AND DIAN OF CORRECTION DENTIFICATION NUMBER		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		MHL060-648	B. WING		02/2	8/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TURN AF	ROUND	****	TEN COURT			
			L, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	-s	V 000			
	on 2/28/25. The co	plaint survey was completed mplaint was substantiated 17). Deficiencies were cited.				
		sed for the following service C 27G .1700 Residential cure for Children or				
	census of 4. The s	sed for 4 and has a current urvey sample consisted of clients and 1 former client.				
V 107	27G .0202 (A-E) Pe	ersonnel Requirements	V 107			
	which:	Il have a written job director and each staff position e minimum level of education, experience and other e position; e duties and responsibilities of y the staff member and the				
	(b) All facilities sha each staff member provides care or se the facility: (1) is at least 1 (2) is able to re follow directions; (3) meets the re competency, work equalifications for the	ead, write, understand and minimum level of education, experience, skills and other				

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

(X6) DATE TITLE

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		MHL060-648	B. WING		02/	28/2025
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
TURN A	ROUND		L, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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) COMPLETE DATE
V 107	neglect listed on the Personnel Registry (c) All facilities or sapplicants for employed conviction. The implection regarding upon the offense in which the applicant (d) Staff of a facility currently licensed, accordance with apservices provided. (e) A file shall be memployed indicating	e North Carolina Health Care dervices shall require that all oyment disclose any criminal pact of this information on a employment shall be based relationship to the job for is applying. If yor a service shall be registered or certified in oplicable state laws for the maintained for each individual of the training, experience and for the position, including	V 107			
	facility failed to com affecting 2 of 13 sta Associate Profession Review on 2/10/25	et as evidenced by: view and interviews, the uplete personnel records ff (House Manager(HM) and uplete (AP)). The findings are: of the personnel record for the				
		for House Manager.				
	Review on 2/11/25	of the personnel record for the				

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	/2025
MHL060-648 B. WING 02/28/	/ Z U Z J
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
TURN AROUND 9709 BATTEN COURT MINT HILL, NC 28227	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 107 Continued From page 2 -Hired 11/16/10. -Hired as the Associate Professional. -No job description for Associate Professional. Interview on 2/14/25 with the HM revealed: -"I am the House Manager." -"I was made House Manager about three weeks ago." -Was not aware of duties in her new role of House Manager, "He (Licensee/Qualified Professional (QP)) has to give me more details." -Had not received a job description for her new position. Interview on 2/13/25 and 2/24/25 with the Licensee/Qualified Professional revealed: -He was responsible for hiring and maintaining staff personnel records. -"(AP] is currently our APyes, he has a job description" -When asked how long in AP role, "it's been years, it's been a while, not sure how many years" -"House Manager is [HM]." -"I'm breaking the news to the rest of the staff about [HM] (becoming HM)" -Had no explanation for why the job description was not in the AP and HM's personnel record. This deficiency is crossed referenced into 10A NCAC 27G. 0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type B rule violation and must be corrected within 23 days. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		MHL060-648	B. WING		02/2	8/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TURN AF	ROUND		TEN COURT _, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 108	Continued From pa	ge 3	V 108		<u> </u>	
V 108	27G .0202 (F-I) Per	sonnel Requirements	V 108			
	10A NCAC 27G .02 REQUIREMENTS (f) Continuing educt (g) Employee training provided and, at a resolution following: (1) general organiz (2) training on clier delineated in 10A N 10A NCAC 26B; (3) training to meet client as specified in plan; and (4) training in infect bloodborne pathogory (h) Except as perm .5602(b) of this Submember shall be an times when a client member shall be traincluding seizure member shall be	cation shall be documented. ing programs shall be minimum, shall consist of the rational orientation; it rights and confidentiality as ICAC 27C, 27D, 27E, 27F and it the mh/dd/sa needs of the in the treatment/habilitation tious diseases and				

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This Rule is not met as evidenced by:

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DIVISION	of Health Service Re	guiation				
	IT OF DEFICIENCIES OF CORRECTION				(X3) DATE COMP	SURVEY LETED
		MHL060-648	B. WING		02/2	8/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TURN AF	ROUND		TEN COURT L, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 108	Continued From pa	ge 4	V 108			
	facility failed to ensi Director/Qualified P 13 staff (Staff #1, #. had current first aid resuscitation (CPR)	Professional (CD/QP) and 8 of 2, #6, #7, #8, #9, #10, #11) /cardiopulmonary training. The findings are:				
	revealed: -Hire date: 11/25/24	of the Staff #1's personnel file I. of first aid/CPR training.				
	revealed: -Hire date: 1/20/25.	of Staff #2's personnel file of first aid/CPR training.				
	revealed: -Hire date: 12/20/24	of Staff #6's personnel file 1. of first aid/CPR training.				
	revealed: -Hire date: 7/10/24.	of Staff #7's personnel file of first aid/CPR training.				
	revealed: -Hire date: 12/17/24	of Staff #8's personnel file 1. of first aid/CPR training.				
	revealed: -Hire date: 6/10/24.	of Staff #9's personnel file of first aid/CPR training.				
	Review on 2/13/25 revealed:	of Staff #10's personnel file				

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-Hire date: 1/28/25.

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DIVISION	of Health Service Re	egulation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		MHL060-648	B. WING		02/2	8/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
IVAIVIL OI I	NOVIDER OR GOLF EIER		TEN COURT			
TURN A	ROUND		L, NC 28227			
040.15	CLIMMA DV CTA		1		ON.	0.5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 108	Continued From pa	ge 5	V 108			
	-No documentation	of first aid/CPR training.				
	revealed: -Hire date: 11/20/24	of Staff #11's personnel file I. of first aid/CPR training.				
	revealed: -Hire date: 2/3/02.	of the CD/QP's personnel file of first aid/CPR training. 23.				
	November 2024 (11 -No documentation aid/CPR training for 1st Shift-11/5, 1	of the Facility's Shift Notes for 1/1/24-11/30/24) revealed: that at least one staff had first r: 1/8, 11/16, 11/22. 11/2, 11/7, 11/9, 11/10, 11/14,				
	December 2024 (12 -No documentation aid/CPR training for 1st Shift-12/27, 2nd Shift-12/9,					
	January 2025 (1/1/2 -No documentation aid/CPR training for	/4, 1/9, 1/11, 1/14, 1/16, 1/17,				
		5 with Staff #10 revealed: d certification, it expired a				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	
		MHL060-648	B. WING		02/2	8/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TURN AF	ROUND		TEN COURT _, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 108	Interview on 2/21/25 -No trainings since -Had first aid/CPR to phone, I don't keep certificates." -"My phone is on two phone charger out oback." -Staff #11 did not can when attempt was round in the complete of the does that training the does that training instructor, 9/19/24-S-Responsible for enfirst aid/CPRWas responsible for enfirst aid/CPR.	raining but no other training e." 5 with Staff #11 revealed: being hired. raining, "I'll have to look in my copies of my training to percentlet me go get my of the car and I'll call you right all back and did not answer made to follow up. 5 with CD/QP revealed: es first aid and CPR training, ghimself." 25 and 2/14/25 with the led: leation as first aid/CPR 3/19/26. suring staff were trained in least of necessary training, as sk of staff personnel records lates. 1/2/28/25 with the led: led: all had first aid/CPR, I did	V 108			
		rossed referenced into 10A				

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Professionals and Associate Professionals

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		MHL060-648	B. WING		02/2	28/2025
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
IONIA	COUND	MINT HIL	L, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 108	Continued From pa	ge 7	V 108			
	(V109) for a Type B rule violation and must be corrected within 23 days.					
	This deficiency con and must be correc	stitutes a re-cited deficiency ted within 30 days.				
V 109	27G .0203 Privilegii	ng/Training Professionals	V 109			
	QUALIFIED PROFI ASSOCIATE PROFI (a) There shall be a qualified profession (b) Qualified profes professionals shall and abilities require (c) At such time as employment system then qualified profe- professionals shall (d) Competence sh exhibiting core skills (1) technical knowl (2) cultural awaren (3) analytical skills; (4) decision-makin (5) interpersonal sl (6) communication (7) clinical skills. (e) Qualified profes NCAC 27G .0104 (1) met the requirement employment system MH/DD/SAS. (f) The governing be develop and implent for the initiation of a plan upon hiring each	ressionals no privileging requirements for als or associate professionals. ssionals and associate demonstrate knowledge, skills d by the population served. a competency-based is established by rulemaking, ssionals and associate demonstrate competence. hall be demonstrated by is including: edge; ess; g; kills;				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			B. WING			
		MHL060-648	l		02/2	8/2025
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TURN A	ROUND		TEN COURT L, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 109	supervised by a qui	ge 8 alified professional with the or the period of time as 104 of this Subchapter.	V 109			
	review, 1 of 2 qualit (Licensee/Qualified demonstrate the kn	, observation, and record				
	Personnel Requirer review and interview complete personne	10A NCAC 27G .0202 ments (V107) Based on record ws, the facility failed to I records affecting 2 of 13 ger(HM) and Associate				
	Personnel Requirer reviews and intervie ensure the Clinical (CD/QP) and 8 of 1 #8, #9, #10, #11) ha	10A NCAC 27G .0202 ments (V108) Based on record ews, the facility failed to Director/Qualified Professional 3 staff (Staff #1, #2, #6, #7, ad current first y resuscitation (CPR) training.				
	Assessment and Tr Service Plan (V112 interviews, the facil treatment plan with	10A NCAC 27G .0205 reatment/Habilitation or) Based on record reviews and ity failed to have a current written consent or agreement onsible party affecting 1 of 4				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		MHL060-648	B. WING		02/2	8/2025
NAME OF	PROVIDER OR SUPPLIER	9709 BAT	DRESS, CITY, S TEN COURT L, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 109	Continued From pa	ge 9	V 109			
	Record Check (V13 and interview, the fa criminal history reco days of making the	G.S. 122C-80 Criminal History 33) Based on record review acility failed to request a ord check within five business conditional offer of f 13 staff (Staff #2 #4, #7, #9				
	(V293) Based on re interviews the facilit assist 4 of 4 clients acquisition of social	10A NCAC 27G .1701 Scope cord reviews, observation and ty failed to ensure services to (#1, #2, #3, #4) in the and recreational skills and care within the client's systements (#2).				
	Requirements for A Based on record re facility failed to ensi	10A NCAC 27G .1703 ssociate Professionals (V295) view and interviews, the ure at least one full time direct equirements of an Associate				
	Minimum Staff Req record reviews, inte facility failed to ensi	10A NCAC 27G .1704 uirements (V296) Based on erviews and observations, the ure the minimum staff ratio of nildren or adolescents.				
	Response Requirer observation, record facility failed to impl	10A NCAC 27G .0603 Incident ments (V366) Based on review and interviews, the lement a policy governing their incidents as required.				
	Location and Exteri	10A NCAC 27G .0303 or Requirements (V736) on and interview the facility in a safe manner.				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MHL060-648	B. WING		02/2	8/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TUDN A	COLIND	9709 BAT	TEN COURT			
TURN AF	ROUND	MINT HILL	., NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 109	Continued From pa	ge 10	V 109			
	Professional's (QP) -Hired 5/21/02Job description for 1/24/11Duties and responday operation of the appointments, mee maintain consumer Review and creden records. Attend me Executive Director. the Executive Director as authorized by the Recommend admir Executive Director. monitoring of progradill, hot water temp Responsible for verof AP (Associate Pr Paraprofessional R or individual activities training. Defuse the nature, and interver recurrence. Ensure services and resour living skills training skills training skills training skills training to helicoping with the you manage the present addiction symptoms implementation of his supports. Services management, intenindividual and/or fainterventions, skills rehabilitative supports.	Program Director/QP dated sibilities: "Monitor the day to a facility. Schedule ting, and etc. Review and medical records and charts. tial documentation for client eting as directed by the Attend meeting as directed by the Attend meeting as directed by tor. Attend trainings sessions as Executive Director. Distrative policy to the Implementation and am. Review facility logs (Fire perature, & safety checks). Dicle mileage logs. Supervision of essional) and esidential Counselors. Group as Sensory stimulation are current crisis, evaluate it the to reduce the likelihood of a linkage to needed community of res. Provide self-help and for youth. Provide parenting per the family build skills for the family build skills for the disorder. Monitor and ting psychiatric and/or and ting psyc				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.	A. BUILDING:		
		MHL060-648	B. WING		02/2	8/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TURN A	ROUND		TEN COURT L, NC 28227			
(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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 109	Interview on 2/13/2 Licensee/QP revea -Was person resporole, which included orientation, arranging training and person scheduling/filling stWas person responsed well-beingWas responsible for clients when away with clients' strengt"I am currently fulfCD/QP "assist w"I am the Human for st"I do training for st"I am responsible and I check them p"I revise and edit the plan)coordinate w"I've been working"yesterday (2/13) day treatment, had assault towards hemyself, but don't gereport. I didn't think incident." -"I do incident reponsioned the poincident on the form (Incident Response myself." -"As QP, I sometime edit the PCP, facility Team Meetings), condensumers, and justice and justice and pushed the proportion of the propo	5, 2/14/25 and 2/17/25 with led: unsible for human resources of hiring staff, new staff and training, keeping up with unel documents, and aff for shifts. unsible for clients' safety and or ensuring supervision of from the facility in accordance hs and needs. illing the QP." ith QP duties." Resource person." aff" ff training." for reviewing the MARs." for keeping up with the MARs	V 109			

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	, ,	E CONSTRUCTION	(X3) DATE	SURVEY
7.1.12 . 27.11			A. BUILDING:			
		MHL060-648	B. WING		02/2	8/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
TURN A	ROUND		TEN COURT			
(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 CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 109	had not been signed can get that signed -"I do that (rideshar two staff at the hou always here when to "They might take [rweek, some weeks -Provided monthly -Was person response scheduling activities." Further interview or revealed: -Was responsible for and guidelines. -Was responsible for and reporting medicalient physician. -Was responsible for the was responsible for medication. Was responsible for the was responsible for medication. Was responsible for the was responsible for medication. -Was responsible for the was r	d and had no explanation, "I ." re) to make sure we maintain se (facility), so two (staff) are they (clients) are picked up." ideshare] once or twice a . I might not use it." supervision with staff. nsible for planning and s and outings for clients. n 2/24/25 with Licensee/QP or adhering to staffing rules or coordinating with resources cation errors to pharmacy or or reporting incidents. for setting up Registered on administration training to stering medications to clients ed. Insible for reviewing and reviewing client MARs. Idays, Monday through y other Sunday, 32 hrs, I think art-time. He works part-time,	V 109			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MHL060-648	B. WING		02/2	8/2025
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TURN A	ROUND		TEN COURT L, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 109	doctor or pharmacy supposed to." -Had not document one incident reports. Review on 2/28 of t signed by CD/QP a -Executive Director. Director as of 2/28/met with the Clinical the Qualified Profescitations. Interim a be assumed by the These duties will be appropriately qualificated available permaner responsibilities. New Human Resources for managing all personnel requirement and completion of a according to compare reponsibilities ensimality and completion of a according to compare requirements while are covered until the on the role.	v, "no, I didn't know I was ed medication errors in level	V 109			
	happens. 1. Immediate hiring immediately begins fill the two key position and Human Resource. Hiring timelines: personnel staff will 04/15/2025 and the will assume the QP	g efforts: New Place, Inc. will seeking qualified candidates to tions of Qualified Professional rece Personnel Staff. The human resource be hired no later than qualified professional staff role no later that 03/31/2025.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			
		MHL060-648	B. WING		02/2	8/2025
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TURN A	ROUND		TEN COURT			
		MINT HILI	L, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 109	Continued From pa	ge 14	V 109			
	review and sign the complete all necess their responsibilities description. This siroles, timelines, and	ir respective job description, sary training to effectively fulfill is as outlined in their job tructure will ensure clarity in d supervision, while also key positions are filled				
	Protection, signed in 2/28/25 revealed: "What immediate a ensure the safety of Executive Director the Clinical Director of 3/3/2025 all consumith Medicaid approbe transported in the staffing ratio of two current pet or new included in the consumer has will be certified a service produmentation, and included in the consumer to all staff receiving Administration train employment and wountil medication and completed and not does not have First receive a conditional upon a criminal hist disclose any disquares.	of the amended Plan of by the CD/QP and dated of the consumers in your care? Is (Licensee/QP) meeting with as of 2/28/25: Effective amers will be provided only oved transportation or they will be community with appropriate staff. Effective 03/3/2028 any nooming pet that any be deemed not necessarily bet, will have all vaccination of the service pet will be sumer Person Centered Plan. Inny rabbit) will receive current /2025. Effective immediately will document all medication as, refusal, hospitalization, etc.) bely New Place, Inc. will review record policy and will adhere First Aid and Medication ing within their first 30 days of will not pass any medication ministration training is work with another staff that Aid training. Ny new hire will all employment offer contingent tory check that does not alifying criminal charges 5 the Clinical Director will				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			7 ti Boilebii (o.			
		MHL060-648	B. WING		02/2	8/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TURN AI	ROUND		TEN COURT			
	T		L, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
V 109	Continued From pa	ge 15	V 109			
	assure all Person C qualifying signature that all plans are up	Centered Plans have a es on the signature page and odated every 30 days to or revision signatures.				
	This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.					
	to 17 years with dia Attention-Deficit/Hy Disorder, Opposition Unspecified Traum. Adjustment Disorder Disappearance/Dea Unspecified Schizo Disorder. The facil from the legal guard plan updated treath human resources, the ensure personal reaction of the Licensee/QP of personnel and train was not employed and in job description in personnel record. Staff were trained to Eight out of thirteen have current First Aresuscitation CPR) ensure that at least Aid/CPR was working thirteen staff did now within 5 business doffer of employment clients (#1, #2, #3, adaptive functioning skills and failed to dresources within the	peractivity, Major Depressive nal Defiant Disorder, a Stressor Related Disorder,				

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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		
		MIII 000 040	B. WING		00/0	0.4000
		MHL060-648			02/2	8/2025
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TURN A	ROUND		TEN COURT L, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 109	transportation out of person proving transportation out of person proving transportations according to secure rate veterinary care for facility. The facility governing their respressed to medication (#4). As the person all functions of the clinical skills, analy and communication health, safety, and This deficiency conwhich is detrimental	of staff ratio, with one staff asportation to 4 clients. The ged for clients' use of the supervision of at least 2 ampanying clients. The facility ies shots and document a pet (rabbit) housed in the failed to implement policy conse to level one incidents on errors (clients #1, #2. #3, identified as responsible for facility, the Licensee/QP failed core skills of competency in tical skills, decision making a skills which impacted the welfare of the clients.	V 109			
V 112	10A NCAC 27G .02 TREATMENT/HAB PLAN (c) The plan shall I assessment, and ir legally responsible of admission for clir receive services be (d) The plan shall i (1) client outcome	De developed based on the a partnership with the client or person or both, within 30 days ents who are expected to eyond 30 days. Include: (s) that are anticipated to be on of the service and a chievement;	V 112			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL060-648	B. WING		02/2	8/2025
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TURN A	ROUND		TEN COURT _, NC 28227			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 112	(4) a schedule for annually in consulta responsible person (5) basis for evalua outcome achievem (6) written consent responsible party, o	review of the plan at least ation with the client or legally or both; ation or assessment of	V 112			
	facility failed to hav written consent or a responsible party a The findings are: Review on 2/11/25 -Admission dated 1 -Age 14 years Diagnoses: Adjust Disturbance of Email Attention-Deficit Hy Hyperactive Type; If Family MemberTreatment plan (cu 12/6/22There was not an	views and interviews, the e a current treatment plan with agreement by the client or ffecting 1 of 4 clients (#3). of client #3's record revealed 2/12/22. atment Disorder, Mixed otions and Conduct; peractivity Disorder, Disappearance and Death of a urrent) was last signed on updated signature or written uardian or responsible party on				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BOILDING.			
		MHL060-648	B. WING		02/2	8/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TURN A	ROUND		TEN COURT L, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 112	Interview on 2/27/2 Professional reveal -Was not aware tre not have updated s responsible party of -"I revise and edit th Plan)." This deficiency is of NCAC 27G .0203 Of Professionals and A (V109) for a Type B corrected within 23	5 the Licensee/Qualified ed: atment plans for client #3 did ignature and guardian or onsent. he PCP (Person Centered rossed referenced into 10A competencies of Qualified Associate Professionals a rule violation and must be	V 112			
	10A NCAC 27G .02 REQUIREMENTS (b) Medication pac (1) Non-prescription dispensed by a phat manufacturer's labely visible; (2) Prescription me or obtained as sam tamper-resistant par risk of accidental in packaging includes with tamper-resista unit-of-use package may be adequate; (3) The packaging drug dispensed mu (A) the client's nam (B) the prescriber's (C) the current disp (D) clear directions	kaging and labeling: In drug containers not Irmacist shall retain the Island with expiration dates clearly Redications, whether purchased ples, shall be dispensed in Ickaging that will minimize the gestion by children. Such plastic or glass bottles/vials Int caps, or in the case of Island drugs, a zip-lock plastic bag Iabel of each prescription Ist include the following: Ine; In name; Inensing date; In or self-administration; Ingth, quantity, and expiration				

