	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVE COMPLETED	Y
		MHL032-568	B. WING		12/17/2024	
IAME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		<u> </u>
NHANC	EMENT HEALTH CA	RF	CASTER STRE /I, NC 27701	EET		
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN(	TION SHOULD BE COMF THE APPROPRIATE DA	(5) PLET ATE
V 000	INITIAL COMMEN	TS	V 000			
	An annual survey v 17, 2024. Deficienc	vas completed on December sies were cited.				
	category: 10A NCA	sed for the following service C 27G .5600C Supervised th Developmental Disability.				
	census of 2. The su	sed for 4 and has a current urvey sample consisted of clients and 1 deceased client.				
V 114	27G .0207 Emerge	ncy Plans and Supplies	V 114			
	AND SUPPLIES (a) Each facility sha and a disaster plan these plans availab to the county emerge request. The plans procedures and rou (b) The plans shall and evacuation pro- posted in the facility. (c) Fire and disaster shall be held at lease repeated for each so Drills shall be cond simulate the facility emergencies.	gency services agencies upon shall include evacuation utes. be made available to all staff cedures and routes shall be er drills in a 24-hour facility st quarterly and shall be shift. ucted under conditions that 's response to fire all have a first aid kit				
	ealth Service Regulation	DER/SUPPLIER REPRESENTATIVE'S SIG		TITLE	(X6) DAT	

STATEMEN	of Health Service Re NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		MHL032-568	B. WING		12/	17/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ENHANC	EMENT HEALTH CA	RF	CASTER STRE I, NC 27701	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 114	Continued From pa	age 1	V 114			
	Based on record re facility failed to ens done quarterly on e	et as evidenced by: eview and interviews, the ure fire and disaster drills were each shift. The findings are:				
	disaster drill log fro 2024) revealed: -There was no fire staff for the 3rd qua of 2024. -There was no disa	4 of the facility's fire and m (March 2024-November drill conducted by the live in arter (July, August, September) ister drill conducted by the nd quarter (April, May, June) of				
		ister drill conducted by the live quarter (July, August, 4.				
	revealed: -She was deaf and	municate with the Division of				
	revealed:	v on 12/12/24 with client #2 nunicate due to his limited /.				
	-She transferred to months ago. -She had not done she worked at the f	upervisor did the fire and				
	Interview on 12/16/ Supervisor revealer -The facility had two ealth Service Regulation					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		MHL032-568	B. WING		12/	17/2024
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
NHANC	EMENT HEALTH CA	RF	CASTER STRE /I, NC 27701	EET		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE <sup>-</sup> DATE
V 114	Continued From pa	ge 2	V 114			
	the clients.	e fire and disaster drills with				
	-The other staff we and disaster drills.	re not consistently doing fire				
	-She was not sure doing the drills.	why the other staff were not				
	-She confirmed the	facility failed to conduct fire				
	and disaster drills d	uarterly on each shift.				
V 118	27G .0209 (C) Med	lication Requirements	V 118			
	10A NCAC 27G .02 REQUIREMENTS	209 MEDICATION				
	(c) Medication adm					
	only be administere	non-prescription drugs shall ed to a client on the written uthorized by law to prescribe				
	drugs.					
	clients only when a	all be self-administered by uthorized in writing by the				
	client's physician. (3) Medications, inc	cluding injections, shall be				
	administered only b	y licensed persons, or by trained by a registered nurse				
	pharmacist or othe	r legally qualified person and e and administer medications				
	(4) A Medication Ac	Iministration Record (MAR) of				
		red to each client must be kep s administered shall be	t			
	recorded immediate MAR is to include t	ely after administration. The he following:				
	(A) client's name;	, and the second s				
		, and quantity of the drug; administering the drug;				
	(E) name or initials	he drug is administered; and of person administering the				
		for medication changes or				
	checks shall be rec	orded and kept with the MAR				

