued From page 4		V 110			
	somebody. It don't ma s**t to me."' -"There were 12 of us there on the sidewalk [FC #5] loud enough to didn't react. This just days ago."	in't s**t.' [Staff #4] said, 'I am atter who you are, you ain't guys (clients) standing and [Staff #4] said this to for all of us to hear. [FC #5] literally occurred a couple of with FC #5 revealed:				
	Interview on 11/22/24 with FC #5 revealed: -He denied Staff #4 disrespected him at any time during his admission. -He denied Staff #4 used profanity toward him. -He had no concerns about his treatment at the program. Interview on 11/22/24 with Staff #4 revealed: -He denied he used profanity toward FC #5 and other clients. -He stated, "I have said a curse word in clients' presence, but it was not directed toward any client." -He denied having made any inappropriate gestures (verbal or non-verbal) toward any client. "[FC #5] and I were joking around in conversation outside the meeting (NA meeting) and he [FC #5]'s ego is right up there sometimes and I said 'You always talking about beating people up, you ain't it.' I didn't say s-h-t." -Clients have "taken me wrong since I have worked at the program and they (clients) have gone to their clinician saying [Staff #4] cursed them." His former house supervisor then discussed "whatever was said" and he has been "working on what he says (to clients)." -He had referred to clients as "children" in the context of "You're like a child at the start of					

Division of Health Service Regulation

STATE FORM Q2IF11 If continuation sheet 5 of 12

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL029-006	B. WING	B. WING		2/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•	
PATH OF I	НОРЕ		CENTER STR N, NC 27292	EET EXTENSION		
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 110	Continued From page	÷ 5	V 110			
V 114	this weekStaff #3 who assum position this week had information about each grievance.	ed the House Supervisor d began gathering th issue in Client #2's aternal investigation into	V 114			
	AND SUPPLIES (a) Each facility shall and a disaster plan at these plans available to the county emerge request. The plans ship procedures and route (b) The plans shall be and evacuation proceposted in the facility. (c) Fire and disaster coshall be held at least repeated for each ship and evacuation proceposted in the facility.	e made available to all staff dures and routes shall be drills in a 24-hour facility quarterly and shall be ft. ted under conditions that response to fire				

Division of Health Service Regulation

STATE FORM Q2IF11 If continuation sheet 6 of 12

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		GOWN LETED	
		MHL029-006	B. WING		11/22/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
PATH OF	НОРЕ		T CENTER STR DN, NC 27292	REET EXTENSION		
040.15	CHMMADY CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTI	ON	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPI	LETE
V 114	Continued From page 6 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire and disaster drills were documented for each shift per quarter. The findings are:		V 114			
	Review on 11/22/24 of the facility's fire and disaster drill log between 12/15/23 and 10/14/24 revealed: -No documentation of a 3rd shift fire drill and a 1st shift disaster drill for January-March 2024 (1st quarter). -No documentation of 3rd shift fire drill and a 1st shift disaster drill for April-June 2024 (2nd quarter). -No documentation of a 2nd shift fire drill and a 3rd shift disaster drill for July-September 2024 (3rd quarter). -No documentation of a 3rd shift fire drill and a 1st shift disaster drill for October 2024-December 2023 (4th quarter).					
	-He thought he had p	with Client #1 revealed: articipated in at least 1 fire ill since his admission in				
	-There were 3 staff sh Sunday at 2 pm to Tu from Tuesday at 5 pm shift from Friday 6 am -There was a written so disaster drills were to -Fire and disaster dril	schedule for when fire and				
	-Fire and Disaster dri	lls were conducted monthly. 24 as the Men's House				

Division of Health Service Regulation

STATE FORM Q2IF11 If continuation sheet 7 of 12

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
		MHL029-006	B. WING		11/22/2024
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	TE. ZIP CODE	
PATH OF I			, ,	EET EXTENSION	
PAIROFI	TOPE	LEXINGT	ON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 114	Continued From page	e 7	V 114		
	Supervisor and understood one of his duties would be to ensure fire and disaster drills were practiced and documented. Interview on 11/22/24 with the Director of Operations revealed: -No documentation on the missing fire and disaster drillsShe believed the fire and disaster drills were conductedShe would follow up with staff to ensure the fire				
	and disaster drills we				
V 736	27G .0303(c) Facility	and Grounds Maintenance	V 736		
	10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.				
	was not maintained in	n and interview, the facility n a safe and attractive			
	manner. The findings are: Observation on 11/22/24 beginning at 11 am of the facility revealed: -In the 2nd living room with the plaid fabric sofa, the ceiling board which surrounded an overhead light fixture had at least 5 linear ceiling cracks of varying lengths and at least 6 horizontal ceiling cracks of varying lengthsIn the kitchen, the front to a refrigerator middle drawer marked "Fresh Produce" with blue-colored semi-circles was missing. The frame at the top of				