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	MIII 000 040			(X3) DATE SURVEY COMPLETED	
	MHL060-648			02/28/2	2025
DER OR SUPPLIER		L	STATE, ZIP CODE	,	
D		TEN COURT			
		_, NC 28227			
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE C	(X5) COMPLETE DATE
tinued From pa	ge 19	V 117			
the name, addr macy or disper	ess, and phone number of the sing location (e.g., mh/dd/sa				
ed on observati views, the facili ications were la	on, record review and ty failed to ensure that abeled as required for 1 of 4				
nission date 6/2 2 16 years. gnoses: Attent gentive Type; Operative Type; Operation of the continuity	ion-Deficit/Hyperactivity, positional Defiant Disorder; pmental Disability Disorder, lood Disorder; Unspecified ctrum and other Psychotic lated 6/20/24 revealed: mphetamine (concentration) se) 20 milligrams (mg) 24 hr e 1 capsule by mouth daily in lated 7/17/24 revealed: marate (mood) 100mg, take in daily as directed. marate (mood) 50mg, take in at bedtime as directed. lated 8/20/24 revealed:				
- ()? -ti threat	SUMMARY STA EACH DEFICIENCY EGULATORY OR LS inued From pathe name, addracy or disperer), and the name of on observationer. Rule is not me of on observationer.	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION) inued From page 19 the name, address, and phone number of the macy or dispensing location (e.g., mh/dd/sa er), and the name of the dispensing itioner. Rule is not met as evidenced by: ad on observation, record review and views, the facility failed to ensure that cations were labeled as required for 1 of 4 ts (#4). The findings are: ew on 2/11/25 of client #4's record revealed: hission date 6/14/24. 16 years. gnoses: Attention-Deficit/Hyperactivity, entive Type; Oppositional Defiant Disorder; ectual Developmental Disability Disorder, Unspecified Mood Disorder; Unspecified zophrenia Spectrum and other Psychotic rder. sician's order dated 6/20/24 revealed: Dexatoamp-Amphetamine (concentration) extended release) 20 milligrams (mg) 24 hr r) capsule, take 1 capsule by mouth daily in norning. sician's order dated 7/17/24 revealed: Quetiapine Fumarate (mood) 100mg, take tablet by mouth daily as directed. Quetiapine Fumarate (mood) 50mg, take tablet by mouth daily as directed. Sician's order dated 8/20/24 revealed: Prozac 20mg (mood) Pulvule capsule, take tapsule by mouth daily in the morning as	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION) Inued From page 19 the name, address, and phone number of the macy or dispensing location (e.g., mh/dd/sa er), and the name of the dispensing litioner. Rule is not met as evidenced by: ad on observation, record review and views, the facility failed to ensure that cations were labeled as required for 1 of 4 ts (#4). The findings are: ew on 2/11/25 of client #4's record revealed: hission date 6/14/24. 16 years. gnoses: Attention-Deficit/Hyperactivity, entive Type; Oppositional Defiant Disorder; ectual Developmental Disability Disorder, Unspecified Mood Disorder; Unspecified zophrenia Spectrum and other Psychotic rder. sician's order dated 6/20/24 revealed: Dexatoamp-Amphetamine (concentration) extended release) 20 milligrams (mg) 24 hr r) capsule, take 1 capsule by mouth daily in norning. sician's order dated 7/17/24 revealed: Quetiapine Fumarate (mood) 100mg, take ablet by mouth daily as directed. Quetiapine Fumarate (mood) 50mg, take ablet by mouth at bedtime as directed. Sician's order dated 8/20/24 revealed: Prozac 20mg (mood) Pulvule capsule, take	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL EQUILATORY OR LSC IDENTIFYING INFORMATION) Inued From page 19 the name, address, and phone number of the macy or dispensing location (e.g., mh/dd/sa ar), and the name of the dispensing itioner. Rule is not met as evidenced by: do no observation, record review and views, the facility failed to ensure that cations were labeled as required for 1 of 4 ts (#4). The findings are: ew on 2/11/25 of client #4's record revealed: hission date 6/14/24. 16 years. gnoses: Attention-Deficit/Hyperactivity, entive Type; Oppositional Defiant Disorder; ectual Developmental Disability Disorder, Unspecified Mood Disorder; this pecified 20phrenia Spectrum and other Psychotic rder. Sician's order dated 6/20/24 revealed: Dexatoamp-Amphetamine (concentration) extended release) 20 milligrams (mg) 24 hr r) capsule, take 1 capsule by mouth daily as directed. Quetiapine Fumarate (mood) 100mg, take ablet by mouth at bedtime as directed. Sician's order dated 8/20/24 revealed: Prozac 20mg (mood) Pulvule capsule, take appealed by mouth daily in the morning as	SUMMARY STATEMENT OF DEFICIENCES SUMMARY STATEMENT OF DEFICIENCY ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 117 Rule is not met as evidenced by: sid on observation, record review and views, the facility failed to ensure that cations were labeled as required for 1 of 4 ts (#4). The findings are: sew on 2/11/25 of client #4's record revealed: sission date 6/14/24. 16 years. gnoses: Attention-Deficit/Hyperactivity, entive Type; Oppositional Defiant Disorder; ectual Developmental Disability Disorder, Unspecified Mood Disorder; Unspecified zophrenia Spectrum and other Psychotic rder. sician's order dated 6/20/24 revealed: Dexatoamp-Amphetamine (concentration) extended release) 20 milligrams (mg) 24 hr r) capsule, take 1 capsule by mouth daily in norming, sician's order dated 7/17/24 revealed: Quetiapine Fumarate (mood) 50mg, take ablet by mouth alily as directed. sician's order dated 8/20/24 revealed: Prozac 20mg (mood) Pulvule capsule, take apsule by mouth daily in the morning as

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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	
		MHL060-648	B. WING	B. WING		9/2025
NAME OF I	PROVIDER OR SUPPLIER		l .	STATE, ZIP CODE	0212	8/2025
TURN AF		9709 BAT	TEN COURT L, NC 28227	,		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 117	Continued From pa	ige 20	V 117			
	Observation on 2/1 12:26pm of client # -A small single pill, "Y17" on one side v sandwich-sized, cle -There was no pace Interview on 2/10/2 revealed: -She was not sure v had placed it in the medication was sep -"Maybe she (client saved it (pill) to sho Professional (QP)). Interview on 2/24/2 revealed: -Was not aware the	0/25 at approximately 4's medication revealed: golden-yellowish color with was in a closed zip locked ear plastic bag. kaging label for the pill. 5 with the House Manager what the medication was, who plastic bag and why the parated without a label. #4) dropped it and they (staff) by him (Licensee/Qualified				
	staff placed it there -"I'll have to ask wh bag), it should be ir -"The only thing I ca refused (medication back in there (bottle This deficiency is c NCAC 27G .0209 N	no put that (pill) in there (plastic in a bottle or bubble pack." an think is she (client #4) in) and they (staff) didn't put it e/bubble pack)." ross referenced into 10A Medication Requirements 1 violation and must be				
V 118	10A NCAC 27G .02 REQUIREMENTS (c) Medication adm		V 118			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		33 22.23	
		MHL060-648	B. WING		02/2	8/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TURN AF	ROUND		TEN COURT			
		MINT HILI	L, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTION OF THE APPROPERTIES OF THE A	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 21	V 118			
	only be administered order of a person a drugs. (2) Medications shat clients only when at client's physician. (3) Medications, incommodistered only bunlicensed persons pharmacist or other privileged to prepare (4) A Medication Administered only bunlicensed persons pharmacist or other privileged to prepare (4) A Medication Administer current. Medication recorded immediate MAR is to include the (A) client's name; (B) name, strength, (C) instructions for (D) date and time the (E) name or initials drug. (5) Client requests a checks shall be recorded.	d to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be y licensed persons, or by trained by a registered nurse, regally qualified person and e and administer medications. ministration Record (MAR) of red to each client must be kept administered shall be ely after administration. The				
	observation, the fac medications were a order of a physiciar kept current affectir	et as evidenced by: views, interviews, and cility failed to ensure dministered on the written a, failed to ensure MARs were ag 4 of 4 audited clients and failed to provide required				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BU	BUILDING:	COMPLETED
MHL060-648 B. W	VING	02/28/2025
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS	S, CITY, STATE, ZIP CODE	
TURN AROUND 9709 BATTEN 0 MINT HILL, NC		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PR	ID PROVIDER'S PLAN OF REFIX (EACH CORRECTIVE AC' TAG CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE COMPLÉTE THE APPROPRIATE DATE
training in the supervision of medication administration for 9 out of 13 Staff (House Manager (HM), #1, #3, #4, #5, #6, #7, #9. #11) The findings are: Cross-Reference: 10A NCAC 27G .0209 Medication Requirements (V117) Based on observation, record review and interviews, the facility failed to ensure that medications were labeled as required for 1 of 4 clients (#4). Cross-Reference: 10A NCAC 27G .0209 Medication Requirements (V121) Based on records reviews and interviews, the facility failed to ensure clients had a drug regimen review at least every six months for 3 of 4 Clients (#2, #3 and #4) who received psychotropic drugs Cross-Reference: 10A NCAC 27G .0209 Medication Requirements (V123) Based on record reviews, observation, and interviews, the facility failed to ensure all medication administration errors were reported immediately to a pharmacist or physician affecting 4 of 4 clients (#1, #2, #3, #4). Finding #1 Review on 2/11/25 of client #1's record revealed: -There were no signed physician orders. Observation on 2/14/25 at approximately 8:48 am of client #1's medication revealed: Empty bottle for Vyvanse (ADHD) 30 milligrams (mg), take one capsule by mouth in the morning for 30 days. Clonidine (ADHD) 0.2 mg, take one tablet by mouth every day at bed time in a plastic bag with handwritten "AM." Guanfacine (ADHD) 2 mg, take one tablet by mouth in the morning.		

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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	
	MHL060-648		B. WING		02/2	8/2025
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 02,2	0,2020
			TEN COURT	•		
TURN AI	ROUND	MINT HILL	., NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 23	V 118			
	Aripiprazole (deprei (5mg total) by mout "AM." Cetirizine (allergy), mouth daily. Fluticasone propior (mcg)/actuation nas nostril nightly. Metronidazole (infeper day was not ava Doxycycline (infectimouth 2 times per depression of the control of t	ssion) 5 mg, take one tablet th daily in a plastic bag marked take one tablet (10mg) by nate (allergy) 50 microgram sal, use one spray in each ction) 500 mg, 1 tablet 2 times allable. on) 100 mg, 1 capsule by day was not available. of client #1's January 30-31, d: mented as administered by ot documented as 30/25 and 1/31/25 ocumented as administered l'25. umented as administered by ocumented as administered by ocumented as administered by ocumented as administered locumented locumen				

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-Was aware of some of her medications and why

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL060-648		B. WING		02/2	8/2025	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TURN AF	ROUND		TEN COURT _, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 118	Guanfacine, Clonid -"I had prescriptions hospital, only had to for stomach issues hospital for, I was fi -"I think I had a yea rash down there (po -"I just take what th they probably threw away when they sa was for a couple of -Had medication m 2/19/25 and to her I changes were mad Interview on 2/14/2 (HM) revealed: -"She (client #1) ca don't have it (Vyvan Doxycycline) becau -Was not aware wh medications and wa been sent to the ph -Did not know clien the medications we Interview on 2/13/2 Professional (AP) r -"I work second shi through Thursday, -Client #1 "just cam -Was not aware of medication errorsWas not aware of without training. Interview on 2/14/2	ed; "one starts with an 'A', ine." Is that came with me from the otake them a couple of days that's what I was in the ull of gas." Is tinfection, I was getting a cointing to her vaginal area)." It (medication for infection) well didn't need it and that it days." It anagement appointment knowledge no medication e. With the House Manager In with medication and we use, Metronidazole, use she is new" It en client #1 ran out of as not sure if medications had armacy for refill. It #1's medications and what are prescribed for. With the Associate evealed: It, evening hoursMonday It is medication refusals or staff administering medication	V 118			
	Professional (QP) r -"I'm going to look i	evealed: nto that (medications),				

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MHL060-648 B. WING	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	
WITE500-040 02/20/2025		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
	NAME OF PROVIDER OR SUPPLIER	
TURN AROUND 9709 BATTEN COURT MINT HILL, NC 28227	TURN AROUND	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE CROSS-REFERENCED TO THE APPROPRIATE DATE) DEFICIENCY DATE	PREFIX (EACH DEFICIENC	
Whatever she (client #1) came in with (medications at admission), that's what is in here; so, I'll have to find where it's (missing medications) atI did the MAR (for client #1)." -"She (client #1) hasn't had her first med (medication) management appointment; that (appointment) has been scheduled for 2/19/25." Further interview on 2/24/25 with the Licensee/QP revealed: -Did not know all of client #1's medications and what each medication was prescribed for"I would have to look and see who was working on those dates (1/30/25-1/31/25) to provide an explanation of why the initial (staff)is missing." -"I don't know why they (staff) left it (MAR) blank"I wouldn't have med (medication) orders from her (client #1) previous provider. It is my understanding that when you have a pill bottle, that's a script. I didn't follow up with the prescribing doctor, but I will. "Ill have to get her med order from her previous doctor or pharmacy." Finding #2 Review on 2/11/25 of client #2's record revealed: Signed physician orders dated 12/19/24 for the following medications: -Lamictal (mood stabilization) 100 mg, take one tablet by mouth twice daily as directedCetirizine 10 mg tab, take one tablet by mouth daily as directedMetformin (pre-diabetes) 500 mg, take two tablets by mouth twice daily as directedClonidine (ADHD) HCL (hydrochloric acid) ER (extended release) 0.1 mg, extended release, 12 hr (hour), take three tablets by mouth once daily as directedSeroquel (depression) 100 mg, take one tablet daily by mouth as directed.	whatever she (clier (medications at adiso, I'll have to find medications) atI -"She (client #1) had (medication) manad (appointment) has Further interview of Licensee/QP reveation of know all of what each medicated. "I would have to loon those dates (1/3 explanation of why -"I don't know why -"I wouldn't have maker (client #1) prevented in the pharmacy." Finding #2 Review on 2/11/25 Signed physician of following medication -Lamictal (mood stablet by mouth twitablets by mouth	

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STATE FORM 6899 2ZN611 If continuation sheet 26 of 104

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, NC 28227 (EACH DEFICIENCY) MIST BE PRECEDED BY FILL (EACH DEFICIENCY MIST BE PRECEDED BY FILL (EACH DEFICIENCY) (EACH DEFIC	STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
TURN AROUND XUMMARY STATEMENT OF DEFICIENCIES XUMMARY STATEMENT OF DEFICIENCIES XEAR ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL NG BY A ID PREFIX TAG REGULATORY OR US: DIENTIFYING INFORMATION) ID PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	MHL060-648		B. WING		02/2	8/2025	
XA D SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) V 118 Continued From page 26 -Sertraline (depression) 100 mg, take two tablets by mouth daily as directed. Physician order dated 7/17/24 for Seroquel (depression) 100mg take 1 tablet twice daily by mouth as directed Physician Order dated 12/18/24 for Accu-check Guide Test Strips (pre-diabetes), take 1 strip 3 times a day by miscellaneous routes as directed of 90 daysNo physician order for Seroquel (depression) 200mg take 1 tablet by mouth at bedtime as directed -No discontinued orders Observation on 2/10/25 at approximately 2:10pm of client #2's medication revealed: -small black zippered pouch with a glucose meter, strips and owner's manual. Observation on 2/10/25 at approximately 2:10pm of client #2's medication revealed: Clonidine HCL ER 0.1 mg tablet, take three tablets by mouth every day as directed. Sertraline HCL 100 mg tablet, take 2 tablets by mouth every day as directed. Sertraline HCL 100 mg tablet, take 2 tablets by mouth every day as directed. Seroquel 200mg tablet, take one tablet by mouth at bedtime as directed (blue "bedtime" sticker in upper right corner, no pills had been dispensed from the bubble pack). Metformin HCL 500 mg tablet, take 2 tablets by mouth wice daily as directed. Lamictal 100mg tablet, take one tablet by mouth	TURN AF	ROUND					
-Sertraline (depression) 100 mg, take two tablets by mouth daily as directed. Physician order dated 7/17/24 for Seroquel (depression) 100mg take 1 tablet twice daily by mouth as directed Physician Order dated 12/18/24 for Accu-check Guide Test Strips (pre-diabetes), take 1 strip 3 times a day by miscellaneous routes as directed for 90 daysNo physician order for Seroquel (depression) 200mg take 1 tablet by mouth at bedtime as directed -No discontinued orders Observation on 2/10/25 at approximately 2:10pm of client #2's medication revealed: -small black zippered pouch with a glucose meter, strips and owner's manual. Observation on 2/10/25 at approximately 2:10pm of client #2's medication revealed: Clonidine HCL ER 0.1 mg tablet, take three tablets by mouth every day as directed. Sertraline HCL 100 mg tablet, take 2 tablets by mouth every day as directed. Sertraline HCL 100 mg tablet, take 2 tablets by mouth every day as directed. Sertraline HCL 100 mg tablet, take 0 ne tablet by mouth at bedtime as directed (blue "bedtime" sticker in upper right corner, no pills had been dispensed from the bubble pack). Metformin HCL 500 mg tablet, take 2 tablets by mouth twice daily as directed. Lamictal 100mg tablet, take 2 tablets by mouth twice daily as directed.	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETE
Cetirizine HCL 10 mg tablet, take one tablet by mouth every day as directed (no pills had been dispensed from the bubble pack).	V 118	-Sertraline (depress by mouth daily as d Physician order data (depression) 100mg mouth as directed Physician Order data Guide Test Strips (ptimes a day by miscellaneous ro-No physician order 200mg take 1 table directed -No discontinued or Observation on 2/10 of client #2's medica-small black zippere meter, strips and ow Observation on 2/10 of client #2's medica-small black zippere meter, strips and ow Observation on 2/10 of client #2's medica-small black zippere meter, strips and ow Observation on 2/10 of client #2's medica-small black zippere meter, strips and ow Observation on 2/10 of client #2's medica-small black zippere meter, strips and ow Observation on 2/10 of client #2's medica-small black zippere meter, strips and ow Observation on 2/10 of client #2's medica-small black zippere meter, strips and ow Observation on 2/10 of client #2's medica-small black zippere meter, strips and ow Observation on 2/10 of client #2's medica-small black zippere meter, strips and ow Observation on 2/10 of client #2's medica-small black zippere meter, strips and ow Observation on 2/10 of client #2's medica-small black zippere meter, strips and ow Observation on 2/10 of client #2's medica-small black zippere meter, strips and ow Observation on 2/10 of client #2's medica-small black zippere meter, strips and ow Observation on 2/10 of client #2's medica-small black zippere meter, strips and ow Observation on 2/10 of client #2's medica-small black zippere meter, strips and ow Observation on 2/10 of client #2's medica-small black zippere meter, strips and ow Observation on 2/10 of client #2's medica-small black zippere meter, strips and ow Observation on 2/10 of client #2's medica-small black zippere meter, strips and ow Observation on 2/10 of client #2's medica-small black zippere meter, strips and ow Observation on 2/10 of client #2's medica-small black zippere meter, strips and ow Observation on 2/10 of client #2's medica-small black zippere meter, strips and ow Observation on 2/10 of client #2's medica-small black zippere me	sion) 100 mg, take two tablets irected. ed 7/17/24 for Seroquel g take 1 tablet twice daily by ted 12/18/24 for Accu-check ore-diabetes), take 1 strip 3 butes as directed for 90 days. For Seroquel (depression) to by mouth at bedtime as eders 0/25 at approximately 2:10pm ation revealed: ed pouch with a glucose wher's manual. 0/25 at approximately 2:10pm ation revealed: 0.1 mg tablet, take three ery day as directed. mg tablet, take 2 tablets by a directed. blet, take one tablet by mouth ted (blue "bedtime" sticker in no pills had been dispensed ock). mg tablet, take 2 tablets by sidirected. blet, take one tablet by mouth ted (blue "bedtime" sticker in no pills had been dispensed ock). mg tablet, take 2 tablets by sidirected. blet, take one tablet by mouth ted. ng tablet, take one tablet by mouth ted. ng tablet, take one tablet by directed (no pills had been	V 118			

6899

Division of Health Service Regulation STATE FORM

Review on 2/10/25 of Client #2's February 2025

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Division of Health Service Regulation

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL060-648	B. WING	B. WING		28/2025	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE			
TURN AF	ROUND		TTEN COURT L, NC 28227				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 118	MAR (2/1/25-2/10// -There was no dood of Accu-check Guidates: 2/1/25 throut through 2/10/25 (6 -On 2/4/25, Staff # and "X" for the Accu-Lamictal was not of for the following damorning doses 2/7 days)Lamictal was dood Staff #4 for the mod 2/1/25 through 2/3/2/10/25 (2 days)Cetirizine was not on 2/6/25 and 2/7/2/2-Cetirizine was dood Staff #4 on 2/1/25 2/8/25 through 2/10/25 (2 days)Metformin was not for the mod 2/1/25 through 2/10/25 (3 days)Metformin was not on 2/6/25 through 2/10/25 (3 days)Metformin was not of the mod 2/1/25 through 2/3/2/10/25 (3 days)Metformin was dood Staff #4 for the mod 2/1/25 through 2/3/2/10/25 (3 days)Metformin was dood Staff #4 for the mod 2/1/25 (3 days)Metformin was dood Staff #4 for the mod 2/1/25 (3 days)Metformin was dood Staff #4 for the mod 2/1/25 (3 days)Metformin was dood Staff #4 for the mod 2/1/25 (3 days).	25) revealed: numentation for administration de Test Strips for the following ugh 2/3/25 (3 days); 2/5/25 days). 5 initials were crossed out with the Check Guide Test Strips. documented as administered dites: 2/6/25 and 2/7/25 for the l/25 for the evening dose (3 lumented as administered by rning and evening doses on l/25 (3 days) and 2/8/25 through lumented as administered by rning dose on 2/4/25 and locumented as administered by rning dose on 2/4/25 and locumented as administered by through 2/3/25 (3 days) and locumented as administered by lumented as ad					
Division of H	Staff #4 for the mo 2/3/25 (3 days) and ealth Service Regulation	cumented as administered by rning dose on 2/1/25 through d 2/8/25 through 2/10/25 (3					

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL060-648		B. WING		02/2	8/2025	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TURN AF	ROUND	9709 BAT	TEN COURT			
1011174			_, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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 APPROPRIED CORRECTION (CROSS-REFERENCE)	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 28	V 118			
	administered for the 2/6/25 through 2/10 -Seroquel (200 mg) administered by Stadays)Seroquel (200 mg) administered by Stadays)Sertraline (200 mg) administered for the 2/6/25, and 2/7/25 (-Sertraline (200 mg) administered by Stadays)Sertraline (200 mg) administered by Stadays).	was documented as aff #4 on 2/2/25 and 2/3/25 (2) was documented as aff #5 on 2/4/25 and 2/5/25 (2) was not documentation as a morning dose on 2/1/25, (3 days).) was documented as aff #4 for the morning dose on 2/8/25 through 2/10/25 (5) was documented as aff #5 for the morning dose on 2 days).				
	MAR revealed: -There was no docu	of Client #2's January 2025 umentation for administration de Test Strips from January				
	for the morning dos 1/15/25, 1/17/25, 1/ days).	ocumented as administered se on 1/1/25 through 1/3/25, 21/25, 1/28/25 and 1/29/25 (8				
	for the evening dos 1/12/25, 1/17/25 thr 1/26/25, 1/29/25 thr -Lamictal was docu the HM for the mori 1/24/25 and 1/31/25 -Lamictal was docu	mented as administered by				
	Staff #3 for the mor	ning dose on 1/7/25, 1/8/25 (2				

days).