If continuation sheet 3 of 12

IT OF DEFICIENCIES OF CORRECTION					
or connection	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:			E SURVEY PLETED
	MHL032-568	B. WING		12/	17/2024
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
EMENT HEALTH CAP	2F		ET		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
Continued From pa	ge 3	V 118			
file followed up by a with a physician.	appointment or consultation				
Based on record re facility failed to kee	views and interviews, the p the MARs current affecting				
revealed: -Admission date of -Diagnoses of Mode Schizoaffective Dise Disorder, Post-Trau Conduct Disorder, Gastroesophageal Hypertension, Urina Deafness, Tachyca Eye Syndrome. -Physician's order of 100 milligrams (mg capsule twice daily	6/16/05. erate Intellectual Disability, order, Intermittent Explosive imatic Stress Disorder, Type II Diabetes, Reflux Disease (GERD), ary Incontinence, Congenital rdia, Mute, Enuresis and Dry dated 2/14/24 for Amantadine ) (Parkinson's Disease), one and Metformin 500 mg				
revealed:					
administered for the November 2024- -Amantadine 100 m	e following- ng on 11/30 8pm dose				
	EMENT HEALTH CAP SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa file followed up by a with a physician. This Rule is not me Based on record re facility failed to kee two of two current of findings are: Review on 12/12/24 revealed: -Admission date of -Diagnoses of Mode Schizoaffective Dis Disorder, Post-Trau Conduct Disorder, T Gastroesophageal Hypertension, Urina Deafness, Tachyca Eye Syndrome. -Physician's order of 100 milligrams (mg capsule twice daily (Diabetes), one tab Review on 12/12/24 revealed: No staff initials to ir administered for the November 2024- -Amantadine 100 m	PROVIDER OR SUPPLIER     STREET AI       917 LAN DURHAN     917 LAN DURHAN       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       Continued From page 3       file followed up by appointment or consultation with a physician.       This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to keep the MARs current affecting two of two current clients (#1 and #2). The findings are:       Review on 12/12/24 of client #1's record revealed: -Admission date of 6/16/05. -Diagnoses of Moderate Intellectual Disability, Schizoaffective Disorder, Intermittent Explosive Disorder, Post-Traumatic Stress Disorder, Conduct Disorder, Type II Diabetes, Gastroesophageal Reflux Disease (GERD), Hypertension, Urinary Incontinence, Congenital Deafness, Tachycardia, Mute, Enuresis and Dry Eye Syndrome. -Physician's order dated 2/14/24 for Amantadine 100 milligrams (mg) (Parkinson's Disease), one capsule twice daily and Metformin 500 mg (Diabetes), one tablet twice daily.       Review on 12/12/24 of a MAR for client #1 revealed: No staff initials to indicate the medication was administered for the following- November 2024- -Amantadine 100 mg on 11/30 8pm dose -Metformin 500 mg on 11/8 thru 11/11 8pm doses	PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, S       PEMENT HEALTH CARE     917 LANCASTER STRIE UURHAM, NC 27701       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX TAG       Continued From page 3 file followed up by appointment or consultation with a physician.     V 118       This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to keep the MARs current affecting two of two current clients (#1 and #2). The findings are:     V 118       Review on 12/12/24 of client #1's record revealed: -Admission date of 6/16/05. -Diagnoses of Moderate Intellectual Disability, Schizoaffective Disorder, Intermittent Explosive Disorder, Post-Traumatic Stress Disorder, Conduct Disorder, Type II Diabetes, Gastroesophageal Reflux Disease (GERD), Hypertension, Urinary Incontinence, Congenital Deafness, Tachycardia, Mute, Enuresis and Dry Eye Syndrome. -Physician's order dated 2/14/24 for Amantadine 100 milligrams (mg) (Parkinson's Disease), one capsule twice daily and Metformin 500 mg (Diabetes), one tablet twice daily.       Review on 12/12/24 of a MAR for client #1 revealed: No staff initials to indicate the medication was administered for the following- November 2024- -Amantadine 100 mg on 11/30 8pm dose -Metformin 500 mg on 11/8 thru 11/11 8pm doses	Image: construction of the second s	Review on 12/12/24 of client #1's record       Review on 12/12/24 of client #1's record       Review on 12/12/24 of client #1's record       Review on 12/12/24 of alk mute, Engres, of CED), Hypertension, Unicomis CEC, Organization       Review on 12/12/24 of alk mute, Engres, of CED), Hypertension, Unicomis CEC, Organization, Unicomis CEC, Organizatio, CEC, Organization, Unicomis CEC, Organization, Unicomis CEC, Org

