

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and complaint survey was completed on 2/28/25. The complaint was substantiated (intake #NC00225417). Deficiencies were cited. This facility is licensed for the following service category 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for 4 and has a current census of 4. The survey sample consisted of audits of 4 current clients and 1 former client.	V 000		
V 107	27G .0202 (A-E) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (a) All facilities shall have a written job description for the director and each staff position which: (1) specifies the minimum level of education, competency, work experience and other qualifications for the position; (2) specifies the duties and responsibilities of the position; (3) is signed by the staff member and the supervisor; and (4) is retained in the staff member's file. (b) All facilities shall ensure that the director, each staff member or any other person who provides care or services to clients on behalf of the facility: (1) is at least 18 years of age; (2) is able to read, write, understand and follow directions; (3) meets the minimum level of education, competency, work experience, skills and other qualifications for the position; and (4) has no substantiated findings of abuse or	V 107		

Division of Health Service Regulation

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

TITLE

(X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 107	<p>Continued From page 1</p> <p>neglect listed on the North Carolina Health Care Personnel Registry.</p> <p>(c) All facilities or services shall require that all applicants for employment disclose any criminal conviction. The impact of this information on a decision regarding employment shall be based upon the offense in relationship to the job for which the applicant is applying.</p> <p>(d) Staff of a facility or a service shall be currently licensed, registered or certified in accordance with applicable state laws for the services provided.</p> <p>(e) A file shall be maintained for each individual employed indicating the training, experience and other qualifications for the position, including verification of licensure, registration or certification.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to complete personnel records affecting 2 of 13 staff (House Manager(HM) and Associate Professional (AP)). The findings are:</p> <p>Review on 2/10/25 of the personnel record for the HM revealed: -Hired 11/6/24. -Hired as Residential Counselor. -No job description for House Manager.</p> <p>Review on 2/11/25 of the personnel record for the AP revealed:</p>	V 107		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 107	<p>Continued From page 2</p> <p>-Hired 11/16/10. -Hired as the Associate Professional. -No job description for Associate Professional.</p> <p>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.</p> <p>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 AP...yes, 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.</p> <p>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.</p> <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 107		

Division of Health Service Regulation
STATE FORM

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 108	<p>Continued From page 4</p> <p>Based on record reviews and interviews, the facility failed to ensure the Clinical Director/Qualified Professional (CD/QP) and 8 of 13 staff (Staff #1, #2, #6, #7, #8, #9, #10, #11) had current first aid/cardiopulmonary resuscitation (CPR) training. The findings are:</p> <p>Review on 2/10/25 of the Staff #1's personnel file revealed: -Hire date: 11/25/24. -No documentation of first aid/CPR training.</p> <p>Review on 2/11/25 of Staff #2's personnel file revealed: -Hire date: 1/20/25. -No documentation of first aid/CPR training.</p> <p>Review on 2/13/25 of Staff #6's personnel file revealed: -Hire date: 12/20/24. -No documentation of first aid/CPR training.</p> <p>Review on 2/11/25 of Staff #7's personnel file revealed: -Hire date: 7/10/24. -No documentation of first aid/CPR training.</p> <p>Review on 2/11/25 of Staff #8's personnel file revealed: -Hire date: 12/17/24. -No documentation of first aid/CPR training.</p> <p>Review on 2/11/25 of Staff #9's personnel file revealed: -Hire date: 6/10/24. -No documentation of first aid/CPR training.</p> <p>Review on 2/13/25 of Staff #10's personnel file revealed: -Hire date: 1/28/25.</p>	V 108		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 108	<p>Continued From page 5</p> <p>-No documentation of first aid/CPR training.</p> <p>Review on 2/11/25 of Staff #11's personnel file revealed: -Hire date: 11/20/24. -No documentation of first aid/CPR training.</p> <p>Review on 2/20/25 of the CD/QP's personnel file revealed: -Hire date: 2/3/02. -No documentation of first aid/CPR training. -Date expired 6/15/23.</p> <p>Review on 2/24/25 of the Facility's Shift Notes for November 2024 (11/1/24-11/30/24) revealed: -No documentation that at least one staff had first aid/CPR training for: 1st Shift-11/5, 11/8, 11/16, 11/22. 2nd Shift-11/1, 11/2, 11/7, 11/9, 11/10, 11/14, 11/15.</p> <p>Review on 2/24/25 of the Facility's Shift Notes for December 2024 (12/1/24-12/31/24) revealed: -No documentation that at least one staff had first aid/CPR training for: 1st Shift-12/27, 12/30. 2nd Shift-12/9, 12/25, 12/28-12/31. 3rd Shift-12/2, 12/9, 12/12, 12/16, 12/23-12/26, 12/31.</p> <p>Review on 2/24/25 of the Facility's Shift Notes for January 2025 (1/1/25-1/23/25) revealed: -No documentation that at least one staff had first aid/CPR training for: 2nd Shift-1/2, 1/4, 1/9, 1/11, 1/14, 1/16, 1/17, 1/21, 1/23. 3rd Shift-1/6, 1/14, 1/21, 1/23.</p> <p>Interview on 2/14/25 with Staff #10 revealed: -"...CPR and first aid certification, it expired a</p>	V 108		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 108	<p>Continued From page 6</p> <p>month ago." -"I had orientation training but no other training since I've been here."</p> <p>Interview on 2/21/25 with Staff #11 revealed: -No trainings since being hired. -Had first aid/CPR training, "I'll have to look in my phone, I don't keep copies of my training certificates." -"My phone is on two percent...let me go get my phone charger out of the car and I'll call you right back." -Staff #11 did not call back and did not answer when attempt was made to follow up.</p> <p>Interview on 2/19/25 with CD/QP revealed: -"[Licensee/QP] does first aid and CPR training, he does that training himself."</p> <p>Interviews on 2/13/25 and 2/14/25 with the Licensee/QP revealed: -Had current certification as first aid/CPR instructor, 9/19/24-9/19/26. -Responsible for ensuring staff were trained in first aid/CPR. -Was responsible for human resources which included notifying staff of necessary training, as well as keeping track of staff personnel records and training certificates.</p> <p>Further interview on 2/28/25 with the Licensee/QP revealed: -"...they (staff) have all had first aid/CPR, I did that training myself." -No evidence of training was provided prior to survey exit.</p> <p>This deficiency is crossed referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals</p>	V 108		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 108	Continued From page 7 (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.	V 108		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	<p>Continued From page 8</p> <p>supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter.</p> <p>This Rule is not met as evidenced by: Based on interview, observation, and record review, 1 of 2 qualified professionals (Licensee/Qualified Professional (QP)) failed to demonstrate the knowledge, skills, and abilities required by the population served. The findings are:</p> <p>Cross Reference: 10A NCAC 27G .0202 Personnel Requirements (V107) Based on record review and interviews, the facility failed to complete personnel records affecting 2 of 13 staff (House Manager(HM) and Associate Professional (AP)).</p> <p>Cross Reference: 10A NCAC 27G .0202 Personnel Requirements (V108) Based on record reviews and interviews, the facility failed to ensure the Clinical Director/Qualified Professional (CD/QP) and 8 of 13 staff (Staff #1, #2, #6, #7, #8, #9, #10, #11) had current first aid/cardiopulmonary resuscitation (CPR) training.</p> <p>Cross Reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112) Based on record reviews and interviews, the facility failed to have a current treatment plan with written consent or agreement by the client or responsible party affecting 1 of 4 clients (#3).</p>	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	<p>Continued From page 9</p> <p>Cross Reference: G.S. 122C-80 Criminal History Record Check (V133) Based on record review and interview, the facility failed to request a criminal history record check within five business days of making the conditional offer of employment for 5 of 13 staff (Staff #2 #4, #7, #9 and #10).</p> <p>Cross Reference: 10A NCAC 27G .1701 Scope (V293) Based on record reviews, observation and interviews the facility failed to ensure services to assist 4 of 4 clients (#1, #2, #3, #4) in the acquisition of social and recreational skills and failed to coordinate care within the client's system of care for 1 of 4 clients (#2).</p> <p>Cross Reference: 10A NCAC 27G .1703 Requirements for Associate Professionals (V295) Based on record review and interviews, the facility failed to ensure at least one full time direct care staff met the requirements of an Associate Professional (AP).</p> <p>Cross Reference: 10A NCAC 27G .1704 Minimum Staff Requirements (V296) Based on record reviews, interviews and observations, the facility failed to ensure the minimum staff ratio of 2 staff for up to 4 children or adolescents.</p> <p>Cross Reference: 10A NCAC 27G .0603 Incident Response Requirements (V366) Based on observation, record review and interviews, the facility failed to implement a policy governing their response to Level I incidents as required.</p> <p>Cross Reference: 10A NCAC 27G .0303 Location and Exterior Requirements (V736) Based on observation and interview the facility was not maintained in a safe manner.</p>	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	Continued From page 10 Review on 2/11/25 of the Licensee/Qualified Professional's (QP) record revealed: -Hired 5/21/02. -Job description for Program Director/QP dated 1/24/11. -Duties and responsibilities: "Monitor the day to day operation of the facility. Schedule appointments, meeting, and etc. Review and maintain consumer medical records and charts. Review and credential documentation for client records. Attend meeting as directed by the Executive Director. Attend training sessions as authorized by the Executive Director. Recommend administrative policy to the Executive Director. Implementation and monitoring of program. Review facility logs (Fire drill, hot water temperature, & safety checks). Responsible for vehicle mileage logs. Supervision of AP (Associate Professional) and Paraprofessional Residential Counselors. Group or individual activities. Sensory stimulation training. Defuse the current crisis, evaluate it nature, and intervene to reduce the likelihood of a recurrence. Ensure linkage to needed community services and resources. Provide self-help and living skills training for youth. Provide parenting skills training to help the family build skills for coping with the youth's disorder. Monitor and manage the presenting psychiatric and/or addiction symptoms. Work with caregivers in the implementation of home-based behavioral supports. Services may include crisis management, intensive case management, individual and/or family therapy, substance abuse interventions, skills training, and other rehabilitative supports to prevent the need for an out-o-home, more restrictive services."	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	Continued From page 11 Interview on 2/13/25, 2/14/25 and 2/17/25 with Licensee/QP revealed: -Was person responsible for human resources role, which included hiring staff, new staff orientation, arranging training, keeping up with training and personnel documents, and scheduling/filling staff for shifts. -Was person responsible for clients' safety and well-being. -Was responsible for ensuring supervision of clients when away from the facility in accordance with clients' strengths and needs. -"I am currently fulfilling the QP." -CD/QP "...assist with QP duties." -"I am the Human Resource person." -"I do training for staff" -"I keep up with staff training." -"I am responsible for reviewing the MARs." -"I am responsible for keeping up with the MARs and I check them periodically." -"I revise and edit the PCP (Person Centered Plan)...coordinate with day treatment..." -"I've been working as QP since March 2023." -"...yesterday (2/13/25) [client #2] had outburst, at day treatment, had property destruction and assault towards her peer; I make a note of it for myself, but don't generally write an incident report. I didn't think that would be a level one incident." -"I do incident reports, staff hand writes the incident on the form; I review it and put in IRIS (Incident Response Improvement System) myself." -"As QP, I sometimes review notes ...I revise and edit the PCP, facilitate CFTs (Child and Family Team Meetings), coordinate with day treatment and enroll clients in day treatment; I schedule doctor appointments, receive grievances from consumers, and just working (fill-in) shifts." -Was not aware that client #3's treatment plan	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	<p>Continued From page 12</p> <p>had not been signed and had no explanation, "I can get that signed."</p> <p>-I do that (rideshare) to make sure we maintain two staff at the house (facility), so two (staff) are always here when they (clients) are picked up."</p> <p>"They might take [rideshare] once or twice a week, some weeks I might not use it."</p> <p>-Provided monthly supervision with staff.</p> <p>-Was person responsible for planning and scheduling activities and outings for clients.</p> <p>Further interview on 2/24/25 with Licensee/QP revealed:</p> <p>-Was responsible for adhering to staffing rules and guidelines.</p> <p>-Was responsible for coordinating with resources and reporting medication errors to pharmacy or client physician.</p> <p>-Was responsible for reporting incidents.</p> <p>-Was responsible for setting up Registered Nurse for medication administration training to ensure staff administering medications to clients were properly trained.</p> <p>-Was person responsible for reviewing medication orders and reviewing client MARs.</p> <p>-"He (AP) works 4 days, Monday through Thursday and every other Sunday, 32 hrs, I think that's considered part-time. He works part-time, 2nd shift."</p> <p>-"...it's my understanding it (background check) doesn't have to be done prior to hire."</p> <p>-"I wouldn't have med (medication) orders from her (client #1) previous provider. It is my understanding that when you have the pill bottle, that's a script. I didn't follow up with the prescribing doctor...I'll have to get her med order from her previous doctor or pharmacy."</p> <p>-"I don't know what an explanation might be for why they (medications) were not given."</p> <p>-Had not reported medication errors to clients'</p>	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	<p>Continued From page 13</p> <p>doctor or pharmacy, "no, I didn't know I was supposed to."