Division of Health Service Regulation

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		ATE SURVEY MPLETED	
			A. DOILDING.	A. BOILDING.			
		MHL060-648	B. WING		02/2	8/2025	
NAME OF PR	OVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
TURN ARO	DUND		TEN COURT L, NC 28227				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
1 - S 1 - S	Staff #4 for the mor 1/6/25, 1/11/25 thro 1/20/25, 1/125/25 thr Lamictal was doculous faff #4 for the ever 1/5/25 (2 days). Lamictal was doculous faff #5 for the mor 1/16/25, 1/23/25, 1/20 for the morning dos 1/17/25, 1/21/25, 1/20 for the morning dos 1/17/25, 1/21/25, 1/20 for the morning was doculous faff #3 for the morning faff #4 for the morning faff #4 for the morning faff #4 for the morning was doculous faff #5 for the morning faff #6 for the morning faff faff #6 for the morning faff faff faff faff faff faff faff fa	mented as administered by ning dose on 1/4/25 through ugh 1/13/25, 1/18/25 through ough 1/27/25 (12 days). mented as administered by ning dose on 1/4/25 and mented as administered by ning dose on 1/9/25, 1/14/25, 30/25 (5 days). documented as administered e on 1/1/25 through 1/3/25, 28/25, 1/29/25 (7 days). 5 initials were crossed out morning dose of Cetirizine. Limented as administered by ning doses on 1/10/25, d 1/31/25 (4 days). Limented as administered by ning dose on 1/7/25. Limented as administered by ning dose on 1/4/25 through 3/25, 1/18/25 through ough 1/27/25 (11 days). Limented as administered by ning dose on 1/8/25, 1/9/25, 23/25 and 1/30/25 (6 days). documented as administered e on 1/1/25 through 1/3/25, 1/21/25, 1/23/25, 29/25 (11 days). documented as administered e on 1/3/25, 1/12/25, 1/23/25, 1/25/24, 1/26/25, 9/25, 1/25/24, 1/26/25,	V 118				

Division of Health Service Regulation

STATE FORM 6899 2ZN611 If continuation sheet 30 of 104

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		SURVEY PLETED	
		MHL060-648	B. WING		02/:	28/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TURN A	ROUND		TEN COURT L, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
V 118	-Metformin was dod Staff #4 for the mor 1/6/25, 1/11/25 thro 1/20/25, 1/25/25 thrometromin was dod Staff #4 for the eve 1/5/25 (2 days). -Metformin was dod Staff #5 for the mor 1/16/25, 1/22/25, arclonidine was not for the morning dos 1/15/25, 1/17/25, 1/16/25, 1/17/25, 1/16/25 (3 dcClonidine refusal for through 1/6/25 (3 dcClonidine was doc the HM for the mor 1/24/25 and 1/31/25-Clonidine was doc Staff #3 for the mor 1/8/25 (2 days). -Clonidine was doc Staff #4 for the mor 1/13/25, 1/18/25 thr 1/27/25 (9 days). -Clonidine was doc Staff #5 for the mor 1/16/25, 1/23/25 and -Seroquel (100 mg) administered for the through 1/3/25, 1/8/1/17/25, 1/21/25 thr 1/29/25 and 1/31/25-Seroquel (100 mg) administer for the et 1/31/25 (31 days). Seroquel (100 mg)	cumented as administered by ming dose on 1/4/25 and high 1/13/25, 1/18/25 through rough 1/27/25 (11 days). Cumented as administered by ming dose on 1/4/25 and cumented as administered by ming dose on 1/9/25, 1/14/25, and 1/30/25 (5 days). documented as administered as administered as administered as on 1/1/25 through 1/3/25, 1/21/25, 1/28/25, and 1/29/25 (8 for the morning dose on 1/4/25 ays). The morning dose on 1/4/25 ays). The morning dose on 1/10/25, 1/22/25, 5 (4 days). The morning dose on 1/1/25 and a dministered by ming dose on 1/11/25 through a dose on 1/11/25 through a dose on 1/9/25, 1/25/25 through a dose on 1/9/25, 1/14/25, d 1/30/25 (5 days). The morning dose on 1/1/25 and a dministered by ming dose on 1/9/25, 1/14/25, d 1/30/25 (5 days). The morning dose on 1/1/25 and a dministered by ming dose on 1/1/25 through a morning dose on 1/				

1/13/25, 1/18/25 through 1/20/25 (9 days) and Division of Health Service Regulation

STATE FORM 6899 2ZN611 If continuation sheet 31 of 104

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED	
MHL060-648 B. WING 02/28/202	
	25
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
TURN AROUND 9709 BATTEN COURT MINT HILL, NC 28227	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	(X5) MPLETE DATE
V 118 Continued From page 31 V 118	
Seroquel (100 mg) was documented as administered by the HM for the morning dose on 1/10/25Seroquel (100 mg) was documented as administered by Staff #3 for the morning dose on 1/17/25Seroquel (100 mg) was documented as administered by Staff #5 for the morning dose on 1/30/25Seroquel (200 mg) was not documented as administere for the morning dose on 1/30/25Seroquel (200 mg) was not documented as administer for the morning dose on 1/1/25 through 1/3/25, 1/14/25 through 1/17/25, 1/2/2/25 and 1/31/25 (14 days)Seroquel (200 mg) was refused for the morning dose on 1/4/25 through 1/5/25, 1/11/25 through 1/27/25 (1/2 days)Seroquel (200 mg) was refused for the morning dose on 1/4/25 through 1/27/25 (1/2 days)Seroquel (200 mg) was documented as administered by the HM for the morning dose on 1/70/25Seroquel (200 mg) was documented as administered by the Staff #3 for the morning dose on 1/7/25Seroquel (200 mg) was documented as administered by Staff #5 for the morning dose on 1/3/25, 1/19/25 and 1/30/25 (3 days)Sertraline was not documented as administered for the morning dose on 1/1/25 (3 days)Sertraline was documented as administered by the HM for the morning dose on 1/10/25, 1/17/25, 1/12/1/25, 1/12/4	

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
	MHL060-648	B. WING		02/2	8/2025	
NAME OF PROVIDER OR SUPPL		DRESS, CITY, S	STATE, ZIP CODE	<u>, </u>	<u> </u>	
TURN AROUND		TEN COURT L, NC 28227				
PREFIX (EACH DEFICI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
the Staff #5 for 1/9/25, 1/14/25. Review on 2/10 MAR revealed: -Accu-check Go the December 2-Lamictal was refor the morning 12/10/24 through 12/20/24, 12/24 -Lamictal was refor the evening 12/14/24, 12/19 12/29/24 (9 day -Lamictal was refor the evening 12/16/24 (6 day -Lamictal was refor the HM for the reformation to the HM for the reformation of the HM for the 12/21/24 through 12/18/24, 12/24 -Lamictal was constaff #4 for the 12/21/24 through 12/30/24 (8 day -Lamictal was constaff #4 for the 12/20/24, 12/21 -Lamictal was constaff #5 for the (2 days)Cetirizine was for the morning 12/10/24 through 12/10/24 t	documented as administered by he morning doses on 1/8/25, 1/16/25, and 1/30/25 (5 days). 25 of Client #2's December 2024 ide Test Strips was not listed on 024 MAR. of documented as administered dose on 12/5/24, 12/6/24, in 12/13/24, 12/17/24 through 12/25 through 12/28/24 (15 days). of documented as administered dose on 12/6/24, 12/13/24, 12/20/24, 12/26/24 through is. of used for the morning dose on 12/9/24 and 12/14/24 through is. of used for the evening dose on 12/12/24, 12/15/24 through is. of used for the evening dose on 12/12/24, 12/15/24 through is. occumented as administered by morning dose on 12/31/24. occumented as administered by morning dose on 12/1/24, 12/2/24, in 12/23/24 and 12/28/24 through in 12/23/	V 118				

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STATE FORM 6899 2ZN611 If continuation sheet 33 of 104

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL060-648			B. WING		02/2	8/2025
NAME OF F	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
TURN AR	OUND		TEN COURT			
TORRE		MINT HILL	., NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 33	V 118			
	the HM for the morn-Cetirizine was door Staff #4 for the morn 12/7/24 through 12/12/16/24, 12/28/24 through 12-Cetirizine was door Staff #5 for the morn (2 days). -Metformin was not for the morning dos 12/10/24 through 12/16/24/24 through 12/16/24/24 through 12/16/24/24 through 12/17/24 and 12/18-Metformin was refulled the HM for the morn 12/16/24/24 through 12/16/24 through 12/16/24, 12/16/2	ning dose on 12/31/24. Jumented as administered by ning dose on 12/1/24, 12/2/24, 19/24, 12/14/24 through through 12/23/24 and 2/30/24 (15 days). Jumented as administered by ning dose 12/3/24 and 12/4/24 documented as administered e on 12/5/24, 12/6/24 2/13/24, 12/19/24, 12/20/24, 2/27/24 (12 days). Jumented as administered e on 12/19/24, 12/20/24, 2/21/24 (9 days). Just for the morning dose on 1/24 (2 days). Just for the evening dose on 1/24 (2 days). Just for the evening dose on 1/24 (2 days). Just for the evening dose on 1/24 (2 days). Just for the evening dose on 1/24 (2 days). Just for the evening dose on 1/24 (2 days). Just for the evening dose on 1/24 (2 days). Just for the evening dose on 1/24 (2 days). Just for the evening dose on 1/2/1/24, 12/2/24, 12/14/24 through 12/23/24, 12/28/24 4 days). Just for the evening dose on 12/1/24, 12/2/24, 12/2/24, 12/14/24 through 12/23/24, 12/28/24 4 days). Just for the evening dose on 12/1/24, 12/2/24,				

Division of Health Service Regulation

12/16/24 (15 days).

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MALE OF PROVIDER OR SUPPLIER TURN AROUND STREET ADDRESS, CITY, STATE_JP CODE 9799 BATTEN COURT MINT HILL, NC 28227 SUMMARY STATEMENT OF DEPTICIENCIES FACTOR FACTOR		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
TURN AROUND STREET ADDRESS, CITY, STATE, ZIP CODE TORN AROUND STREET ADDRESS, CITY, STATE, ZIP CODE THE COURT MINT HILL, NC 28227 PROVIDERS PLAN OF CORRECTION REGULATORY OR ISC IDENTIFYING INFORMATION) V 118 Continued From page 34 -Clonidine was documented as administered by the HM for the morning dose on 12/31/24Clonidine was documented as administered by Staff ## for the morning dose on 12/5/24, through 12/23/24 through 12/23/24 through 12/23/24 through 12/23/24 through 12/23/24 through 12/31/24, 12/16/24 through 12/31/24, 12/16/24 through 12/31/24, 12/16/24 (3 days). -Seroquel (100 mg) was refused for the morning dose on 12/6/24, 12/16/24 through 12/31/24 (12 days). -Seroquel (100 mg) was refused for the morning dose on 12/6/24, 12/16/24 through 12/31/24 and 13/31/24 through 12/31/24 through 12/31/24 through 12/31/24 and 13/31/24 through 12/31/24 through 12/31/24 and 13/31/24 through 12/31/24 through 12/31/24 and 13/31/31/31/3			MHI 060-648	B. WING		02/2	8/2025
TURN AROUND SUMMARY STATEMENT OF DEFICIENCIES MINT HILL, NC. 28227 MINT HILL, NC. 28	NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 02/2	0/2020
MINT HILL., NC. 28227 SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION V 118 Continued From page 34 Condition was documented as administered by the HM for the morning dose on 12/31/24. -Clonidine was documented as administered by Staff #4 for the morning dose on 12/31/24 through 12/23/24, 12/28/24 through 12/30/24 (6 days). -Seroquel (100 mg) was not documented as administered for the evening dose on 12/61/24, 12/10/24, 12/10/24, 12/10/24, 12/10/24, 12/10/24, 12/10/24 through 12/36/24 (3 days). -Seroquel (100 mg) was not documented as administered for the evening dose on 12/61/24, 12/10/24, 1							
PRÉFEIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) V 118 Continued From page 34 -Clonidine was documented as administered by the HM for the morning dose on 12/31/24, -Clonidine was documented as administered by Staff #4 for the morning dose on 12/31/24 through 12/23/24, 12/28/24 through 12/30/24 (6 days)Seroquel (100 mg) was not documented as administered for the worning dose on 12/5/24, 12/6/24, 12/10/24 through 12/31/24 (21 days)Seroquel (100 mg) was not documented as administered for the evening dose on 12/14/24 through 12/31/24 (21 days)Seroquel (100 mg) was refused for the morning dose on 12/14/24 through 12/31/24 through 12/18/24, 12/1	TURN AF	ROUND	MINT HILI	L, NC 28227	,		
-Clonidine was documented as administered by the HM for the morning dose on 12/31/24Clonidine was documented as administered by Staff #4 for the morning dose on 12/21/24 through 12/23/24, 12/28/24 through 12/30/24 (6 days), -Seroquel (100 mg) was not documented as administered for the morning dose on 12/5/24, 12/6/24, 12/10/24 through 12/13/24, 12/17/24 through 12/31/24 (21 days), -Seroquel (100 mg) was not documented as administered for the evening dose on 12/6/24, 12/19/24, 12/10/24, 12/24/24 through 12/27/24 and 12/31/24 (18 days), -Seroquel (100 mg) was refused for the morning dose on 12/14/24 through 12/16/24 (3 days), -Seroquel (100 mg) was refused for the evening dose on 12/14/24 through 12/18/24, 12/21/24 through 12/23/24 and 12/28/24 and 12/28/24 through 12/30/24 (24 days), -Seroquel (100 mg) was documented as administered by Staff #4 for the morning and evening dose on 12/11/24, 12/2/24, 12/7/24 through 12/32/24 (5 days), -Seroquel (100 mg) was documented as administered by Staff #5 for the morning dose on 12/3/24 and 12/28/24 (5 days), -Seroquel (200 mg) was not documented as administered by 12ff #5 for the morning dose on 12/3/24 and 12/24/24 (2 days), -Seroquel (200 mg) was not documented as administered by 12ff #4 for the evening dose on 12/5/24, 12/12/24, 12	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
the HM for the morning dose on 12/31/24Clonidine was documented as administered by Staff #4 for the morning dose on 12/21/24 through 12/23/24, 12/28/24 through 12/30/24 (6 days)Seroquel (100 mg) was not documented as administered for the morning dose on 12/5/24, 12/16/24, 12/10/24 through 12/13/24, 12/17/24 through 12/31/24 (21 days)Seroquel (100 mg) was not documented as administered for the evening dose on 12/6/24, 12/19/24, 12/10/24, 12/24/24 through 12/27/24 and 12/31/24 (18 days)Seroquel (100 mg) was refused for the morning dose on 12/14/24 through 12/16/24 (3 days)Seroquel (100 mg) was refused for the evening dose on 12/10/24 through 12/18/24, 12/21/24 through 12/23/24 and 12/31/24 and 12/31/24 and 12/31/24 and 12/31/24 and 12/31/24 and 12/31/24 and 12/31/24, 12/21/24 through 12/23/24 and 12/31/24 (100 mg) was documented as administered by Staff #4 for the morning and evening dose on 12/1/24, 12/12/24, 12/17/24 through 12/92/4 (5 days)Seroquel (100 mg) was documented as administered by Staff #5 for the morning dose on 12/3/24 and 12/31/24 (2 days)Seroquel (200 mg) was refused for the evening dose on 12/324, 12/13/24, 12/13/24 12/13/24, 12/13/24, 12/13/24, 12/13/24 12/13/24, 12/13/	V 118	·		V 118			
		the HM for the more Clonidine was doc Staff #4 for the more through 12/23/24, 1 days). -Seroquel (100 mg) administered for the 12/6/24, 12/10/24 through 12/31/24 (18 days). -Seroquel (100 mg) administered for the 12/19/24, 12/10/24 and 12/31/24 (18 days). -Seroquel (100 mg) dose on 12/14/24 through 12/23/24 ard (24 days). -Seroquel (100 mg) administered by State evening doses on 1 through 12/9/24 (5 days). -Seroquel (100 mg) administered by State evening doses on 1 through 12/9/24 (5 days). -Seroquel (200 mg) administered for the 12/12/24, 12/13/24 through 12/29/24, a days). -Seroquel (200 mg) administered for the 12/12/24, 12/13/24 through 12/29/24, a days). -Seroquel (200 mg) dose on 12/5/24, 12/14/24 through 12/23/24 and 12/30 dose on 12/5/24, 12/14/24 through 13/23/24 and 12/30 dose on 12/5/24, 12/23/24 and 12/30 dose on 12/5/24 and 12/30 dose on 1	ning dose on 12/31/24. umented as administered by rning dose on 12/21/24. 12/28/24 through 12/30/24 (6) was not documented as emorning dose on 12/5/24, hrough 12/13/24, 12/17/24. 21 days).) was not documented as e evening dose on 12/6/24, 12/24/24 through 12/27/24 ays).) was refused for the morning hrough 12/16/24 (3 days).) was refused for the evening hrough 12/18/24, 12/21/24 and 12/28/24 through 12/30/24) was documented as aff #4 for the morning and 12/1/24, 12/2/24, 12/7/24 days).) was documented as aff #5 for the morning dose on 4 (2 days).) was not documented as evening dose on 12/6/24, 12/19/24 12/20/24, 12/24/24 and 12/31/24 (12 days).) was refused for the evening 2/7/24 through 12/11/24, 2/18/24, 12/21/24 through 1/24 (15 days).) was documented as				

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for the morning dose on 12/5/24, 12/6/24,

