| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|--------------------------|--|-------------------------------|--------------------------|
| | | | A. BUILDING: | | R | |
| | | MHL092-862 | B. WING | | | 5/2025 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| HEAVEN | LY PLACE 2 | | KLAND DRIV , NC 27610 | VE | | |
| (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 000 | INITIAL COMMENT | rs | V 000 | | | |
| | | w up survey was completed Deficiencies were cited. | | | | |
| | | sed for the following service C 27G .5600A Supervised h Mental Illness. | | | | |
| | | ed for 6 and has a current urvey sample consisted of clients. | | | | |
| V 107 | 27G .0202 (A-E) Pe | ersonnel Requirements | V 107 | | | |
| | description for the d which: (1) specifies the competency, work of qualifications for the (2) specifies the the position; (3) is signed by supervisor; and (4) is retained (b) All facilities shall each staff member provides care or see | Ill have a written job director and each staff position he minimum level of education, experience and other | | | | |
| | (2) is able to refollow directions; (3) meets the recompetency, work of qualifications for the (4) has no sub- | stantiated findings of abuse or e North Carolina Health Care | | | | |

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|--------------------------|--|-------|--------------------------|
| | | | A. BUILDING. | | R | |
| | | MHL092-862 | B. WING | | 1 | 5/2025 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| HEAVEN | LY PLACE 2 | | KLAND DRIV , NC 27610 | VE | | |
| (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 107 | applicants for emplicanticion. The implementation applicant decision regarding upon the offense in which the applicant (d) Staff of a facility currently licensed, accordance with appropriate accordance with appropriate application app | services 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. You or 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 | | | |
| | failed to have a cor | et as evidenced by: view and interview, the facility nplete personnel record o audited staff (#4). The | | | | |
| | revealed: -Hire date of 5/19/2 -She was hired as t | of Staff #4's personnel record 2. the House Manager. of educational verification. | | | | |
| | -She thought she h | 5 with Staff #4 revealed: ad shared her education he applied for the job. d from high school. | | | | |

Division of Health Service Regulation

STATE FORM 6899 KFBR11 If continuation sheet 2 of 11

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|----------------|--|-------------------------------|------------------|
| | | | 7 th BOILBING. | | F | , |
| | | MHL092-862 | B. WING | | | 5/2025 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| HEAVEN | LY PLACE 2 | | KLAND DRI | VE | | |
| (X4) ID | SLIMMARY STA | TEMENT OF DEFICIENCIES | ID ID | PROVIDER'S PLAN OF CORREC | TION | (X5) |
| PREFIX TAG | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | COMPLETE DATE |
| V 107 | Continued From pa | ge 2 | V 107 | | | |
| | -She did not know was not in her perso | why her school information onnel record. | | | | |
| | Interview on 4/25/25 revealed: | 5 with the Administrator | | | | |
| | have her education | | | | | |
| | high school diploma record. | today to bring in a copy of her a and it would be filed in her | | | | |
| | | the facility failed to have a I record for Staff #4. | | | | |
| V 118 | 27G .0209 (C) Med | ication Requirements | V 118 | | | |
| | 10A NCAC 27G .02 REQUIREMENTS | 09 MEDICATION | | | | |
| | (c) Medication adm | | | | | |
| | only be administere | non-prescription drugs shall and to a client on the written uthorized by law to prescribe | | | | |
| | | all be self-administered by uthorized in writing by the | | | | |
| | client's physician. | sluding injections, shall be | | | | |
| | administered only b | y licensed persons, or by trained by a registered nurse, | | | | |
| | pharmacist or other | legally qualified person and e and administer medications. | | | | |
| | (4) A Medication Ad all drugs administer | ministration Record (MAR) of red to each client must be kept | | | | |
| | recorded immediate | s administered shall be ely after administration. The | | | | |
| | MAR is to include the (A) client's name; | - | | | | |
| | (C) instructions for | and quantity of the drug; administering the drug; ne drug is administered; and | | | | |