</p> <p>-Had not documented medication errors in level one incident reports, "no, I didn't."</p> <p>Review on 2/28 of the initial Plan of Protection signed by CD/QP and dated 2/28/25 revealed:</p> <p>-Executive Director's meeting with the Clinical Director as of 2/28/25: The Executive Director met with the Clinical Director to review duties of the Qualified Professional in referenced above citations. Interim assumption of the QP duties will be assumed by the Clinical Director temporarily. These duties will be carried out until an appropriately qualified professional can be made available permanently to fully take on QP responsibilities. New Place, Inc. will designate a Human Resource staff member to be responsible for managing all personnel records. The HR (Human Resource) staff will ensure that all personnel requirements are met prior to hiring and completion of all training for staff is finalized according to company policy. This change in responsibilities ensures that New Place, Inc. maintains compliance with personnel and training requirements while also ensuring that QP duties are covered until the right professional can take on the role.</p> <p>Describe your plans to make sure the above happens.</p> <p>1. Immediate hiring efforts: New Place, Inc. will immediately begin seeking qualified candidates to fill the two key positions of Qualified Professional and Human Resource Personnel Staff.</p> <p>2. Hiring timelines:-The human resource personnel staff will be hired no later than 04/15/2025 and the qualified professional staff will assume the QP role no later that 03/31/2025. Upon hiring, each individual in these roles will</p>	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	<p>Continued From page 14</p> <p>review and sign their respective job description, complete all necessary training to effectively fulfill their responsibilities as outlined in their job description. This structure will ensure clarity in roles, timelines, and supervision, while also ensuring that both key positions are filled promptly and properly trained."</p> <p>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? -Executive Director's (Licensee/QP) meeting with the Clinical Director as of 2/28/25: Effective 03/3/2025 all consumers will be provided only with Medicaid approved transportation or they will be transported in the community with appropriate staffing ratio of two staff. Effective 03/3/2028 any current pet or new incoming pet that any consumer has will be deemed not necessarily certified a service pet, will have all vaccination documentation, and the service pet will be included in the consumer Person Centered Plan. The current pet (bunny rabbit) will receive current vaccination by 03/3/2025. Effective immediately AP Edwin Freeman will document all medication errors (missed dose, refusal, hospitalization, etc.) Effective immediately New Place, Inc. will review it current personnel record policy and will adhere to all staff receiving First Aid and Medication Administration training within their first 30 days of employment and will not pass any medication until medication administration training is completed and not work with another staff that does not have First Aid training. Ny new hire will receive a conditional employment offer contingent upon a criminal history check that does not disclose any disqualifying criminal charges Effective 02/28/2025 the Clinical Director will</p>	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	<p>Continued From page 15</p> <p>assure all Person Centered Plans have a qualifying signatures on the signature page and that all plans are updated every 30 days to include update and/or revision signatures.</p> <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p> <p>The facility served clients between the ages of 14 to 17 years with diagnoses of Attention-Deficit/Hyperactivity, Major Depressive Disorder, Oppositional Defiant Disorder, Unspecified Trauma Stressor Related Disorder, Adjustment Disorder, Mood Disorder, Disappearance/Death of a Family Member, Unspecified Schizophrenia and other Psychotic Disorder. The facility failed to acquire a signature from the legal guardian for client #3's treatment plan updated treatment plan. As the facility's human resources, the Licensee/QP to failed to ensure personal records of staff were complete. The Licensee/QP did not keep up to date personnel and training records for staff. The AP was not employed at least full-time and there was no job description in the AP and the HM's personnel record. There was no evidence that staff were trained to administer medications. Eight out of thirteen staff and the CD/QP did not have current First Aid/cardiopulmonary resuscitation CPR) training and the facility did not ensure that at least one person with First Aid/CPR was working on each shift. Five out of thirteen staff did not have criminal history check within 5 business days of making a conditional offer of employment. The facility did not assist clients (#1, #2, #3, #4) in the acquisition of adaptive functioning in social and recreational skills and failed to coordinate with other resources within the client's (#3) system of care. Clients (#1, #2, #3, #4) were being provided</p>	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	Continued From page 16 transportation out of staff ratio, with one staff person proving transportation to 4 clients. The Licensee/QP arranged for clients' use of rideshare without the supervision of at least 2 staff persons accompanying clients. The facility failed to secure rabies shots and document veterinary care for a pet (rabbit) housed in the facility. The facility failed to implement policy governing their response to level one incidents related to medication errors (clients #1, #2, #3, #4). As the person identified as responsible for all functions of the facility, the Licensee/QP failed to demonstrate the core skills of competency in clinical skills, analytical skills, decision making and communication skills which impacted the health, safety, and welfare of the clients. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety, and welfare of the clients and must be corrected within 45 days.	V 109		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible;	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	<p>Continued From page 17</p> <p>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;</p> <p>(5) basis for evaluation or assessment of outcome achievement; and</p> <p>(6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to have a current treatment plan with written consent or agreement by the client or responsible party affecting 1 of 4 clients (#3). The findings are:</p> <p>Review on 2/11/25 of client #3's record revealed -Admission dated 12/12/22. -Age 14 years. - Diagnoses: Adjustment Disorder, Mixed Disturbance of Emotions and Conduct; Attention-Deficit Hyperactivity Disorder, Hyperactive Type; Disappearance and Death of a Family Member. -Treatment plan (current) was last signed on 12/6/22. -There was not an updated signature or written consent from the guardian or responsible party on client #3's updated treatment plan.</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	Continued From page 18 Interview on 2/27/25 the Licensee/Qualified Professional revealed: -Was not aware treatment plans for client #3 did not have updated signature and guardian or responsible party consent. -"I revise and edit the PCP (Person Centered Plan)." 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.	V 112		
V 117	27G .0209 (B) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and	V 117		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 117	<p>Continued From page 19</p> <p>(F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner.</p> <p>This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure that medications were labeled as required for 1 of 4 clients (#4). The findings are:</p> <p>Review on 2/11/25 of client #4's record revealed: -Admission date 6/14/24. -Age 16 years. -Diagnoses: Attention-Deficit/Hyperactivity, Inattentive Type; Oppositional Defiant Disorder; Intellectual Developmental Disability Disorder, Mild; Unspecified Mood Disorder; Unspecified Schizophrenia Spectrum and other Psychotic Disorder. -Physician's order dated 6/20/24 revealed: -Dexatoamp-Amphetamine (concentration) ER (extended release) 20 milligrams (mg) 24 hr (hour) capsule, take 1 capsule by mouth daily in the morning. -Physician's order dated 7/17/24 revealed: -Quetiapine Fumarate (mood) 100mg, take one tablet by mouth daily as directed. -Quetiapine Fumarate (mood) 50mg, take one tablet by mouth at bedtime as directed. -Physician's order dated 8/20/24 revealed: -Prozac 20mg (mood) Pulvule capsule, take one capsule by mouth daily in the morning as directed.</p>	V 117		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 117	Continued From page 20 Observation on 2/10/25 at approximately 12:26pm of client #4's medication revealed: -A small single pill, golden-yellowish color with "Y17" on one side was in a closed zip locked sandwich-sized, clear plastic bag. -There was no packaging label for the pill. Interview on 2/10/25 with the House Manager revealed: -She was not sure what the medication was, who had placed it in the plastic bag and why the medication was separated without a label. -"Maybe she (client #4) dropped it and they (staff) saved it (pill) to show him (Licensee/Qualified Professional (QP))." Interview on 2/24/25 with the Licensee/QP revealed: -Was not aware the single pill was in client #4's medication box and did not know when or what staff placed it there. -"I'll have to ask who put that (pill) in there (plastic bag), it should be in a bottle or bubble pack." -"The only thing I can think is she (client #4) refused (medication) and they (staff) didn't put it back in there (bottle/bubble pack)." This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a type A1 violation and must be corrected within 23 days.	V 117		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall	V 118		

Division of Health Service Regulation
STATE FORM

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 22</p> <p>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:</p> <p>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).</p> <p>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</p> <p>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).</p> <p>Finding #1 Review on 2/11/25 of client #1's record revealed: -There were no signed physician orders.</p> <p>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.</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 23</p> <p>Aripiprazole (depression) 5 mg, take one tablet (5mg total) by mouth daily in a plastic bag marked "AM."</p> <p>Cetirizine (allergy), take one tablet (10mg) by mouth daily.</p> <p>Fluticasone propionate (allergy) 50 microgram (mcg)/actuation nasal, use one spray in each nostril nightly.</p> <p>Metronidazole (infection) 500 mg, 1 tablet 2 times per day was not available.</p> <p>Doxycycline (infection) 100 mg, 1 capsule by mouth 2 times per day was not available.</p> <p>Review on 2/14/25 of client #1's January 30-31, 2025, MAR revealed:</p> <ul style="list-style-type: none"> -Vyvanse was documented as administered by Staff #9 on 1/31/25 -Guanfacine was not documented as administered on 1/30/25 and 1/31/25 -Aripiprazole was documented as administered by Staff #9 on 1/31/25. -Cetirizine was documented as administered by Staff #9 on 1/31/25. -Doxycycline was documented as administered by Staff #9 for the morning dose on 1/31/25. -Doxycycline was not documented as administered on 1/30/25 and 1/31/25 for the evening dose. -Metronidazole was documented as administered by Staff #9 on 1/31/25 for the morning dose. <p>Client #1 did not have a February 2025 MAR.</p> <p>Interview on 2/7/25 with client #1 revealed:</p> <p>- "I get my medications, I've never missed."</p> <p>Further interview and observation between 2:20pm-2:30pm on 2/24/25 with client #1 revealed:</p> <p>- Was aware of some of her medications and why</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 24</p> <p>they were prescribed; "one starts with an 'A', Guanfacine, Clonidine." -"I had prescriptions that came with me from the hospital, only had to take them a couple of days for stomach issues; that's what I was in the hospital for, I was full of gas." -"I think I had a yeast infection, I was getting a rash down there (pointing to her vaginal area)." -"I just take what they (staff) give (administer) me; they probably threw it (medication for infection) away when they saw I didn't need it and that it was for a couple of days." -Had medication management appointment 2/19/25 and to her knowledge no medication changes were made.</p> <p>Interview on 2/14/25 with the House Manager (HM) revealed: -"She (client #1) came with medication and we don't have it (Vyvanse, Metronidazole, Doxycycline) because she is new..." -Was not aware when client #1 ran out of medications and was not sure if medications had been sent to the pharmacy for refill. -Did not know client #1's medications and what the medications were prescribed for.</p> <p>Interview on 2/13/25 with the Associate Professional (AP) revealed: -"I work second shift, evening hours...Monday through Thursday, 5pm-11pm..." -Client #1 "just came." -Was not aware of medication refusals or medication errors. -Was not aware of staff administering medication without training.</p> <p>Interview on 2/14/25 with the Licensee/Qualified Professional (QP) revealed: -"I'm going to look into that (medications),</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 25</p> <p>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) at ...I did the MAR (for client #1)."</p> <p>"She (client #1) hasn't had her first med (medication) management appointment; that (appointment) has been scheduled for 2/19/25."</p> <p>Further interview on 2/24/25 with the Licensee/QP revealed:</p> <p>-Did not know all of client #1's medications and what each medication was prescribed for.</p> <p>"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."</p> <p>"I don't know why they (staff) left it (MAR) blank."</p> <p>"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. I'll have to get her med order from her previous doctor or pharmacy."</p> <p>Finding #2</p> <p>Review on 2/11/25 of client #2's record revealed: Signed physician orders dated 12/19/24 for the following medications:</p> <p>-Lamictal (mood stabilization) 100 mg, take one tablet by mouth twice daily as directed.</p> <p>-Cetirizine 10 mg tab, take one tablet by mouth daily as directed.</p> <p>-Metformin (pre-diabetes) 500 mg, take two tablets by mouth twice daily as directed.</p> <p>-Clonidine (ADHD) HCL (hydrochloric acid) ER (extended release) 0.1 mg, extended release, 12 hr (hour), take three tablets by mouth once daily as directed.</p> <p>-Seroquel (depression) 100 mg, take one tablet daily by mouth as directed.</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 26</p> <p>-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 days. -No physician order for Seroquel (depression) 200mg take 1 tablet by mouth at bedtime as directed -No discontinued orders</p> <p>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.