Division of Health Service Regulation STATE FORM

If continuation sheet 4 of 12

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		MHL032-568	B. WING		10/	17/2024
	PROVIDER OR SUPPLIER		DDRESS, CITY, S1		12/	17/2024
	-ROVIDER OR SUFFLIER		CASTER STRE			
NHANC	EMENT HEALTH CAI	RF	I, NC 27701			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
V 118	Continued From pa	ige 4	V 118			
	record revealed: -Admission date of -Diagnoses of Seve Atopic Dermatitis, O Congenital Skeleta Vein Thrombosis at -Physician's order of 0/06% (Allergies), p nostrils three times -Physician's order of Acetaminophen 500 three times daily; A inhale one puff twice (Depression), one f Omeprazole 20 mg -Physician's order of (Constipation), one Review on 12/12/24 revealed: No staff initials to ir administered for the October 2024- -Ipratropium 0/06% 10/30 8am doses; 10/30 2pm doses -Acetaminophen 50 8pm doses; 10/28 2 -Advair 100/50 Disk doses; 10/27 and 1 -Trazodone 50 mg -Omeprazole on 10 -Senna Plus on 10/	ere Intellectual Disability, Dsteoporosis, GERD, Asthma, I Deformities, History of Deep and Anemia. dated 11/11/24 for Ipratropium place 2 sprays into both daily. dated 10/11/24 for 0 mg (Pain Relief), two tablets dvair 100/50 Diskus (Asthma) e daily; Trazodone 50 mg tablet at bedtime and 1 (GERD), one capsule daily dated 1/24/24 for Senna Plus tablet daily. 4 of a MAR for client #2 ndicate the medication was e following- 0 on 10/22 thru 10/24, 10/29, 10/21 thru 10/24, 10/28 thru and 10/21 thru 10/24, 10/28, 00 mg on 10/20 thru 10/31 2pm dose and 10/29 8am dose (us on 10/28 and 10/29 8am 0/28 8pm doses on 10/29 1/29	,			

	of Health Service Re	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		MHL032-568	B. WING		12/	17/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
ENHANG	CEMENT HEALTH CAI	RF	ASTER STRE , NC 27701	ET		
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
V 118	Continued From pa	ge 5	V 118			
	and #2 had blank s -She wasn't sure w to indicate the med -She confirmed the for clients #1 and # Interview on 12/16/ Supervisor revealed -"There was a lot gu [Deceased Client # ago." -"[Former Staff #3] giving any notice th -The clients did get -Staff didn't consist MARs to indicate th administered.	hy staff did not put their initials ication was administered. MARs were not kept current 2. 24 with the Residential d: oing on in this facility with 3] being sick a few months also quit the facility without at she was leaving." their medication. ently put their initials on the ne medication was MARs were not kept current				
V 128	10A NCAC 26C .03 REQUIREMENTS. (a) Upon learning of currently receiving a report in accordance these Rules. A fact learned of a death information that the (b) A written notice listed under Paragr made immediately seven days of physic client. (c) A written notice under Paragraph (c)	eath Reporting Requirements 603 DEATH REPORTING of the death of a client services, a facility shall file a se with G.S. 122C-31 and lity shall be deemed to have when any facility staff obtains e death occurred. • containing the information aph (d) of this Rule shall be for deaths occurring within ical restraint or seclusion of a containing the information a) of this Rule shall be made f any death resulting from	V 128			

STATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		MHL032-568			12/	17/2024	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
ENHANC	EMENT HEALTH CAP	RF	CASTER STRE I, NC 27701	=E I			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
V 128	Continued From pa	ge 6	V 128				
	violence. accident.	suicide or homicide.					
		may be submitted in person,					
		ctronic mail. If the reporting					
		ve the capacity or capability to					
		tice immediately, the					
	information contained in the notice can be reported by telephone following the same time						
		r Subparagraph (b) and (c) of					
		time the written notice can be					
		tice shall include at least the					
	following informatio						
		(1) Reporting facility: name, address, county,					
		applicable); Medicare/Medicaid					
		applicable); facility director					
		ber; name and title of person					
		st person to learn of death eive report of death; facility					
		and date and time report					
	prepared;	and date and time report					
		on: name, client record					
	number, unit/ward (	(if applicable);					
		number (if applicable); date of					
		eight, sex, race, competency,					
		s, primary or secondary					
		elopmental disability or					
		iagnoses, primary/secondary ditions diagnosed prior to					
		st two medical examinations (if	F				
		ist recent admission to a					
		chiatric, developmental					
		nce abuse facility (if known);					
		ecent admission to an acute					
		ysical illness (if known);					
		of death: place and address					
		ed; date and time death was					
		al location decedent was ath (if known), whether or not					
		ained at the time of death or					
		of death and if so, a description	n				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		MHL032-568	B. WING		12/	17/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
ENHANC	EMENT HEALTH CA	RF	CASTER STRE /I, NC 27701	ET		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 128	Continued From pa	age 7	V 128			
	not decedent was in death or within seve description of the s description of the e and (4) Other informati such as law enforce Department of Soc notified, have invest	aint and its usage; whether or n seclusion at the time of en days of death and if so, a eclusion episode(s); and a events surrounding the death; ion: list of other authorities ement or the County ial Services that have been stigated or are in the process death or events related to the				
	Based on record re facility failed to file death of one of one	et as evidenced by: eview and interviews, the a report upon learning of the e deceased client (DC #3) services in the facility. The				
	-Admission date of -Diagnoses of Unsp Schizophrenia-Para Cancer, Hypertens	pecified Intellectual Disability, anoid Type, Pancreatic ion, Dorsalgia, Vitamin D ation, Obesity and Chronic				
	DC #3 dated 8/27/2	plications during surgery for	r			
	Professional (QP) r	24 with the Qualified revealed: port after DC #3 passed away				