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. DOILDING.			
		MHL060-648	B. WING		02/2	8/2025
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TURN A	ROUND		TEN COURT _, NC 28227			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 118	12/9/24, 12/11/24 through 12/20/24, 12/31/24 (14 days)Sertraline was refu 12/10/24 and 12/14 -Sertraline was doo Staff #4 on 12/1/24 12/21/24 through 1 12/30/24 (10 days)Sertraline was doo Staff #5 on 12/3/24 Review on 2/10/25 MAR revealed: -Lamictal was not of for the morning dos days)Lamictal was dood Staff #3 for the morning dos days)Lamictal was dood Staff #4 for the morning dos days)Lamictal was dood Staff #4 for the morning 11/4/24, 11/9/24 through 11/18/24, 11/30/24 (12 days)Lamictal was dood Staff #4 for the even 11/3/24, 11/8/24 through 11/17/24, 11/8/24 through 11/17/24, 11/8/24 through 11/13/24, 11/8/24 through 11/13/24, 11/8/24 through 11/13/24, 11/8/24 through 11/13/24, 11/8/24 through 11/22/24, 11/8/24, 11/13/24 through 11/22/24, 11/8/24 through 11/22/24	hrough 12/13/24, 12/18/24 12/24/24 through 12/27/24 and used for the morning dose on 1/24 through 12/17/24 (5 days). cumented as administered by 1, 12/2/24, 12/7/24, 12/8/24, 2/23/24, 12/28/24 through cumented as administered by 12/4/24 (2 days). of client #2's November 2024 documented as administered se on 11/1/24 and 11/29/24 (2 documented as administered se on 11/1/24, and 11/30/24 (2 documented as administered se on 11/29/24 and 11/30/24 (2 documented as administered se on 11/29/24 through rough 11/11/24, 11/16/24 11/23/24, 11/24/25 and	V 118			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILDING:			
	MHL060-648	B. WING		02/2	8/2025
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
TURN AROUND		TEN COURT			
		L, NC 28227			
PREFIX (EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 118 Continued From pa	ige 36	V 118			
days)Cetirizine was doc Staff #3 for the mor 11/12/24 and 11/19 -Cetirizine was doc Staff #4 for the mor 11/4/24, 11/9/24 thr through 11/18/24, 1 11/30/24 (13 days)Cetirizine was doc Staff #5 for the mor 11/8/24, 11/13/24 through 11/22/24, 1 days)Metformin was doc the morning dose or days)Metformin was doc Staff #3 for the mor 11/12/24, and 11/19 -Metformin was doc Staff #4 for the mor and 11/9/24 through 11/18/24, 11/23/24 (12 days)Metformin was doc Staff #4 for the eve 11/3/24, 11/8/24 through 11/17/24 ar (12 days)Metformin was doc Staff #5 for the mor 11/8/24, 11/13/24 through 11/13/24 through 11/13/24 ar (12 days).	umented as administered by rning dose on 11/5/24, //24 (9 days). umented as administered by rning dose on 11/2/24 through rough 11/11/24, 11/16/24 1/23/24 through 11/25/24 and umented as administered by rning dose on 11/6/24 through rough 11/15/24, 11/20/24 1/26/24 through 11/28/24 (12 cumented as administered for n 11/1/24 and 11/29/24 (2 cumented as administered for n 11/29/24 and 11/30/24 (2 cumented as administered by rning dose on 11/5/24,	V 118			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLI	ETED
MHL060-648 B. WING 02/28	3/2025
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
TURN AROUND 9709 BATTEN COURT	
MINT HILL, NC 28227	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118 Continued From page 37 days). -Clonidine was refused for the morning dose on 11/27/24, 11/28/24, 11/30/24 (3 days). -Clonidine was documented as administered by Staff #3 for the morning dose on 11/5/24, 11/12/24, and 11/19/24 (3 days). -Clonidine was documented as administered by Staff #4 for the morning dose on 11/2/24 through 11/12/24, 11/19/24 through 11/12/24, 11/19/24 through 11/12/24, 11/19/24 through 11/16/24 through 11/18/24, 11/19/24 through 11/16/24 through 11/18/24, 11/19/24 through 11/15/24, 11/19/24 through 11/15/24, 11/13/24 through 11/15/24, 11/12/02/4 through 11/22/24, 11/26/24 (10 days). -Seroquel (100 mg) was not documented as administered for the morning dose on 11/29/24 and 11/29/24 (2 days). -Seroquel (100 mg) was not documented as administered for the evening dose on 11/29/24 and 11/30/24 (2 days). -Seroquel (100 mg) was documented as administered for the evening dose on 11/29/24 and 11/30/24 (2 days). -Seroquel (100 mg) was documented as administered by Staff #3 for the morning dose on 11/22/24, 11/19/24, and 11/19/24 (3 days). -Seroquel (100 mg) was documented as administered by Staff #4 for the morning dose on 11/22/24, 11/19/24, and 11/19/24 (3 days). -Seroquel (100 mg) was documented as administered by Staff #4 for the morning dose on 11/2/24, 11/19/24, 41/19/24 (3 days). -Seroquel (100 mg) was documented as administered by Staff #4 for the morning dose on 11/2/24 through 11/18/24, 11/19/24 (1 days). -Seroquel (100 mg) was documented as administered by Staff #4 for the evening dose on 11/10/24, 11/15/24 through 11/18/24, 11/19/24 (1 days). -Seroquel (100 mg) was documented as administered by Staff #4 for the evening dose on 11/19/24 through 11/18/24, 11/18/24 through 11/18/	

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	MHL060-648		B. WING		02/2	8/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
TURN AF	POLIND	9709 BAT	TEN COURT			
TORNAI	COOND	MINT HILL	, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
V 118	and 11/30/24 (2 day-Seroquel (200 mg) administered by Sta 11/1/24 through 11/11/10/24, 11/16/24, 11/24/24 (11 days)Sertraline was not for the morning dos through 11/30/24 (2-Sertraline was doc Staff #4 for the morn 11/4/24 (2 days)Sertraline was doc Staff #5 for the morn 11/4/24 (2 days)Sertraline was doc Staff #5 for the morn 11/4/24 (2 days)Sertraline was doc Staff #5 for the morn 11/4/24 (2 days)Sertraline was doc Staff #5 for the morn 11/4/24 (2 days)Sertraline was doc Staff #5 for the morn 11/4/24 (2 days)Sertraline was doc Staff #5 for the morn 11/4/24 (2 days)Sertraline was doc Staff #5 for the morn 11/4/24 (2 days)Sertraline was doc Staff #6 for the morn 11/4/24 (2 days)Token edication betwee #2Licensee/QP called office and asked with daily blood sugar of glucometer or the service and asked with daily blood sugar of	e evening dose on 11/29/24 //s). I was documented as aff #4 for the evening dose on 3/24, 11/8/24 through 11/17/24, 11/22/24 through documented as administered se on 11/1/24, 11/5/24, 11/7/24 //s days). I umented as administered by ming dose on 11/2/24 through umented as administered by ming dose on 11/6/24. I dose on 11/	V 118	DEFICIENCY)		
		aff #4] or [Staff #3] give medications; in the evening				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	SURVEY LETED
71101 1211	OF CONTROLLED FOR	A. BUILDING:				
	MHL060-648		B. WING		02/2	8/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TURN AF	ROUND		TEN COURT L, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 39	V 118			
	-Had never refused refused meds; now	medications, "No, I never I'm confused."				
	Interview on 2/14/29 revealed:	5 with the Licensee/QP				
	MARs as "[Staff #3, Staff #4, HM]."	out some of staff initials on Associate Professional (AP),				
	on those dates to p the initial is missing					
	-"[Client #2] is not a diabetic, she is pre-diabetic. She takes Metformin, that's for prediabetes. I need to check with the doctor for clarification, but there should be documentation if she is checking					
	her blood sugar."	g				
	Interview on 2/24/29 revealed:	5 with the Licensee/QP				
	-Was not aware wh	ether staff were administering d 200mg doses of Seroquel to				
		ook at it (client #2's MAR). I explanation might be for why were not given."				
	I'll ask when it (Sero and I'll have to get a	acy sent a discontinue order. oquel 100mg) was stopped a discontinue order for that; I y the 100 milligram (Seroquel)				
	that was discontinu- -"She (client #2) wil sugar) herself; I will	ed." I be able to check that (blood get the doctor to write the				
		peen taking blood sugar vit's not documented."				
	revealed:	5 with the Licensee/QP				
		or from the doctor regarding uation order for Seroquel				

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, OTY, STATE_ZIP CODE 9709 BATTEN COURT MINT HILL, NC 28227 MAY JOD PREFER SUMMARY STATEMENT OF DEFICIENCIES JD PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEPICENCY MAST BIE PRECEDED BY PLAL) PREFER PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEPICENCY MAST BIE PRECEDED BY PLAL) PREFER PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEPICENCY MAST BIE PRECEDED BY PLAL) PREFER PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEPICENCY MAST BIE PRECEDED BY PLAL) PREFER PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEPICENCY MAST BIE PRECEDED BY PLAL) PREFER PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEPICENCY) PREFER BE PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEPICENCY) PREFER BE PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEPICENCY) PREFER BE PLAN OF CORRECTION SHOULD BE (EACH DEPICENCY) PREFER BE PLAN OF CORRECTION SHOULD BE (EACH DEPICENCY) PREFER BE PLAN OF CORRECTION SHOULD BE (EACH DEPICENCY) PREFER BE PLAN OF CORRECTION SHOULD BE (EACH DEPICENCY) PREFER BE PLAN OF CORRECTION SHOULD BE (EACH DEPICENCY) PREFER BE PLAN OF CORRECTION SHOULD BE (EACH DEPICENCY) PREFER BE PLAN OF CORRECTION SHOULD BE (EACH DEPICENCY) PREFER BE PLAN OF CORRECTION SHOULD BE (EACH DEPICENCY) PREFER BE PLAN OF CORRECTION SHOULD BE (EACH DEPICENCY) PREFER BE PLAN OF CORRECTION SHOULD BE (EACH DEPICENCY) PREFER BE PLAN OF CORRECTION SHOULD BE (EACH DEPICENCY) PREFER BE PLAN OF CORRECTION SHOULD BE (EACH DEPICENCY) PREFER BE PLAN OF CORRECTION SHOULD BE (EACH DEPICENCY) PREFER BE PLAN OF CORRECTION SHOULD BE (EACH DEPICENCY) PREFER BE PLAN OF CORRECTION SHOULD BE (EACH DEPICENCY) PREFER BE PLAN OF CORRECTION SHOULD BE (EACH DEPICENCY) PREFER BE PLAN OF CORRECTION SHOULD BE (EACH DE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, NC 28227 CALL OF THE COURT SUMMARY STATEMENT OF DEFICIENCIES DEACH CORRECTION SHOULD BE (EACH GERICENCY MUST BE PRECEDED BY FULL REQUARDORY OR LES DESTIFYING INFORMATION) TAG V 118				7. BOILDING.			
TURN AROUND MINT HILL, NC 28227 MINT HILL, NC 28227			MHL060-648	B. WING		02/2	8/2025
CALL	NAME OF F	PROVIDER OR SUPPLIER					
V118 Continued From page 40 V118 Continued From page 40 "I spoke with the pharmacy and they (pharmacy) said they never got a discontinue order, they said they had two refills (Seroquel 100mg) and when those ran out, it (Seroquel 100mg) and when those ran out, it (Seroquel 100mg) was not refilled. They clidn't fill the prescription (Seroquel 100mg) in February (2025) because they didn't get a new prescription order (Seroquel 100mg) from the doctor. There were extra medications (Seroquel 100mg) in her (client #2) box (medication) and I asked staff to throw them away. From what the pharmacy is saying, they didn't send the medication (Seroquel 100mg) for February (2025) and it (Seroquel 100mg) was not on the February (2025) and it (Seroquel 100mg) was not on the February (2025) and it (Seroquel 100mg) was discontinued and I will ask him for the drug regimen reviews (requested 2/25/25)." Finding #3 Review on 2/11/25 of client #3's record revealed: -Signed physician orders dated 10/31/24 for the following medications: -Clonidine (hypertension) HCL 0.1 mg tablet, take one tablet by mouth at bedtime as directedDepakote ER (mood) 500mg tablet, take one tablet by mouth at bedtime as directed. Observation on 2/10/25 at approximately 1:16pm of client #3's medication revealedClonidine HCL 0.1 mg tablet, take one tablet by mouth wice daily as directed (dispense date 1/27/25)Clonidine HCL 0.1 mg tablet, take one tablet by mouth wice daily as directed (dispense date 1/27/25)Clonidine HCL 0.1 mg tablet, take one tablet by mouth wice daily as directed (dispense date 1/27/27)Clonidine HCL 0.1 mg tablet, take one tablet by mouth wice daily as directed (dispense date 1/27/27)Clonidine HCL 0.1 mg tablet, take one tablet by mouth wice daily as directed (dispense date 1/27/27)Clonidine HCL 0.1 mg tablet, take one tablet by	TURN AF	ROUND					
-"I spoke with the pharmacy and they (pharmacy) said they never got a discontinue order, they said they had two refills (Seroquel 100mg) and when those ran out, it (Seroquel 100mg) and when those ran out, it (Seroquel 100mg) are they didn't get a new prescription order (Seroquel 100mg) in February (2025) because they didn't get a new prescription order (Seroquel 100mg) from the doctor. There were extra medications (Seroquel 100mg) in her (client #2) box (medication) and I asked staff to throw them away. From what the pharmacy is saying, they didn't send the medication (Seroquel 100mg) for February (2025) and it (Seroquel 100mg) for February (2025) and it (Seroquel 100mg) was not on the February (2025) and it (Seroquel 100mg) was discontinued and I will ask him for the drug regimen reviews (requested 2/25/25)." Finding #3 Review on 2/11/25 of client #3's record revealed: -Signed physician orders dated 10/31/24 for the following medications: -Clonidine (hypertension) HCL 0.1mg tablet, take one tablet by mouth wice daily as directedDepakote ER (mood) 500mg tablet, take one tablet by mouth at bedtime as directedTrazadone (depression) 100mg tablet, take one tablet by mouth at bedtime as directedClonidine HCL 0.1 mg tablet, take one tablet by mouth twice daily as directed (dispense date 1/27/25)Clonidine HCL 0.1 mg tablet, take one tablet by mouth twice daily as directed (dispense date 1/27/25)Clonidine HCL 0.1 mg tablet, take one tablet by mouth twice daily as directed (dispense date 1/2/27/4)Clonidine HCL 0.1 mg tablet, take one tablet by mouth twice daily as directed (dispense date 1/2/27/4)Clonidine HCL 0.1 mg tablet, take one tablet by	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	JLD BE	COMPLETE
mouth twice daily as directed (dispense date 12/30/24; handwritten blue "bedtime" sticker in	V 118	-"I spoke with the p said they never got they had two refills those ran out, it (Se refilled. They didn't 100mg) in February get a new prescript from the doctor. The (Seroquel 100mg) is (medication) and I away. From what the didn't send the medication are gimen reviews (refinding #3 Review on 2/11/25 - Signed physician of following medication - Clonidine (hypertegimen reviews (refinding #3 Review on 2/11/25 - Signed physician of following medication - Clonidine (hypertegimen tablet by mouth at become tablet	harmacy and they (pharmacy) a discontinue order, they said (Seroquel 100mg) and when eroquel 100mg) was not if fill the prescription (Seroquel / (2025) because they didn't ion order (Seroquel 100mg) here were extra medications in her (client #2) box asked staff to throw them he pharmacy is saying, they dication (Seroquel 100mg) for dit (Seroquel 100mg) was not 225) MAR. I am waiting to talk out when it (Seroquel 100mg) and I will ask him for the drug equested 2/25/25)." of client #3's record revealed: orders dated 10/31/24 for the instance of the drug equested 2/25/25)." of client #3's record revealed: orders dated 10/31/24 for the instance of the drug equested 2/25/25)." of client #3's record revealed: orders dated 10/31/24 for the instance of the drug equested 2/25/25)." of client #3's record revealed: orders dated 10/31/24 for the instance of the drug equested 2/25/25)." of client #3's record revealed: orders dated 10/31/24 for the instance of the drug equested 2/25/25)." of client #3's record revealed: orders dated 10/31/24 for the instance of the drug equested 2/25/25)." of client #3's record revealed: orders dated 10/31/24 for the instance of the drug equested 2/25/25)." of client #3's record revealed: orders dated 10/31/24 for the instance of the drug equested 2/25/25)." of client #3's record revealed: orders dated 10/31/24 for the instance of the drug equested 2/25/25)." of client #3's record revealed: orders dated 10/31/24 for the instance of the drug equested 2/25/25)."	V 118			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
	MHL060-648				02/2	28/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
TURN A	ROUND		TEN COURT L, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	JLD BE	(X5) COMPLETE DATE
V 118	mouth at bedtime a 12/2/24; empty bub -Trazodone 100 mg mouth at bed time a 12/30/24; blue "bed corner)Depakote SOD 50 bedtime as directed Review on 2/10/25 MAR (2/1/25-2/10/2-Clonidine was doc Staff #4 for the mor 2/3/25, 2/8/25 throu-Clonidine was doc Staff #5 for the eve 2/8/25, and 2/9/25 (-Clonidine was doc Staff #5 for the eve -Depakote was doc Staff #4 for the eve 2/8/25, and 2/9/25 (-Trazodone was do Staff #4 for the eve 2/8/25, and 2/9/25 (-Trazodone was do Staff #4 for the eve 2/8/25, and 2/9/25 (-Trazodone was do Staff #4 for the eve 2/8/25, and 2/9/25 (-Clonidine was refu 1/16/25Clonidine was doc the HM for the mor 1/22/25 (2 days)Clonidine was doc the HM for the mor 1/22/25 (2 days)Clonidine was doc the HM for the mor 1/22/25 (2 days)Clonidine was doc	g tablet, take one tablet by a directed (dispense date ble pack) tablet, take one tablet by as directed (dispense date time" sticker in upper right 0 mg tablet, take one tablet at d. of client #3's February 2025 through as administered by ming dose on 2/1/25 through and 2/10/25 (6 days). The stablet at d. umented as administered by ming dose on 2/2/25, 2/3/25, 4 days). The stablet as administered by ming dose on 2/4/25 through the stablet as administered by ming dose on 2/4/25. The stablet as administered by ming dose on 2/2/25, 2/3/25, 4 days). The stablet as administered by ming dose on 2/2/25, 2/3/25, 4 days). The stablet as administered by ming dose on 2/2/25, 2/3	V 118	DEFICIENCY)		

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Division of Health Service Regulation		1				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` ′	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		MHL060-648	B. WING	B. WING		8/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
IVAIVIL OF I	NOVIDEN ON GOLL FIELD		TEN COURT			
TURN AF	ROUND		L, NC 28227			
			1			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
V 118	Continued From pa	ne 42	V 118			
V 110	·	_	V 110			
		umented as administered by				
		ning dose on 1/28/25.				
		umented as administered by				
		ning dose on 1/4/25 through				
		ugh 1/13/24, 1/18/25 through				
		ough 1/27/25 (12 days). umented as administered by				
		ning dose on 1/4/25.				
		umented as administered by				
		ning dose on 1/1/25, 1/2/25,				
		/25, 1/16/25, 1/23/25, 1/30/25				
	and 1/31/25 (9 days					
		umented as administered by				
		ning dose on 1/23/25, 1/25/25				
	and 1/27/25 (3 days					
	-Clonidine was doci	umented as administered by				
	Staff #11 for the eve	ening dose on 1/15/25 and				
	1/24/24 (2 days).					
	-Depakote was refu 1/29/25.	sed for the evening dose on				
		umented as administered by				
		ning dose on 1/4/24.				
		umented as administered by				
		ening dose on 1/24/25.				
		cumented as administered by				
		ning dose on 1/4/25.				
		cumented as administered by ening dose on 1/4/25.				
	Stall #11 for the eve	ening dose on 1/4/25.				
	.Review on 2/10/25	of client #3's December 2024				
	revealed:					
	-No MAR for Decen	nber 2024.				
		of client #3's November 2024				
	MAR revealed:					
		documented as administered				
		e on 11/1/24 and 11/29/24 (2				
	days).					
		umented as administered by ning dose on 11/5/24,				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	MHL060-648		B. WING		02/2	8/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TURN AF	ROUND		TEN COURT _, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 118	Staff #4 for the mor 11/4/24, 11/9/24 thr through 11/18/24, 1 11/30/24 (13 days)Clonidine was doc Staff #4 for the eve 11/3/24, 11/8/24 thr through 11/17/24, 1 days)Clonidine was doc Staff #5 for the mor 11/8/24, 11/13/24 through 11/22/24, 1 days)Clonidine was doc Staff #5 for the eve -Depakote was doc Staff #4 for the eve 11/3/24, 11/8/24 thr through 11/17/24 at (12 days)Trazodone was do Staff #4 for the eve 11/3/24, 11/8/24 thr through 11/17/24, 1 days).	/24 (3 days). umented as administered by rning dose on 11/2/24 through ough 11/11/24, 11/16/24 1/23/24 through 11/25/24 and umented as administered by ning dose on 11/1/24 through ough 11/10/24, 11/15/24 1/22/24 through 11/24/24 (12 umented as administered by rning dose on 11/6/24 through 11/15/24, 11/20/24 1/26/24 through 11/28/24 (12 umented as administered by rning dose on 11/1/24, 11/20/24 1/26/24 through 11/128/24 (12 umented as administered by ning dose on 11/11/24. sumented as administered by ning dose on 11/1/24 through ough 11/10/24, 11/15/24 and 11/22/24 through 11/24/24 cumented as administered by ning dose on 11/1/24 through ough 11/10/24, 11/15/24 1/23/24 and 11/24/24 (11	V 118			
		with client #3 revealed: medications on time and was of medications.				
	-Did not know medione of them, trazoc are for behavior, sle anxiety pill. I had ar know what triggere	5 with client #3 revealed: cations, "I think clonidine? Is lone? Think they (medications) eep or both. I think I take an anxiety attack today; I don't d it."				