</p> <p>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 twice daily as directed. Lamictal 100mg tablet, take one tablet by mouth twice daily as directed. Cetirizine HCL 10 mg tablet, take one tablet by mouth every day as directed (no pills had been dispensed from the bubble pack).</p> <p>Review on 2/10/25 of Client #2's February 2025</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 27 MAR (2/1/25-2/10/25) revealed: -There was no documentation for administration of Accu-check Guide Test Strips for the following dates: 2/1/25 through 2/3/25 (3 days); 2/5/25 through 2/10/25 (6 days). -On 2/4/25, Staff #5 initials were crossed out with and "X" for the Accu Check Guide Test Strips. -Lamictal was not documented as administered for the following dates: 2/6/25 and 2/7/25 for the morning doses 2/7/25 for the evening dose (3 days). -Lamictal was documented as administered by Staff #4 for the morning and evening doses on 2/1/25 through 2/3/25 (3 days) and 2/8/25 through 2/10/25 (3 days). -Lamictal was documented as administered by Staff #5 for the morning dose on 2/4/25 and 2/5/25 (2 days). -Cetirizine was not documented as administered on 2/6/25 and 2/7/25 (2 days). -Cetirizine was documented as administered by Staff #4 on 2/1/25 through 2/3/25 (3 days) and 2/8/25 through 2/10/25 (3 days). -Cetirizine was documented as administered by Staff #5 on 2/4/25 and 2/5/25 (2 days). -Metformin was not documented as administered for the morning doses on 2/6/25 and 2/7/25 (2 days). -Metformin was not documented as administered for the evening dose on 2/7/25. -Metformin was documented as administered by Staff #4 for the morning and evening doses 2/1/25 through 2/3/25 (3 days) and 2/8/25 through 2/10/25 (3 days). -Metformin was documented as administered by Staff #5 for the morning dose on 2/4/25 and 2/5/25 (2 days). -Clonidine was documented as administered by Staff #4 for the morning dose on 2/1/25 through 2/3/25 (3 days) and 2/8/25 through 2/10/25 (3	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 28</p> <p>days).</p> <p>-Seroquel (200 mg) mg was not documented as administered for the morning dose on 2/1/25, 2/6/25 through 2/10/25 (11 days).</p> <p>-Seroquel (200 mg) was documented as administered by Staff #4 on 2/2/25 and 2/3/25 (2 days).</p> <p>-Seroquel (200 mg) was documented as administered by Staff #5 on 2/4/25 and 2/5/25 (2 days).</p> <p>-Sertraline (200 mg) was not documentation as administered for the morning dose on 2/1/25, 2/6/25, and 2/7/25 (3 days).</p> <p>-Sertraline (200 mg) was documented as administered by Staff #4 for the morning dose on 2/2/25, 2/3/25 and 2/8/25 through 2/10/25 (5 days).</p> <p>-Sertraline (200 mg) was documented as administered by Staff #5 for the morning dose on 2/4/25 and 2/5/25 (2 days).</p> <p>Review on 2/10/25 of Client #2's January 2025 MAR revealed:</p> <p>-There was no documentation for administration of Accu Check Guide Test Strips from January 1-31,2025 (31 days)</p> <p>-Lamictal was not documented as administered for the morning dose on 1/1/25 through 1/3/25, 1/15/25, 1/17/25, 1/21/25, 1/28/25 and 1/29/25 (8 days).</p> <p>-Lamictal was not documented as administered for the evening dose on 1/3/25, 1/10/25 through 1/12/25, 1/17/25 through 1/19/25, 1/25/25, 1/26/25, 1/29/25 through 1/31/25 (11 days).</p> <p>-Lamictal was documented as administered by the HM for the morning dose on 1/10/25, 1/22/25, 1/24/25 and 1/31/25 (4 days).</p> <p>-Lamictal was documented as administered by Staff #3 for the morning dose on 1/7/25, 1/8/25 (2 days).</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 29 -Lamictal was documented as administered by Staff #4 for the morning dose on 1/4/25 through 1/6/25, 1/11/25 through 1/13/25, 1/18/25 through 1/20/25, 1/25/25 through 1/27/25 (12 days). -Lamictal was documented as administered by Staff #4 for the evening dose on 1/4/25 and 1/5/25 (2 days). -Lamictal was documented as administered by Staff #5 for the morning dose on 1/9/25, 1/14/25, 1/16/25, 1/23/25, 1/30/25 (5 days). -Cetirizine was not documented as administered for the morning dose on 1/1/25 through 1/3/25, 1/17/25, 1/21/25, 1/28/25, 1/29/25 (7 days). -On 1/15/25, Staff #5 initials were crossed out with and "X" for the morning dose of Cetirizine. -Cetirizine was documented as administered by the HM for the morning doses on 1/10/25, 1/22/25, 1/24/25 and 1/31/25 (4 days). -Cetirizine was documented as administered by Staff #3 for the morning dose on 1/7/25. -Cetirizine was documented as administered by Staff #4 for the morning dose on 1/4/25 through 1/6/25 , 1/11/25, 1/13/25, 1/18/25 through 1/20/25, 1/25/25 through 1/27/25 (11 days). -Cetirizine was documented as administered by Staff #5 for the morning dose on 1/8/25, 1/9/25, 1/14/25, 1/16/25, 1/23/25 and 1/30/25 (6 days). -Metformin was not documented as administered for the morning dose on 1/1/25 through 1/3/25, 1/7/25, 1/15/25, 1/17/25, 1/21/25, 1/23/25, 1/24/25, 1/28/25, 1/29/25 (11 days). -Metformin was not documented as administered for the evening dose on 1/3/25, 1/10/25, 1/12/25, 1/17/25 through 1/19/25, 1/25/24, 1/26/25, 1/29/25 through 1/31/25 (11 days). -Metformin was documented as administered by the HM for the morning dose on 1/10/25 and 1/31/25 (2 days). -Metformin was documented as administered by Staff #3 for the morning dose on 1/8/25.	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 30 -Metformin was documented as administered by Staff #4 for the morning dose on 1/4/25 and 1/6/25, 1/11/25 through 1/13/25, 1/18/25 through 1/20/25, 1/25/25 through 1/27/25 (11 days). -Metformin was documented as administered by Staff #4 for the evening dose on 1/4/25 and 1/5/25 (2 days). -Metformin was documented as administered by Staff #5 for the morning dose on 1/9/25, 1/14/25, 1/16/25, 1/22/25, and 1/30/25 (5 days). -Clonidine was not documented as administered for the morning dose on 1/1/25 through 1/3/25, 1/15/25, 1/17/25, 1/21/25, 1/28/25, and 1/29/25 (8 days). -Clonidine refusal for the morning dose on 1/4/25 through 1/6/25 (3 days). -Clonidine was documented as administered by the HM for the morning dose on 1/10/25, 1/22/25, 1/24/25 and 1/31/25 (4 days). -Clonidine was documented as administered by Staff #3 for the morning dose on 1/7/25 and 1/8/25 (2 days). -Clonidine was documented as administered by Staff #4 for the morning dose on 1/11/25 through 1/13/25, 1/18/25 through 1/20/25, 1/25/25 through 1/27/25 (9 days). -Clonidine was documented as administered by Staff #5 for the morning dose on 1/9/25, 1/14/25, 1/16/25, 1/23/25 and 1/30/25 (5 days). -Seroquel (100 mg) was not documented as administered for the morning dose on 1/1/25 through 1/3/25, 1/8/25, 1/9/25, 1/14/25 through 1/17/25, 1/21/25 through 1/24/25, 1/28/25, 1/29/25 and 1/31/25 (17 days). -Seroquel (100 mg) was not documented as administer for the evening dose on 1/1/25 through 1/31/25 (31 days). Seroquel (100 mg) refusal for the morning dose on 1/4/25 through 1/6/25, 1/11/25 through 1/13/25, 1/18/25 through 1/20/25 (9 days) and	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 31 Seroquel (100 mg) was documented as administered by the HM for the morning dose on 1/10/25 . -Seroquel (100 mg) was documented as administered by Staff #3 for the morning dose on 1/7/25. -Seroquel (100 mg) was documented as administered by Staff #5 for the morning dose on 1/30/25. -Seroquel (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, 1/21/25 through 1/24/25, 1/28/25, 1/29/25 and 1/31/25 (14 days). -Seroquel (200 mg) was refused for the morning dose on 1/4/25 through 1/6/25, 1/11/25 through 1/13/25, 1/18/25 through 1/20/25 and 1/25/25 through 1/27/25 (12 days). -Seroquel (200 mg) was documented as administered by the HM for the morning dose on 1/10/25. -Seroquel (200 mg) was documented as administered by the Staff #3 for the morning dose on 1/7/25. -Seroquel (200 mg) was documented as administered by Staff #5 for the morning dose on 1/8/25, 1/9/25 and 1/30/25 (3 days) -Sertraline was not documented as administered for the morning dose on 1/1/25 through 1/3/25, 1/15/25, 1/17/25, 1/21/25, 1/24/25, 1/28/25 and 1/29/25 (9 days). -Sertraline was documented as administered by the HM for the morning dose on 1/10/25, 1/22/25, 1/23/25 and 1/31/25 (4 days). -Sertraline was documented as administered by the Staff #3 for the morning dose on 1/7/25. -Sertraline was documented as administered by the Staff #4 the morning doses on 1/4/25 through 1/6/25, 1/11/25 through 1/13/25, 1/18/25 through 1/20/25, 1/25/25/ through 1/27/25 (12 days).	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 32</p> <p>-Sertraline was documented as administered by the Staff #5 for the morning doses on 1/8/25, 1/9/25, 1/14/25, 1/16/25, and 1/30/25 (5 days).</p> <p>Review on 2/10/25 of Client #2's December 2024 MAR revealed:</p> <p>-Accu-check Guide Test Strips was not listed on the December 2024 MAR.</p> <p>-Lamictal 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 12/20/24, 12/24/25 through 12/28/24 (15 days).</p> <p>-Lamictal was not documented as administered for the evening dose on 12/6/24, 12/13/24, 12/14/24, 12/19/24, 12/20/24, 12/26/24 through 12/29/24 (9 days).</p> <p>-Lamictal was refused for the morning dose on 12/7/24 through 12/9/24 and 12/14/24 through 12/16/24 (6 days).</p> <p>-Lamictal was refused for the evening dose on 12/7/24 through 12/12/24, 12/15/24 through 12/18/24, 12/24/24 and 12/25/24 (12 days).</p> <p>-Lamictal was documented as administered by the HM for the morning dose on 12/31/24.</p> <p>-Lamictal was documented as administered by Staff #4 for the morning dose on 12/1/24, 12/2/24, 12/21/24 through 12/23/24 and 12/28/24 through 12/30/24 (8 days).</p> <p>-Lamictal was documented as administered by Staff #4 for the evening dose on 12/1/24, 12/20/24, 12/21/24, 12/22/24 (4 days).</p> <p>-Lamictal was documented as administered by Staff #5 for the morning dose on 12/3/24, 12/4/24 (2 days).</p> <p>-Cetirizine 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 12/19/24 and 12/24/24 through 12/27/24 (13 days).</p> <p>-Cetirizine was documented as administered by</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 33 the HM for the morning dose on 12/31/24. -Cetirizine was documented as administered by Staff #4 for the morning dose on 12/1/24, 12/2/24, 12/7/24 through 12/9/24, 12/14/24 through 12/16/24, 12/20/24 through 12/23/24 and 12/28/24 through 12/30/24 (15 days). -Cetirizine was documented as administered by Staff #5 for the morning dose 12/3/24 and 12/4/24 (2 days). -Metformin was not documented as administered for the morning dose on 12/5/24, 12/6/24 12/10/24 through 12/13/24, 12/19/24, 12/20/24, 12/24/24 through 12/27/24 (12 days). -Metformin was not documented as administered for the evening dose on 12/19/24, 12/20/24, 12/24/24 through 12/31/24 (9 days). -Metformin was refused for the morning dose on 12/17/24 and 12/18/24 (2 days). -Metformin was refused for the evening dose on 12/8/24 and 12/16/24 through 12/18/24 (4 days). -Metformin was documented as administered by the HM for the morning dose on 12/31/24. -Metformin was documented as administered by Staff #4 for the morning dose on 12/1/24, 12/2/24, 12/7/24 through 12/9/24, 12/14/24 through 12/16/24, 12/21/24 through 12/23/24, 12/28/24 through 12/30/24 (14 days). -Metformin was documented as administered by Staff #4 for the evening dose on 12/1/24, 12/7/24, 12/15/25, 12/21/24, 12/22/24 (5 days). -Metformin was documented as administered by Staff #5 for the morning dose on 12/3/24, 12/4/24 (2 days). -Clonidine was not documented as administered for the morning dose on 12/13/24, 12/17/24 through 12/20/24, and 12/24/24 through 12/27/24 (9 days). -Clonidine was refused on for the morning dose on 12/1/24 through 12/12/24 , 12/14/24 through 12/16/24 (15 days).	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 12/21/24 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 12/10/24 through 12/18/24, 12/21/24 through 12/23/24 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 doses on 12/1/24, 12/2/24, 12/7/24 through 12/9/24 (5 days). -Seroquel (100 mg) was documented as administered by Staff #5 for the morning dose on 12/3/24 and 12/4/24 (2 days). -Seroquel (200 mg) was not documented as administered for the evening dose on 12/6/24, 12/12/24, 12/13/24 12/19/24 12/20/24, 12/24/24 through 12/29/24, and 12/31/24 (12 days). -Seroquel (200 mg) was refused for the evening dose on 12/5/24, 12/7/24 through 12/11/24, 12/14/24 through 12/18/24, 12/21/24 through 12/23/24 and 12/30/24 (15 days). -Seroquel (200 mg) was documented as administered by Staff #4 for the evening on 12/1/24. -Sertraline was not documented as administered for the morning dose on 12/5/24, 12/6/24,	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 35</p> <p>12/9/24, 12/11/24 through 12/13/24, 12/18/24 through 12/20/24, 12/24/24 through 12/27/24 and 12/31/24 (14 days).</p> <p>-Sertraline was refused for the morning dose on 12/10/24 and 12/14/24 through 12/17/24 (5 days).</p> <p>-Sertraline was documented as administered by Staff #4 on 12/1/24, 12/2/24, 12/7/24, 12/8/24, 12/21/24 through 12/23/24, 12/28/24 through 12/30/24 (10 days).</p> <p>-Sertraline was documented as administered by Staff #5 on 12/3/24 and 12/4/24 (2 days).</p> <p>Review on 2/10/25 of client #2's November 2024 MAR revealed:</p> <p>-Lamictal was not documented as administered for the morning dose on 11/1/24 and 11/29/24 (2 days).</p> <p>-Lamictal was not documented as administered for the evening dose on 11/29/24 and 11/30/24 (2 days).</p> <p>-Lamictal was documented as administered by Staff #3 for the morning dose 11/5/24, 11/12/24, and 11/19/24 (3 days).</p> <p>-Lamictal was documented as administered by Staff #4 for the morning dose 11/2/24 through 11/4/24, 11/9/24 through 11/11/24, 11/16/24 through 11/18/24, 11/23/24, 11/24/25 and 11/30/24 (12 days).</p> <p>-Lamictal was documented as administered by Staff #4 for the evening dose 11/1/24 through 11/3/24, 11/8/24 through 11/10/24, 11/15/24 through 11/17/24, 11/22/24 through 11/24/25 (12 days).</p> <p>-Lamictal was documented as administered by Staff #5 for the morning dose 11/6/24 through 11/8/24, 11/13/24 through 11/15/24, 11/20/24 through 11/22/24, 11/26/24 through 11/28/24 (12 days).