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	MHL032-568	D. WING		12/	17/2024
VIDER OR SUPPLIER					
IENT HEALTH CAP	RF		ET		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE	(X5) COMPLET DATE
ontinued From pa	ae 8	V 128			
He filled out the ind 3's death but did r OC #3 passed awa ought they were r	cident report document for DC not submit it to anyone. ay at the hospital and he not required to file a report				
Manager revealed. -She didn't file a report aft on 8/27/24.	oort after DC #3 passed away				
7G .0604 Incident	Reporting Requirements	V 367			
EPORTING REQ ATEGORY A AND a) Category A and vel II incidents, ex- is provision of billa onsumer is on the cidents and level whom the provid days prior to the exponsible for the ervices are provide ecoming aware of e submitted on a f ecretary. The rep person, facsimile iteans. The report formation: ) reporting entification inform 2) client ider	UIREMENTS FOR D B PROVIDERS B providers shall report all accept deaths, that occur during able services or while the providers premises or level III II deaths involving the clients er rendered any service within incident to the LME catchment area where ed within 72 hours of the incident. The report shall form provided by the ort may be submitted via mail, or encrypted electronic is shall include the following provider contact and lation; ntification information;				
	Pride Provide Provide Provider OF Supplier OF Supplier OF Supplier International Supplier International Supplier International Supplier OF Supplier International Supplier OF Supplier International Supplier OF S	CORRECTION     IDENTIFICATION NUMBER:       MHL032-568     MHL032-568       INIDER OR SUPPLIER     STREET AL       NENT HEALTH CARE     917 LAN       DURHAM     DURHAM       SUMMARY STATEMENT OF DEFICIENCIES     (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       Ontinued From page 8     the filled out the incident report document for DC 3's death but did not submit it to anyone.       OC #3 passed away at the hospital and he ought they were not required to file a report stated to her death.     terview on 12/13/24 with the Residential anager revealed.       She didn't file a report after DC #3 passed away n 8/27/24.     she thought the QP filed a report for DC #3's eath.       7G .0604 Incident Reporting Requirements     DA NCAC 27G .0604 INCIDENT EPORTING REQUIREMENTS FOR ATEGORY A AND B PROVIDERS       D/ Category A and B providers shall report all vel II incidents, except deaths, that occur during e provision of billable services or while the onsumer is on the providers premises or level III cidents and level II deaths involving the clients       O Most provider rendered any service within 0 days prior to the incident. The report shall esubmitted on a form provided by the eccretary. The report may be submitted via mail, person, facsimile or encrypted electronic eans. The report shall include the following formation:       )     reporting provider contact and entification information;       2)     client identification information; <td>AF DEFICIENCIES CORRECTION     (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:     (X2) MULTIPLE A. BUILDING:</td> <td>FDEFICIENCIES     (X1) PROVIDERSUPPLIENCLA IDENTIFICATION NUMBER:     (X2) MULTIPLE CONSTRUCTION A BUILDING:       MHL032-568     B. WING       WIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       THENT HEALTH CARE     917 LANCASTER STREET DURHAM, NC 27701       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX TAG     PROVIDERS PLAN OF (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX TAG     PROVIDERS PLAN OF (EACH DEFICIENCY CROSS-REFERENCED TO DEFICIENCY MUST BE PRECEDED BY FULL PREFIX       St death but did not submit it o anyone. DC #3 passed away at the hospital and he ought they were not required to file a report lated to her death.     V 128       V 12/3/24 with the Residential anager revealed.     Stath     V 367       Abe didn't file a report for DC #3's path.     V 367       YG .0604 Incident Reporting Requirements     V 367       VA AND B PROVIDERS I) Category A and B providers premises or level III cidents, except deaths, that occur during e provision of billable services or while the onsumer is on the providers premises or level III cidents and level II deaths involving the clients whom the provider rendered any service within 0 days prior to the incident. The report shall e submitted on a form provider contact and envices are provided within 72 hours of secorning aware of the incident. The report shall e submi</td> <td>FFDEFICIENCIES CORRECTION     (X1) PROVIDER/SUPPLIER/CLA DENTIFICATION NUMBER:     (X2) MULTIPLE CONSTRUCTION A BUILDING:     (X3) DATE A BUILDING:       MHL032-568     B. WING     12/       VIDER OR SUPPLIER     STREET ADDRESS, CITV, STATE, ZIP CODE     12/       RENT HEALTH CARE     917 LANCASTER STREET DURHAM, NC 27701     PROVIDER'S PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY MUST BE PRECEDED BY FULL PEGULATORY OR LSC IDENTIFYING INFORMATION)     PD PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       ontinued From page 8     V 128       V 128     V 128       C#3 passed away at the hospital and he ought they were not required to file a report lated to her death.     V 367       CG .0604 Incident Reporting Requirements     V 367       X16 ADD B PROVIDERS DANCAC 27G .0604 INCIDENT EPORTING REQUIREMENTS FOR ATEGORY A AND B PROVIDERS DI Category A and B providers shall report all vol II incidents, except deaths, that occur during e provision of bilable services or while the nsumer is on the providers premises or level III cidents and level II deaths involving the cients whom the provider rendered any service within 0 ays prior to the incident. The report shall submitted on a form provided by the escretary. The report may be submitted via mail, southill or encrypted electronic ears. The report shall include the following formation: 0 menting trovider contact and entification information;</td>	AF DEFICIENCIES CORRECTION     (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:     (X2) MULTIPLE A. BUILDING:	FDEFICIENCIES     (X1) PROVIDERSUPPLIENCLA IDENTIFICATION NUMBER:     (X2) MULTIPLE CONSTRUCTION A BUILDING:       MHL032-568     B. WING       WIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       THENT HEALTH CARE     917 LANCASTER STREET DURHAM, NC 27701       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX TAG     PROVIDERS PLAN OF (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX TAG     PROVIDERS PLAN OF (EACH DEFICIENCY CROSS-REFERENCED TO DEFICIENCY MUST BE PRECEDED BY FULL PREFIX       St death but did not submit it o anyone. DC #3 passed away at the hospital and he ought they were not required to file a report lated to her death.     V 128       V 12/3/24 with the Residential anager revealed.     Stath     V 367       Abe didn't file a report for DC #3's path.     V 367       YG .0604 Incident Reporting Requirements     V 367       VA AND B PROVIDERS I) Category A and B providers premises or level III cidents, except deaths, that occur during e provision of billable services or while the onsumer is on the providers premises or level III cidents and level II deaths involving the clients whom the provider rendered any service within 0 days prior to the incident. The report shall e submitted on a form provider contact and envices are provided within 72 hours of secorning aware of the incident. The report shall e submi	FFDEFICIENCIES CORRECTION     (X1) PROVIDER/SUPPLIER/CLA DENTIFICATION NUMBER:     (X2) MULTIPLE CONSTRUCTION A BUILDING:     (X3) DATE A BUILDING:       MHL032-568     B. WING     12/       VIDER OR SUPPLIER     STREET ADDRESS, CITV, STATE, ZIP CODE     12/       RENT HEALTH CARE     917 LANCASTER STREET DURHAM, NC 27701     PROVIDER'S PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY MUST BE PRECEDED BY FULL PEGULATORY OR LSC IDENTIFYING INFORMATION)     PD PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       ontinued From page 8     V 128       V 128     V 128       C#3 passed away at the hospital and he ought they were not required to file a report lated to her death.     V 367       CG .0604 Incident Reporting Requirements     V 367       X16 ADD B PROVIDERS DANCAC 27G .0604 INCIDENT EPORTING REQUIREMENTS FOR ATEGORY A AND B PROVIDERS DI Category A and B providers shall report all vol II incidents, except deaths, that occur during e provision of bilable services or while the nsumer is on the providers premises or level III cidents and level II deaths involving the cients whom the provider rendered any service within 0 ays prior to the incident. The report shall submitted on a form provided by the escretary. The report may be submitted via mail, southill or encrypted electronic ears. The report shall include the following formation: 0 menting trovider contact and entification information;