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	(X3) DATE SURVEY COMPLETED	
MHL060-648 B. WING 02/28/	/2025	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
TURN AROUND 9709 BATTEN COURT MINT HILL, NC 28227		
(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 REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
V 118 [Staff #4] gives evening (medications); weekends, I don't remember" -Never refused medications, "sometimes I don't want to take (medication), but I do." Finding #4 Review on 2/11/25 of client #4's record revealed: -Signed physician orders dated 6/20/24 for the following medications: Dexatoamp-Amphetamine (concentration/ADHD) ER 20mg 24 hr capsule, extended release, take 1 capsule by mouth daily in the morningSigned physician orders dated 7/17/24: Seroquel (depression) 100mg, take one tablet by mouth daily as directed. Seroquel fomg, take one tablet by mouth at bedtime as directedSigned physician orders dated 8/20/24: Prozac 20mg (mood/depression) Pulvule capsule, take one capsule by mouth daily in the morning as directed. Observation on 2/10/25 at approximately 12:26pm of client #4's medication revealed: -Adderall ER 20 mg, take one capsule by mouth every mouthSeroquel 100 mg tablet, take tablet mouth every day as directedProzac HCL 20 mg capsule, take one capsule by mouth every morning as directedSeroquel 50 mg tablet, take one tablet by mouth at bedtime as directed. Review on 2/10/25 of client #4's February 2025 MAR (2/1/25-2/10/25) revealed: -Adderall was documented as administered by Staff #4 for the morning dose on 2/1/25 through 2/3/25, 2/8/25 through 2/10/25 (6 days)Adderall was documented as administered by		

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
TURN AROUND 9709 BATTEN COURT MINT HILL, NC 28227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE CROSS-REFERENCED TO THE APPROPRIATE DATE	MHL060-648		B. WING		02/2	8/2025	
TURN AROUND MINT HILL, NC 28227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE CROSS-REFERENCED TO THE APPROPRIATE DATE	NAME OF PROVIDER OR SUPPLIER	ER STREET A	.DDRESS, CITY, S	STATE, ZIP CODE			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	TURN AROUND	9709 BA	TTEN COURT				
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	TOWN AROUND	MINT HI	LL, NC 28227				
	PREFIX (EACH DEFICIENC)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	.D BE	(X5) COMPLETE DATE	
V118 Continued From page 45 2/5/25 (2 days). -Prozac was documented as administered by Staff #4 for the morning dose on 2/1/25 through 2/3/25 and 2/8/25 through 2/10/25 (6 days). -Prozac was documented as administered by Staff #5 for the morning dose on 2/4/25 and 2/5/25 (2 days). -Seroquel (100mg) was documented as administered by Staff #5 for the morning dose on 2/10/25 (6 days). -Seroquel (100mg) was documented as administered by Staff #5 for the morning dose on 2/10/25 (6 days). -Seroquel (100mg) was documented as administered by Staff #5 for the morning dose on 2/4/25 and 2/5/25 (2 days). -Seroquel (50mg) was documented as administered by Staff #4 for evening dose on 2/2/25, 2/23/25, 2/8/25 and 2/9/25 (4 days). Review on 2/10/25 of client #4's January 2025 MAR revealed: -Adderall was documented as administered by the HM for the morning dose on 1/10/25 and 1/22/25 (2 days). -Adderall was documented as administered by Staff #3 for the morning dose on 1/4/25 through 1/30/25, 1/18/25 through 1/30/25, 1/18/25 through 1/30/25, 1/18/25 through 1/30/25, 1/18/25, 1/23/25, and 1/30/25 (6 days). -Prozac was documented as administered by Staff #3 for the morning dose on 1/1/25. -Prozac was documented as administered by Staff #3 for the morning dose on 1/1/25. -Prozac was documented as administered by Staff #3 for the morning dose on 1/1/125. -Prozac was documented as administered by Staff #3 for the morning dose on 1/1/125. -Prozac was documented as administered by Staff #3 for the morning dose on 1/1/125. -Prozac was documented as administered by Staff #3 for the morning dose on 1/11/25. -Prozac was documented as administered by Staff #3 for the morning dose on 1/11/25. -Prozac was documented as administered by Staff #3 for the morning dose on 1/11/25. -Prozac was documented as administered by Staff #4 for the morning dose on 1/11/25.	2/5/25 (2 days)Prozac was docum Staff #4 for the mode 2/3/25 and 2/8/25 theorem and 2/5/25 (2 days)Seroquel (100mg) administered by Sta 2/1/25 through 2/3/ (6 days)Seroquel (100mg) administered by Sta 2/4/25 and 2/5/25 (100mg) administered by Sta 2/4/25 and 2/5/25 (100mg) administered by Sta 2/4/25, 2/23/25, 2/23/25, 2/23/25, 2/23/25, 2/23/25, 2/23/25, 2/23/25, 2/23/25, 2/23/25, 2/23/25 (2 days)Adderall was docum the HM for the mode 1/22/25 (2 days)Adderall was docum Staff #4 for the mode 1/6/25, 1/11/25 through 1/6/25, 1/16/25, 1/14/25, 1/16/25, 1/14/25 through 1/6/25	cumented as administered by morning dose on 2/1/25 through 2/10/25 (6 days). Cumented as administered by morning dose on 2/4/25 and and ang) was documented as Staff #4 for the morning dose on 2/3/25 and 2/8/25 through 2/10/25 ang) was documented as Staff #5 for the morning dose on 2/5 (2 days). Staff #4 for evening dose on 2/8/25 and 2/9/25 (4 days). Staff #4 for evening dose on 2/8/25 and 2/9/25 (4 days). Staff #4 for evening dose on 2/8/25 and 2/9/25 (4 days). Staff #4 for evening dose on 1/10/25 and 1/10/25 and 1/10/25 and 1/10/25 and 1/10/25 and 1/10/25 and 1/10/25 through 1/13/25, 1/18/25 through 1/13/25, 1/18/25 through 1/13/25, 1/18/25 through 1/13/25, 1/18/25 through 1/13/25, and 1/30/25 (6 days). Succumented as administered by morning dose on 1/8/25, 1/9/25, 3, 1/23/25, and 1/30/25 (6 days). Succumented as administered by Staff and dose on 1/7/25. Sumented as administered by Staff and dose on 1/7/25. Sumented as administered by Staff and dose on 1/7/25. Sumented as administered by Staff and dose on 1/7/25. Sumented as administered by Staff and dose on 1/7/25. Sumented as administered by Staff and dose on 1/7/25. Sumented as administered by Staff and dose on 1/7/25.	ff				

through 1/27/25 (9 days).

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
			B. WING		02/	28/2025
NAME OF	PROVIDER OR SUPPLIER	9709 BAT	TEN COURT	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
V 118	-Prozac was docum Staff #5 for the mor 1/16/25 , 1/23/25 ar -Prozac was docum HM for the morning (2 days)Seroquel (100mg) administered for the 1/24/25, 1/31/25 (3 -Seroquel (100mg) administered by the 1/10/25, 1/22/25 (2 -Seroquel (100mg) administered by Sta 1/7/25Seroquel (100mg) administered by Sta 1/4/25 through 1/6/1/18/25 through 1/6/1/18/25 through 1/2 (12 days)Seroquel (100mg) administered by Sta 1/8/25, 1/9/25, 1/14 (6 days)Seroquel (50mg) wadministered for the 1/24/25 and 1/31/25 -Seroquel (50mg) wadministered by the 1/11/25 and 1/12/25 -Seroquel (50mg) wadministered by Sta 1/4/25 and 1/5/25 (5 Review on 2/10/25 MAR revealed: -Adderall was docuthe HM for the morro-Adderall was docuthe IM for the morro-Adderall was docuthe I	nented as administered by ming dose on 1/9/25, 1/14/25, and 1/30/25 (5 days). The nented as administered by the dose on 1/10/25 and 1/22/25 was not documented as a morning dose on 1/21/25, days). Was documented as aff #3 for the morning dose on days). Was documented as aff #4 for the morning dose on 25, 1/11/25 through 1/13/25, 20/25, 1/25/25 through 1/27/25 was documented as aff #5 for the morning dose on 1/25 1/16/25, 1/23/25 1/30/25 was not documented as a evening dose on 1/3/25, as documented as a HM for the evening dose on 5 (2 days). Was documented as a HM for the evening dose on 3 was documented as a HM for the evening dose on 3 (2 days). Was documented as a HM for the evening dose on 3 (2 days). Was documented as a HM for the evening dose on 3 (2 days).	V 118			

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DIVISION	of Health Service Re	guiation				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		MHL060-648	B. WING		02/28/2025	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TURN A	ROUND		TEN COURT L, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 47	V 118			
	12/9/24, 12/14/24 th through 12/23/24, 1 days)Adderall was docu Staff #5 for the mor 12/4/24, 12/10/24 th through 12/20/24 (9-Prozac was not do the morning dose o-Prozac was docum Staff #4 for the mor through 12/9/24, 12/21/24 through 12-Prozac not docume #5 for the morning 12/10/24 through 12/20/24 (8 days)Prozac was refuse 12/28/24 through 12/31/24Seroquel (100mg) administered by Sta 12/1/24, 12/7/24 thr through 12/16/24, 1 12/28/24 through 12-Seroquel (100mg) administered by Sta 12/1/24, 12/18/24 through 12-Seroquel (50mg) wadministered for the Seroquel (50mg) wadministered by Sta 12/1/24, 12/7/24, 12/18/24 through 12-Seroquel (50mg) wadministered by Sta 12/1/24, 12/18/24, 12	prough 12/16/24, 12/21/24 2/28/24, and 12/30/24 (11) mented as administered by ning dose on 12/2/24 through prough 12/12/24 and 12/18/24 days). Cumented as administered for n 12/31/24 mented as administered by ning dose on 12/1/24, 12/7/24 mented as administered by ning dose on 12/1/24, 12/7/24 mented as administered by ning dose on 12/1/24, 12/7/24 mented as administered by Staff dose on 12/2/24, 12/3/24, 12/18/24 through defor the morning dose on 12/2/24, 12/3/24, 12/12/24, 12/18/24 through defor the morning dose on was documented as aff #4 for the morning dose on 12/30/24 (13 days). was documented as aff #5 for the morning dose on 2/10/24 through 12/12/24, and 2/20/24 (8 days). was documented as aff #5 for the morning dose on 2/10/24 through 12/12/24, and 2/20/24 (8 days). was not documented as a evening dose on 12/31/24. was documented as aff #4 for the evening dose on 2/8/24, 12/15/24 through 12/22/24, and 12/28/24				

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Review on 2/10/25 of client #4's November 2024

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STATEME	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	SURVEY LETED
7412 1 274	VOI CONTRACTION	BERTH IO WIOTROWNER.	A. BUILDING:			
		MHL060-648	B. WING		02/28/2025	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TURN A	ROUND		TEN COURT L, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 118	for the morning dos days)Adderall was docu the Manager for the -Adderall was docu Staff #3 for the mor 11/12/24, 11/19/24 -Adderall was docu Staff #4 for the mor 11/4/24, 11/9/24 thr 11/17/24, 11/23/24 12/30/24 (12 days)Adderall was docu Staff #5 for the mor 11/8/24, 11/13/24 through 11/22/24, 1 days)Adderall was docu Staff #6 for the mor -Prozac was not do the morning dose or -Prozac was docum House Manager for -Prozac was docum Staff #3 for the mor 11/12/24, 11/19/24 -Prozac was docum Staff #4 for the mor 11/4/24, 11/9/24 thr through 11/18/24, 1 11/30/24 (13 days)Prozac was docum Staff #5 for the mor 11/8/24, 11/13/24 thr through 11/13/24 through 11/12/24, 1 days)Seroquel (100mg)	ocumented as administered e on 11/1/24 and 11/29/24 (2 mented as administered by morning dose on 11/31/24. mented as administered by ning dose on 11/5/24, (3 days). mented as administered by ning dose on 11/2/24 through ough 11/11/24, 11/16/2, through 11/25/24, and mented as administered by ning dose on 11/6/24 through 11/26/24 through 11/28/24 (12 mented as administered by ning dose on 11/18/24. cumented as administered by ning dose on 11/18/24. cumented as administered by ning dose on 11/18/24. cumented as administered by the the morning dose on 11/31. mented as administered by ning dose on 11/5/24, (3 days). mented as administered by ning dose on 11/2/24 through ough 11/11/24, 11/16/24 1/23/24 through 11/25/24, and	V 118			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	MHL060-648	B. WING		02/2	8/2025
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TURN AROUND		TEN COURT L, NC 28227			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
administered by the 11/31/24 (30 days in 11/31/24 (30 days in 11/31/24, 11/12/24 and seroquel (100mg) administered by St. 11/2/24 through 11/21/24 through 11/25/24 and seroquel (100mg) administered by St. 11/6/24 through 11/25/24 and seroquel (100mg) administered by St. 11/6/24 through 11/28/24 (100mg) administered for the seroquel (50mg) administered for the seroquel (50mg) administered by St. 11/10/24, 11/10/24, 11/15/24 through 11/24/24 (100mg) administered by St. 11/10/24, 11/15/24 through 11/25/24. Title of Residentianella distribution.	was documented as a HM for the morning dose on n November). was documented as aff #3 for the morning dose on nd 11/19/24 (3 days). was documented as aff #4 for the morning dose on 4/24, 11/9/24 through through 11/18/24, 11/23/24 and 11/30/24 (13 days). was documented as aff #5 for the morning dose on 8/24, 11/13/24 through through 11/22/24, 11/26/24 I2 days). was not documented as a evening dose on 11/29/24 ys). was documented as aff #4 for the evening dose on 13/24, 11/8/24 through through 11/17/24 and 11/22/24 ys). was on 2/7/25 and 2/24/24 with accessful because she had "yes" to all questions or "no" of Staff #1's record revealed: I Counselor. ed training for medication of Staff #3's record revealed:	V 118			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND LITHIN	O. CONNECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COIVIP	1 0
		MIII 000 040	B. WING		00/0	0/0005
		MHL060-648	D. WINO		02/2	8/2025
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TURN AF	ROUND		TEN COURT L, NC 28227			
	OUR MAA DV CTA		1			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
V 118	Continued From page 50		V 118			
	administration.					
	-Hired 1/29/24. -Title of Residential	of Staff #5's record revealed: Counselor. ed training for medication				
	Review on 2/13/25 of Staff #6's record revealed: -Hired 12/22/24Title of Residential CounselorHad no documented training for medication administration.					
	-Hired 7/10/24. -Title of Residential	of Staff #7's record revealed: Counselor. ed training for medication				
	-Hired 6/10/24. -Title of Residential	of Staff #9's record revealed: Counselor. ed training for medication				
	-Hired 11/20/24. -Title of Residential	of Staff #11's record revealed: Counselor. ed training for medication				
	-Hired 11/5/24. -Title of House Man	of HM's record revealed: ager. ed training for medication				
	Review on 2/25/25 Nursing website rev	of the North Carolina Board of realed:				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL060-648	B. WING		02/28/2025	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TURN AF	ROUND		TEN COURT _, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CONTROL OF THE PROPERTY OF T	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 51	V 118			
	-Nurse/Trainer who Licensee/QP identified as providing the medication administration training was a Licensed Practical Nurse (LPN). Interview on 2/13/25 with the Nurse/Trainer/Licensed Practical Nurse (LPN) revealed: -"Yes, I am the one that done the actual training." -"I have a sign in log I can provideI will send that to you by noon (2/14/25)."					
	provided by a Regis	stration training can only be stered Nurse (RN).				
	revealed:	with Former Staff #1				
		r staff had training to distribute ations to the clients"				
	-On a typical day, ".	with Staff #1 revealed: and I'll do (administer) meds				
		after me will do meds." ve medications, not sure				
	when but I think it w -He had not given n	as in January (2025)." nedications and without t aware of other staff				
	-"When I first starte	cations without training. d he (Licensee/QP) would ng my shift that was already				
	certified to do meds of December (2024	b. I was trained either the end or beginning of January her the name of the trainer;				
	yes, she was a nurs					
	-Did not administer aware of any staff a without training.	with Staff #2 revealed: medications and was not dministering medications meds 7am to 7pm and				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL060-648	B. WING		02/28/2025	
NAME OF I				STATE, ZIP CODE	UZIZ	0/2023
NAME OF I	PROVIDER OR SUPPLIER		TEN COURT	,		
TURN AF	ROUND		., NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	-Did not know who his shift (second, m -Was not aware of medications or medications aware of administer) meds; sometimes I don't, I care of it (medications -Was not aware of administration without administer meds, the -No medication issultimedications or medications or medications. Attempted contact or requested assistant and left voice messions. Interview on 2/13/25 -"I do meds (administer medications in; on the wedo it (administer medications) it (administer medication). [Clinical Director training, it's (training weeks ago." -"I did it (training) weeks ago." -"I did it (training) weeks ago." -"Yes, I document in medications of the period of	own) comes in to administer." administered medications on addishift 12-8pm). medication refusals, missed dication errors. 5 with Staff #3 revealed: s are done properly, give sometimes I do and because third shift will take on administration)" staff doing medication out training, "everybody has be are only two shifts that hird and second shifts." Les, "not on my shift, not when with Staff #4 on 2/13/25 and the from Licensee/QP. Called the age, no return call. with Staff #5 on 2/13/25 and the from Licensee/QP. Called the age, no return call. 5 with Staff #8 revealed: ister medications) when I first the elications. I got training on it bor/QP (CD/QP)] did the go been about a couple of then I first came, I don't keep training), they have it at the a copy and keep it in my	V 118			
		lity staff] and [HM] are usually				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		MHL060-648	B. WING		02/	28/2025
NAME OF	PROVIDER OR SUPPLIER	9709 BAT	DRESS, CITY, S TEN COURT L, NC 28227	TATE, ZIP CODE		
(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) COMPLETE DATE
V 118	already there, I only -Was not aware of a medications who we was in the medication were trained; a black Yes, she was a nurse but it was kept at the Interview on 2/14/22-"part of my duties but I haven't started medication administion name], a company the last company I was a copy of the certification." -"[Licensee/QP] saidless. I know how the want to sign the body certification." -"I provided him (Licertifications." -"I don't know anyou (staff) have their trainave to take the class. I have to take the class. I have seen to the company of the certification of the certification of the certification of the certification." -"I don't know anyou (staff) have their trainave to take the class. I have seen to take the class of the certification of the certification of the certification of the certification of the certification." -"I don't know anyou (staff) have their trainave to take the class of the certification of the cer	know about first shift." staff administering ere not trained, "everybody on meeting and I think they ok lady provided the training. se; yes, she gave a certificate, e office." with Staff #10 revealed: s is to pass (administer) meds that yetI did take the tration through [Company that does virtual class through worked for. I've been trying to ertificate for that training." d he'll just have me take his to pass meds, but I just didn't ok (MAR) without the copy of censee/QP) with all my he here, so I don't know if they lining for med administration; I	V 118			

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Division	of Health Service Re	egulation	1		1	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL060-648	B. WING		02/2	8/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TURN AF	ROUND		TEN COURT L, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
	-"I'm qualified to giv -"No one has admir training, no, everybe -Was not aware of e "they (clients) take and try again (if clients) take works." -"[Licensee/QP] keet the office, he has a certification in the our and are all the control of t	epted my license (CNA)." re medications." nistered medications without ody has training." client refusal of medications, e medicationI walk away ent refuses) and usually that eps copies of my training in copy of my license and ffice." 25), I am still administering 5 with the Associate ed:				
	Professional revealed: -Was not aware of staff doing administering medication without trainingIf it is left blank, staff may have gone home, "that means the consumer got the medications, but there is not time to complete the MAR" and the MAR will need to be left empty, "and another shift will come and check (to see if the client got their medication)." -"If there is no initial (staff), notify staff (that worked that shift)." -"I document on the MAR, as soon as you see consumer taking medscall the consumer (client) one at a time and you see them take it (medication). Some (clients) in the past put it (medication) under their tongue; if they refuse, I document it." -Was not aware of missed medications, refusals or medication errors. Interview on 2/19/25 with the CD/QP revealed:					

medications without training.