</p> <p>-Cetirizine not documented as administered for the morning dose on 11/1/24 and 11/29/24 (2</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 36 days). -Cetirizine was documented as administered by Staff #3 for the morning dose on 11/5/24, 11/12/24 and 11/19/24 (9 days). -Cetirizine was documented as administered by Staff #4 for the morning dose on 11/2/24 through 11/4/24, 11/9/24 through 11/11/24, 11/16/24 through 11/18/24, 11/23/24 through 11/25/24 and 11/30/24 (13 days). -Cetirizine was documented as administered by Staff #5 for the morning dose on 11/6/24 through 11/8/24, 11/13/24 through 11/15/24, 11/20/24 through 11/22/24, 11/26/24 through 11/28/24 (12 days). -Metformin was documented as administered for the morning dose on 11/1/24 and 11/29/24 (2 days). -Metformin was documented as administered for the evening dose on 11/29/24 and 11/30/24 (2 days). -Metformin was documented as administered by Staff #3 for the morning dose on 11/5/24, 11/12/24, and 11/19/24 (3 days). -Metformin was documented as administered by Staff #4 for the morning dose on 11/2/24, 11/4/24, and 11/9/24 through 11/11/24, 11/16/24 through 11/18/24, 11/23/24 through 11/25/24 and 11/30/24 (12 days). -Metformin was documented as administered by Staff #4 for the evening dose on 11/1/24 through 11/3/24, 11/8/24 through 11/10/24, 11/15/24 through 11/17/24 and 11/22/24 through 11/24/24 (12 days). -Metformin was documented as administered by Staff #5 for the morning dose on 11/6/24 through 11/8/24, 11/13/24 through 11/15/24, 11/20/24 through 11/22/24 and 11/26/24 through 11/28/24 (12 days). -Clonidine was not documented as administered for the morning dose on 11/1/24 and 11/29/24 (2	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 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 11/4/24, 11/9/24 through 11/11/24, 11/16/24 through 11/18/24, 11/23/24 through 11/25/24 and 11/30/24 (13 days). -Clonidine was documented as administered by Staff #5 for the morning dose on 11/6/24 through 11/8/24, 11/13/24 through 11/15/24, 11/20/24 through 11/22/24, 11/26/24 (10 days). -Seroquel (100 mg) was not documented as administered for the morning dose on 11/1/24 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 by Staff #3 for the morning dose on 11/5/24, 11/12/24, and 11/19/24 (3 days). -Seroquel (100 mg) was documented as administered by Staff #4 for the morning dose on 11/2/24 through 11/4/24, 11/9/24 through 11/11/24, 11/16/24 through 11/18/24, 11/23/24 through 11/25/24 and 11/30/24 (13 days). -Seroquel (100 mg) was documented as administered by Staff #4 for the evening dose on 11/1/24 through 11/3/24, 11/8/24 through 11/10/24, 11/15/24 through 11/17/24, 11/22/24 through 11/24/24 (12 days). -Seroquel (100 mg) was documented as administered by Staff #5 for the morning dose on 11/6/24 through 11/8/24, 11/13/24 through 11/15/24, 11/20/24 through 11/22/24, 11/26/24 through 11/28/24 (12 days). -Seroquel (200 mg) was not documented as	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 38</p> <p>administered for the evening dose on 11/29/24 and 11/30/24 (2 days). -Seroquel (200 mg) was documented as administered by Staff #4 for the evening dose on 11/1/24 through 11/3/24, 11/8/24 through 11/10/24, 11/16/24, 11/17/24, 11/22/24 through 11/24/24 (11 days). -Sertraline was not documented as administered for the morning dose on 11/1/24, 11/5/24, 11/7/24 through 11/30/24 (23 days). -Sertraline was documented as administered by Staff #4 for the morning dose on 11/2/24 through 11/4/24 (2 days). -Sertraline was documented as administered by Staff #5 for the morning dose on 11/6/24.</p> <p>Observation on 2/24/25 at approximately 1:45pm revealed: -Interaction between the Licensee/QP and client #2. -Licensee/QP called client #2 into the facility office and asked why client #2 was not getting her daily blood sugar checks, "are you missing the glucometer or the strips?" -Client #2 responded, "I'm missing strips...I don't remember the last time it (blood sugar) was checked. I don't keep track of dates like that."</p> <p>Interview on 2/10/25 with client #2 revealed: -Took medications, got medications on time and had missed "when sleep, but never missed a whole day; staff will remind me."</p> <p>Further interview on 2/24/25 with client #2 revealed: -"I know most of them (medications), not really, Metformin for my blood sugar, Seroquel?" -"In the morning [Staff #4] or [Staff #3] give (administered) me medications; in the evening [Staff #4]."</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 39</p> <p>-Had never refused medications, "...No, I never refused meds; now I'm confused."</p> <p>Interview on 2/14/25 with the Licensee/QP revealed: -Was able to make out some of staff initials on MARs as "[Staff #3, Associate Professional (AP), Staff #4, HM]."</p> <p>- "I would have to look and see who was working on those dates to provide an explanation of why the initial is missing."</p> <p>- "[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."</p> <p>Interview on 2/24/25 with the Licensee/QP revealed: -Was not aware whether staff were administering both the 100mg and 200mg doses of Seroquel to client #2.</p> <p>- "...I would have to look at it (client #2's MAR). I don't know what an explanation might be for why they (medications) were not given."</p> <p>- "I know the pharmacy sent a discontinue order. I'll ask when it (Seroquel 100mg) was stopped and I'll have to get a discontinue order for that; I think it was definitely the 100 milligram (Seroquel) that was discontinued."</p> <p>- "She (client #2) will be able to check that (blood sugar) herself; I will get the doctor to write the order; she has not been taking blood sugar readings, that's why it's not documented."</p> <p>Interview on 2/26/25 with the Licensee/QP revealed: -Was waiting to hear from the doctor regarding client #2's discontinuation order for Seroquel 100mg.</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 40</p> <p>- "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) was not refilled. They didn'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) MAR. I am waiting to talk to the doctor to find out when it (Seroquel 100mg) was discontinued and I will ask him for the drug regimen reviews (requested 2/25/25)."</p> <p>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 twice daily as directed. -Depakote ER (mood) 500mg tablet, take one tablet by mouth at bedtime as directed. -Trazadone (depression) 100mg tablet, take one tablet by mouth at bedtime as directed.</p> <p>Observation on 2/10/25 at approximately 1:16pm of client #3's medication revealed. -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 12/2/24). -Clonidine HCL 0.1 mg tablet, take one tablet by mouth twice daily as directed (dispense date 12/30/24; handwritten blue "bedtime" sticker in</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 41</p> <p>upper right corner).</p> <p>-Trazodone 100 mg tablet, take one tablet by mouth at bedtime as directed (dispense date 12/2/24; empty bubble pack)</p> <p>-Trazodone 100 mg tablet, take one tablet by mouth at bed time as directed (dispense date 12/30/24; blue "bedtime" sticker in upper right corner).</p> <p>-Depakote SOD 500 mg tablet, take one tablet at bedtime as directed.</p> <p>Review on 2/10/25 of client #3's February 2025 MAR (2/1/25-2/10/25) revealed:</p> <p>-Clonidine 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).</p> <p>-Clonidine was documented as administered by Staff #4 for the evening dose on 2/2/25, 2/3/25, 2/8/25, and 2/9/25 (4 days).</p> <p>-Clonidine was documented as administered by Staff #5 for the morning dose on 2/4/25 through 2/6/25 (3 days).</p> <p>-Clonidine was documented as administered by Staff #5 for the evening dose on 2/4/25.</p> <p>-Depakote was documented as administered by Staff #4 for the evening dose on 2/2/25, 2/3/25, 2/8/25, and 2/9/25 (4 days).</p> <p>-Trazodone was documented as administered by Staff #4 for the evening dose on 2/2/25, 2/3/25, 2/8/25, and 2/9/25 (4 days).</p> <p>Review on 2/10/25 of client #3's January 2025 MAR revealed:</p> <p>-Clonidine was refused for the evening dose on 1/16/25.</p> <p>-Clonidine was documented as administered by the HM for the morning dose on 1/10/25 and 1/22/25 (2 days).</p> <p>-Clonidine was documented as administered by Staff #3 for the morning dose on 1/7/25.</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 42</p> <p>-Clonidine was documented as administered by Staff #3 for the evening dose on 1/28/25.</p> <p>-Clonidine was documented as administered by Staff #4 for the morning dose on 1/4/25 through 1/6/25, 1/11/25 through 1/13/24, 1/18/25 through 1/20/25, 1/25/25 through 1/27/25 (12 days).</p> <p>-Clonidine was documented as administered by Staff #4 for the morning dose on 1/4/25.</p> <p>-Clonidine was documented as administered by Staff #5 for the morning dose on 1/1/25, 1/2/25, 1/8/25, 1/9/25, 1/14/25, 1/16/25, 1/23/25, 1/30/25 and 1/31/25 (9 days).</p> <p>-Clonidine was documented as administered by Staff #7 for the evening dose on 1/23/25, 1/25/25 and 1/27/25 (3 days).</p> <p>-Clonidine was documented as administered by Staff #11 for the evening dose on 1/15/25 and 1/24/24 (2 days).</p> <p>-Depakote was refused for the evening dose on 1/29/25.</p> <p>-Depakote was documented as administered by Staff #4 for the evening dose on 1/4/24.</p> <p>-Depakote was documented as administered by Staff #11 for the evening dose on 1/24/25.</p> <p>Trazodone was documented as administered by Staff #3 for the evening dose on 1/4/25.</p> <p>Trazodone was documented as administered by Staff #11 for the evening dose on 1/4/25.</p> <p>.Review on 2/10/25 of client #3's December 2024 revealed: -No MAR for December 2024.</p> <p>Review on 2/10/25 of client #3's November 2024 MAR revealed: -Clonidine was not documented as administered for the morning dose on 11/1/24 and 11/29/24 (2 days).</p> <p>-Clonidine was documented as administered by Staff #3 for the morning dose on 11/5/24,</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 43</p> <p>11/12/25 and 11/19/24 (3 days).</p> <p>-Clonidine was documented as administered by Staff #4 for the morning dose on 11/2/24 through 11/4/24, 11/9/24 through 11/11/24, 11/16/24 through 11/18/24, 11/23/24 through 11/25/24 and 11/30/24 (13 days).</p> <p>-Clonidine was documented as administered by Staff #4 for the evening dose on 11/1/24 through 11/3/24, 11/8/24 through 11/10/24, 11/15/24 through 11/17/24, 11/22/24 through 11/24/24 (12 days).</p> <p>-Clonidine was documented as administered by Staff #5 for the morning dose on 11/6/24 through 11/8/24, 11/13/24 through 11/15/24, 11/20/24 through 11/22/24, 11/26/24 through 11/28/24 (12 days).</p> <p>-Clonidine was documented as administered by Staff #5 for the evening dose on 11/11/24.</p> <p>-Depakote was documented as administered by Staff #4 for the evening dose on 11/1/24 through 11/3/24, 11/8/24 through 11/10/24, 11/15/24 through 11/17/24 and 11/22/24 through 11/24/24 (12 days).</p> <p>-Trazodone was documented as administered by Staff #4 for the evening dose on 11/1/24 through 11/3/24, 11/8/24 through 11/10/24, 11/15/24 through 11/17/24, 11/23/24 and 11/24/24 (11 days).</p> <p>Interview on 2/7/25 with client #3 revealed: -Was administered medications on time and was not sure of names of medications.</p> <p>Interview on 2/24/25 with client #3 revealed: -Did not know medications, "I think clonidine? Is one of them, trazodone? Think they (medications) are for behavior, sleep or both. I think I take an anxiety pill. I had an anxiety attack today; I don't know what triggered it." -[Staff #3] or [Staff #5] gives me morning meds;</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 44</p> <p>[Staff #4] gives evening (medications); weekends, I don't remember ..."</p> <p>-Never refused medications, "sometimes I don't want to take (medication), but I do."</p> <p>Finding #4 Review on 2/11/25 of client #4's record revealed: -Signed physician orders dated 6/20/24 for the following medications: Dexatopamp-Amphetamine (concentration/ADHD) ER 20mg 24 hr capsule, extended release, take 1 capsule by mouth daily in the morning. -Signed physician orders dated 7/17/24: Seroquel (depression) 100mg, take one tablet by mouth daily as directed. Seroquel 50mg, take one tablet by mouth at bedtime as directed. -Signed physician orders dated 8/20/24: Prozac 20mg (mood/depression) Pulvule capsule, take one capsule by mouth daily in the morning as directed.</p> <p>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 mouth. -Seroquel 100 mg tablet, take tablet mouth every day as directed. -Prozac HCL 20 mg capsule, take one capsule by mouth every morning as directed. -Seroquel 50 mg tablet, take one tablet by mouth at bedtime as directed.</p> <p>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 Staff #5 for the morning dose on 2/4/25 and</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 45</p> <p>2/5/25 (2 days).</p> <p>-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).</p> <p>-Prozac was documented as administered by Staff #5 for the morning dose on 2/4/25 and 2/5/25 (2 days).</p> <p>-Seroquel (100mg) 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).</p> <p>-Seroquel (100mg) was documented as administered by Staff #5 for the morning dose on 2/4/25 and 2/5/25 (2 days).</p> <p>-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).</p> <p>Review on 2/10/25 of client #4's January 2025 MAR revealed:</p> <p>-Adderall was documented as administered by the HM for the morning dose on 1/10/25 and 1/22/25 (2 days).</p> <p>-Adderall was documented as administered by Staff #3 for the morning dose on 1/7/25.</p> <p>-Adderall was documented as administered by Staff #4 for the morning dose on 1/4/25 through 1/6/25, 1/11/25 through 1/13/25, 1/18/25 through 1/20/25, 1/25/25 through 1/27/25 (11 days).</p> <p>-Adderall was documented as administered by Staff #5 for the morning dose on 1/8/25, 1/9/25, 1/14/25, 1/16/25, 1/23/25, and 1/30/25 (6 days).</p> <p>-Prozac was refused for the morning dose on 1/4/25 through 1/6/25 (3 days).</p> <p>Prozac was documented as administered by Staff #3 for the morning dose on 1/7/25.</p> <p>-Prozac was documented as administered by Staff #4 for the morning dose on 1/11/25 through 1/13/25, 1/18/25 through 1/20/25 and 1/25/25 through 1/27/25 (9 days).</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 46</p> <p>-Prozac was documented as administered by Staff #5 for the morning dose on 1/9/25, 1/14/25, 1/16/25, 1/23/25 and 1/30/25 (5 days).</p> <p>-Prozac was documented as administered by the HM for the morning dose on 1/10/25 and 1/22/25 (2 days).</p> <p>-Seroquel (100mg) was not documented as administered for the morning dose on 1/21/25, 1/24/25, 1/31/25 (3 days).</p> <p>-Seroquel (100mg) was documented as administered by the HM for the morning dose on 1/10/25, 1/22/25 (2 days).</p> <p>-Seroquel (100mg) was documented as administered by Staff #3 for the morning dose on 1/7/25.</p> <p>-Seroquel (100mg) was documented as administered by Staff #4 for the morning dose on 1/4/25 through 1/6/25, 1/11/25 through 1/13/25, 1/18/25 through 1/20/25, 1/25/25 through 1/27/25 (12 days).</p> <p>-Seroquel (100mg) was documented as administered by Staff #5 for the morning dose on 1/8/25, 1/9/25, 1/14/25, 1/16/25, 1/23/25, 1/30/25 (6 days).</p> <p>-Seroquel (50mg) was not documented as administered for the evening dose on 1/3/25, 1/24/25 and 1/31/25 (3 days).</p> <p>-Seroquel(50mg) was documented as administered by the HM for the evening dose on 1/11/25 and 1/12/25 (2 days).</p> <p>-Seroquel (50mg) was documented as administered by Staff #4 for the evening dose on 1/4/25 and 1/5/25 (2 days).</p> <p>Review on 2/10/25 of client#4's December 2024 MAR revealed:</p> <p>-Adderall was documented as administered by the HM for the morning dose on 12/31/24.</p> <p>-Adderall was documented as administered by Staff #4 for the morning dose on 12/1/24, 12/8/24,</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 47</p> <p>12/9/24, 12/14/24 through 12/16/24, 12/21/24 through 12/23/24, 12/28/24, and 12/30/24 (11 days).</p> <p>-Adderall was documented as administered by Staff #5 for the morning dose on 12/2/24 through 12/4/24, 12/10/24 through 12/12/24 and 12/18/24 through 12/20/24 (9 days).</p> <p>-Prozac was not documented as administered for the morning dose on 12/31/24</p> <p>-Prozac was documented as administered by Staff #4 for the morning dose on 12/1/24, 12/7/24 through 12/9/24, 12/14/24 through 12/16/24, 12/21/24 through 12/23/24 (10 days).</p> <p>-Prozac not documented as administered by Staff #5 for the morning dose on 12/2/24, 12/3/24, 12/10/24 through 12/12/24, 12/18/24 through 12/20/24 (8 days).