Division of Health Service Regulation STATE FORM

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STATEMEN	of Health Service Re NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		MHL032-568	B. WING		12/	17/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
ENHANC	CEMENT HEALTH CAP	2F	CASTER STRE I, NC 27701	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 367	Continued From pa	-	V 367			
	or responding. (b) Category A and missing or incomple shall submit an upd report recipients by day whenever: (1) the provid information provide erroneous, mislead (2) the provid required on the inci- unavailable. (c) Category A and upon request by the obtained regarding (1) hospital re- obtained regarding (1) hospital re- information; (2) reports by (3) the provid (d) Category A and of all level III incident Mental Health, Deve Substance Abuse S becoming aware of providers shall send incidents involving a Health Service Reg becoming aware of client death within s or restraint, the prov- immediately, as req .0300 and 10A NCA (e) Category A and report quarterly to th catchment area who The report shall be	T; and viduals or authorities notified B providers shall explain any ete information. The provider ated report to all required the end of the next business er has reason to believe that d in the report may be ing or otherwise unreliable; or er obtains information dent form that was previously B providers shall submit, e LME, other information the incident, including: ecords including confidential other authorities; and er's response to the incident. B providers shall send a copy in reports to the Division of elopmental Disabilities and ervices within 72 hours of the incident. Category A d a copy of all level III a client death to the Division of ulation within 72 hours of the incident. In cases of seven days of use of seclusion vider shall report the death uired by 10A NCAC 26C AC 27E .0104(e)(18). B providers shall send a he LME responsible for the ere services are provided a electronic means and shall				

	of Health Service Re NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		MHL032-568	B. WING		12/	17/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
ENHANG	CEMENT HEALTH CAI	RF	CASTER STRE I, NC 27701	EET		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 367	include summary ir (1) medication definition of a level (2) restrictive the definition of a level (3) searches (4) seizures (4) seizures (5) the total r incidents that occur (6) a statement been no reportable incidents have occur meet any of the crit	aformation as follows: on errors that do not meet the II or level III incident; e interventions that do not meet evel II or level III incident; of a client or his living area; of client property or property in a client; number of level II and level III rred; and ent indicating that there have incidents whenever no urred during the quarter that teria as set forth in Paragraphs Rule and Subparagraphs (1)				
	Based on record re facility failed to ens to the Local Manag Organization (LME, where services are becoming aware of are: Review on 12/12/24 -Admission date of -Diagnoses of Uns Schizophrenia-Para Cancer, Hypertens	et as evidenced by: eview and interviews, the ure an incident was reported ement Entity/Managed Care /MCO) for the catchment area provided within 72 hours of a client's death. The findings 4 of DC #3's record revealed: 1/31/22. pecified Intellectual Disability, anoid Type, Pancreatic ion, Dorsalgia, Vitamin D ation, Obesity and Chronic				