Division of Health Service Regulation

STATE FORM 6899 KFBR11 If continuation sheet 3 of 11

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPL | E CONSTRUCTION | (X3) DATE | SURVEY | |
|---|--|---|---------------------|---|-----------|--------------------------|
| | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLETED | |
| | | | | | R | |
| | | MHL092-862 | B. WING | | 1 | 5/2025 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| HE AVEN | LY PLACE 2 | 3120 TUC | KLAND DRIV | /E | | |
| IILAVLIN | LI FLAGE 2 | RALEIGH | , NC 27610 | | | |
| (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 3 | V 118 | | | |
| | (E) name or initials drug. (5) Client requests to checks shall be rec | of person administering the for medication changes or orded and kept with the MAR appointment or consultation | | | | |
| | interviews, the facili current affecting thr #2 and #3). The find | on, record reviews and ty failed to keep the MARs ee of three audited clients (#1, | | | | |
| | -Admission date of -Diagnoses of Bipol Pain; History of Rer Anxiety; Mixed Inco Tobacco Use. | | | | | |
| | 1% (skin rash), app twice daily as neede -There was no phys | ly topically to affected area | | | | |
| | Client #1's medicati -Hydrocortisone 1 % | | | | | |
| | from February 1, 20 revealed: | of Client #1's MARs MARs 025 through April 24, 2025 had not been initialed by staff | | | | |

Division of Health Service Regulation

STATE FORM 6899 KFBR11 If continuation sheet 4 of 11

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING: | I` COMPLETED I |
|--|--|
| MHL092-862 B. WING | R |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | · |
| HEAVENLY PLACE 2 3120 TUCKLAND DRIVE RALEIGH, NC 27610 | |
| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH COF | ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE |
| V 118 Continued From page 4 as administeredHydrocortisone 2.5% had been initialed by staff as administered twice daily. Review on 4/24/25 of Client #2's record revealed: -Admission date of 1/13/25Diagnoses of Schizophrenia, Hyperlipidemia, Essential Hypertension, Type 2 Diabetes, Gastroesophageal Reflux Disease (GERD), HypothyroidismPhysician's order dated 12/11/24: -Atorvastatin 20 milligrams (mg) (hypertension), take one tablet by mouth at bedtimeLevothyroxine 100 micrograms (mcg) (hypothyroidism), take one tablet by mouth every dayMetformin HCl 500 mg (diabetes), take one tablet by mouth every dayNaproxen 500 mg (pain relief), take one tablet by mouth every 12 hours as needed with meals. -Physician's order dated 3/9/25: -Omeprazole DR 40mg (GERD), take one capsule by mouth every dayPhysician's order dated 4/15/25: -Clozapine 200mg (schizophrenia), take one tablet by mouth at bedtimeClozapine 50mg, take one tablet by mouth at bedtimeDivalproex Sodium Delayed Release (DR) 500mg (anti-psychotic), take one tablet by mouth three times dailyCyclobenzaprine 10mg (pain relief), take one tablet by mouth three times daily as needed for painAripiprazole 15mg (schizophrenia), take one | |

Division of Health Service Regulation

STATE FORM 6899 KFBR11 If continuation sheet 5 of 11

| DIVISION | of Fleatill Service IN | galation | | | | |
|--------------------------|---|---|---------------------|--|-------------------|--------------------------|
| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1` 'co | | (X3) DATE COMP | SURVEY |
| | | A. BUILDING: | | OOW ELVED | | |
| MIII 002 002 | | B. WING | | F 04/2 | | |
| | | MHL092-862 | | | 04/2 | 25/2025 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| HEAVEN | LY PLACE 2 | | KLAND DRI | VE | | |
| | | | , NC 27610 | | | 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 pa | ge 5 | V 118 | | | |
| V 118 | -Aripiprazole 30 dailyPhysician's order of -Venlafaxine H0 150mg (depression mouth twice dailyAripiprazole 15 twice a day, discont Observation on 4/2 Client #2's medications list. Review on 4/24/25 February 1, 2025 th February 2025-Clozapine 200 mg administered on 2/2 -Clozapine 50 mg hadministered on 2/2 -Aripiprazole 15 mg administered 2/28Venlafaxine HCl Elinitialed as administ 2/28. | Omg, take one tablet by mouth dated 4/24/25: CI Extended Release (ER) /anxiety), take 2 capsules by omg, take one tablet by mouth tinued (D/C). 4/25 at about 10:24 am of ions revealed: ed were available. of client #2's MARs from arough April 24, 2025 revealed: had not been initialed as 28. and not been initialed as 28. g had not been initialed as 28. R 150mg had not been tered for 8:00 PM dose on | V 118 | | | |
| | | n DR 500mg had not been tered for the 5:00 PM and 8:00 | | | | |
| | -Aripiprazole 30 mg administered from 4 -Aripiprazole 15 mg administered from 4 -Venlafaxine HCl El MAR were different bubble pack. MAR | had been initialed as | | | | |