</p> <p>-Prozac was refused for the morning dose on 12/28/24 through 12/30/24 (3 days).</p> <p>-Seroquel (100mg) was documented as administered by the HM for the morning dose on 12/31/24.</p> <p>-Seroquel (100mg) was documented as administered by Staff #4 for the morning dose on 12/1/24, 12/7/24 through 12/9/24, 12/14/24 through 12/16/24, 12/21/24 through 12/23/24, 12/28/24 through 12/30/24 (13 days).</p> <p>-Seroquel (100mg) was documented as administered by Staff #5 for the morning dose on 12/2/24, 12/3/24, 12/10/24 through 12/12/24, and 12/18/24 through 12/20/24 (8 days).</p> <p>-Seroquel (50mg) was not documented as administered for the evening dose on 12/31/24.</p> <p>-Seroquel (50mg) was documented as administered by Staff #4 for the evening dose on 12/1/24, 12/7/24, 12/8/24, 12/15/24 through 12/17/24, 12/21/24, 12/22/24, and 12/28/24 through 12/30/24 (11 days).</p> <p>Review on 2/10/25 of client #4's November 2024</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 48 MAR revealed: -Adderall was not documented as administered for the morning dose on 11/1/24 and 11/29/24 (2 days). -Adderall was documented as administered by the Manager for the morning dose on 11/31/24. -Adderall was documented as administered by Staff #3 for the morning dose on 11/5/24, 11/12/24, 11/19/24 (3 days). -Adderall was documented as administered by Staff #4 for the morning dose on 11/2/24 through 11/4/24, 11/9/24 through 11/11/24, 11/16/2, 11/17/24, 11/23/24 through 11/25/24, and 12/30/24 (12 days). -Adderall was documented as administered by Staff #5 for the morning dose on 11/6/24 through 11/8/24, 11/13/24 through 11/15/24, 11/20/24 through 11/22/24, 11/26/24 through 11/28/24 (12 days). -Adderall was documented as administered by Staff #6 for the morning dose on 11/18/24. -Prozac was not documented as administered for the morning dose on 11/1/24. -Prozac was documented as administered by the House Manager for the morning dose on 11/31. -Prozac was documented as administered by Staff #3 for the morning dose on 11/5/24, 11/12/24, 11/19/24 (3 days). -Prozac was documented as administered by Staff #4 for the morning dose on 11/2/24 through 11/4/24, 11/9/24 through 11/11/24, 11/16/24 through 11/18/24, 11/23/24 through 11/25/24, and 11/30/24 (13 days). -Prozac was documented as administered by Staff #5 for the morning dose on 11/6/24 through 11/8/24, 11/13/24 through 11/15/24, 11/20/24 through 11/22/24, 11/26/24 through 11/28/24 (12 days). -Seroquel (100mg) was not documented as administered for the morning dose on 11/1/24.	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 49</p> <p>-Seroquel (100mg) was documented as administered by the HM for the morning dose on 11/31/24 (30 days in November).</p> <p>-Seroquel (100mg) was documented as administered by Staff #3 for the morning dose on 11/5/24, 11/12/24 and 11/19/24 (3 days).</p> <p>-Seroquel (100mg) was documented as administered by Staff #4 for the morning dose on 11/2/24 through 11/4/24, 11/9/24 through 11/11/24, 11/16/24 through 11/18/24, 11/23/24 through 11/25/24 and 11/30/24 (13 days).</p> <p>-Seroquel (100mg) was documented as administered by Staff #5 for the morning dose on 11/6/24 through 11/8/24, 11/13/24 through 11/15/24, 11/20/24 through 11/22/24, 11/26/24 through 11/28/24 (12 days).</p> <p>-Seroquel (50mg) was not documented as administered for the evening dose on 11/29/24 and 11/30/24 (2 days).</p> <p>-Seroquel (50mg) was documented as administered by Staff #4 for the evening dose on 11/1/24 through 11/3/24, 11/8/24 through 11/10/24, 11/15/24 through 11/17/24 and 11/22/24 through 11/24/24 (12 days).</p> <p>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.</p> <p>Review on 2/10/25 of Staff #1's record revealed:</p> <p>-Hired 11/25/24.</p> <p>-Title of Residential Counselor.</p> <p>-Had no documented training for medication administration.</p> <p>Review on 2/11/25 of Staff #3's record revealed:</p> <p>-Hired 11/20/24.</p> <p>-Title of Residential Counselor.</p> <p>-Had no documented training for medication</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 50</p> <p>administration.</p> <p>Review on 2/11/25 of Staff #5's record revealed: -Hired 1/29/24. -Title of Residential Counselor. -Had no documented training for medication administration.</p> <p>Review on 2/13/25 of Staff #6's record revealed: -Hired 12/22/24. -Title of Residential Counselor. -Had no documented training for medication administration.</p> <p>Review on 2/11/25 of Staff #7's record revealed: -Hired 7/10/24. -Title of Residential Counselor. -Had no documented training for medication administration.</p> <p>Review on 2/11/25 of Staff #9's record revealed: -Hired 6/10/24. -Title of Residential Counselor. -Had no documented training for medication administration.</p> <p>Review on 2/11/25 of Staff #11's record revealed: -Hired 11/20/24. -Title of Residential Counselor. -Had no documented training for medication administration.</p> <p>Review on 2/10/25 of HM's record revealed: -Hired 11/5/24. -Title of House Manager. -Had no documented training for medication administration.</p> <p>Review on 2/25/25 of the North Carolina Board of Nursing website revealed:</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 51</p> <p>-Nurse/Trainer who Licensee/QP identified as providing the medication administration training was a Licensed Practical Nurse (LPN).</p> <p>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 provide...I will send that to you by noon (2/14/25)." -Medication administration training can only be provided by a Registered Nurse (RN).</p> <p>Interview on 2/6/25 with Former Staff #1 revealed: -"None of the newer staff had training to distribute (administer) medications to the clients..."</p> <p>Interview on 2/7/25 with Staff #1 revealed: -On a typical day, "...and I'll do (administer) meds or the person (staff) after me will do meds." -"I had training to give medications, not sure when but I think it was in January (2025)." -He had not given medications and without training and was not aware of other staff administering medications without training. -"When I first started he (Licensee/QP) would have someone during my shift that was already certified to do meds. I was trained either the end of December (2024) or beginning of January (2025), don't remember the name of the trainer; yes, she was a nurse." -Medications had not been missed or refused by clients.</p> <p>Interview on 2/7/25 with Staff #2 revealed: -Did not administer medications and was not aware of any staff administering medications without training. -"They (clients) get meds 7am to 7pm and</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 52</p> <p>another staff (unknown) comes in to administer." -Did not know who administered medications on his shift (second, midshift 12-8pm). -Was not aware of medication refusals, missed medications or medication errors.</p> <p>Interview on 2/13/25 with Staff #3 revealed: -"...make sure meds are done properly, give (administer) meds; sometimes I do and sometimes I don't, because third shift will take care of it (medication administration)..." -Was not aware of staff doing medication administration without training, "everybody has had the training; there are only two shifts that administer meds, third and second shifts." -No medication issues, "not on my shift, not when I'm working."</p> <p>Attempted contact with Staff #4 on 2/13/25 and requested assistance from Licensee/QP. Called and left voice message, no return call.</p> <p>Attempted contact with Staff #5 on 2/13/25 and requested assistance from Licensee/QP. Called and left voice message, no return call.</p> <p>Interview on 2/13/25 with Staff #8 revealed: -"I do meds (administer medications) when I first come in; on the weekend I come in at 7am and I do it (administer medications). I got training on it too, [Clinical Director/QP (CD/QP)] did the training, it's (training) been about a couple of weeks ago." -"I did it (training) when I first came, I don't keep documentation (of training), they have it at the office. I need to get a copy and keep it in my binders." -"Yes, I document in the MARs." -"...I gave meds like one time there (facility) because [sister facility staff] and [HM] are usually</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 53</p> <p>already there, I only know about first shift." -Was not aware of staff administering medications who were not trained, "everybody was in the medication meeting and I think they were trained; a black lady provided the training. Yes, she was a nurse; yes, she gave a certificate, but it was kept at the office."</p> <p>Interview on 2/14/25 with Staff #10 revealed: -"...part of my duties is to pass (administer) meds but I haven't started that yet...I did take the medication administration through [Company name], a company that does virtual class through the last company I worked for. I've been trying to get a copy of the certificate for that training." -"[Licensee/QP] said he'll just have me take his class. I know how to pass meds, but I just didn't want to sign the book (MAR) without the copy of certification." -"I provided him (Licensee/QP) with all my certifications." -"I don't know anyone here, so I don't know if they (staff) have their training for med administration; I have to take the class over again."</p> <p>Interview on 2/21/25 with Staff #11 revealed: -"I don't administer medications; if on shift with [HM], she will do it (administer medications); with [Staff #10], she does it; [Staff #1], he would do it." -"Yes, I have seen them (HM, #10, and #1) do it (administer medications); they put it (medication) in a cup and call them (clients) one by one, give them water, pour (medication) from cup to their (client's) hand, and they (clients) open their mouth and lift their tongue, and they (staff) watch to make sure they (clients) take it (medication)." -Was not aware of medication errors and refusal of medications.</p> <p>Interview on 2/7/25 and 2/14/25 with the HM</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 54</p> <p>revealed:</p> <ul style="list-style-type: none"> - "I do medication administration, he (Licensee/QP) accepted my license (CNA)." - "I'm qualified to give medications." - "No one has administered medications without training, no, everybody has training." - Was not aware of client refusal of medications, "...they (clients) take medicationI walk away and try again (if client refuses) and usually that works." - "[Licensee/QP] keeps copies of my training in the office, he has a copy of my license and certification in the office." - "As of today (2/14/25), I am still administering medications." <p>Interview on 2/13/25 with the Associate Professional revealed:</p> <ul style="list-style-type: none"> - Was not aware of staff doing administering medication without training. - If 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 meds...call 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. <p>Interview on 2/19/25 with the CD/QP revealed:</p> <ul style="list-style-type: none"> - Was not aware of staff administering medications without training. 	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 55</p> <p>- "The missed documentation on the MARs is an oversight by employees who have received MAR training and have adequate information provided to them, but there is a disconnect when it's (training) put into practice."</p> <p>- "[Licensee/QP] checks MARs monthly to ensure that that errors don't continue to occur."</p> <p>- "I am trained to administer medications, there have been no refusals or medication errors."</p> <p>Interview on 2/13/25 and 2/14/25 with the Licensee/QP revealed:</p> <p>- Was person responsible for reviewing the MARs.</p> <p>- Reviewed MARs "periodically."</p> <p>- Was not aware of refusals and documentation errors on the clients' MARs.</p> <p>- "I would have to look and see who was working on those dates to provide an explanation of why the initial (staff) is missing (on the MAR)."</p> <p>- "It will be the same answer for all of them (MAR); I will have to check to see why they (clients) didn't get the medication."</p> <p>- All but newly hired staff had medication administration training in January 2025.</p> <p>- Was not aware that an RN had to provided the medication administration training for staff.</p> <p>- "The training was on 12/30/24, we (he and trainer) agreed to that date on 12/24/24; we need to find another nurse. I guess I try to be loyal."</p> <p>- "[Staff #3, AP, HM, and Staff #4] are trained to medication administration, they have all had the training a month ago."</p> <p>- "[Staff #3] has been with us 7 or 8 years. She got her med training under the other house we were working with. I don't have her chart on flash drive...but I'll look at hers."</p> <p>- Did not have Certified Nursing Assistance credentials for HM, "she transferred from [out of state]...so, she needs to stop administering medications...we got a training coming up and I</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 56</p> <p>can get her trained..."</p> <p>- "I talked to staff about not passing (administering) medications without the training ..."</p> <p>Due to failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician.</p> <p>Review on 2/28/25 of the initial 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? -An immediate review of all medication to include requesting a medication review from the attending psychiatrist, review of all MAR's, and request of all current medication scripts from the pharmacy. These request will be made beginning on 02/28/2025 by the agency's Clinical Director (CD/QP).</p> <p>Describe your plans to make sure the above happens.</p> <p>The agency is implementing a thorough process to address medication administration errors.</p> <p>1. Review of all MAR's (Medication Administration Records): The Clinical Director and Nurse will examine all MAR's to identify any errors or discrepancies in medication administration. This review will help ensure that the correct medication is given at the proper times, and that any mistakes are caught.</p> <p>2. Training Review: The Nurse will provide ongoing or refresher training to all staff involved in medication administration. This training will focus on understanding MAR legends, ensuring that the staff know how to accurately interpret and follow medication orders.</p> <p>3. Incident response to medication errors: The</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 57</p> <p>review will also address proper responses to any medication errors. This ensures that staff are aware of how to report, manage, and correct any medication errors promptly to minimize harm and improve patient safety."</p> <p>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 review. -Effective 02/28/2025 AP [AP] will administer all AM and PM medications.</p> <p>Describe your plans to make sure the above happens. The agency is implementing a thorough process to address medication administration errors. 1. Review of all MAR's (Medication Administration Records): The Clinical Director and Nurse (RN) will examine all MAR's to identify any errors or discrepancies in medication administration. 2. Training Review: The Nurse (RN) will provide ongoing or refresher training to all staff involved in medication administration.</p> <p>The facility served clients ranging in age from 14 to 17 years, with diagnoses of Attention-Deficit/Hyperactivity, Major Depressive Disorder, Oppositional Defiant Disorder, Unspecified Trauma Stressor Related Disorder, Adjustment Disorder, Mood Disorder, Disappearance/Death of a Family Member,</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 58 Unspecified Schizophrenia and other Psychotic Disorder. The facility failed to train 9 paraprofessional staff to administer and document medications on client MARs, following the written orders of the clients' physician. The total number of days untrained staff administered medications was approximately 154. Medication errors (clients #1, #2, #3, #4), from 11/1/24 through 2/10/25, included a total of approximately 410 days that medication was not documented as administered to clients, approximately 121 days of refusals of medications, medication not present in the facility (client #1, #2, #3), and failure to follow labeling guidelines (client # 4) for medication. Clients' physician or pharmacist was never contacted and made aware of the missed medications or refusals and did not ensure that clients (#2, #3, #4) had a drug regimen review at 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.	V 118		
