STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL040-015	A. BUILDING: _____ B. WING _____	R-C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDS GROUP HOME	306 WEST GREENE STREET SNOW HILL, NC 28580

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint and follow up survey was completed on April 17, 2025. One complaint was unsubstantiated (intake # NC00227776) and one complaint was substantiated (intake #NC00227608). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. The facility is licensed for 6 and has a current census of 4. The survey sample consisted of audits of 2 current client.	V 000		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals.	V 291		

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V 291	Continued From page 1 (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record reviews, observation and interviews, the facility failed to maintain coordination between the facility operator and the professionals who are responsible for the client's treatment, affecting one of two audited clients (#4). The findings are: Finding #1: Review on 04/17/25 of client #4's record revealed: -Date of admission: 11/05/21 -Diagnoses of Schizophrenia, Gastroesophageal Reflux Disease (GERD), Hypertension, History of Cerebrovascular Accident (History of CVA), Hyperlipidemia, Vitamin D Deficiency, Selective Mutism. Review on 04/14/25 of medical records for client #4 dated 03/04/25 to 04/11/25 revealed: -On 03/04/25 client #4 the entered the Emergency Department (ED) with abdominal pain as a result of a fall. -03/04/25 the provider refused to take client #4 back to the facility because he did not ambulate on his own. -On 03/07/25 the facility would potentially take client #4 back if he began walking again.	V 291		

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V 291	Continued From page 2 -On 03/14/25 the Qualified Professional (QP)/Licensee was made aware that client #4 had gained strength and had begun to ambulate and that Physical Therapy (PT) could be worked into his schedule at the facility. -The QP/Licensee continued to be updated on Client #4's progress because the QP/Licensee had not stated Client #4 could not return to the facility. -The hospital Physical Therapist agreed to be available to assist Client #4 with ambulating to show the QP/Licensee Client #4's improvement. -Two appoinments scheduled on 4/2/25 and 4/3/25 at 10:00am for the QP/Licensee to see client #4 ambulate were not kept as the QP/Licensee did not show up. Finding #2: Observation on 04/11/25 between 10:00am-10:15am of a video recording by the Hospital Social Worker revealed: -Client #4 was ambulated with the assistance of a rolling walker. -Client #4 sat up in his bed without staff assistance from Hospital Social Worker. Interview on 04/09/25, 04/11/25 and 04/15/25 the Hospital Social Worker revealed: -On 03/04/25 Client #4 was transported from the facility to the emergency department for abdominal pain. Client #4 had previously been prescribed a rolling walker during a 2/20/25-2/25/25 hospital stay. -On 03/07/25 the Qualified Professional (QP)/Licensee stated client #4 could return to the facility when client #4 could walk without assistance. -She recorded client #4 on 4/11/25 when he ambulated with a walker. He was not allowed to	V 291		

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V 291	Continued From page 3	V 291		

ambulate in the hospital without staff or physical therapy in the room per hospital rules.
-The QP/Licensee visited client #4 on 4/7/25 and refused to take the client home because he did not fully ambulate without a walker.
-"The hospital had no resources. The resource pool is very small" for placement.
-The Licensee/QP informed her that Client #4 could return to facilty and the QP/Licensee would request additional funding prior to Client #4's discharge from the hospital.
-"[Client #4] came to the emergency department, him walking without the walker is not going to happen."
-The "The hospital wanted to discharge client #4 to the group home with a walker and PT for 1 to 2 hours 3 days a week. The QP/Licensee wanted [Client #4] to return to the facility if he was fully ambulating without devices, but the QP/Licensee had not discharged client."
-If the QP/Licensee had discharged client #4, she "could have worked directly with the guardian to find an alternate placement."

Interview on 04/09/25 and 04/11/25 with Department of Social Services Legal Guardian for client #4 revealed:
-She was aware of a previous hospital admission on 02/25/25 client #4 was discharged back to the facility with a walker and shower chair.
-Client #4 was admitted on 03/04/25 to the emergency department. He was a selected mute. She felt that it may be his choice not to walk.
-On 04/09/25 a 30-day notice of discharge was issued by the Licensee/Qualified Professional because client #4 could not ambulate without a walker.
-"[QP/Licensee] did not want want her license in jeopardy. I started the process to look for placement."