Division of Health Service Regulation

STATE FORM 6899 KFBR11 If continuation sheet 6 of 11

| | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|---|--|--------------------------|---|------|--------------------------|
| | | MUU aaa aaa | | | F | |
| | | MHL092-862 | D. WINO | | 04/2 | 5/2025 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| HEAVEN | LY PLACE 2 | | KLAND DRIV , NC 27610 | VE | | |
| (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 6 | V 118 | | | |
| | instructions were 'take two capsules by mouth daily.' MAR instructions were consistent with physician's order dated 4/24/25. Review on 4/24/25 of Client #3's record revealed: -Admission date of 1/7/2025Diagnoses of Schizophrenia Disorder, Tobacco Use Disorder, Genital Herpes simplex 2, HyperprolactinemiaPhysician's order dated 1/21/25: -Vitamin D3 400 units (iu), 100 (Vitamin D deficiency), take one tablet by mouth every dayFolic Acid 1mg (nutritional supplement), take one-half tablet by mouth in the morningSenna Laxative 8.6mg (constipation), take two tablets by mouth twice a dayBisacodyl EC 5mg (constipation), take two tablets by mouth at bedtime. Observation on 4/24/25 at about 11:18 am of Client #3's medications revealed: | | | | | |
| | | | | | | |
| | Review on 4/24/25 February, 2025 rev | of client #3's MAR from ealed: | | | | |
| | administered 2/26-2 -Folic Acid 1 mg ha administered 2/26-2 -Senna Laxative 8.6 administered 2/26-2 | d not been initialed as 2/28. 5 mg had not been initialed as 2/28. g had not been initialed as | | | | |
| | -She had not had a medications. | 5 with Client #1 revealed: ny issues in receiving her drocortisone for a skin irritation | | | | |

Division of Health Service Regulation

that developed above her lips.

STATE FORM 6899 KFBR11 If continuation sheet 7 of 11

| AND DIAN OF CORRECTION IDENTIFICATION NUMBER | | | | | X3) DATE SURVEY COMPLETED | |
|--|---|--|--------------------------|---|------------------------------|------------------|
| | | | 7. BOILDING. | | R | |
| | | MHL092-862 | B. WING | | | 5/2025 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| HEAVEN | LY PLACE 2 | | KLAND DRI\ , NC 27610 | VE. | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | ON | (X5) |
| PREFIX TAG | | / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | | COMPLETE DATE |
| V 118 | Continued From pa | ge 7 | V 118 | | | |
| | clearing. | orking because her skin was using the Hydrocortisone 1% | | | | |
| | Interview on 4/25/2 revealed: | 5 with Clients #2 and #3 | | | | |
| | -They reported they time and daily. | receive their medications on | | | | |
| | Interview on 4/24/25 with with Staff #4 revealed: -The last of the previous package for Client #3 had been administered that morning and they were due to get another package that day. The Vitamin D3 would be coming in today. | | | | | |
| | Hydrocortisone 2.5 #1Client #1 had develoeing treated with the pharmacy had service -QP spoke with the the Aripiprazole 15 rediscontinued 4/15/2-New dose of Aripipration -QP coordinated with new physician's ord 4/24, for Venlafaxing dosing schedule on which is consistent -QP acknowledged provide an explana | that staff had been marking % as administered for Client elop a skin condition and was the Hydrocortisone tube that sent to the facility. pharmacy and reported that mg for Client #2 had been elopated to the facility or azole 30 mg was to begin the prescriber and received a der for Client #2 on 4/24, dated the HCl 150 mg confirming the of the new physician's order with the MAR. That staff was unable to tion for the discrepancies or rect dosages of medication | | | | |
| | Due to the failure to | accurately document | | | | |

