STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		7. BOILBING	R		
		MHL020-079	B. WING		01/24/2025
NAME OF PROVIDER OR SUPPLIER STREET ADD			DDRESS, CITY, STATI	E. ZIP CODE	
			IPTON CHURCH R		
THE RISIN	ľ		7, NC 28906		
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION	(-/
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	
V 000	INITIAL COMMENTS		V 000		
	An annual, complaint, and follow up survey was completed on January 24, 2025. The complaint was unsubstantiated (NC# 00225079). Deficiencies were cited.				
	category: 10A NCAC	d for the following service 27G .5600C Supervised Developmental Disability.			
The facility is licensed for 5 and has a current census of 5. The survey sample consisted of audits of 3 current clients.					
V 111	27G .0205 (A-B) Assessment/Treatmen	nt/Habilitation Plan	V 111		
	10A NCAC 27G .0205 TREATMENT/HABILIT	ASSESSMENT AND TATION OR SERVICE			
	(a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to:				
	(1) the client's present(2) the client's needs(3) a provisional or a	• .			
	of admission, except t	determined within 30 days that a client admitted to a 24-hour medical program hed diagnosis upon			
	admission;	, family, and medical history;			
	(5) evaluations or as psychiatric, substance	e abuse, medical, and			
	(b) When services are establishment and imp				

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			, a Boilbing.			R	
		MHL020-079	B. WING		01	/24/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STA	TE, ZIP CODE			
THE RISIN	ľ		PTON CHURCH , NC 28906	ROAD			
0(0) 15	SHIMMADV ST	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF	CORRECTION	0(5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETE DATE	
V 111	Continued From page	e 1	V 111				
		an," strategies to address the oblem shall be documented.					
	failed to ensure an as prior to the delivery of audited clients (#2 and Review on 1/15/25 of Admission Date: 9/1 -Diagnoses: Intellectut (IDD), Moderate; Maj (D/O).	ew and interview, the facility assessment was completed f services affecting 2 of 3 and #3). The findings are:					
	-Admission Date: 9/1 -Diagnoses: IDD, Mo D/O with mild anxious Traumatic Stress Dis -No evidence of asse admission.	derate; Major Depressive s distress, and Post order. essment completed prior to with Client #3 revealed: lity for "months."					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
				R
MHL020-079	B. WING		01	/24/2025
STREET A	DDRESS, CITY, STATE	, ZIP CODE		
201 HAN	IPTON CHURCH R	OAD		
MURPHY	Y, NC 28906			
CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
e 2	V 111			
e paperwork for clients from				
nistration: on-prescription drugs shall to a client on the written thorized by law to prescribe be self-administered by thorized in writing by the uding injections, shall be clicensed persons, or by trained by a registered nurse, trained by a registered nurse, trained by a registered nurse, trained by a redications. The definition of the drugth of t	V 118			
	MHL020-079 STREET A 201 HAM	MHL020-079 STREET ADDRESS, CITY, STATE 201 HAMPTON CHURCH R MURPHY, NC 28906 TATEMENT OF DEFICIENCIES CYMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) TAG PREFIX TAG PREFIX TAG ID PREFIX TAG ID PREFIX TAG ID PREFIX TAG ID PREFIX TAG ID PREFIX TAG ID PREFIX TAG ID PREFIX TAG ID PREFIX TAG ID PREFIX TAG ID PREFIX TAG ID PREFIX TAG ID PREFIX TAG ID PREFIX TAG ID PREFIX TAG ID PREFIX	MHL020-079 STREET ADDRESS, CITY, STATE, ZIP CODE 201 HAMPTON CHURCH ROAD MURPHY, NC 28906 TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) PREFIX TAG TAG PREFIX TAG PREFIX CROSS-REFERENCED TO TO DEFICIENCY BY MEDICATION Instration: In-prescription drugs shall It to a client on the written thorized by law to prescribe It be self-administered by thorized in writing by the Unding injections, shall be licensed persons, or by trained by a registered nurse, egally qualified person and and administer medications. Ininistration Record (MAR) of id to each client must be kept administering the drug; defining the drug; d	MHL020-079 STREET ADDRESS, CITY, STATE, ZIP CODE 201 HAMPTON CHURCH ROAD MURPHY, NC 28906 INTERMENT OF DEFICIENCIES DYMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) PREFIX TAG TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PREFIX TAG V 111 Admission assessment. PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PREFIX TAG V 118 V 118 V 118 PMEDICATION Inistration: In-prescription drugs shall It to a client on the written thorized by law to prescribe Ibe self-administered by thorized in writing by the Luding injections, shall be Ilicensed persons, or by trained by a registered nurse, egally qualified person and and administer medications. Inistration Record (MAR) of a did to each client must be kept administered shall be yafter administration. The a following: and quantity of the drug; derived in administering the drug; and quantity of the d

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
		MHL020-079	B. WING		R 01/24/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	ΓΕ, ZIP CODE	
THE DION		201 HAM	PTON CHURCH	ROAD	
THE RISIN		MURPHY	, NC 28906		
(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 APPROPE DEFICIENCY)	BE COMPLETE
V 118	Continued From page	3	V 118		
	current for all drugs a audited clients, (#1, # are: Review on 1/15/25 of -Admission Date: 3/3-Diagnoses: Intellectu (IDD), Moderate; Uns Control and Conduct Disorder, and Other s-Physician order -Otezla 30 milligram (n, record review and ailed to keep the MAR dministered affecting 3 of 3 2, and #3). The findings Client #1's record revealed: 1/17. Ital Developmental Disability pecified Disruptive, Impulse D/O; Major Depressive pecified mental D/O. for the following medication:			
	11/1/24 to 1/14/25 rev -Otezla 30mg tab, 1 to 7:00AM and 8:00PM 12/5/24. -on the back of the Mmissed dose." -12/8/24, 8:00PM, bla	ab BID, scheduled at initialed as administered on AR, 12/5/24 "7pm, Otezla			
	Interview on 1/14/25 vgot his medications of Review on 1/15/25 of Admission Date: 9/10	e back of the MAR. with Client #1 revealed: every day. Client #2's record revealed:			

