	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			E SURVEY PLETED	
	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:				
		MHL026-912	B. WING			R / <b>06/2025</b>	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
	OME CARE II		STIC RIDGE	18			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 000	INITIAL COMMENT	ſS	V 000				
	An annual, complaint and follow up survey was completed on February 6, 2025. The complaint was unsubstantiated (intake #NC00224938). Deficiencies were cited.						
	category: 10A NCA	ed for the following service C 27G .5600C Supervised h Developmental Disability.					
		sed for 4 and has a current urvey sample consisted of clients.					
V 118	27G .0209 (C) Med	ication Requirements	V 118				
	only be administere						
	clients only when an client's physician. (3) Medications, inc	all be self-administered by uthorized in writing by the cluding injections, shall be by licensed persons, or by					
	pharmacist or other privileged to prepar (4) A Medication Ad	trained by a registered nurse legally qualified person and e and administer medications ministration Record (MAR) of					
	current. Medication recorded immediate MAR is to include th	red to each client must be kep s administered shall be ely after administration. The ne following:					
	(C) instructions for	and quantity of the drug; administering the drug; ne drug is administered; and					

Division	of Health Service Re	egulation			FORM	APPROVE
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		MHL026-912	B. WING			R 06/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
		6303 RU	STIC RIDGE			
UNITTH	OME CARE II	HOPE M	ILLS, NC 2834	18		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 1	V 118			
	drug. (5) Client requests checks shall be rec	of person administering the for medication changes or orded and kept with the MAR appointment or consultation				
	interview the facility medications on the affecting one of thre keep the MARs cur	view, observation and failed to administer written order of a physician ee clients (#1) and failed to				
	revealed: -Admission date of -Diagnoses of Intell Developmental Dise Anxiety Disorder, U Hyperactive Disord Intermittent Explosi	ectual Disability/Intellectual order-Severe, Unspecified nspecified Attention Deficit er, Prader Willi Syndrome,				
	take one capsule b -Ozempic (diabetes under the skin ever -Levothyroxine 112 tablet by mouth dai	ety) 100 milligrams (mg) tablet				

	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		MHL026-912	B. WING			R 06/2025	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
	OME CARE II		STIC RIDGE				
		HOPE M	ILLS, NC 2834	8			
(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 HE APPROPRIATE	(X5) COMPLETI DATE	
V 118	Continued From pa	ge 2	V 118				
		pedtime for bed wetting ler for Hydroxyzine take once t bedtime.					
	MARs revealed: Hy Imipramine Hydrocl the MAR but did no	o of client #1's January 2025 droxyzine, Levothyroxine and nloric Acid were transcribed or t have instructions to indicate quency of how medications ered:	1				
	Attempted interview unsuccessful due to to understand respo	client #1's muffled and hard					
	revealed: -Admission date of -Diagnoses of Mode Disorder, Overweig	erate Intellectual Developmen ht and Obesity, order, Unspecified Intermitten					
	orders revealed: 12/27/24 -Atorvastatin (lower tablet by mouth at r	5 of client #2's Physician ccholesterol) 20mg Take 1 night.					
	mouth qam (mornin (night) in addition ca	ophrenia) 2.5mg 1 tab by ng) and 2 tab by mouth qhs an take 1 extra tablet prn (as per day for agitation.					
	Take 1 tablet by mo tablets by mouth at	ate (schizophrenia) 200mg outh every morning and take 2 bedtime. sion) 100mg Take 1 tablet by					

	of Health Service Re	egulation				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL026-912	MHL026-912 B. WING			R <b>06/2025</b>
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
		6303 RU	STIC RIDGE			
	OME CARE II	HOPE M	ILLS, NC 2834	8		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST 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) COMPLETE DATE
V 118	Continued From pa	ge 3	V 118			
	mouth twice daily. -Topiramate (seizur mouth daily.	es) 50mg Take 1 tablet by				
	Review on 02/05/25 of client #2's February 2025 MAR revealed no staff initials on the following dates to indicate the medication had been administered: -Atorvastatin 20mg: 02/01/25, 02/02/25. -Olanzapine 2.5mg: 02/01/25, 02/02/25.					
	-Sertraline 100mg: 8am and 02/04/25 a	02/01/25 at 8am, 02/03/25 at				
	MAR revealed the F had the same instru- medication and the	o of client #2's February 2025 Physician order and the MAR actions for administering the label on the bubble pack of match the Physician order and	I			
	-Bubble Pack instru Topiramate 50mg ta daily.	ake 1 tablet by mouth daily.				
	MAR Instructions: -Topiramate 50mg 1	ake 1 tablet by mouth daily.				
	Attempted Interview unsuccessful as clie respond to questior	ent #2 just stared and did not				
	revealed: -Understood the M/ -"they had new staf understand the imp	25 the House Manager ARs needed to be current. f and they did not quite ortance of the MAR." te in the medications without				

Division of Health Service Regulation STATE FORM

Division	of Health Service Re	egulation				APPROVED
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		MHL026-912	B. WING			R 06/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
UNITY H	OME CARE II		STIC RIDGE LLS, NC 2834	18		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PRÉFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	E APPROPRIATE	COMPLETE DATE
V 118	Continued From pa	ge 4	V 118			
V 120	how the medication She would let the st write everything on -She would make s the correct place. -She would check b -Client #1's medicat and there were no c orders because the his last doctors app Interview on 02/06/0 revealed: -She was aware that completed with staf -The new staff were MARs. -She would make s retraining on medication -She was unaware in" without any docu administer the med -She would check b manager weekly to initials." -She would make s orders and discontin listed on the MARs. 27G .0209 (E) Medication stora (1) All medication stora (A) in a securely loc	ure that staff put their initials in behind staff in the future. tions were written on the MAR discontinue orders or physician changes recently occurred at ointment in January of 2025. 05 the Qualified Professional at the MAR should be f initials. e learning how to complete the ure that staff received proper ations. that medications were "written umentation on how to ications for client #1. behind the "staff and the home make sure each box had staff ure each client had physician nue orders for medications ication Requirements 09 MEDICATION age:				