Division of Health Service Regulation

STATE FORM 6899 KFBR11 If continuation sheet 8 of 11

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLI A. BUILDING: | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|--------------------------|---|-------------------------------|--------------------------|
| | | MHL092-862 | B. WING | | | ⋜ 25/2025 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | TATE, ZIP CODE | | |
| HEAVEN | LY PLACE 2 | * * - * - | KLAND DRI\ , NC 27610 | /E | | |
| (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 CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF T | ULD BE | (X5) COMPLETE DATE |
| V 118 | | tration, it could not be lents received their medication | V 118 | | | |
| V 736 | 10A NCAC 27G .03 EXTERIOR REQUI (c) Each facility and maintained in a safe manner and shall b odor. This Rule is not me Based on observati was not maintained manner and free fr findings are: Observation on 4/24 revealed: -Kitchen: -Water stain on -Bedroom 2: Clients room -Urine smellBathroom 2 (Hall): -Quarter round the roomBaseboard cor shower/tub- appear -Multiple (20-30 between shower/tub | lits grounds shall be e, clean, attractive and orderly e kept free from offensive et as evidenced by: on and interviews, the facility in a clean, attractive, orderly om offensive odor. The 4/25 at approximately 9:12 AM ceiling approximately 8' long. es #2, and #3 reside in this molding missing all around ming off wall at corner near es water damaged. b) brownish stains on wall of and toilet. ed (left handle turns on cold, | V 736 | | | |
| | -Staff bedroom on center of door a | door stained: dark gray patch oproximately 12"x12", water at corner of door approximately | | | | |

Division of Health Service Regulation

STATE FORM 6899 KFBR11 If continuation sheet 9 of 11

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | . , | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|--------------------------|---|-------------------------------|--------------------------|
| | ***** | | B. WING | | R 04/25/2025 | |
| | | MHL092-862 | | | 04/2 | 5/2025 |
| NAME OF F | PROVIDER OR SUPPLIER | | , , | STATE, ZIP CODE | | |
| HEAVEN | LY PLACE 2 | | KLAND DRIV , NC 27610 | VE | | |
| (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 736 | 12"x5", water stain -Couch cushior coming out of the to -Outside: -Paint peeling of window) on front tw -On the side of stand (4'x4' approxicrosspiece 1' from (approximately 12" to 3" thick around th lying on the ground -Back door: box | on ceiling approximately around patch. In torn open with stuffing op. | V 736 | | | |
| V 750 | · · | | V 750 | | | |

Division of Health Service Regulation STATE FORM

6899 KFBR11 If continuation sheet 10 of 11

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | COMPLETED | | |
|---|--|---|---------------------|--|------|--------------------------|
| | | MHL092-862 | B. WING | | F | R 5/2025 |
| NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | 04/2 | 3/2023 |
| | LY PLACE 2 | | KLAND DRI | | | |
| ПЕАУЕН | LT PLACE 2 | RALEIGH | , NC 27610 | | | |
| (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 750 | Continued From pa | ge 10 | V 750 | | | |
| | systems shall be macondition. | aintained in operating | | | | |
| | failed to maintain el operating conditions Observation on 4/24 | on and interview, the facility ectrical systems in safe s. The findings are: 4/25 from about 8:30 am to | | | | |
| | 1:30 pm of the facility revealed: -Two smoke detectors located at the hallway leading to the clients' bedrooms made the alarm warning noises (chirping sounds) indicating that the batteries needed replacing. | | | | | |
| | -She had not notice chirping.-She believed the n-She acknowledged | 5 with Staff #4 revealed: d the smoke detectors oise had just started today. If the facility failed to ensure is were maintained in second | | | | |
| | | | | | | |
| | | | | | | |

Division of Health Service Regulation STATE FORM

6899 KFBR11 If continuation sheet 11 of 11