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A. BUILDING: R MHL020-079 B. WING 01/24/	./2025
	/2025
101/24/	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
THE RISIN' 201 HAMPTON CHURCH ROAD MURPHY, NC 28906	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118 (IDD), Moderate; Major Depressive D/O -Physicians orders for the following medications included: -Loratadine 10 mg, (allergies) tab, 1 tab by mouth (PO), every day (QD) at 7:00AM, ordered 9/19/23Risperidone 0.5 mg tab (anti-psychotic), 1 tab PO QD at 7AM, ordered 7/30/24Azelastine 0.1% nasal spray, (allergies), 1 spray each nostril BID, ordered 10/9/23Sertraline HCL 100 mg tab, (depression), 1 tab PO BID, ordered 7/30/24Omeprazole DR 20mg tab, (antacid), 1 tab, 30 minutes prior to meals, ordered 11/24/24. Review on 1/15/25 and 1/23/25 of Client #2's MARs dated 11/1/24 to 1/14/25 revealed: -MAR instructions reflected to circle initials when a medication was refusedLoratadine 10mg tab, 1 tab QD, scheduled at 7:00AM, 12/26/24-12/28/24 staff initialed and circled the MAR on these datesRisperidone 0.5mg tab, 1 tab PO QD scheduled at 7:00AM, 12/26/24-12/28/24 staff initialed and circled the MAR on these datesAzelastine 0.1% nasal spray, one spray each nostril, BID, scheduled at 7:00AM and 8:00PM, staff initialed and circled the PM dose of 12/25/24, Am and PM doses on 12/26/24, and the AM doses on 12/27/24 and 12/28/24, -Sertraline HCL 100mg tab, 1 tab PO, BID, scheduled at 7:00AM and 8:00PM, staff initialed and circled the PM dose on 12/27/25/24, AM and PM doses on 12/27/25/24, and the morning doses on 12/27/24 and 12/28/24, -Omeprazole DR 20mg tab, 1 tab QD, scheduled at 5:00PM, staff initialed and circled 12/28/24, -Omeprazole DR 20mg tab, 1 tab QD, scheduled at 5:00PM, staff initialed and circled 12/28/24Omeprazole DR 20mg tab, 1 tab QD, scheduled at 5:00PM, staff initialed and circled 12/28/24.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING			
		MHL020-079	B. WING		R 01/24/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
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	•	MURPHY	, NC 28906			
(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 APPROPRIED TO THE	BE COMPLETE	
V 118	Continued From page	e 5	V 118			
	"all meds."					
	-Admission Date: 9/10 -Diagnoses: IDD, Mod D/O with mild anxious Traumatic Stress Disc Physician orders medications: -Zenatane 40mg caps with a fatty meal, ordered starting Observation on 1/14/2 medications revealed -Zenatane 40mg, 2 cameal, dispensed 1/2/2 Review on 1/14/25 ar MARs dated 11/1/24 -Zenatane 40mg caps staff as administered Interview on 1/14/25 staff gave him his metook 1 Zenatane cap Interview on 1/24/25 -administered client in -"everyone missed" the #3's Zenataneattended medication again.	derate; Major Depressive s distress, and Post order. for the following sule (cap), (acne), 1 cap QD ered 12/1/24. 2 caps QD with a fatty g 12/31/24. 25 at 3:30pm of Client #3's: aps PO QD with a fatty 25. and 1/23/25 of Client #3's to 1/14/25 revealed: 1 cap QD and initialed by from 1/1/25-1/14/25. with Client #3 revealed: edication every day. with Staff #2 revealed;				
	supposed to sign it, c the back the MAR.	with the Director revealed:				

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-oversaw the medications, medication changes,

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
	MHL020-079		B. WING		R 01/24/2025	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE RISIN	ı,	201 HAMF	TON CHURCH	ROAD		
THE KISIN		MURPHY,	NC 28906			
(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 APPROPR DEFICIENCY)	BE COMPLETE	
V 118	Continued From page	e 6	V 118			
	and checking medications in to the facilitiesacknowledged that some of the paperwork was "sloppy." -there had been staff turnover at the pharmacy the facility usesthe Licensee was looking at going back to an electronic MAR systemstaff were sent for re-training on medication administration when there were errors.					
V 752 27G .0304(b)(4) Hot Water Temperatures		V 752				
	10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (4) In areas of the facility where clients are exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit.					
	failed to maintain wat 100-116 degrees Fah exposed to hot water. Observation on 1/14/2 revealed: -The water temperatushower was 125 degree.	n and interview, the facility er temperature between irenheit where clients are . The findings are: 25 of the facility at 2:30PM ire in the downstairs client rees Fahrenheit.				
	-Did not have problems with the water temperature in his shower.					

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		A. BUILDING:			
	MHL020-079	B. WING		R 01/24/2025	
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
THE RISIN'		TON CHURCH NC 28906	ROAD		
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
high and would contacturned downNo complaints regard Interviews on 1/16/25 Manager revealed: -Responsible for main		V 752			

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