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DIVISION	of Health Service Re	guiation				
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL060-648	B. WING		02/28/2025	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TURN A	ROUND		TEN COURT L, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 55	V 118			
	oversight by employ training and have a to them, but there is (training) put into provide that that errors donus and have been no refuse that that errors donus and have been no refuse the training of the training and have been no refuse the medication on those dates to put the initial (staff) is not aware of the initial (staff) is not aware that the medication administration training. "The training was of trainer) agreed to the to find another nurse training a month agonic amount agonic medication administration administration administration administration and month agonic amount agonic medication administraining a month agonic amount agonic medication administraining a month agonic medication administration training a month agonic medication admin	ecks MARs monthly to ensure it continue to occur." minister medications, there als or medication errors." 5 and 2/14/25 with the led: nsible for reviewing the MARs. periodically." refusals and documentation is MARs. ok and see who was working rovide an explanation of why missing (on the MAR)." answer for all of them (MAR); to see why they (clients) didn't is staff had medication ing in January 2025. It an RN had to provided the tration training for staff. In 12/30/24, we (he and the interest of the inter				

medications...we got a training coming up and I

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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	
		MHL060-648	B. WING		02/	28/2025
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE		
IONNAN	COULD	MINT HIL	L, NC 28227			
(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) COMPLETE DATE
V 118	Due to failure to acc administration, it co clients received the the physician. Review on 2/28/25 signed by the CD/Q "What immediate arensure the safety or -An immediate revier requesting a medica attending psychiatri request of all currer pharmacy. These ron 02/28/2025 by th (CD/QP). Describe your plans happens. The agency is implet to address medication. Review of all MA Administration Recand Nurse will exame errors or discrepance administration. This the correct medicat times, and that any 2. Training Review ongoing or refreshe in medication admin focus on understan	curately document medication and not be determined if ir medications as ordered by of the initial Plan of Protection and dated 2/28/25 revealed: ction will the facility take to fee the consumers in your care? and fill medication to include ation review from the st, review of all MAR's, and and medication scripts from the request will be made beginning the agency's Clinical Director as to make sure the above the ementing a thorough process ion administration errors. AR's (Medication ords): The Clinical Director and all MAR's to identify any cies in medication as review will help ensure that ion is given at the proper mistakes are caught. The Nurse will provide are training to all staff involved instration. This training will ding MAR legends, ensuring how to accurately interpret and	V 118			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL060-648	B. WING		02/2	8/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
TURN AF	ROUND	* * * * * - * * * * * * * * * * * * * *	TEN COURT			
	T		L, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 118	V 118 Continued From page 57		V 118			
	review will also add medication errors. aware of how to rep	ress proper responses to any This ensures that staff are port, manage, and correct any romptly to minimize harm and				
	Review on 2/28/25 of the amended Plan of Protection signed by the CD/QP and dated 2/28/25 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? -Effective 02/28/2025 Clinical Director [CD/QP] will begin seek a Registered Nurse to perform all Medication Administration Trainings and to consult with the agency (facility) on MAR and medication reviewEffective 02/28/2025 AP [AP] will administer all AM and PM medications.					
	happens. The agency is impleto address medicat 1. Review of all MA Administration Recand Nurse (RN) will any errors or discreadministration. 2. Training Review	ords): The Clinical Director l examine all MAR's to identify pancies in medication The Nurse (RN) will provide training to all staff involved				
	to 17 years, with dia Attention-Deficit/Hy Disorder, Oppositio Unspecified Trauma Adjustment Disorde	peractivity, Major Depressive nal Defiant Disorder, a Stressor Related Disorder,				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL060-648	B. WING		02/28/2025	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TURN AF	ROUND		TEN COURT _, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
V 118	Disorder. The faciliparaprofessional st document medications the written orders of total number of day medications was appeared to clients #1, # through 2/10/25, ind 410 days that medicadministered to client of refusals of medication the facility (client follow labeling guide medication. Clients never contacted an medications or refusals every 6 month medications. The acconstitutes a Type A	phrenia and other Psychotic ity failed to train 9 aff to administer and ons on client MARs, following f the clients' physician. The s untrained staff administered oproximately 154. Medication 2, #3, #4), from 11/1/24 cluded a total of approximately cation was not documented as ents, approximately 121 days extions, medication not present #1, #2, #3), and failure to elines (client # 4) for s' physician or pharmacist was d made aware of the missed sals and did not ensure that had a drug regimen review at as for psychotropic actions of the facility A1 rule violation for serious	V 118			
V 121	least every 6 months for psychotropic medications. The actions of the facility constitutes a Type A1 rule violation for serious neglect and must be corrected in 23 days. 27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable		V 121			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
			A. BOILDING.			
		MHL060-648	B. WING		02/2	28/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TURN A	ROUND		TEN COURT L, NC 28227			
(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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 121	Continued From pa	nge 59	V 121			
	Based on records recipion facility failed to ensing review at least ever (#2, #3 and #4) who will be findings are: Review on 2/11/25 - Admission date 3/2 - Age 17. -Diagnoses: Major Recurrent; Attentio (ADHD), Combined Disorder; Unspecific Disorder. -Physician's ordersion-Lamictal (mood (mg), take one tabled - Clonidine (AD (extended release) mouth once daily. -Seroquel (deputablet daily by mouth a sertraline (deputablets by mouth dare a service of client #2 - Service of cl	Depressive Disorder, n-Deficit/Hyperactivity Disorder Type; Oppositional Defiant ded Trauma Stressor Related dated 2/19/24: d stabilization) 100 milligram et by mouth twice daily. HD) HCL (hydrochloric acid) Er 0.1 mg, take three tablets by ression) 100 mg, take one th. pression) 100 mg, take two aily. umentation of a drug regimen dimen reviews were not				
	-Admission date 12 -Age 14.	of client #3's record revealed: 2/12/22. tment Disorder, Mixed;				

Division of Health Service Regulation

STATE FORM 6899 2ZN611 If continuation sheet 60 of 104

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X3 DATE SURVEY COMPLETED	<u>Division</u>	of Health Service Re	egulation				
NAME OF PROVIDER OR SUPPLIER TURN AROUND STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, NC 28227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				
TURN AROUND 9709 BATTEN COURT MINT HILL, NC 28227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)			MHL060-648	B. WING		02/2	8/2025
TURN AROUND MINT HILL, NC 28227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
	TURN A	ROUND					
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY)	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
Disturbance of Emotions and Conduct; Attention-Deficit Hyperactivity Disorder, Hyperactive Type; Disappearance and Death of a Family MemberPhysician's orders dated 10/31/24: -Depakote (mood) ER 500mg, take one tablet by mouth at bedtimeTrazadone (depression) 100mg, take one tablet by mouth at bedtimeThere was no documentation of a drug regimen review for client #3. Client #3's drug regimen reviews were not received by the survey exit date. Review on 2/11/25 of client #4's record revealed: -Admission date 6/14/24Age 16Diagnoses: Attention-Deficit/Hyperactivity Disorder, Inattentive Type; Oppositional Defiant Disorder, Intellectual Developmental Disability Disorder, Mild; Unspecified Mood Disorder; Unspecified Schizophrenia Spectrum and other Psychotic DisorderPhysician order dated 6/20/24: -Dexatoamp-Amphetamine (concentration/ADHD) ER 20mg, take 1 capsule by mouth daily in the morning, -Physician order dated 7/17/24: -Quetiapine Fumarate (depression) 100mg, take one tablet by mouth daily, -Quetiapine Fumarate Somg, take one tablet by mouth aliy in the morning, -Physician order dated 8/20/24: -Prozac (mood/depression) 20mg, take one capsule by mouth daily in the morningThere was no documentation of a drug regimen review for client #4.	V 121	Disturbance of Emo Attention-Deficit Hy Hyperactive Type; I Family MemberPhysician's orders -Depakote (mo- by mouth at bedtim -Trazadone (de tablet by mouth at be- There was no docureview for client #3. Client #3's drug regreceived by the survey for client #3. Client #3's drug regreceived by the survey for client #3. Client #3's drug regreceived by the survey for client #3. Client #3's drug regreceived by the survey for client #3. Client #3's drug regreceived by the survey for client #3. Client #3's drug regreceived by the survey for client #3. Client #3's drug regreceived by the survey for client #3. Client #3's drug regreceived by the survey for client #3. Client #3's drug regreceived by the survey for client #3. Client #3's drug regreceived by the survey for client #3. Client #3's drug regreceived by the survey for client #3. Client #3's drug regreceived by the survey for client #3. Client #3's drug regreceived by the survey for client #3. Client #3's drug regreceived by for client #3.	otions and Conduct; peractivity Disorder, Disappearance and Death of a dated 10/31/24: od) ER 500mg, take one tablet e. pression) 100mg, take one bedtime. Lumentation of a drug regimen dimen reviews were not vey exit date. of client #4's record revealed: 14/24. ion-Deficit/Hyperactivity e Type; Oppositional Defiant al Developmental Disability pecified Mood Disorder; phrenia Spectrum and other ated 6/20/24: mphetamine ated 6/20/24: mphetamine ated 7/17/24: marate (depression) 100mg, mouth daily. marate 50mg, take one tablet e. ted 8/20/24: depression) 20mg, take one laily in the morning. Lumentation of a drug regimen	V 121			

Client #4's drug regimen reviews were not
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED		
		MHL060-648	B. WING		02/2	19/2025
		WITIL000-046			02/2	28/2025
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TURN A	ROUND		FTEN COURT .L, NC 28227			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU	LD BE	(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY))PRIATE	DATE
V 121	Gommana Francisco		V 121			
	received by the sur	•				
	Professional (QP) r					
	-Was aware that all clients had medications reviewed by psychiatrist, "the end of January." Interview 2/26/25 with the Licensee/QP revealed: -"I am waiting to talk to the doctor and will ask					
	him for the drug reg	gimen reviews."				
		ross referenced into 10A Medication Requirements				
		1 rule violation and must be				
V 123	27G .0209 (H) Med	ication Requirements	V 123			
	10A NCAC 27G .02 REQUIREMENTS	09 MEDICATION				
	and significant adve	rs. Drug administration errors erse drug reactions shall be				
	reported immediate pharmacist. An enti	ely to a physician or ry of the drug administered				
	in the drug record.	on shall be properly recorded A client's refusal of a drug				
	shall be charted.					
	This Rule is not me	et as evidenced by:				
		views, observation, and				

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6899 2ZN611 If continuation sheet 62 of 104

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL060-648	B. WING		02/28/2025	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TURN AF	ROUND		TEN COURT			
	OLIMANA DV. OTA		L, NC 28227		ON.	4.5
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 123	Continued From page 62		V 123			
	interviews, the facility failed to ensure all medication administration errors were reported immediately to a pharmacist or physician affecting 4 of 4 clients (#1, #2, #3, #4). The findings are:					
	Review on 2/11/25 of client #1's record revealed: -Admission date 1/30/25Age 15.					
	-Diagnoses: Attention-Deficit/Hyperactivity Disorder (ADHD), Combined Presentation; Major Depressive Disorder, Recurrent Episode, Moderate.					
	-Had no signed phy	sician orders.				
	Observation on 2/14/25 at approximately 8:48am of client #1's medications revealed: -Vyvanse (ADHD) 30 milligrams (mg), 1 capsule in mornings (empty bottle). -Clonidine (ADHD) 0.2 mg tablet, 1 tablet at bedtime.					
	morning.	DHD) 2 mg, 1 tablet in epression) 5 mg, 1 tablet by				
	-Cetirizine (allemorning.	rgy) 10 mg, 1 tablet in onate (allergy) 50				
	(micrograms) mcg, night.	1 spray in each nostril at				
	available in the faci					
	Client #1 did not ha (2/1/25 through 2/1	ve a MAR for February 2025 0/25).				
	revealed:	of client #1's January MAR				
	administered on 1/3	s not documented as 30/25 and 1/31/25				

Division of Health Service Regulation

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DIVISION	of Health Service Re	guiation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		MHL060-648	B. WING		02/28/2025	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			TEN COURT			
TURN AF	ROUND		L, NC 28227			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	NC NC	(X5)
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				,		
V 123	Continued From page 63		V 123			
	Doxycycline wa	s not documented as				
		30/25 and 1/31/25 for the				
	evening dose.					
	N					
		that administration errors were				
	physician.	ed to a pharmacist or				
	priyololari.					
	Review on 2/11/25 of client #2's record revealed: -Admission date 3/28/24Age 17.					
		Depressive Disorder,				
		Combined Type; Oppositional				
	Related Disorder.	nspecified Trauma Stressor				
	-Physician's order of	lated 12/19/24:				
		d stabilization) 100 mg, take				
	one tablet by mouth					
		rgy) 10 mg , take one tablet by				
	mouth daily.					
		betes/pre-diabetes) 500 mg,				
	take two tablets by					
		HD) HCL (hydrochloric acid) se) 0.1 mg, take three tablets				
	by mouth once daily	, -				
	•	ression) 100 mg, take one				
	tablet daily by mout					
		ression) 100 mg, take two				
	tablets by mouth da					
		er for Seroquel (depression)				
	bedtime.	ablet daily by mouth at				
	bealine.					
	Review on 2/10/25	of client #2's 11/1/24 through				
	2/10/25 MARs reve					
		proximately 17 days total):				
		ot documented as				
		6/25 and 2/7/25 for the				
	morning doses (2 d					
	Lamictai was n	ot documented as				

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DIVISION	Of Fleatur Service IN	i Squiation	1			
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		MHL060-648	B. WING		02/2	8/2025
		WITE060-648			02/2	0/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		9709 BAT	TEN COURT	•		
TURN AF	ROUND	MINT HIL	L, NC 28227	•		
(V4) ID	QUIMMADV QTA	TEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX	=	/ MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIES		DATE
				DEFICIENCY)		
V 123	Continued From no	ugo 64	V 123			
V 123	Continued From pa	ige 04	V 123			
	administrated on 2/	7/25 for the evening dose.				
	Cetirizine was r	not documented as				
	administrated on 2/	6/25 and 2/7/25 (2 days).				
		not documented as				
		6/25 and 2/7/25 for the				
	morning doses (2 d					
		not documented as				
		7/25 for the evening dose .				
		not documented as				
		1/25, 2/6/25 through 2/10/25				
	for the morning dos					
		not documented as				
		1/25, 2/6/25, and 2/7/25 for				
	the morning dose (3					
		roximately 153 days total) :				
		ot documented as				
		1/25 through 1/3/25, 1/15/25,				
		/28/25 and 1/29/25 for the				
	morning dose (8 da	ot documented as				
		3/25, 1/10/25 through 1/12/25,				
		19/25, 1/25/25, 1/26/25,				
		n 1/31/25 for the evening dose				
	(12 days)					
		not documented as				
		1/25 through 1/3/25, 1/17/25,				
		29/25 for the morning dose				
	(7 days).					
		not documented as				
		1/25 through 1/3/25, 1/7/25,				
		/21/25, 1/23/25, 1/24/25,				
		5 for the morning dose (11				
	days).					
		not documented as				
		3/25, 1/10/25, 1/12/25,				
		9/25, 1/25/24, 1/26/25,				
	1/29/25 through	n 1/31/25 for the evening dose				
	(11 days).					
	Clonidine was r	not documented as				
	administrated on 1/	1/25 through 1/3/25, 1/15/25,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		SURVEY PLETED	
		MHL060-648	B. WING		02/2	28/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, S	TATE, ZIP CODE	-	
TUDN A	DOLIND	9709 BAT	TEN COURT			
TURN A	ROUND	MINT HIL	L, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 123	Continued From page 65		V 123			
	1/17/25, 1/21/25, 1/morning dose (8 da Clonidine was ron 1/4/25 through 1 Seroquel 100 m administrated on 1/1/9/25, 1/14/25 through 1/24/25, 1/2 the morning dose (31 d Seroquel 100 m administrated on 1/evening dose (31 d Seroquel 200 m administrated on 1/13/25, 1/18/25 through 1/17/25, 1/21/28/25, 1/29/25 and dose (15 days). Seroquel 200 m morning dose on 1/through 1/13/25, 1/125/25 through 1/2 Sertraline 00 m administrated on 1/1/17/25, 1/21/25, 1/25, 1/25, 1/25, 1/25, 1/25, 1/25, 1/25, 1/25, 1/25, 1/25, 1/25, 1/25, 1/25, 1/25, 1/25, 1/	28/25, and 1/29/25 for the tys). refused for the morning dose /6/25 (3 days). reg was not documented as 1/25 through 1/3/25, 1/8/25, rugh 1/17/25, 1/21/25 (28/25, 1/29/25 and 1/31/25 for 17 days). reg was not documented as 1/25 through 1/31/25 for the reg was refused for the morning rugh 1/6/25, 1/11/25 through 1/20/25 (9 days). reg was refused for the morning rugh 1/6/25, 1/11/25 through 1/20/25 (1/25 through 1/3/25, 1/14/25 (1/25 through 1/3/25, 1/14/25 (1/25 through 1/6/25, 1/11/25 (1/25 through 1/6/25, 1/11/25 (1/25 through 1/6/25, 1/11/25 (1/25 through 1/6/25, 1/11/25 (1/25 through 1/3/25, 1/15/25, 1/25 (1/25 through 1/3/25, 1/15/25, 1/25 through 1/3/25, 1/15/25, 1/25/24, 1/28/24 for the morning of documented as 1/5/24, 1/2/13/24, 1/2/14/24, 1/2/26/24 through 1/2/29/24				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		MHL060-648	B. WING		02/2	8/2025
NAME OF PRO	VIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TURN AROU	JND		TEN COURT ., NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
on 12 12 12 12 12 12 12 14 14 14 17 16 16 16 16 16 16 16 16 16 16 16 16 16	2/16/24 (6 days). Lamictal was rec/7/24 through 12/2/18/24, 12/24/24 Lamictal was rec/9/24, 12/14/24, 12/16/24, 12/10/24, 12/16/24, 12/10/24, 12/16/24, 12/17/24, 12/25/24 for evening cetirizine was rec/9/24/24 throring dose (13 days). Metformin was dministered on 12/27/26/24, 12/13/24, 1and 12/24/24 through 12/13/24, 1and 12/24/24 through 12/31/24 for days). Metformin was dministered on 12/27/26/24, and 12/24/24 through 12/31/24 for days). Metformin was a 12/17/24 and 12/26/26/24, and 12/26/26/26/26/26/26/26/26/26/26/26/26/26	12/9/24 and 12/14/24 through afused for the evening dose on 12/24, 12/15/24 through and 12/25/24 (12 days). If used on 12/7/24, 12/8/24, 12/15/24, and 12/16/24 for ys); If used on 12/7/24, 12/8/24, 12/11/24, 12/12/24, 12/15/24, 12/11/24, 12/12/24, and g dose (12 days). In the documented as 15/24, 12/6/24 12/10/24 12/17/24 through 12/19/24 12/19/24, 12/20/24, 12/24/24 12/19/24, 12/20/24, 12/24/24 12/19/24, 12/20/24, 12/24/24 12/10/24 12/19/24, 12/20/24, 12/24/24 12/10/24 12/19/24, 12/20/24, 12/24/24 12/10/24 12/19/24, 12/20/24, 12/24/24 12/19/24, 12/20/24, 12/24/24 12/19/24, 12/20/24, 12/24/24 12/19/24, 12/20/24, 12/24/24 12/19/24, 12/20/24, 12/24/24 12/19/24, 12/20/24, 12/24/24 12/19/24, 12/20/24, 12/24/24 12/19/24, 12/19/24 12/19/24 12/19/24 12/19/24 12/19/24 through 12/18/24 (4 12/14/24 through 12/27/24 for the 12/24 through 12/27/24 for the 12/24, 12/14/24	V 123			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL060-648	B. WING		02/2	8/2025
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TURN A	ROUND		TEN COURT _, NC 28227			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 123	through 12/13/24, 1 the morning dose (2 Seroquel 100 m administered on 12 12/24/24 through 12 evening dose (8 da Seroquel 100m dose on 12/14/24 th Seroquel 100m dose on 12/10/24 th through 12/23/24 at (15 days). Seroquel (200 m administered on 12 12/19/24, 12/20/24, 12/29/24, and 1 (12 days). Seroquel (200 m evening dose on 12 12/11/24, 12/14/24 through 12/23/24 at Sertraline was administered on 12 12/11/24 through 12 12/11/24 through 12 12/20/24, 12/24 12/31/24 for the more Sertraline was administered on 12 days). November 2024 total): Lamictal was madministered on 11 morning dose (2 da Lamictal was madministered on 11 evening dose (2 da Cetirizine was madministered on 11 evening dose (2 da Cetirizine was madministered on 11 evening dose (2 da Cetirizine was madministered on 11 evening dose (2 da	2/17/24 through 12/31/24 for 21 days). ng was not documented as /6/24, 12/19/24, 12/10/24, 2/27/24 and 12/31/24 for the ys). g was refused for the morning nrough 12/16/24 (2 days). g was refused for the evening nrough 12/18/24, 12/21/24 and 12/28/24 through 12/30/24 mg) was not documented as /6/24, 12/12/24, 12/13/24, 12/24/24 through 12/31/24 for the evening dose mg) was refused for the 2/5/24, 12/7/24 through through 12/18/24, 12/21/24 and 12/30/24 (15 days). not documented as /5/24, 12/6/24, 12/18/24 through 12/27/24 and orning dose (14 days). refused for the morning dose /14/24 through 12/17/24 (5 4 (approximately 43 days of documented as /1/24 and 11/29/24 for the lys). not documented as /1/24 and 11/29/24 for the lys). not documented as /1/24 and 11/29/24 for the lys). not documented as /1/24 and 11/29/24 for the lys). not documented as /1/24 and 11/29/24 for the lys). not documented as /1/24 and 11/29/24 for the lys).	V 123			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL060-648	B. WING	B. WING		8/2025
NAME OF I	PROVIDER OR SUPPLIER		I.	STATE, ZIP CODE	1 02/2	0/2020
NAME OF I	- NOVIDEN ON SOFFEIEN		TEN COURT			
TURN AF	ROUND		_, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
V 123	Clonidine was radministered on 11, morning dose (2 da Seroquel 200 madministered on 11, evening dose (2 da Sertraline was radministered on 11, 11/30/24 for mornin Clonidine was ron 11/27/24, 11/28/2 Seroquel 100 madministered on 11, morning dose (2 da Seroquel 100 madministered on 11, evening dose (2 da No documentation immediately reporter physician. Review on 2/10/25 -Admission date 12 -Age 14Diagnoses: Adjust Disturbance of Emol Hyperactive Type; Examily MemberPhysician's orders -Clonidine (hypone tablet by mouth -Depakote ER (by mouth at bedtim)	not documented as (1/24 and 11/29/24 for the tys). Ing was not documented as (29/24 and 11/30/24 for the tys). Inot documented as (1/24, 11/5/24, 11/7/24 through tys). Inot documented as (1/24, 11/5/24, 11/7/24 through tys). Ing dose (26 days). Ing was (26 days). Ing was not documented as (1/24 and 11/29/24 for the tys). Ing was not documented as (1/29/24 and 11/30/24 for the tys). Ing was not documented as (1/29/24 and 11/30/24 for the tys). Ithat administration errors were that administration errors were that a pharmacist or In the documented as (1/2/22). Ithat administration errors were that administration error erro	V 123			
	2024-January, 2025	of Client #3's November, 5 MARs revealed: refused for the evening dose				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		MHL060-648	B. WING		02/2	8/2025
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TURN A	ROUND		TEN COURT L, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 123	on 1/16/25. Depakote was on 1/29/25. Clonidine was administered for the 11/29/24. No documentation immediately reporter physician. Review on 2/11/25Admission date 6/2-Age 16Diagnoses: ADHE Oppositional Defiar Developmental Dis Unspecified Mood I Schizophrenia Specified M	refused for the evening dose not documented as e morning dose on 11/1/24 and that administration errors were ed to a pharmacist or of client #4's record revealed: 14/24. O, Inattentive Type; nt Disorder; Intellectual ability Disorder, Mild; Disorder; Unspecified ctrum and other Psychotic luation dated 4/16/24 notedlimited effective use of often say 'yeah, yeah' in lestion but did not seem to e question as she would often h, yeah' if asked the opposite." entration/ADHD) 20mg, take 1 daily in the morning dated ression) 100mg, take one ly dated 7/17/24. g, take one tablet by mouth at	V 123			
	2024-January, 2025					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMF	SURVEY
		MHL060-648	B. WING		02/2	28/2025
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TURN A	ROUND		TEN COURT _, NC 28227			
(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 CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF T	ULD BE	(X5) COMPLETE DATE
V 123	January 2025 (6 da Prozac was ref (3 days). Seroquel 50 mg administered on 1/3 the evening dose (3 December 2024 (4 Prozac was ref 12/30/24 (2 days). Prozac was not on 12/31/24. Seroquel 50 mg administered on 12 November 2024 (6 Adderall was not administered on 11 morning dose (2 da Prozac was not on 11/1/24 for the n Seroquel 100 n administered on 11 Seroquel 50mg administered on 11 Seroquel 50mg administered on 11 evening dose (2 da No documentation immediately reported physician. Review on 2/7/25 or revealed: -There was no doctor physician was con the seroquel and the seroquel for the seroq	nys total): used on 1/4/25 through 1/6/25 g was not documented as 3/25, 1/24/25 and 1/31/25 for 3 days). days total): used on 12/28/24 through t documented as administered g was not documented as //31/24 for the evening dose. days total): ot documented as //1/24 and 11/29/24 for the ays). t documented as administered norning dose. ng was not documented as //1/24 for the morning dose. g was not documented as //1/24 for the morning dose. g was not documented as //1/24 for the morning dose. g was not documented as //29/24 and 11/30/24 for the ys). that administration errors were ed to a pharmacist or of the facility's records umentation that a pharmacist ontacted regarding clients #1 ed medications and refusals. 5 and 2/25/25 with client #1 medications and was not	V 123			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			SURVEY LETED
		MHL060-648	B. WING		02/2	8/2025
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TURN A	ROUND		TEN COURT L, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 123	Continued From pa	ge 71	V 123			
	was not sure if med completed.	lication regimen was				
	revealed: -Took medications, had missed "when whole day; staff will	medications, "No, I never				
	Interview on 2/10/25 and 2/24/25 with client #3 revealed: -Had never refused medications"sometimes I don't want to take (medication), but I do."					
	client #4 were unsu	vs on 2/7/25 and 2/24/24 with accessful because she had "yes" to all questions or "no"				
	revealed: -"she (client #2) n medications)" -"The person that a (medications) that o	day didn't sign (initial)" sed to be 'X', maybe refused				
	Professional reveal -"if (medication) is	5 with the Associate ed: s refused we document it'R' ent on back of the MAR'X' is				
	Professional reveal	5 with the Licensee/Qualified ed: R, "means medication was not				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL060-648	B. WING		02/2	8/2025
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	_	
TURN AI	ROUND		TEN COURT _, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 123	given or can be a cithat should be docu MAR. X' means ref takenHad not made report I didn't know I was selectedDid not contact clies prescribing pharmal"I don't know why tellow the contact clies prescribing pharmal"I wouldn't have maken (client #1)'s prescribent that that a script. I didres prescribing doctor, med order from her pharmacy." This deficiency is contact.	lient refusal of medication, but amented on the back of the fusal, it was definitely not ort to doctor or pharmacy, "no supposed to." ent #1's physician or cy regarding medications. hey (staff) left it (MAR) blank. ed (medication) orders from vious provider. It is my when you have a pill bottle, n't follow up with the but I will. I'll have to get her	V 123			
V 133	G.S. §122C-80 CRI CHECK REQUIRED APPLICANTS FOR (a) Definition As a "provider" applies to program and any position of the program and any position of the program and any position of the provider is lices. (b) Requirement A provider licensed un applicant to fill a position of the provider applicant to have an conditioned on constitution of the provider of the provider applicant to the provider applicant applican		V 133			