V 121	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		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 121	<p>Continued From page 59</p> <p>This Rule is not met as evidenced by: 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. The findings are:</p> <p>Review on 2/11/25 of client #2's record revealed: -Admission date 3/28/24. -Age 17. -Diagnoses: Major Depressive Disorder, Recurrent; Attention-Deficit/Hyperactivity Disorder (ADHD), Combined Type; Oppositional Defiant Disorder; Unspecified Trauma Stressor Related Disorder. -Physician's orders dated 2/19/24: -Lamictal (mood stabilization) 100 milligram (mg), take one tablet by mouth twice daily. -Clonidine (ADHD) HCL (hydrochloric acid) Er (extended release) 0.1 mg, take three tablets by mouth once daily. -Seroquel (depression) 100 mg, take one tablet daily by mouth. -Sertraline (depression) 100 mg, take two tablets by mouth daily. -There was no documentation of a drug regimen review for client #2.</p> <p>Client #2's drug regimen reviews were not received by the survey exit date.</p> <p>Review on 2/10/25 of client #3's record revealed: -Admission date 12/12/22. -Age 14. -Diagnoses: Adjustment Disorder, Mixed;</p>	V 121		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 121	<p>Continued From page 60</p> <p>Disturbance of Emotions and Conduct; Attention-Deficit Hyperactivity Disorder, Hyperactive Type; Disappearance and Death of a Family Member.</p> <p>-Physician's orders dated 10/31/24: -Depakote (mood) ER 500mg, take one tablet by mouth at bedtime. -Trazadone (depression) 100mg, take one tablet by mouth at bedtime. -There was no documentation of a drug regimen review for client #3.</p> <p>Client #3's drug regimen reviews were not received by the survey exit date.</p> <p>Review on 2/11/25 of client #4's record revealed: -Admission date 6/14/24. -Age 16. -Diagnoses: Attention-Deficit/Hyperactivity Disorder, Inattentive Type; Oppositional Defiant Disorder; Intellectual Developmental Disability Disorder, Mild; Unspecified Mood Disorder; Unspecified Schizophrenia Spectrum and other Psychotic Disorder. -Physician 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 50mg, take one tablet by mouth at bedtime. -Physician order dated 8/20/24: -Prozac (mood/depression) 20mg, take one capsule by mouth daily in the morning. -There was no documentation of a drug regimen review for client #4.</p> <p>Client #4's drug regimen reviews were not</p>	V 121		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 121	Continued From page 61 received by the survey exit date. Interview on 2/10/24 with the Licensee/Qualified Professional (QP) revealed: -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 regimen reviews." This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type A1 rule violation and must be corrected within 23 days.	V 121		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. . This Rule is not met as evidenced by: Based on record reviews, observation, and	V 123		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 123	<p>Continued From page 62</p> <p>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:</p> <p>Review on 2/11/25 of client #1's record revealed: -Admission date 1/30/25. -Age 15. -Diagnoses: Attention-Deficit/Hyperactivity Disorder (ADHD), Combined Presentation; Major Depressive Disorder, Recurrent Episode, Moderate. -Had no signed physician orders.</p> <p>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. -Guanfacine (ADHD) 2 mg, 1 tablet in morning. -Aripiprazole (depression) 5 mg, 1 tablet by mouth once daily. -Cetirizine (allergy) 10 mg, 1 tablet in morning. -Flonase Propionate (allergy) 50 (micrograms) mcg, 1 spray in each nostril at night. -Doxycycline and Metronidazole were not available in the facility.</p> <p>Client #1 did not have a MAR for February 2025 (2/1/25 through 2/10/25).</p> <p>Review on 2/14/24 of client #1's January MAR revealed: Guanfacine was not documented as administered on 1/30/25 and 1/31/25</p>	V 123		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 123	<p>Continued From page 63</p> <p>Doxycycline was not documented as administered on 1/30/25 and 1/31/25 for the evening dose.</p> <p>No documentation that administration errors were immediately reported to a pharmacist or physician.</p> <p>Review on 2/11/25 of client #2's record revealed: -Admission date 3/28/24. -Age 17. -Diagnoses: Major Depressive Disorder, Recurrent; ADHD, Combined Type; Oppositional Defiant Disorder; Unspecified Trauma Stressor Related Disorder.. -Physician's order dated 12/19/24: -Lamictal (mood stabilization) 100 mg, take one tablet by mouth twice daily. -Cetirizine (allergy) 10 mg , take one tablet by mouth daily. -Metformin (diabetes/pre-diabetes) 500 mg, take two tablets by mouth twice daily. -Clonidine (ADHD) HCL (hydrochloric acid) ER (extended release) 0.1 mg, take three tablets by mouth once daily. -Seroquel (depression) 100 mg, take one tablet daily by mouth. -Sertraline (depression) 100 mg, take two tablets by mouth daily. -no physician's order for Seroquel (depression) 200 mg, take one tablet daily by mouth at bedtime.</p> <p>Review on 2/10/25 of client #2's 11/1/24 through 2/10/25 MARs revealed: February 2025 (approximately 17 days total): Lamictal was not documented as administered on 2/6/25 and 2/7/25 for the morning doses (2 days). Lamictal was not documented as</p>	V 123		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 123	Continued From page 64 administrated on 2/7/25 for the evening dose. Cetirizine was not documented as administrated on 2/6/25 and 2/7/25 (2 days). Metformin was not documented as administrated on 2/6/25 and 2/7/25 for the morning doses (2 days). Metformin was not documented as administrated on 2/7/25 for the evening dose . Seroquel was not documented as administrated on 2/1/25, 2/6/25 through 2/10/25 for the morning dose (6 days). Sertraline was not documented as administrated on 2/1/25, 2/6/25, and 2/7/25 for the morning dose (3 days). January 2025 (approximately 153 days total) : Lamictal was not documented as administrated on 1/1/25 through 1/3/25, 1/15/25, 1/17/25, 1/21/25, 1/28/25 and 1/29/25 for the morning dose (8 days). Lamictal was not documented as administrated on 1/3/25, 1/10/25 through 1/12/25, 1/17/25 through 1/19/25, 1/25/25, 1/26/25, 1/29/25 through 1/31/25 for the evening dose (12 days) Cetirizine was not documented as administrated on 1/1/25 through 1/3/25, 1/17/25, 1/21/25, 1/28/25, 1/29/25 for the morning dose (7 days). Metformin was not documented as administrated on 1/1/25 through 1/3/25, 1/7/25, 1/15/25, 1/17/25, 1/21/25, 1/23/25, 1/24/25, 1/28/25, 1/29/25 for the morning dose (11 days). Metformin was not documented as administrated on 1/3/25, 1/10/25, 1/12/25, 1/17/25 through 1/19/25, 1/25/24, 1/26/25, 1/29/25 through 1/31/25 for the evening dose (11 days). Clonidine was not documented as administrated on 1/1/25 through 1/3/25, 1/15/25,	V 123		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 123	<p>Continued From page 65</p> <p>1/17/25, 1/21/25, 1/28/25, and 1/29/25 for the morning dose (8 days). Clonidine was refused for the morning dose on 1/4/25 through 1/6/25 (3 days). Seroquel 100 mg was not documented as administered on 1/1/25 through 1/3/25, 1/8/25, 1/9/25, 1/14/25 through 1/17/25, 1/21/25 through 1/24/25, 1/28/25, 1/29/25 and 1/31/25 for the morning dose (17 days). Seroquel 100 mg was not documented as administered on 1/1/25 through 1/31/25 for the evening dose (31 days). Seroquel 100mg was refused for the morning dose on 1/4/25 through 1/6/25, 1/11/25 through 1/13/25, 1/18/25 through 1/20/25 (9 days). Seroquel 200 mg was not documented as administered on 1/1/25 through 1/3/25, 1/14/25 through 1/17/25, 1/21/25 through 1/24/25, 1/28/25, 1/29/25 and 1/31/25 for the morning dose (15 days). Seroquel 200 mg was refused for the morning dose on 1/4/25 through 1/6/25, 1/11/25 through 1/13/25, 1/18/25 through 1/20/25 and 1/25/25 through 1/27/25 (12 days). Sertraline 00 mg was not documented as administered on 1/1/25 through 1/3/25, 1/15/25, 1/17/25, 1/21/25, 1/24/25, 1/28/25 and 1/29/25 for the morning dose (9 days). December 2024 (approximately 145 days total): Lamictal was not documented as administered on 12/5/24, 12/6/24, 12/10/24 through 12/13/24, 12/17/24 through 12/20/24, 12/24/25 through 12/28/24 for the morning dose (15 days). Lamictal was not documented as administered on 12/6/24, 12/13/24, 12/14/24, 12/19/24, 12/20/24, 12/26/24 through 12/29/24 for the evening dose (9 days). Lamictal was refused for the morning dose</p>	V 123		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 123	Continued From page 66 on 12/7/24 through 12/9/24 and 12/14/24 through 12/16/24 (6 days). Lamictal was refused for the evening dose on 12/7/24 through 12/12/24, 12/15/24 through 12/18/24, 12/24/24 and 12/25/24 (12 days). Lamictal was refused on 12/7/24, 12/8/24, 12/9/24, 12/14/24, 12/15/24, and 12/16/24 for morning dose (6 days); Lamictal was refused on 12/7/24, 12/8/24, 12/9/24, 12/10/24, 12/11/24, 12/12/24, 12/15/24, 12/16/24, 12/17/24, 12/18/24, 12/24/24, and 12/25/24 for evening dose (12 days). Cetirizine was not documented as administered on 12/5/24, 12/6/24 12/10/24 through 12/13/24, 12/17/24 through 12/19/24 and 12/24/24 through 12/27/24 for the morning dose (13 days). Metformin was not documented as administered on 12/5/24, 12/6/24 12/10/24 through 12/13/24, 12/19/24, 12/20/24, 12/24/24 through 12/27/24 for the morning dose (12 days). Metformin was not documented as administered on 12/19/24, 12/20/24, 12/24/24 through 12/31/24 for the evening dose (10 days). Metformin was refused for the morning dose on 12/17/24 and 12/18/24 (3 days). Metformin was refused for the evening dose on 12/8/24 and 12/16/24 through 12/18/24 (4 days). Clonidine was not documented as administered on 12/13/24, 12/17/24 through 12/20/24, and 12/24/24 through 12/27/24 for the morning dose (9 days). Clonidine was refused on for the morning dose on 12/1/24 through 12/12/24 , 12/14/24 through 12/16/24 (15 days). Seroquel 100 mg was not documented as administered on 12/5/24, 12/6/24, 12/10/24	V 123		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 123	<p>Continued From page 67</p> <p>through 12/13/24, 12/17/24 through 12/31/24 for the morning dose (21 days).</p> <p>Seroquel 100 mg was not documented as administered on 12/6/24, 12/19/24, 12/10/24 , 12/24/24 through 12/27/24 and 12/31/24 for the evening dose (8 days).</p> <p>Seroquel 100mg was refused for the morning dose on 12/14/24 through 12/16/24 (2 days).</p> <p>Seroquel 100mg was refused for the evening dose on 12/10/24 through 12/18/24, 12/21/24 through 12/23/24 and 12/28/24 through 12/30/24 (15 days).</p> <p>Seroquel (200 mg) was not documented as administered on 12/6/24, 12/12/24, 12/13/24, 12/19/24, 12/20/24, 12/24/24 through 12/29/24, and 12/31/24 for the evening dose (12 days).</p> <p>Seroquel (200 mg) was refused for the evening dose on 12/5/24, 12/7/24 through 12/11/24, 12/14/24 through 12/18/24, 12/21/24 through 12/23/24 and 12/30/24 (15 days).</p> <p>Sertraline was not documented as administered on 12/5/24, 12/6/24, 12/9/24, 12/11/24 through 12/13/24, 12/18/24 through 12/20/24, 12/24/24 through 12/27/24 and 12/31/24 for the morning dose (14 days).</p> <p>Sertraline was refused for the morning dose on 12/10/24 and 12/14/24 through 12/17/24 (5 days).</p> <p>November 2024 (approximately 43 days total):</p> <p>Lamictal was not documented as administered on 11/1/24 and 11/29/24 for the morning dose (2 days).</p> <p>Lamictal was not documented as administered on 11/29/24 and 11/30/24 for the evening dose (2 days).</p> <p>Cetirizine was not documented as administered on 11/1/24 and 11/29/24 for the morning dose (2 days).</p>	V 123		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 123	<p>Continued From page 68</p> <p>Clonidine was not documented as administered on 11/1/24 and 11/29/24 for the morning dose (2 days).</p> <p>Seroquel 200 mg was not documented as administered on 11/29/24 and 11/30/24 for the evening dose (2 days).</p> <p>Sertraline was not documented as administered on 11/1/24, 11/5/24, 11/7/24 through 11/30/24 for morning dose (26 days).</p> <p>Clonidine was refused for the morning dose on 11/27/24, 11/28/24, 11/30/24 (3 days).</p> <p>Seroquel 100 mg was not documented as administered on 11/1/24 and 11/29/24 for the morning dose (2 days).</p> <p>Seroquel 100 mg was not documented as administered on 11/29/24 and 11/30/24 for the evening dose (2 days).</p> <p>No documentation that administration errors were immediately reported to a pharmacist or physician.</p> <p>Review on 2/10/25 of client #3's record revealed: -Admission date 12/12/22. -Age 14. -Diagnoses: Adjustment Disorder, Mixed; Disturbance of Emotions and Conduct; ADHD, Hyperactive Type; Disappearance and Death of a Family Member. -Physician's orders dated 10/31/24: -Clonidine (hypertension) HCL 0.1mg, take one tablet by mouth twice daily. -Depakote ER (mood) 500mg, take one tablet by mouth at bedtime. -Trazadone (depression) 100mg, take one tablet by mouth at bedtime.</p> <p>Review on 2/10/25 of Client #3's November, 2024-January, 2025 MARs revealed: Clonidine was refused for the evening dose</p>	V 123		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 123	<p>Continued From page 69</p> <p>on 1/16/25. Depakote was refused for the evening dose on 1/29/25. Clonidine was not documented as administered for the morning dose on 11/1/24 and 11/29/24.</p> <p>No documentation that administration errors were immediately reported to a pharmacist or physician.</p> <p>Review on 2/11/25 of client #4's record revealed: -Admission date 6/14/24. -Age 16. -Diagnoses: ADHD, Inattentive Type; Oppositional Defiant Disorder; Intellectual Developmental Disability Disorder, Mild; Unspecified Mood Disorder; Unspecified Schizophrenia Spectrum and other Psychotic Disorder. -Psychological Evaluation dated 4/16/24 noted language deficits, " ...limited effective use of language ...would often say 'yeah, yeah' in re-response to a question but did not seem to truly understand the question as she would often again respond 'yeah, yeah' if asked the opposite." -Physician's orders: -Adderall (concentration/ADHD) 20mg, take 1 capsule by mouth daily in the morning dated 6/20/24. -Seroquel (depression) 100mg, take one tablet by mouth daily dated 7/17/24. -Seroquel 50mg, take one tablet by mouth at bedtime dated 7/17/24. -Prozac (mood/depression) 20mg, take one capsule by mouth daily in the morning dated 8/20/24.