STATEMEN	of Health Service Re	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
		MHL026-912	B. WING			R / <b>06/2025</b>	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE			
	OME CARE II	6303 RUS	STIC RIDGE				
		HOPE MI	LLS, NC 2834	8			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
V 120	Continued From pa	ige 5	V 120				
	degrees and 46 degrefrigerator is used shall be kept in a second container; (C) separately for e (D) separately for e (E) in a secure mar for a client to self-m (2) Each facility tha controlled substance registered under the Substances Act, G.	<ul> <li>(B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container;</li> <li>(C) separately for each client;</li> <li>(D) separately for external and internal use;</li> <li>(E) in a secure manner if approved by a physician for a client to self-medicate.</li> <li>(2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments.</li> </ul>					
	interviews the facilit medications in a loc three clients (#1 an Review on 02/05/25 revealed: -Admission date of -Diagnoses of Intell Developmental Disc Anxiety Disorder, U	views, observations and ty failed to keep refrigerated cked container affecting two of d #3). The findings are: 5 of client #1's record 03/07/24 lectual Disability/Intellectual order Severe, Unspecified Inspecified Attention Deficit er, Prader Willi Syndrome,					
	Review on 02/05/25 revealed: -Admission date of -Diagnoses of Oppo	5 of client #3's record 12/03/10 ositional Defiant Disorder, lation, Encephalopathy,					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. DOILDING.			П
		MHL026-912	B. WING			R <b>06/2025</b>
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
JNITY H	OME CARE II		ISTIC RIDGE IILLS, NC 2834	18		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
V 120	Continued From pa	ge 6	V 120			
	Disorder, Attention combined type, Enu Rasmussen's ence Thoracolumbar sco disorder, thyroid, al syndrome, and high Observation on 02/ facility's refrigerator Client #1: -1 box of Ozempic shelf of the refrigera Client #3:	Unspecified Disruptive Impulse Control Conduct Disorder, Attention Deficit Hyperactivity Disorder combined type, Enuresis, Encopresis, Rasmussen's encephalitis, constipation, Thoracolumbar scoliosis, History of seizure disorder, thyroid, allergies, Irritable bowel syndrome, and high cholesterol. Observation on 02/05/25 at 11:40am of the facility's refrigerator revealed: Client #1: -1 box of Ozempic (weight loss) stored on the shelf of the refrigerator.				
	revealed: -The medication bo at the office and loc -"The Facility Owner client #1 'that morn take the medication he had some erran	02/05/25 the House Manager x was kept in the refrigerator ked "most" of the time. er administered Ozempic to ing' 02/05/25 and could not with him to secure it because ds to run and could not go to e medications are stored."				
	Professional reveal -Will make sure the locked.	e medication box remained ure that all refrigerated				
V 736	27G .0303(c) Facili	ty and Grounds Maintenance	V 736			
	EXTERIOR REQUI	03 LOCATION AND REMENTS I its grounds shall be				

STATE FORM

8KIU11

If continuation sheet 7 of 9

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED <b>R</b>
		MHL026-912	B. WING			06/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
JNITY H	OME CARE II		STIC RIDGE LLS, NC 2834	18		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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	TION SHOULD BE	(X5) COMPLET DATE
V 736	Continued From pa	ge 7	V 736			
		e, clean, attractive and orderly e kept free from offensive				
	This Rule is not met as evidenced by: Based on observation and interviews, the facility was not maintained in a clean, safe, attractive and orderly manner. The findings are:					
	Observations on 02/05/25 at approximately 10:30 am revealed: -The inside of the microwave had a build up of food particles on the inside of the top, back and left and right sides. -The cabinet located on the left side of the refrigerator had a loose handle. -The cabinet knob next to the sliding door had a loose knob when touched would turn in an 90					
	was missing. Hallway -2 smoke detectors entrance of bedrood Hall Bathroom					
	side of light fixture a fixture. -shower curtain mis Living Room	blown, 1 located on the left and 2 on the right side of ssing 2 hooks. ch piece of loose floor				
	molding on the floo desk. -Near the left side o	r beside the right side of staff's of the loveseat there was inch piece of floor molding				
	Vacant bedroom - 3 of 4 drawers in o unable to close.	dresser were off track and side of the bedroom wall				

STATE FORM

AME OF P	DF CORRECTION ROVIDER OR SUPPLIER	IDENTIFICATION NUMBER: MHL026-912	A. BUILDING: B. WING			PLETED			
INITY HC (X4) ID PREFIX			B. WING						
INITY HC (X4) ID PREFIX		STREET AD				R 06/2025			
(X4) ID PREFIX	OME CARE II	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
PREFIX				•					
PREFIX			LS, NC 2834						
	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE			
V 736	Continued From pa	ige 8	V 736						
	2 large unpainted p Bedroom #2 (Client -unpainted patched size of a baseball. Interview with the C 02/06/25 revealed: -They had not been -The landlord was n repairs. -She would ensure would be completed	t #3): I over hole behind the couch, Qualified Professional on in the facility long. not easy to be contacted for that the repairs of the facility d. stitutes a recited deficiency							
	alth Service Regulation								