of Health Service Re IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		SURVEY
OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
	MHL032-568	B. WING	B. WING		17/2024
PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
EMENT HEALTH CAP	RE		EET		
					()(5)
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE	(X5) COMPLET DATE
Continued From pa	ge 11	V 367			
-She died on 8/27/2	4.				
DC #3 dated 8/27/2 -"Death due to com	4 revealed: plications during surgery for				
Incident Response revealed: -There was no leve	Improvement System (ÌRIŚ) I II incident report submitted				
Professional (QP) r -He filled out the ind #3's death but did n -He was told in the required to do a rep occur at the facility. -DC #3 passed awa thought they were r related to her death -He confirmed the f	evealed: cident report document for DC tot put it in IRIS. past that the facility was not bort in IRIS if the death did not ay at the hospital and he not required to file a report acility failed to report DC #3's				
Manager revealed. -She didn't know sh incident report in IR 8/27/24. -She thought the Qu #3's death.	e should have done an IS for DC #3's death on				
	OF CORRECTION PROVIDER OR SUPPLIER EMENT HEALTH CAF SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa -She died on 8/27/2 Review on 12/16/24 DC #3 dated 8/27/2 -"Death due to com Pancreatic Cancer." Review on 12/16/24 Incident Response revealed: -There was no leve by the facility for DC Interview on 12/13/2 Professional (QP) r -He filled out the ind #3's death but did n -He was told in the required to do a rep occur at the facility. -DC #3 passed awa thought they were r related to her death -He confirmed the f death to the LME/M Interview on 12/13/2 Manager revealed. -She didn't know shi incident report in IR 8/27/24. -She thought the QU #3's death.	OF CORRECTION     IDENTIFICATION NUMBER:       MHL032-568     MHL032-568       PROVIDER OR SUPPLIER     STREET AD       EMENT HEALTH CARE     917 LANC       DURHAM     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       Continued From page 11     -She died on 8/27/24.       Review on 12/16/24 of a Level I incident report for DC #3 dated 8/27/24 revealed: -"Death due to complications during surgery for Pancreatic Cancer."       Review on 12/16/24 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed: -There was no level II incident report submitted by the facility for DC #3's death on 8/27/24.       Interview on 12/13/24 with the Qualified Professional (QP) revealed: -He filled out the incident report document for DC #3's death but did not put it in IRIS. -He was told in the past that the facility was not required to do a report in IRIS if the death did not occur at the facility. -DC #3 passed away at the hospital and he thought they were not required to file a report related to her death. -He confirmed the facility failed to report DC #3's death to the LME/MCO within 72 hours.       Interview on 12/13/24 with the Residential Manager revealed. -She didn't know she should have done an incident report in IRIS for DC #3's death on 8/27/24. -She thought the QP did the report in IRIS for DC #3's death.	OF CORRECTION     IDENTIFICATION NUMBER:     A. BUILDING:       MHL032-568     B. WING	OF CORRECTION     IDENTIFICATION NUMBER:     A. BUILDING:       MHL032-568     B. WING       PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       SUMMARY STATEMENT OF DEFICIENCIES     917 LANCASTER STREET       DURHAM, NC 27701     SUMMARY STATEMENT OF DEFICIENCIES       SUMMARY STATEMENT OF DEFICIENCIES     ID       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)     PREFIX       TAG     PREVIDENT       Continued From page 11     V 367       -She died on 8/27/24.     V 367       Review on 12/16/24 of a Level I incident report for DC #3 dated 8/27/24 revealed:     DEFICIENCIES       -"Death due to complications during surgery for Pancreatic Cancer."     Review on 12/16/24 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed:     Interview on 12/13/24 with the Qualified Professional (QP) revealed:       -There was no level II incident report submitted by the facility for DC #3's death on 8/27/24.     Interview on 12/13/24 with the Qualified Professional (QP) revealed:       -He was told in the past that the facility was not required to do a report in IRIS if the death did not occur at the facility failed to report DC #3's death to the LME/MCO within 72 hours.       Interview on 12/13/24 with the Residential Manager revealed.       -She didn't know she should have done an incident report in IRIS for DC #3's death on 8/27/24.	OF CORRECTION     IDENTIFICATION NUMBER:     A. BUILDING:     COM       MHL032-568     B. WING     12/       PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     12/       REMENT HEALTH CARE     917 LANCASTER STREET DURHAM, NC 27701     PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE VILST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     PREFX TAG     PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       Continued From page 11     V 367     V 367       -She died on 8/27/24.     V 367       Review on 12/16/24 of a Level I incident report for DC #3 dated 8/27/24 revealed:     V 367       -There was no level II incident report submitted by the facility for DC #3's death on 8/27/24.     V 367       Interview on 12/13/24 with the Qualified Professional (QP) revealed:     Free valed:       -There was no level II incident report submitted by the facility for DC #3's death on 8/27/24.     Free valed:       -He dield out the incident report document for DC #3's death but did not put it in IRIS.     Free valed:       -He may told in the past that the facility was not required to do a report in IRIS fit the death did not occur at the facility.     Free valed.       -DC #3 passed away at the hospital and he thought they were not required to file a report related to he death.     Free valed.       -He tonfilmed the f