</p> <p>Review on 2/10/25 of Client #4's November, 2024-January, 2025 MARs revealed:</p>	V 123		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 123	<p>Continued From page 70</p> <p>January 2025 (6 days total): Prozac was refused on 1/4/25 through 1/6/25 (3 days). Seroquel 50 mg was not documented as administered on 1/3/25, 1/24/25 and 1/31/25 for the evening dose (3 days). December 2024 (4 days total): Prozac was refused on 12/28/24 through 12/30/24 (2 days). Prozac was not documented as administered on 12/31/24. Seroquel 50 mg was not documented as administered on 12/31/24 for the evening dose. November 2024 (6 days total): Adderall was not documented as administered on 11/1/24 and 11/29/24 for the morning dose (2 days). Prozac was not documented as administered on 11/1/24 for the morning dose. Seroquel 100 mg was not documented as administered on 11/1/24 for the morning dose. Seroquel 50mg was not documented as administered on 11/29/24 and 11/30/24 for the evening dose (2 days).</p> <p>No documentation that administration errors were immediately reported to a pharmacist or physician.</p> <p>Review on 2/7/25 of the facility's records revealed: -There was no documentation that a pharmacist or physician was contacted regarding clients #1 #2, #3 and #4 missed medications and refusals.</p> <p>Interview on 2/10/25 and 2/25/25 with client #1 revealed: -Was administered medications and was not aware of missed medications. -Had medications provided from hospital stay and</p>	V 123		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 123	<p>Continued From page 71</p> <p>was not sure if medication regimen was completed.</p> <p>Interview on 2/10/25 and 2/24/25 with client #2 revealed: -Took medications, got medications on time and had missed "when sleep, but never missed a whole day; staff will remind me." -Had never refused medications, "...No, I never refused meds; now I'm confused."</p> <p>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."</p> <p>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.</p> <p>Interview on 2/7/25 with House Manager revealed: -"...she (client #2) never missed (taking medications) ..." -"The person that administered meds (medications) that day didn't sign (initial) ..." -"Refused is supposed to be 'X', maybe refused (client), I have no idea ..."</p> <p>Interview on 2/13/25 with the Associate Professional revealed: -"...if (medication) is refused we document it...'R' for refusal...document on back of the MAR...'X' is out of medication."</p> <p>Interview on 2/24/25 with the Licensee/Qualified Professional revealed: -An "X" on the MAR, "means medication was not</p>	V 123		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 123	Continued From page 72 given or can be a client refusal of medication, but that should be documented on the back of the MAR. X' means refusal, it was definitely not taken. -Had not made report to doctor or pharmacy, "no I didn't know I was supposed to." -Did not contact client #1's physician or prescribing pharmacy regarding medications. -"I don't know why they (staff) left it (MAR) blank." -"I wouldn't have med (medication) orders from her (client #1)'s 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. I'll have to get her med order from her previous doctor or pharmacy." This deficiency is cross referenced into 10A NCAC 27.0209 Medication Requirements (V118) for a Type A1 violation and must be corrected within 23 days.	V 123		
V 133	G.S. 122C-80 Criminal History Record Check G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT. (a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter. (b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 133	Continued From page 73 the applicant has been 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 national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 133	Continued From page 74 the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency. (c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant: (1) The level and seriousness of the crime. (2) The date of the crime. (3) The age of the person at the time of the conviction. (4) The circumstances surrounding the commission of the crime, if known. (5) The nexus between the criminal conduct of the person and the job duties of the position to be filled. (6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed. (7) The subsequent commission by the person of a relevant offense. The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider.	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 133	Continued From page 75 If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant. (d) Limited Immunity. - A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for: (1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual. (2) Failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section. (e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19,	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 133	Continued From page 76 False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5. (f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor. (g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met: (1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10. (2) The provider shall submit the request for a	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 133	<p>Continued From page 77</p> <p>criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.)</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to request a criminal history record check within five business days of making the conditional offer of employment for 5 of 13 staff (Staff #2 #4, #7, #9 and #10). The findings are:</p> <p>Review on 2/11/25 of Staff #2's personnel file revealed: -Date of hire 1/20/25. -Title of Residential Counselor. -No evidence a criminal history check was conducted.</p> <p>Review on 2/11/25 of Staff #4's personnel file revealed: -Date of hire 10/7/21. -Title of Residential Counselor. -Criminal history check requested on 9/6/22.</p> <p>Review on 2/11/25 of Staff # 7's personnel file revealed: -Date of hire 7/10/24. -Title of Residential Counselor. -Criminal history check requested on 8/7/24.</p> <p>Review on 2/11/25 of Staff #9's personnel file revealed: -Date of hire 6/10/24.</p>	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 133	Continued From page 78 -Title of Residential Counselor. -Criminal history check requested on 8/7/24. Review on 2/13/25 of Staff #10's personnel file revealed: -Date of hire 1/28/25. -Title of Residential Counselor. -No evidence a criminal history check was requested. Interview on 2/24/25 with the Licensee/Qualified Professional (QP) revealed: -Was responsible for hiring staff and conducting criminal history checks. -"...it's my understanding it (criminal history check) doesn't have to be done prior to hire." -When asked about requesting criminal history records within 5 business days of making a conditional offer employment the Licensee/QP had no response. 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.	V 133		
V 293	27G .1701 Residential Tx. Child/Adol - Scope 10A NCAC 27G .1701 SCOPE (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility. (b) Staff secure means staff are required to be awake during client sleep hours and supervision	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 293	Continued From page 79 shall be continuous as set forth in Rule .1704 of this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to a community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting. (e) Services shall be designed to: (1) include individualized supervision and structure of daily living; (2) minimize the occurrence of behaviors related to functional deficits; (3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting. (f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care.	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 293	<p>Continued From page 80</p> <p>This Rule is not met as evidenced by: Based on record reviews, observation and interviews the facility failed to ensure services to assist 4 of 4 clients (#1, #2, #3, #4) in the acquisition of social and recreational skills and failed to coordinate care within the client's system of care for 1 of 4 clients (#2). The findings are:</p> <p>Review on 2/11/25 of client #1's record revealed: -Admission date 1/30/25. -Age 15. -Diagnoses: Attention-Deficit/Hyperactivity Disorder (ADHD), Combined presentation; Major depressive Disorder, Recurrent Episode, Moderate. -Enjoyed cooking and doing hair. -Treatment Plan 1/28/25 noted, "...will increase her coping behaviors of peer socialization, physical activity and self-assurance to decrease depressive symptoms..."</p> <p>Review on 2/11/25 of client #2's record revealed: -Admission date 3/28/24. -Age: 17. -Diagnoses: Major Depressive Disorder, Recurrent; ADHD, Combined Type; Oppositional Defiant Disorder; Unspecified Trauma Stressor Related Disorder. -Loved animals; enjoyed writing. -Treatment Plan 10/1/24 noted, "...completing clinical assignments and activities which address healthy boundaries and socially appropriate behaviors..." - Physician order dated 12/18/24 for Accu-check Guide Test Strips (blood sugar check), take 1</p>	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 293	<p>Continued From page 81</p> <p>strip 3 times a day by miscellaneous routes as directed for 90 days.</p> <p>- No documentation of coordination to follow doctors order for client #2's blood sugar check.</p> <p>Review on 2/10/25 of client #2's Medication Administration Record (MAR) November 2024 thru February 2025 revealed:</p> <p>-no documentation to follow doctors order for client #2's blood sugar check</p> <p>Observation on 2/10/25 at approximately 2:10pm of client #2's medications revealed:</p> <p>-A small black zippered pouch with glucose meter, test strips and an owners manual in client #2's medication box.</p> <p>Observation on 2/24/25 at approximately 1:45pm revealed:</p> <p>-Interaction between Licensee/QP and client #2.</p> <p>-Licensee/QP called client #2 into the facility office and asked why client #2 was not getting her daily blood sugar checks, "are you missing the glucometer or the strips?"</p> <p>-Client #2 responded, "I'm missing strips...I don't remember the last time it was checked. I don't keep track of dates like that."</p> <p>Interview on 2/7/25 and 2/14/25 with the House Manager revealed:</p> <p>-Was not aware if or when client #2 had blood sugar checked.</p> <p>-Was not able to provide log documenting dates client #2's blood sugar had been checked.</p> <p>Interview on 2/13/25 with the Associate Professional revealed:</p> <p>-"Normally there are blood sugar checks for [client #2]; I'm not going to lie, we are not current with that."</p>	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 293	<p>Continued From page 82</p> <p>- "It (blood sugar check) should be put in a book and placed (documented) on back of the MAR."</p> <p>- "We need to create a book to keep up with [client #2]'s blood sugar checks."</p> <p>Interview on 2/13/25 and 2/14/25 with the Licensee/QP revealed:</p> <p>- "[Client #2] is not a diabetic, she is pre-diabetic. She takes Metformin, that's for pre-diabetes."</p> <p>- "I need to check with the doctor for clarification, but there should be documentation if she is checking her blood sugar."</p> <p>Further interview on 2/25/25 with the Licensee/QP revealed:</p> <p>- "She will be able check that (blood sugar) herself."</p> <p>- "She has not been taking blood sugar readings, that's why it's not documented."</p> <p>Review on 2/11/25 of client #3's record revealed:</p> <p>- Admission date 12/12/22.</p> <p>- Age 14.</p> <p>- Diagnoses: Adjustment Disorder, Mixed Disturbance of Emotions and Conduct; ADHD, Hyperactive Type; Disappearance and Death of a Family Member.</p> <p>- Enjoyed dancing, television, walking outdoors.</p> <p>- Treatment plan 2/20/24 noted, "...will develop and implement age appropriate communication skills...age appropriate hygiene..."</p> <p>Review on 2/11/25 of client #4's record revealed:</p> <p>- Admission date 6/14/24.</p> <p>- Age 16 years.</p> <p>- Diagnoses: ADHD, Inattentive Type; Oppositional Defiant Disorder; Intellectual Developmental Disability Disorder, Mild; Unspecified Mood Disorder; Unspecified Schizophrenia Spectrum and other Psychotic</p>	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 293	<p>Continued From page 83</p> <p>Disorder.</p> <p>-Psychological Evaluation dated 4/16/24 noted language deficits, " ...limited effective use of language ...would often say 'yeah, yeah' in response to a question but did not seem to truly understand the question as she would often again respond 'yeah, yeah' if asked the opposite."</p> <p>-Enjoyed electronics (cell phone, tablet), getting hair and nails done.</p> <p>-Treatment Plan 6/7/24 noted, "...will participate in individual and group therapy for the purposes of identifying and developing positive communication skills...building healthy relationships</p> <p>Interview on 2/7/25 and 2/24/25 with client #1 revealed:</p> <p>- "I like to do hair, I did [client # 3]'s hair (braids)."</p> <p>- "They (facility) said they will do activities, but not yet."</p> <p>- Had no issues with peers, "they (peers) are just there."</p> <p>- "I have not declined outings, we went to the movies about a week ago, I think it was last Sunday (2/16/25)."</p> <p>Interview on 2/10/25 and 2/24/25 with client #2 revealed:</p> <p>- "We used to go to the pool, skating, movies, bowling ...it's been a while, can't remember last outing. I think he (Licensee/Qualified Professional-QP) was planning one (outing/activity) this Saturday or next Saturday."</p> <p>- "We went to the movies, haven't been doing it that much often."</p> <p>- "I never declined going on an outing."</p> <p>Interview on 2/7/25 and 2/24/25 with Client #3 revealed:</p> <p>- "We do activities like swimming, bowling,</p>	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 293	<p>Continued From page 84</p> <p>skating; I like bowling." -Was unable to recall the last time she had participated in an activity. -"I like spelling and I like to walk outside; not going in places like skating, but I go so I don't spoil everybody else's fun. I play in the arcade." -"It's been a long time since we went skating."</p> <p>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.</p> <p>Interview on 2/7/25 with Staff #1 revealed: -"The facility does not plan activities, not to my knowledge; he (Licensee/QP) will do (celebrate) Christmas and give gift cards for like getting chores done, but as far as outings, other than case workers, I'm not aware of any..."</p> <p>Interview on 2/7/25 and 2/13/25 with Staff #2 revealed: -"help them with cooking...since I've been here (1/20/25), no community activities." -"they (clients) went to the farm yesterday (2/12/25), movies last week; they do things (activities), it's just spread out."</p> <p>Interview on 2/13/25 with Staff #8 revealed: -"They might ride to another kid's (client) doctor appointment; they don't really do a lot of activities, maybe with other shifts because it's later in the day, I don't know."