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DIVISION	Division of Health Service Regulation						
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED	
		MHL060-648	B. WING		02/28/2025		
NAME OF I		CTDEET AD		STATE ZID CODE			
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
TURN AF	ROUND		TEN COURT				
	Г		L, NC 28227				
(X4) ID	_	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE	
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPRO		DATE	
				DEFICIENCY)			
V/ 133	Continued From pa	ge 73	V 133				
V 100			V 133				
		een a resident of this State for					
	less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The						
		story record check shall					
		he applicant's fingerprints. If					
		een a resident of this State for					
	five years or more, then the offer is conditioned						
	on consent to a State criminal history record						
		ant. A provider shall not					
		t who refuses to consent to a					
		ord check required by this					
		otherwise provided in this					
		ive business days of making					
		r of employment, a provider est to the Department of					
		114-19.10 to conduct a					
		ord check required by this					
		mit a request to a private					
		State criminal history record					
		his section. Notwithstanding					
		Department of Justice shall					
		national criminal history					
		mployment positions not					
	covered by Public L						
	Department of Hea	lth and Human Services,					
	Criminal Records C	check Unit. Within five					
	business days of re	ceipt of the national criminal					
		n, the Department of Health					
		es, Criminal Records Check					
		provider as to whether the					
		d may affect the employability					
		no case shall the results of the					
		story record check be shared					
		roviders shall make available					
		cation that a criminal history					
		mpleted on any staff covered					
		ounty that has adopted an					
	Lannronriate local or	dinance and has access to					

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		MHL060-648			02/2	8/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TUDNIA	201112	9709 BAT	TEN COURT			
TURN AF	ROUND	MINT HILI	_, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
V 133	Continued From pa	ge 74	V 133			
V 133	the Division of Crimmay conduct on be criminal history reconsection without the request to the Department of the case, the county should be conditional offer of the conditional history is subsection, the term business regularly of the conditional history records obtained from the conditional offers, of the following fact the conditional offers of the conviction.	sinal Information data bank half of a provider a State ord check required by this provider having to submit a artment of Justice. In such a all commence with the State ord check required by this business days of the employment by the provider. Information received by the stial and may not be disclosed, and as provided in subsection for purposes of this in "private entity" means a engaged in conducting ord checks utilizing public orm a State agency. Soplicant's criminal history alls one or more convictions of the provider shall consider all ors in determining whether to be riousness of the crime. Serson at the time of the consider at the consider	V 133			
	(6) The prison, jail, rehabilitation, and e person since the da (7) The subsequent a relevant offense. The fact of convictionshall not be a bar to	probation, parole, employment records of the ate the crime was committed. It commission by the person of on of a relevant offense alone of employment; however, the person of the considered by the provider.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	MHL060-648		B. WING		02/28/2025	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TURN AI	ROUND		TEN COURT _, NC 28227			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ION SHOULD BE COMPLÉTE HE APPROPRIATE DATE	
V 133	If the provider disques consideration of the provider may discle the criminal history to the disqualification of the criminal history to the disqualification of the criminal history applicant. (d) Limited Immunition employee of a procomplies with this scivil liability for: (1) The failure of the individual on the base the criminal history (2) Failure to check criminal offenses if history record check criminal offenses if history record check compliance with this indictment of a criminal history relevant offense relevant offense relevant offense deral criminal history persons needing music disabilities, or subscrimes include the any of the following General Statutes: A Issuing Monetary Sendangering Execuntary of the following General Statutes: A Issuing Monetary Sendangering Execuntary of Damage be Incendiary Device of and Other Housebrother Burnings; Article 6.	ualifies an applicant after e relevant factors, then the se information contained in record check that is relevant on, but may not provide a copy bry record check to the ey A provider and an officer rovider that, in good faith, section shall be immune from the provider to employ an sis of information provided in record check of the individual. It an employee's criminal k is requested and received in	V 133			

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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	
		MHL060-648	B. WING		02/28/2025	
					02/2	.0/2025
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TURN AROUND		TEN COURT _, NC 28227				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 133	Continued From particle Pretenses an Obtaining Property Fraudulent Use of Carticle 19B, Financi Act; Article 20, Frau 26, Offenses Agains Decency; Article 26 Article 27, Prostituti 29, Bribery; Article 35, Office; Article 36A, Article 39, Protection Protection of the Fallntoxication; and Article 39, Protection Protection of the Fallntoxication; and Article 39, Protection Offenses such as saviolation of G.S. 18l impaired in violation G.S. 20-138.5. (f) Penalty for Furni applicant for employ supplies, or otherwi an employment approximinal history reconshall be guilty of a Central Computer of Central States of Central Employment approximinal history reconshall be guilty of a Central Cent	ge 76 d Cheats; Article 19A, or Services by False or Credit Device or Other Means; al Transaction Card Crime ids; Article 21, Forgery; Article ist Public Morality and A, Adult Establishments; on; Article 28, Perjury; Article 31, Misconduct in Public iffenses Against the Public Riots and Civil Disorders; of Minors; Article 40, imily; Article 59, Public iticle 60, Computer-Related is also include possession or ation of the North Carolina ces Act, Article 5 of Chapter tatutes, and alcohol-related is also include possession or ation of the North Carolina ces Act, Article 5 of Chapter tatutes, and alcohol-related is of G.S. 20-138.1 through shing False Information Any yment who willfully furnishes, se gives false information on olication that is the basis for a ord check under this section class A1 misdemeanor. Class A1 misdemeanor. Sloyment A provider may the conditionally prior to so of a criminal history record is applicant if both of the ints are met: all not employ an applicant is applicant's consent for	V 133			
	subsection (b) of th fingerprint cards as	ord check as required in is section or the completed required in G.S. 114-19.10. all submit the request for a				

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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	
		MHL060-648	B. WING		02/	28/2025
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE	-	
TURN AI	SUIND	9709 BA	TTEN COURT			
TOINIT AI	(OOND	MINT HIL	L, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 133	Continued From pa	ge 77	V 133			
	criminal history reco business days after conditional employr 2001-155, s. 1; 200	ord check not later than five the individual begins nent. (2000-154, s. 4; 4-124, ss. 10.19D(c), (h); 4, 5(a); 2007-444, s. 3.)				
	failed to request a d within five business conditional offer of	et as evidenced by: view and interview, the facility criminal history record check days of making the employment for 5 of 13 staff and #10). The findings are:				
	revealed: -Date of hire 1/20/2 -Title of Residential					
	revealed: -Date of hire 10/7/2 -Title of Residential					
	revealed: -Date of hire 7/10/2 -Title of Residential					
	Review on 2/11/25 orevealed: -Date of hire 6/10/2	of Staff #9's personnel file 4.				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL060-648	B. WING		02/2	8/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TURN AF	ROUND		TEN COURT _, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 133	-Title of Residential -Criminal history ch Review on 2/13/25 revealed: -Date of hire 1/28/2 -Title of Residential -No evidence a crim requested. Interview on 2/24/2 Professional (QP) r -Was responsible forminal history che -"it's my understatecheck) doesn't have -When asked about records within 5 but conditional offer emhad no response. This deficiency is c NCAC 27G .0203 C Professionals and A	Counselor. leck requested on 8/7/24. of Staff #10's personnel file 5. Counselor. Ininal history check was 5 with the Licensee/Qualified revealed: In hiring staff and conducting locks. Inding it (criminal history et to be done prior to hire." It requesting criminal history siness days of making a hiployment the Licensee/QP rossed referenced into 10A Competencies of Qualified Associate Professionals Is rule violation and must be	V 133			
V 293	10A NCAC 27G .17 (a) A residential trechildren or adolesce free-standing reside intensive, active the interventions within shall not be the prir who is not a client (b) Staff secure me	eatment staff secure facility for ents is one that is a ential facility that provides erapeutic treatment and a system of care approach. It mary residence of an individual	V 293			

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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		
		MHL060-648	B. WING		02/28/2025	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TURN AF	ROUND		TEN COURT _, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC 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 293	this Section. (c) The population adolescents who had mental illness, emosubstance-related of co-occurring disord disabilities. These not meet criteria for (d) The children or require the following (1) removal fit community-based of facilitate treatment; (2) treatment (e) Services shall be (1) include instructure of daily liv (2) minimized related to functiona (3) ensure sa control behaviors in management with of (4) assist the acquisition of adapt communication, so (5) support the gaining the skills neintensive treatment (f) The residential to shall coordinate with the support of the shall coordinate with the support of the shall coordinate with support of the support of the shall coordinate with support of the suppor	as set forth in Rule .1704 of served shall be children or ave a primary diagnosis of tional disturbance or lisorders; and may also have ers including developmental children or adolescents shall inpatient psychiatric services. adolescents served shall g: from home to a residential setting in order to and in a staff secure setting. The designed to: dividualized supervision and fing; the occurrence of behaviors a deficits; fety and deescalate out of cluding frequent crisis or without physical restraint; child or adolescent in the ive functioning in self-control, cial and recreational skills; and the edded to step-down to a less	V 293	DEFICIENCY)		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			7 50.25 10.			
		MHL060-648	B. WING		02/2	8/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TURN A	ROUND		TEN COURT L, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 293	Continued From pa	ge 80	V 293			
	interviews the faciliassist 4 of 4 clients acquisition of social failed to coordinate of care for 1 of 4 clients. Review on 2/11/25 -Admission date 1/3-Age 15Diagnoses: Attenti Disorder (ADHD), 0 depressive Disorder ModerateEnjoyed cooking a -Treatment Plan 1/3 her coping behavior physical activity and depressive symptons.	views, observation and ty failed to ensure services to (#1, #2, #3, #4) in the I and recreational skills and care within the client's system tents (#2). The findings are: of client #1's record revealed: 30/25. on-Deficit/Hyperactivity Combined presentation; Major er, Recurrent Episode, and doing hair. 28/25 noted, "will increase rs of peer socialization, diself-assurance to decrease ms				
	-Admission date 3/2 -Age: 17Diagnoses: Major Recurrent; ADHD, Defiant Disorder; U Related DisorderLoved animals; en -Treatment Plan 10 clinical assignment healthy boundaries behaviors" - Physician order de	Depressive Disorder, Combined Type; Oppositional nspecified Trauma Stressor				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MIII 000 040	B. WING		00/00/005	
		MHL060-648	1		02/2	8/2025
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TURN AI	ROUND		TEN COURT L, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 293	Continued From pa	ge 81	V 293			
	directed for 90 days - No documentation doctors order for cli	by miscellaneous routes as s. n of coordination to follow ient #2's blood sugar check.				
	Administration Rec thru February 2025	ord (MAR) November 2024 revealed: to follow doctors order for				
	Observation on 2/10/25 at approximately 2:10pm of client #2's medications revealed: -A small black zippered pouch with glucose meter, test strips and an owners manual in client #2's medication box.					
	revealed: -Interaction betwee -Licensee/QP calledoffice and asked will daily blood sugar cliglucometer or the significant #2 responder	ed, "I'm missing stripsI don't time it was checked. I don't				
	Manager revealed: -Was not aware if c sugar checkedWas not able to pr client #2's blood su	and 2/14/25 with the House or when client #2 had blood ovide log documenting dates gar had been checked.				
	Professional reveal -"Normally there are					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL060-648	B. WING		02/2	8/2025
NAME OF PROVIDER OR	SUPPLIER			STATE, ZIP CODE		
TURN AROUND			FEN COURT ., NC 28227			
PREFIX (EACH	DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
and place -"We need #2]'s blood Interview of Licensee/or-"[Client # She takes -"I need to but there is checking of rurther int Licensee/or-"She will herself." -"She has that's why Review or -Admissio -Age 14Diagnose Disturband Hyperactiv Family Me -Enjoyed or -Treatmer and imple skillsage Review or -Admissio -Age 16 ye -Diagnose Opposition Developm	sugar ch d (docum d to create d sugar ci on 2/13/2 QP revea 2] is not a s Metform o check w should be her blood terview or QP revea be able c not been v it's not do n 2/11/25 on date 12 es: Adjust ce of Emo ve Type; I ember. dancing, t on t plan 2/2 ment age e appropr n 2/11/25 on date 6/ ears. es: ADHE nal Defiar nental Dis nental Dis	eck) should be put in a book ented) on back of the MAR." e a book to keep up with [client hecks." 5 and 2/14/25 with the led: a diabetic, she is pre-diabetic. in, that's for pre-diabetes." ith the doctor for clarification, documentation if she is sugar." 1 2/25/25 with the led: heck that (blood sugar) taking blood sugar readings, ocumented." of client #3's record revealed: //12/22. tment Disorder, Mixed otions and Conduct; ADHD, Disappearance and Death of a lelevision, walking outdoors. 20/24 noted, "will develop appropriate communication inte hygiene" of client #4's record revealed:	V 293			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		A. BUILDING.	A. BUILDING:			
	MHL060-648	B. WING		02/2	02/28/2025	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
TURN AROUND		TEN COURT L, NC 28227				
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE	
language deficits, " languagewould oft response to a questic understand the ques respond 'yeah, yeah' -Enjoyed electronics hair and nails doneTreatment Plan 6/7/2 individual and group identifying and develor communication skills relationships Interview on 2/7/25 a revealed: -"I like to do hair, I die -"They (facility) said to yet." -Had no issues with perference." -"I have not declined movies about a week Sunday (2/16/25)." Interview on 2/10/25 revealed: -"We used to go to the bowlingit's been a outing. I think he (Lic Professional-QP) wa (outing/activity) this Sen'ye went to the month that much often." -"I never declined go Interview on 2/7/25 a revealed:	nation dated 4/16/24 notedlimited effective use of ten say 'yeah, yeah' in on but did not seem to truly tion as she would often again if asked the opposite." (cell phone, tablet), getting '24 noted, "will participate in therapy for the purposes of oping positive sbuilding healthy and 2/24/25 with client #1 d [client # 3]'s hair (braids)." they will do activities, but not peers, "they (peers) are just outings, we went to the k ago, I think it was last and 2/24/25 with client #2 ne pool, skating, movies, while, can't remember last pensee/Qualified as planning one Saturday or next Saturday." vies, haven't been doing it	V 293				

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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		
		MHL060-648	B. WING		02/2	8/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TURN A	ROUND		TEN COURT L, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 293	skating; I like bowling. Was unable to recoparticipated in an are "I like spelling and going in places like spoil everybody elser lit's been a long time. Attempted interview client #4 were unauguick responses of to all questions. Interview on 2/7/25 - "The facility does reached to all questions. Interview on 2/7/25 - "The facility does reached to all questions." Interview on 2/7/25 revealed: - "help them with composite (2/12/25), no commosite (2/12/25), movies lagactivities), it's just appointment; they composite with other set day, I don't know." Interview on 2/14/2 - "He (Licensee/QP) (clients) go out on the there have be of"	ng." all the last time she had ctivity. I like to walk outside; not skating, but I go so I don't e's fun. I play in the arcade." me since we went skating." ws on 2/7/25 and 2/24/24 with accessful because she had "yes" to all questions or "no" with Staff #1 revealed: not plan activities, not to my ensee/QP) will do (celebrate) e gift cards for like getting is far as outings, other than not aware of any" and 2/13/25 with Staff #2 okingsince I've been here nunity activities." It to the farm yesterday ast week; they do things	V 293			

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STATE FORM 6899 2ZN611 If continuation sheet 85 of 104

STATEMENT OF DEFICI AND PLAN OF CORREC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MHL060-648	B. WING		02/2	8/2025
NAME OF PROVIDER O	R SUPPLIER			STATE, ZIP CODE		
TURN AROUND			TEN COURT L, NC 28227			
PREFIX (EACH	H DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
somethin clients sa what the anyone so (Licensed used to coll asked to c	aid they did plans (act plans (act plans) (act plans) because of the plans of the p	weekend (2/8/25-2/9/25) and dn't want to go. I don't know ivities) are, and I didn't hear dn't want to go. I asked ause that was something I was clients. I don't usually drive, so eeded to plan to drive" with her grandmother and her not some things for [client #4] clients to do in the facility." 5 with Staff #11 revealed: phones and they look at TV ch cartoons." and 2/14/25 with the House like walking, I walk with them." 5 with the Associate led: nes, cook; except in the winter, the pool, park (summer)." the one to take care of that sometimes he does." as an outing was about two birthday they (clients) may get ocations (sister facility) get	V 293			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	MHL060-648	B. WING	B. WING		/2025	
NAME OF PROVIDER OR SUPPL	ER STREET AL	DRESS, CITY, S	STATE, ZIP CODE			
TURN AROUND		TEN COURT L, NC 28227				
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
(clients) all can our horizon." -"When we (stat lackluster, it's like sheltered and houtings." -"They (clients) confidence to communicate no proactive with in them to practice. Interview on 2/1 Licensee/QP resolution outings"Clients did active swimming, move outings"minimally the twice a month." -"They (clients) and will select wester going (2/14/25)""I send money clients will say the "No, I don't possusually it's last resolution." This deficiency NCAC 27G .020 Professionals and select wester going (2/14/25) and will say the "No, I don't possusually it's last resolution."	ns." It to provide outings when they participate; we need to broaden If) ask, they (clients) are If e pulling teeth; they (clients, build If e pulling teeth; they (clients, build If e pulling teeth; they want If e pulling teeth; they want they If e pulling teeth; they want to do If e pulling teeth; they (clients) and they want to do If e pulling teeth; they (clients) and the staff or If e pulling teeth; they (clients) and the staff or If e pulling teeth; they (clients) and the staff or If e pulling teeth; they (clients) and the staff or If e pulling teeth; they (clients) and they want to do If e pulling teeth; they (clients) are If e pulling teeth; they (clients)	V 293				