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V 291	Continued From page 4 -On 04/10/25 the QP/Licensee rescinded the discharge from the facility and stated that she would take client back. -The Licensee/QP needed to contact someone from the state (Licensure Section) to see if she could take client #4 back in to her facility. -"I was not in a rush to seek placement if he could return to the facility. [Client #4] is a hard to place because of the history of trying to stab a nursing home employee." He did well at the facility and "I prefer to keep him there." -Client #4 continued to be in the care of the local hospital in the emergency department. He had not walked without a walker since being in the ED. -She emailed the Hospital Social Worker so a new placement could be found for Client #4. -She would issue the Licensee/QP a 30 day notice of discharge if new placement is found. Interview on 04/09/25 and 04/15/25 with Qualified Professional/Licensee revealed: -03/04/25 the Group Home Manager called EMS because client #4 was on the floor and had trouble when he attempted to walk. He was transported from the facilty to to her that client #4 could walk and he was ready to be discharged back the facility. -She told Hospital Social Worker the emergency department for abdominal pain because of a fall. -She had contact with Hospital Social Worker since Client #4 was transported to the ED. -Since 03/04/25 or 03/05/25 the Hospital Social Worker stated that client #4 could be discharged back to the facility. -Hospital Social Worker reported that client #4 needed to ambulate independently to be in the facility and he was non ambulatory. -She decided on 04/09/25 to send a notice of discharge to the DSS Legal Guardian for client	V 291		

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V 291	Continued From page 5 #4. -The hospital and the DSS Legal Guardian looked for client #4 placement alternatives. -As the Qualified Professional (QP) she did not assist with the placement process. "It is not my job, it is the hospital and guardian's responsibility to look for placement since client #4 remains in the emergency department ." -She stated that she never contacted the state licensure about having non ambulatory clients or the Managed Care Organization (MCO) about additional funding. -She discussed with DSS Legal Guardian for client #4 that if he could ambulate independently, he could be discharged back to the facility. -Client #4 continued to remain in the ED on 04/17/25.	V 291		
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 record review, observations and interviews the facility and its grounds was not maintained in a safe, clean and attractive manner. The findings are: Observation on 04/09/25 at approximately 10:40am a tour of the facility revealed: -There was approximately two inches of white siding hanging from edge of the roof. -There was a large amount of greenish substance on the white siding of facility.	V 736		

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V 736	Continued From page 6 -There were approximately 10 to 20 rotten wood rails in the handicap ramp to the home. Dining Room: -The dining room area had unknown food particles under the table. -In the dining area, the wall paper was not affixed to the wall next to the entrance. Approximately 3 inches was separated and hung away from the wall. -Baseboards in the dining area were discolored with a brown unknown substance. -The air conditioning grates in the dining area had a orangish-brownish substance on the entire surface area. Living Room: -The front screen door ad approximately a 6 inch open space at the bottom right corner. -The door knob to front door was loose and had a large spacing on the entire ring of door. -The door lock strike plate was loose and not secured in place and there were smaller pieces of wood that were approximately 1 to 2 inches chipped from around the bottom of door strike plate. -There were cobb webs covered from the top to bottom of the right corner by the door. - In the living room the upper corner of the wall between the sofa and recliner chair there were 4 areas that had a black ovaluar shaped substance approximately 3 to 5 inches long. -The white baseboard and the outlet on the right side of the sofa in the living room had several areas approximately 1 to 2 inches of black substance. -There was approximately a 3 to 5 inch brownish stain on the top of the ceiling area in living room. -There were cobb webs approximately 5 inches down the right corner of the wall located near the	V 736		