Division of Health Service Regulation

of the refrigerator had multiple red, yellow, and

STATE FORM 6899 Q2IF11 If continuation sheet 8 of 12

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION (X3) DA			
744012744	or connection	IBERTIN ISTATION TO MBETA	A. BUILDING:		55	
		MHL029-006	B. WING		11	/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STAT	E. ZIP CODE	•	
				EET EXTENSION		
PATH OF	HOPE		ON, NC 27292			
(V4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	,	PROVIDER'S PLAN OF C	ORRECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
V 736	Continued From page	e 8	V 736			
	brown snots. There w	as a soiled red and gray				
		laying on the floor in front of				
	the refrigerator.	laying on the neer in hem er				
		porch where the washer,				
		ers were located, the exterior				
		scratches which were				
	brown-colored. A whit	te plate with blue decorative				
		yellow substance on the				
	plate and was laying					
	-In bedroom #1 which was located on the bottom floor:					
		the room between the head				
		o, there were at least 4-5				
		anged from 2-3 inches to 1				
		sed white-colored drywall				
	board. A surface-leve					
		et in length was observed				
	from the top of the lar	np on the wall. Filing behind the bedroom				
	_	ely 9 black-colored spots				
		iling paint of approximately				
		ling paint was loose on both				
	sides of the crack.	mig paint was 1999e on 2011				
		edroom door frame at the				
	top right side was unp	painted and had a thin loose				
	board at the top right	side.				
	-In the upstairs bathro					
		t had a white sheet of paper				
	marked with "Do Not basin.	Use" taped across the sink				
	-Next to the bathroo	om window, the inside toilet				
	· · ·	of unpeeled paint which				
	exposed the brown co					
		dow was missing a cover to				
		during personal hygiene.				
		was located on the 2nd				
	floor:					
		ttom window on the left side				
		5 glass shards on the left ards on the top side near				
	i side and b-n diass sh	arus on me iod side hear	1			ı

Division of Health Service Regulation

STATE FORM Q2IF11 If continuation sheet 9 of 12

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SUR'	
			A. BUILDING: _			
		MHL029-006	B. WING		11/22/2	2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
PATH OF	НОРЕ		CENTER STR N, NC 27292	EET EXTENSION		
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	(X5) COMPLETE DATE
TAG	NEGOL/WORL OR I		TAG	DEFICIENCY)	TAVAL	
V 736	the window locks. The screen in this same window was bent at the bottom in a "v" shape and faced toward the exterior of the facility. -A closet with a set of blinds laying in disarray on the closet floor with 3 sides of the closet and the closet door with multiple streaks of unpeeled paint. -In bedroom #4, the attic door attached to the ceiling was missing 1 piece of frame located on the side near the latch and lockIn bedroom #6, there were at least 20 white-colored spots on the left wall and next to		V 736			
	the head where Clien					
		with Client #1 revealed: ny repairs needed to the				
	Interview on 11/22/24 with Client #2 revealed: -The cracks on the wall near his bed had been there since his admission. He did not know what caused the wall cracksHe did not know what caused the black spots on the corner ceiling of his room.					
	-He stated, "I don't wa about the white spots	with Client #4 revealed: ant to touch it," when asked on the wall beside his bed. te spots may have been				
	Interview on 11/22/24 with Staff #1 revealed: -The 2nd living room with the ceiling cracks around the overhead light fixture had been "like that" since he started work at the facility over a year ago. This living room was a room where the clients spent time watching TV and socializing. -He did not know what happened to the missing front of a refrigerator middle drawer or what caused the drawer frame to crack. The red,					

Division of Health Service Regulation

STATE FORM Q2IF11 If continuation sheet 10 of 12

Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SU COMPLE	
			71. 501251110.			
		MHL029-006	B. WING		11/22	/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
PATH OF I	HODE	1675 EAS	T CENTER STR	EET EXTENSION		
- AIII OI I	TOPE	LEXINGT	ON, NC 27292			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 736	Continued From page	e 10	V 736			
	yellow and brown sporefrigerator were food -The brown scratches rust and the plate on client (unknown) after He removed the plate -No explanation for th the wall cracks, the co black-colored spots of downstairs bedroom. of this room's bedroom. of this room's bedroom. The sign "Do Not Us in the upstairs bathroom (week of 11/11/24). H what's wrong with it." -A set of blinds which window was removed the blinds were broke -He was not aware of and bent window scre slid the dresser over to -The closet in bedroo -He believed a client at some time to open of the frames was mis this door remained lo -No explanation for the bedroom wall. Interview on 11/22/24 Operations revealed: -Staff #4 had poured the upstairs bathroom -The Facility Director windowpane for bedro	ots at the bottom of the I debris. Is on top of the dryer were the dryer was likely left by a rethe client finished eating. It immediately from the dryer. It is cause or a timeframe of eiling crack or the in the ceiling in the He had not noticed the top im door was unpainted. It is taped to one of the sinks om was not there last week it is estated, I don't know to covered the bathroom I 6-8 months ago because in. If the broken windowpane is een in bedroom #2 until he to one side. If it is the was used for storage. I (unknown) must have tried the attic door because one is sing and the lock placed on cked. It is with the Director of it is a household cleaner down in sink to unclog the drain. In had ordered a replacement	V 750			
	windowpane for bedro Interview on 11/22/24 revealed:	oom #2.				

#2.
Division of Health Service Regulation

STATE FORM Q2IF11 If continuation sheet 11 of 12

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DAT CON			E SURVEY PLETED	
		MHL029-006	B. WING		11	/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE		
PATH OF	НОРЕ		ST CENTER STRI ON, NC 27292	EET EXTENSION		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
V 736	-Each client had a res bedroom, and each c were responsible for. -Clients could report a	sponsibility to clean their lient had cleaning tasks they any facility repairs they saw. on identified items that	V 736			

Division of Health Service Regulation

STATE FORM Q2IF11 If continuation sheet 12 of 12