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	IT OF DEFICIENCIES		(VO) MULTIPL	E CONSTRUCTION	L(V2) DATE	CLIDVEV
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	LETED
			A. DOILDING.			
		MHL060-648	B. WING		02/2	8/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TIIDN AF	POLIND	9709 BAT	TEN COURT			
TURN AF	ROUND	MINT HILI	L, NC 28227	•		
(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 SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 295	Continued From page 87		V 295			
V 295	27G .1703 Residential Tx. Child/Adol - Req. for A		V 295			
	ASSOCIATE PROF (a) In addition to the specified in Rule .1' facility shall have at staff who meets or an associate profest NCAC 27G .0104(1) (b) The governing facility shall develop policies that specify associate profession policies shall addre (1) management (1) management (2) supervision regarding responsibility implementation of extreatment plan; and	e qualified professional 702 of this Section, each least one full-time direct care exceeds the requirements of sional as set forth in 10A). body responsible for each and implement written the responsibilities of its mal(s). At a minimum these set the following: nent of the day to day no of the facility; on of paraprofessionals bilities related to the each child or adolescent's				
	facility failed to ens	view and interviews, the ure at least one full time direct equirements of an Associate				
	Review on 2/12/25 -Hired 11/16/10. -Job title Associate	of the AP's record revealed: Professional.				
	Interview on 2/13/2	5 with the AP revealed:				

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DIVISION	of Health Service Re	eguiation				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. DUILDING:			
		MHL060-648	B. WING		02/2	8/2025
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TURN AI	DOLIND	9709 BAT	TEN COURT			
TURN A	ROUND	MINT HILI	_, NC 28227			
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 295	Continued From pa	ge 88	V 295			
	-"I'm the APnorma -"I started in 2010 a have another job." "-I work second shift Monday through Th -"I provide clinical s orientation), therape appointments, prov for safety." -"I supervise staff th new hires; I provide show them how the Interview on 2/13/25 revealed: -"I am a residential (at facility) almost 1 -"The AP is [License Professional-QP]." Interview on 2/7/25 Manager revealed: -Was not aware wh Interview on 2/13/25 revealed: -"[AP] is currently of been a while, not su had the position)." -"He works 4 days, and every other Sur considered part-tim This deficiency is on NCAC 27G .0203 C Professionals and A	ally the AP." and work part-time because I ally the AP." and ally 5 pm-11pm." approvision (new staff and care in the home (facility) and is in the home (facility), at is in the home (facility), at training for them on-the-job; acility operates." and 2/21/25 with Staff #3 acounselor, been working there and 2/14/25 with the House and 2/14/25 with the				

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DIVISION	<u>of Health Service Re</u>	egulation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL060-648	B. WING		02/28/2025	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TURN AF	ROUND		TEN COURT _, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 296	Continued From pa	ge 89	V 296			
V 296	27G .1704 Residen Staffing	tial Tx. Child/Adol - Min.	V 296			
	REQUIREMENTS (a) A qualified profit telephone or page. able to reach the fat times. (b) The minimum required when child present and awake (1) two direct one, two, three or for five, six, seven or adolescents; and (3) four direct nine, ten, eleven or adolescents. (c) The minimum reduring child or adolescents. (c) The minimum reduring child or adolescents. (d) two direct and one shall be avechildren or adolescents. (a) two direct and both shall be avechildren or adolescents. (a) three direct can be adolescents. (b) The minimum reduring child or adolescents. (c) The minimum reduring child or adolescents. (d) In addition to the care staff set forth in Rule, more direct cather facility based or	care staff shall be present for our children or adolescents; ct care staff shall be present or eight children or to care staff shall be present for twelve children or twelve staff escent sleep hours is as care staff shall be present wake for one through four ents; care staff shall be present wake for five through eight				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL060-648	B. WING		02/2	8/2025
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TURN AI	ROUND		TEN COURT L, NC 28227			
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 296	(e) Each facility she supervision of child are away from the f child or adolescent needs as specified	all be responsible for ensuring ren or adolescents when they acility in accordance with the sindividual strengths and in the treatment plan.	V 296			
	observations, the faminimum staff ratio or adolescents. The Review on 2/11/25 -Admission date 1/3 -Age 15Diagnoses: Attention Disorder, Combined	views, interviews and acility failed to ensure the of 2 staff for up to 4 children e findings are: of client #1's record revealed:				
	-Admission date 3/2 -Age: 17Diagnoses: Major Recurrent; Attention Disorder, Combined Disorder; Unspecific Disorder.	Depressive Disorder, n-Deficit/Hyperactivity d Type; Oppositional Defiant ed Trauma Stressor Related of client #3's record revealed:				

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DIVISION	of Health Service Re	guiation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` ′	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		MHL060-648	B. WING		02/2	8/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			TEN COURT			
TURN AF	ROUND		L, NC 28227			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	 NN	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
V 296	Continued From pa	ge 91	V 296			
	-Diagnoses: Adjust	ment Disorder, Mixed				
	Disturbance of Emo					
		peractivity Disorder,				
		Disappearance and Death of a				
	Family Member.					
	Paviou on 2/11/25	of client #4's record revealed:				
	-Admission date 6/1					
	-Age 16.	,				
		ion-Deficit/Hyperactivity,				
		ppositional Defiant Disorder;				
		mental Disability Disorder,				
		lood Disorder; Unspecified				
	Schizophrenia Speci Disorder.	ctrum and other Psychotic				
		uation dated 4/16/24 noted				
		limited effective use of				
		ften say 'yeah, yeah' in				
	response to a ques	tion but did not seem to truly				
		stion as she would often again				
	respond 'yeah, yeah	n' if asked the opposite."				
	Observation on 2/10	0/25 from approximately				
	12:55pm to 2:20pm					
	,	s overheard telling the House				
		she (Staff #9) was going to				
		school. Clients #1, #2, #3, the facility with Staff #9 alone				
	at approximately 2:	•				
	a. approximatory 2.0	2 - 10 4.0				
		and 2/24/25 with client #1				
	revealed:	(-11				
		us (clients #1, #2, #3, and #4)				
		(day treatment program)."] before, without staff; not				
	sure how often."	j bolole, without stall, hot				
		own) comes weekly (to				
		who she is, she has short				
		takes us to appointments,				
	just her by herself."					

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MHL060-648	B. WING		02/2	8/2025
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TURN A	ROUND		TEN COURT _, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 296	Continued From pa	ge 92	V 296			
	Interview on 2/10/2 revealed: -"Usually one persor from school." -"There are usually facility)." -"We take [rideshar staff work and don't car; usually every a -One staff member treatment, "[Staff # morning." -"No staff ride with people at school knus, so they keep ar Interview on 2/7/25 revealed: -There are usually 2-"We take [rideshardon't ride with us. (rideshare), [Licens (QP)] or [Day Treat [Day Treatment Product of the content #4 were unsufficient #4 were unsuff	5 and 2/24/25 with client #2 on does transportation to and 2 staff, sometimes 3 staff (in re] every now and then when t have a car or can't use their fternoon to come home." transports clients to day 11] usually takes us in the us in the [rideshare], the low the [rideshare] is taking a eye out." and 2/24/25 with client #3 2 staff on each shift. re] a lot, everyday now; staff They just order them ee/Qualified Professional ment Staff] the principal at ogram]." us on 2/7/25 and 2/24/24 with accessful because she had "yes" to all questions or "no" 5 with Staff #2 revealed: (transport clients) in my car clients; other days it's arranged not sure how (clients are				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL060-648	B. WING		02/	28/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
TURN A	ROHND	9709 BAT	TEN COURT			
TOKNA	KOOND	MINT HIL	L, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 296	revealed: -"I transportI take Program] in the mo their programs. Yes -Wasn't sure if rides clients, "I just know Interview on 2/13/2! -"I do pick up and d the only one that do -"It's just me in the clients)." -"the other day [cl when I went to pick [Licensee/QP] and to be picked up), he speaker, she told hi her a [rideshare] or was last week (2/2/remember what day the week." Interview on 2/25/2! rewealed: -Rideshare used by (facility) are having -"In the morning, he (rideshare) to drop Treatment)." -"Normally [License sets it (rideshare) u program) have roor them (facility clients -"I like to watch their safety reasons." -"He'll (Licensee/QF running late." -"I don't call [rideshare count, he (License)	them to [Day Treatment rning. I take them (clients) to a, I drive them by myself." share was used to transport what I do." 5 with Staff #8 revealed: rop off (day treatment), not out (other staff transport also)." car (when transporting lient #3] wouldn't get in the car them (clients) upcalled let him know (client #3 refused eask to put her (client #3) on im no tooI don't know, he got he brought her home, this 25-2/8/25), no I don't y, it was at the beginning of swith the Day Treatment Staff issues with their vehicles." It (Licensee/QP) use it them (clients) off (at Day e/QP] makes the decision and p; if we (day treatment m in our van, we'll transport sp." of (clients in rideshare) for ease I would he's limit the clients in rideshare) if he's lare] myself, I don't have an				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL060-648	B. WING		02/2	8/2025
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TURN A	ROUND		TEN COURT _, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 296	pay; I'm cheap." -"We're all in this to safety of our childre." Interview on 2/7/25 revealed: -Two people on sta -"[Staff #9] picked u #4) from school alo clients in the backs seat, so no space for the seat, so no space for th	gether, we look out for the en at all cost." and 2/14/25 with the HM If each shift. In the clients (#1, #2, #3, and ne because there were three eat and a client in the front or staff (additional)." If with the Clinical Professional revealed: Staff transport clients to and exare extenuating ensee/QP] will make [rideshare]." by facility, "I would say about companied by staff." aff transport to and from example, I'm not totally sure." a commercial exercise with that exercise with that exercise with that exercise with the exercise with the exercise more proactive with the exercise more proactive with the exercise more proactive with the exercise material exercise with the exercise more proactive with the exercise material exercis	V 296			

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OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		(X3) DATE S	
		A. BUILDING.			
	MHL060-648	B. WING		02/2	8/2025
ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
OUND					
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE DATE
always here (facility picked up." -"They might take [I week, some weeks This deficiency is concared to the concared to the concared to the corrected within 23 This deficiency was	rideshare] once or twice a I might not use it." rossed referenced into 10A Competencies of Qualified Associate Professionals a rule violation and must be days.	V 296			
27G .0603 Incident 10A NCAC 27G .06 RESPONSE REQUENTEGORY A AND (a) Category A and implement written presponse to level I, shall require the profession of individuals involved to element witten in the profession of individuals involved the profession	Response Requirements O3 INCIDENT JIREMENTS FOR DB PROVIDERS B providers shall develop and policies governing their II or III incidents. The policies povider to respond by: to the health and safety needs red in the incident; ng the cause of the incident; g and implementing corrective g to provider specified exceed 45 days; g and implementing measures acidents according to provider respond to exceed 45 days; person(s) to be responsible of the corrections and res; to confidentiality requirements	V 366			
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa always here (facility picked up." -"They might take [i week, some weeks This deficiency is concerted within 23 Professionals and A (V109) for a Type B corrected within 23 This deficiency was 6/30/23, 11/29/23, 2 27G .0603 Incident 10A NCAC 27G .06 RESPONSE REQUE CATEGORY A AND (a) Category A and implement written presponse to level I, shall require the pro (1) attending of individuals involv (2) determining (3) developin measures accordin timeframes not to e (4) developin to preventive measure (5) assigning for implementation preventive measure (6) adhering set forth in G.S. 75, set forth in G.S. 75,	MHL060-648 ROVIDER OR SUPPLIER STREET AD 9709 BAT MINT HIL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 95 always here (facility) when they (clients) are picked up." -"They might take [rideshare] once or twice a week, some weeks I might not use it." This deficiency is crossed referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type B rule violation and must be corrected within 23 days. This deficiency was cited 5 times on 3/13/23, 6/30/23, 11/29/23, 2/21/24, 7/11/24. 27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (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: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;	MHL060-648 B. WING	MHL060-648 MHL060-648 STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, NC 28227 SUMMARY STATEMENT OF DEFICIENCY MINT HILL, NC 28227 SUMMARY STATEMENT OF DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 95 Always here (facility) when they (clients) are picked up." 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The policies shall require the provider to respond by; (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) achering to confidentiality requirements set forth in G. 5, 75, Article 2A, 10A NCAC 26B,	MHL060-648 STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, NC 28227 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 95 Always here (facility) When they (clients) are picked up." 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The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing orders by a signing person(s) to be responsible for implementation of the corrections and preventive measures; (6) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G. S. 75, Article 2A, 10A NCAC 2BB,

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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		
		MHL060-648	B. WING		02/28/2025		
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
TURN AROUND		TEN COURT _, NC 28227					
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 366	Continued From pa	ge 96	V 366				
	164; and (7) maintaining Subparagraphs (a) (b) In addition to the Paragraph (a) of the shall address incident regulations in 42 Classical color of the providers, excluding develop and impler their response to a while the provider is or while the client is The policies shall response to a while the client is The policies shall response to a while the client is The policies shall response to a while the client is The policies shall response to a while the client is The policies shall response to a while the client is The policies shall response to a while the client is the policies shall response to a while the client is the policies shall response to a while the client is the policies shall response to a while the provider is making a (C) certifying (D) transferring review team within internal review tea	and documentation regarding (1) through (a)(6) of this Rule. The requirements set forth in the Rule, ICF/MR providers are required by the federal FR Part 483 Subpart I. The requirements set forth in the Rule, Category A and B and Individuals are requirements set forth in the Rule, Category A and B and Individuals are required in the policies governing level III incident that occurs are delivering a billable service on the provider's premises. The require the provider to respond the client record the client record and the copy's completeness; and and the copy's completeness; and and the copy's the incident. The inshall consist of individuals are did not the client's direct care or the provident. The incident and who be for the client's direct care or the copy of the client record to and causes of the incident endations for minimizing the					

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL060-648	B. WING		02/2	8/2025	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
TURN AF	ROUND		TEN COURT L, NC 28227				
(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 APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 366			V 366				

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This Rule is not met as evidenced by:

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			B 14/10			
		MHL060-648	B. WING		02/2	28/2025
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TURN AROUND		TEN COURT L, NC 28227				
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 366	Continued From pa	nge 98	V 366			
	Based on observation, record review and interviews, the facility failed to implement a policy governing their response to Level I incidents as required. The findings are:					
		of Medication Administration or client #2 revealed:				
	Client #2 refused m dates and times:	nedication for the following				
	-Cetirizine was refu 1/15/25. -Clonidine was refu 1/4/25 through 1/6/ -Seroquel 100 million morning doses on through 1/13/25, 1/ 1/25/25 through 1/2 -Seroquel 200 mg von 1/4/25 through 1	gram (mg) was refused for 1/4/25 through 1/6/25, 1/11/25 18/25 through 1/20/25, and 27/25 (12 days). was refused for morning doses 1/6/25, 1/11/25 through rough 1/20/25, and 1/25/25				
	-Lamictal was refus 12/7/24 through 12 12/16/24 (6 days)Lamictal was refus 12/7/24 through 12 12/18/24, and 12/2-Metformin was refus 12/18/24 (2 days)Metformin was refus 12/8/24, and 12/16/24 through 12 12/16/24 (15 days).	pproximately 76 days total): sed for morning doses on /9/24, and 12/14/24 through sed for evening doses on /12/24, 12/15/24 through 4/24 and 12/25/24 (12 days). used on 12/17/24 and used for evening doses on /24 through 12/18/24 (4 days). used for the morning dose on /12/24, and 12/14/24 through				

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TURN AROUND		TEN COURT L, NC 28227				
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 366	dose on 12/14/24 th -Seroquel 100 mg was on 12/10/24 through 12/23/24, a (14 days)Seroquel 200 mg was on 12/5/24, 12/7/24 through 12/18/24, 1 12/30/24 (15 days)Zoloft was refused 12/10/24, and 12/14 days). November 2024 (ap-Clonidine was refured 11/27/24, 11/28/24, -Clonidine was refured 11/16/24 and 11/17 Review on 2/10/25 Records (MARs) for Client #3 refused mates and times: -Clonidine was refured 11/16/24Depakote was refured 11/29/24Depakote was refured 11/29/24Depakote was refured 11/29/24Depakote was refured 11/29/24Review on 2/10/25 -Records (MARs) for Review on 2/10/25	hrough 12/16/24 (3 days). was refused for the evening through 12/18/24, 12/21/24 and 12/28/24 through 12/30/24 was refused for evening doses through 12/11/24, 12/14/24 (12/21/24 through 12/23/24, and 12/24/24 through 12/23/24, and 13/24 through 12/17/24 (5 pproximately 5 days total): used for morning doses on and 11/30/24 (3 days). used for evening doses on 2/24 (2 days). of Medication Administration or client #3 revealed: medication for the following used for evening dose on used for morning and evening of Medication Administration or client #4 revealed: medication for the following used for morning and evening of Medication Administration or client #4 revealed: medication for the following	V 366			
	-Prozac was refuse	ed for morning dose on 1/4/24				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		MHL060-648	B. WING		02/28/2025	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TURN AROUND		TEN COURT L, NC 28227				
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 366	Continued From pa	ge 100	V 366			
	through 1/6/24 (3 d	ays).				
	December 2024 (3 days): Prozac was refused for morning doses on 12/28/24 through 12/30/25 (3 days).					
	Review on 2/7/25 of the facility's incident reports revealed: -No documentation of Level I incident reports related to clients #2, #3, #4's medication refusals from 11/1/24 through 2/10/25. -There was no documentation to determine whether a physician or pharmacist had been contacted to report medication refusals. -There was no documentation of risk/cause analysis to determine cause of medication refusals. -No documentation to indicate whether facility developed and implemented corrective measures no measures to prevent similar incidents and whether person(s) were assigned to be responsible for implementation of the corrections and preventive measures.					
	revealed: -Was not aware of a control of the contro	the medication errors. an explanation might be for ons) were not given." they (staff) left it (MAR) blank. to see who was working. 'X' nedication)was definitely not clients' physician to report now he was supposed to idn't know I was supposed to." ed Level 1 incident reports for d the cause of the incidents, as or corrective measures				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL060-648	B. WING		02/2	8/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TURN AROUND		TEN COURT _, NC 28227				
(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 SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 366	developed and implincidentsHad not assigned pimplementing corremeasures. This deficiency is concerned in the concerned within 23 developed and implementing corrected within 23 developed and implementation of the corrected within 24 developed and impl	demented to prevent similar person(s) to be responsible for ctions and preventive rossed referenced into 10A competencies of Qualified associate Professionals rule violation and must be days.	V 366			
V 736	27G .0303(c) Facility and Grounds Maintenance 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. This Rule is not met as evidenced by: Based on observation and interview the facility was not maintained in a safe manner. The findings are: Observation on 2/10/25, approximately 3:54pm revealed: -Client #2's bedroom had clutter of rabbit's items such as a small animal cage, container with straw/grass, and water bowl on the floorClient #2's rabbit was not in the cage and was not visible in the room.		V 736			

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NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
TURN AI	ROUND		TEN COURT L, NC 28227			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
V 736	Continued From pa	ge 102	V 736			
	-Rabbit was in the r free-range."	room, "under the bedshe's				
		5 with client #2 revealed: newhere (in client #2's				
	Interview on 2/24/25 with client #1 revealed: -Did not have a problem with client #2's pet"rabbit doesn't bother me, it doesn't move around, it stays in [client #2]'s room."					
	Interview on 2/24/25 with client #3 revealed: -"the rabbit is nice, cute and fluffy; it stays in [client #2]'s room."					
	Attempted interviews on 2/7/25 and 2/24/24 with client #4 were unsuccessful because she had quick responses of "yes" to all questions or "no" to all questions.					
	Interview on 2/7/25 and 2/14/25 with the House Manager revealed: -Client #2 "has a rabbit." -Other clients in the facility "have no problem with [client #2]'s animal, how they have problem when it's (rabbit) always in the room"					
	Interview on 2/13/25 with the Associate Professional revealed: -"[Client #4], working on participation[Client #2], usually by herself, most of the time she will just be in her roomcome out to do chorescontent with animals (rabbit)other clients may say, 'you have to clean your room'we (staff) encourage her to keep her room clean. I will bring it to [Licensee/QP]'s attention to sanitize her room."					
		b with the Clinical Professional (QP) revealed:				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING: (X3) DATE SUR COMPLETE				
		MHL060-648	B. WING		02/2	28/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE	•	
TURN AI	ROUND		TTEN COURT L, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 736	-"The rabbit is not in plan; I have no clue -"The rabbit came the Program], it appears they love it." Interview on 2/13/25 Licensee/QP reveative and the plant is a plant if it is a plant if it is a plant if it is a provided" -"I spoke with her (of the rabbit), she (SW me for the rabies she (rabbit)." This deficiency is concave and for the plant is not in the plant is not	h her (client #2) treatment about shot records." hrough [Day Treatment is healthy; the other clients, and 2/24/25 with the led: shot records for the animals it) was a gift from the Day #2's Social Worker (SW) that to have animals, the animal oved immediatelyor shot client #2) social worker (about by) said she would reimburse not, I just need to take her rossed referenced into 10A competencies of Qualified associate Professionals a rule violation and must be	V 736			

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