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V 736	Continued From page 7 door. -The main entrance doorway to the home had large cobb webs approximately 3 to 5 inches with a large black spider in the right corner. Vacant Front Bedroom: -There was approximately 14 slats that were missing from the right side of the blind located behind the bed. -The window sills had multiple dead insects. -There was approximately 2 to 3 slat that were missing from the blind located on the window on the right side of the bed. -There was a beige metal blind on the left side of the bed with 3 slates were missing. -The Chest had a broken handle on the bottom drawer and 3 of 5 doors missing. Hallway: - The door had several 3 to 4 inch areas that the white paint was chipped and a lighter green color showed underneath the paint. -The hallway had an uncovered doorbell, that wires were exposed. -The hallway floor had approximately a circular shaped 3 inch piece missing out of the laminate. -The hallway had a circular shaped brownish substance approximately 3 inches on the ceiling. -The hallway ceiling had two areas approximately 2 to 4 inches where paint had peeled away from the ceiling. Kitchen: -There was thick greasy substance that covered all of the cabinets over stove area and the cabinets where food was stored. -The stove had dried food spills and food particles on the eyelets. -There was a white refrigerator that did not work and was not being used by the facility located	V 736		

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V 736	Continued From page 8	V 736		

beside another refrigerator directly in front of the main entrance of the kitchen.
-There was a dried food spill in the right corner or the cabinet by the white refrigerator.
-There was a large space with a 3 inch piece of sharp metal hanging from door at the bottom right corner of the screen door.

Laundry Room:
-There were multiple tiles missing from a large are of the floor.
-There was a brown unknown substance on several areas on the back door.
-There were several cobb webs 1-2 inches in size in the left corners of ceiling and two areas of wall at the back doorway into the kitchen.

Vacant Bedroom #2:
-The blinds had multiple number of missing slats.
-The chest of drawers 1 of 4 drawers did not have a handle.
-2 of 7 of the dresser drawers had a black unknown substance inside them.
-The baseboard had a small space with 6 inch piece of laminate missing from floor.
-The air vent was corroded and the entire vent was covered with a orangish brown substance.

Bedroom 3 (client #1 and client #3):
-The bedroom dresser the drawers on the right side was missing knobs on the right middle and top drawers. The middle section of the dresser had no handles on the top and bottom drawer. The left side of dresser had no knobs on the dresser drawers.
-The blue lace curtain hanging from the window next to the closet had a tennis ball size hole on the left side of curtain.
-The ceiling close to the fire alarm had multiple stains of a brown unknown substance.

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V 736	Continued From page 9 -There was a large area of the ceiling with a circular brownish stain with small spore-like appearance that covered approximately 2 feet by 4 feet from the entrance to the middle ceiling. Bathroom: -The main bathroom ceiling had a black unknown substance with a cotton-spore like appearance and 2 circular brownish orangish stains approximately 6 inches in diameter. -There was a large area of missing floor tiles around the toilet area in the bathroom. -There was an air vent with a tennis ball size hole in the grate of the vent and the entire air vent was covered with an orangish brown substance. -There was outlet without a covering next to the mirror. -There were 2 fluorescent light bulbs over the mirror that did not work with no light fixture covering. -The entire tub molding had multiple areas of soft wood with approximately 1 to 2 inch chips of wood missing; A larger piece of wood missing approximately 2 inches of wood in the right corner. Bedroom 4 (client #2 and client #4): -The bedroom dresser next to the window had 6 missing knobs on the top drawer. -The ceiling had multiple areas with an unknown black substance. Interview on 04/09/25 the Licensee/Qualified Professional/ Registered Nurse stated: -This was the first time she had seen all the repairs that needed to be made. -Everything would be repaired as soon as possible. -She had someone to look at the roof and there were no leaks that could be seen.	V 736		

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V 736	Continued From page 10 -She did not know what the unknown black substance was in the living room, bedroom #4 and in the drawers of bedroom #4. -There were some modifications that would be completed in the bathroom. -She would make sure the cobb webs were clean and the flooring was replaced in the laundry room. This deficiency has been cited 3 times since the original cite on January 5, 2022 and must be corrected within 30 days.	V 736		