</p> <p>Interview on 2/14/25 with Staff #10 revealed: -"He (Licensee/QP) did say that he lets them (clients) go out on the weekends, but since being here there have been no activities that I'm aware of..." -"He (Licensee/QP) said he had planned</p>	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 293	<p>Continued From page 85</p> <p>something for last weekend (2/8/25-2/9/25) and clients said they didn't want to go. I don't know what the plans (activities) are, and I didn't hear anyone say they didn't want to go. I asked (Licensee/QP) because that was something I was used to doing with clients. I don't usually drive, so I asked to see if I needed to plan to drive ..."</p> <p>-"[Client #4] went with her grandmother and her grandmother bought some things for [client #4] and the rest of the clients to do in the facility."</p> <p>Interview on 2/21/25 with Staff #11 revealed: -"...they don't have phones and they look at TV and stuff, they watch cartoons."</p> <p>Interview on 2/7/25 and 2/14/25 with the House Manager revealed: -"...some activities like walking, I walk with them."</p> <p>Interview on 2/13/25 with the Associate Professional revealed: -"We play card games, cook; except in the winter, they (clients) go to the pool, park (summer)." -"[Licensee/QP] is the one to take care of that (outings, activities) sometimes he does." -"Last time there was an outing was about two months ago." -"If it's someone's birthday they (clients) may get together." -"Sometimes both locations (sister facility) get together for Christmas."</p> <p>Interview on with the Clinical Director/QP revealed: -"They (clients) go to the library, shopping sprees, dinner, lunch, skating; pretty much weekly, unless there's inclement weather, transportation issues or other extenuating circumstances." -"In the summer, they (clients) went swimming a lot; they do more activities in the summer than in</p>	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 293	<p>Continued From page 86</p> <p>the cooler months."</p> <p>"We (staff) want to provide outings when they (clients) all can participate; we need to broaden our horizon."</p> <p>"When we (staff) ask, they (clients) are lackluster, it's like pulling teeth; they (clients) are sheltered and haven't participated in community outings."</p> <p>"They (clients) need to learn confidence, build confidence to communicate effectively and communicate needs; we need to be more proactive with increasing individual living skills for them to practice without adult supervision."</p> <p>Interview on 2/13/25 and 2/14/25 with the Licensee/QP revealed:</p> <p>-Clients did activities like skating, bowling, swimming, movies, library, and community outings.</p> <p>"...minimally they (clients) do activities at least twice a month."</p> <p>"They (clients) are asked what they want to do and will select whatever they want."</p> <p>"They (clients) go out to eat. They don't know it, but we're going to [pizza restaurant] today (2/14/25)".</p> <p>"I send money (for activities) and the staff or clients will say they don't want to go."</p> <p>"No, I don't post or plan activities ahead of time, usually it's last minute and mostly on weekends."</p> <p>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.</p>	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 295	Continued From page 87	V 295		
V 295	<p>27G .1703 Residential Tx. Child/Adol - Req. for A P</p> <p>10A NCAC 27G .1703 REQUIREMENTS FOR ASSOCIATE PROFESSIONALS</p> <p>(a) In addition to the qualified professional specified in Rule .1702 of this Section, each facility shall have at least one full-time direct care staff who meets or exceeds the requirements of an associate professional as set forth in 10A NCAC 27G .0104(1).</p> <p>(b) The governing body responsible for each facility shall develop and implement written policies that specify the responsibilities of its associate professional(s). At a minimum these policies shall address the following:</p> <p>(1) management of the day to day day-to-day operations of the facility;</p> <p>(2) supervision of paraprofessionals regarding responsibilities related to the implementation of each child or adolescent's treatment plan; and</p> <p>(3) participation in service planning meetings.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure at least one full time direct care staff met the requirements of an Associate Professional (AP). The findings are:</p> <p>Review on 2/12/25 of the AP's record revealed: -Hired 11/16/10. -Job title Associate Professional.</p> <p>Interview on 2/13/25 with the AP revealed:</p>	V 295		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 295	<p>Continued From page 88</p> <p>- "I'm the AP...normally the AP." - "I started in 2010 and work part-time because I have another job." - "I work second shift, evening hours...I work Monday through Thursday, 5pm-11pm." - "I provide clinical supervision (new staff orientation), therapeutic care, attend meetings, appointments, provide care in the home (facility) for safety." - "I supervise staff that is in the home (facility), new hires; I provide training for them on-the-job; show them how the facility operates."</p> <p>Interview on 2/13/25 and 2/21/25 with Staff #3 revealed: - "I am a residential counselor, been working there (at facility) almost 10 years." - "The AP is [Licensee/Qualified Professional-QP]."</p> <p>Interview on 2/7/25 and 2/14/25 with the House Manager revealed: - Was not aware who the AP was for the facility.</p> <p>Interview on 2/13/25 with the Licensee/QP revealed: - "[AP] is currently our AP...it's been years, it's been a while, not sure how many years (AP has had the position)." - "He works 4 days, Monday through Thursday and every other Sunday, 32 hrs, I think that's considered part-time."</p> <p>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.</p>	V 295		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 296	Continued From page 89	V 296		
V 296	<p>27G .1704 Residential Tx. Child/Adol - Min. Staffing</p> <p>10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS</p> <p>(a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times.</p> <p>(b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows:</p> <p>(1) two direct care staff shall be present for one, two, three or four children or adolescents;</p> <p>(2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and</p> <p>(3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents.</p> <p>(c) The minimum number of direct care staff during child or adolescent sleep hours is as follows:</p> <p>(1) two direct care staff shall be present and one shall be awake for one through four children or adolescents;</p> <p>(2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and</p> <p>(3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents.</p> <p>(d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan.</p>	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 296	<p>Continued From page 90</p> <p>(e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan.</p> <p>This Rule is not met as evidenced by: Based on record reviews, interviews and observations, the facility failed to ensure the minimum staff ratio of 2 staff for up to 4 children or adolescents. The findings are:</p> <p>Review on 2/11/25 of client #1's record revealed: -Admission date 1/30/25. -Age 15. -Diagnoses: Attention-Deficit/Hyperactivity Disorder, Combined presentation; Major depressive Disorder, Recurrent Episode, Moderate.</p> <p>Review on 2/11/25 of client #2's record revealed: -Admission date 3/28/24. -Age: 17. -Diagnoses: Major Depressive Disorder, Recurrent; Attention-Deficit/Hyperactivity Disorder, Combined Type; Oppositional Defiant Disorder; Unspecified Trauma Stressor Related Disorder.</p> <p>Review on 2/11/25 of client #3's record revealed: -Admission date 12/12/22. -Age 14.</p>	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 296	<p>Continued From page 91</p> <p>-Diagnoses: Adjustment Disorder, Mixed Disturbance of Emotions and Conduct; Attention-Deficit Hyperactivity Disorder, Hyperactive Type; Disappearance and Death of a Family Member.</p> <p>Review on 2/11/25 of client #4's record revealed: -Admission date 6/14/24. -Age 16. -Diagnoses: Attention-Deficit/Hyperactivity, Inattentive Type; Oppositional Defiant Disorder; Intellectual Developmental Disability Disorder, Mild; Unspecified Mood Disorder; Unspecified Schizophrenia Spectrum and other Psychotic Disorder. -Psychological Evaluation dated 4/16/24 noted language deficits, "...limited effective use of language ...would often say 'yeah, yeah' in response to a question but did not seem to truly understand the question as she would often again respond 'yeah, yeah' if asked the opposite."</p> <p>Observation on 2/10/25 from approximately 12:55pm to 2:20pm revealed: -Staff (Staff #9) was overheard telling the House Manager (HM) that she (Staff #9) was going to pick clients up from school. Clients #1, #2, #3, and #4 returned to the facility with Staff #9 alone at approximately 2:30-2:45 alone.</p> <p>Interview on 2/7/25 and 2/24/25 with client #1 revealed: -"One person takes us (clients #1, #2, #3, and #4) to and from school (day treatment program)." -"We got [rideshare] before, without staff; not sure how often." -"Some lady (unknown) comes weekly (to transport), not sure who she is, she has short silver hair; she also takes us to appointments, just her by herself."</p>	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 296	<p>Continued From page 92</p> <p>Interview on 2/10/25 and 2/24/25 with client #2 revealed: -"Usually one person does transportation to and from school." -"There are usually 2 staff, sometimes 3 staff (in facility)." -"We take [rideshare] every now and then when staff work and don't have a car or can't use their car; usually every afternoon to come home." -One staff member transports clients to day treatment, "[Staff #11] usually takes us in the morning." -"No staff ride with us in the [rideshare], the people at school know the [rideshare] is taking us, so they keep an eye out."</p> <p>Interview on 2/7/25 and 2/24/25 with client #3 revealed: -There are usually 2 staff on each shift. -"We take [rideshare] a lot, everyday now; staff don't ride with us. They just order them (rideshare), [Licensee/Qualified Professional (QP)] or [Day Treatment Staff] the principal at [Day Treatment Program]."</p> <p>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.</p> <p>Interview on 2/24/25 with Staff #2 revealed: -"Sometimes I take (transport clients) in my car and I'm alone with clients; other days it's arranged by [Licensee/QP], not sure how (clients are transported to day treatment) -Rideshare is used, "on occasion, clients are alone (no staff)."</p> <p>Interview on 2/13/25 and 2/21/25 with Staff #3</p>	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 296	<p>Continued From page 93</p> <p>revealed:</p> <p>- "I transport...I take them to [Day Treatment Program] in the morning. I take them (clients) to their programs. Yes, I drive them by myself."</p> <p>- Wasn't sure if rideshare was used to transport clients, "I just know what I do."</p> <p>Interview on 2/13/25 with Staff #8 revealed:</p> <p>- "I do pick up and drop off (day treatment), not the only one that do it (other staff transport also)."</p> <p>- "It's just me in the car (when transporting clients)."</p> <p>- "...the other day [client #3] wouldn't get in the car when I went to pick them (clients) up...called [Licensee/QP] and let him know (client #3 refused to be picked up), he ask to put her (client #3) on speaker, she told him no too...I don't know, he got her a [rideshare] or he brought her home, this was last week (2/2/25-2/8/25), no I don't remember what day, it was at the beginning of the week."</p> <p>Interview on 2/25/25 with the Day Treatment Staff revealed:</p> <p>- Rideshare used by facility, "depending on if staff (facility) are having issues with their vehicles."</p> <p>- "In the morning, he'll (Licensee/QP) use it (rideshare) to drop them (clients) off (at Day Treatment)."</p> <p>- "Normally [Licensee/QP] makes the decision and sets it (rideshare) up; if we (day treatment program) have room in our van, we'll transport them (facility clients)."</p> <p>- "I like to watch them (clients in rideshare) for safety reasons."</p> <p>- "He'll (Licensee/QP) use it (rideshare) if he's running late."</p> <p>- "I don't call [rideshare] myself, I don't have an account, he (Licensee/QP) sets it up."</p> <p>- "If I have to ride with a stranger, I'm not going to</p>	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 296	<p>Continued From page 94</p> <p>pay; I'm cheap." -"We're all in this together, we look out for the safety of our children at all cost."</p> <p>Interview on 2/7/25 and 2/14/25 with the HM revealed: -Two people on staff each shift. -"[Staff #9] picked up the clients (#1, #2, #3, and #4) from school alone because there were three clients in the backseat and a client in the front seat, so no space for staff (additional)."</p> <p>Interview on 2/19/25 with the Clinical Director/Qualified Professional revealed: -"Most of the time staff transport clients to and from school, if there are extenuating circumstances, [Licensee/QP] will make adjustments, utilize [rideshare]." -Rideshare is used by facility, "I would say about twice a week, not accompanied by staff." -"More than one staff transport to and from school, I would hope, I'm not totally sure." -"We (facility) need a commercial van...employees have to use their personal vehicles, we have to be more proactive with that (transportation)."</p> <p>Interviews on 2/14/25, 2/17/25 with the Licensee/QP revealed: -Regarding client #3's refusal to be transported by staff, "she's (client #3) done that often; she's done that a couple of times last week. She refused to get in the car with the [rideshare] car that I provided because she thought her peers were picking at her. [Sister facility staff] or another staff is there (day treatment), they (staff) will give me a call, and they will pick her up, or I'll go pick her up." -"I do that (rideshare) to make sure we maintain two staff at the house (facility), so two (staff) are</p>	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 296	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.	V 296		
V 366	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; (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) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	Continued From page 96 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The	V 366		

Division of Health Service Regulation
STATE FORM

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	<p>Continued From page 98</p> <p>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:</p> <p>Review on 2/10/25 of Medication Administration Records (MARs) for client #2 revealed:</p> <p>Client #2 refused medication for the following dates and times:</p> <p>January 2025 (approximately 27 days total):</p> <ul style="list-style-type: none"> -Cetirizine was refused for morning dose on 1/15/25. -Clonidine was refused for morning dose on 1/4/25 through 1/6/24 (2 days). -Seroquel 100 milligram (mg) was refused for morning doses on 1/4/25 through 1/6/25, 1/11/25 through 1/13/25, 1/18/25 through 1/20/25, and 1/25/25 through 1/27/25 (12 days). -Seroquel 200 mg was refused for morning doses on 1/4/25 through 1/6/25, 1/11/25 through 1/13/25, 1/18/25 through 1/20/25, and 1/25/25 through 1/27/25 (12 days). <p>December 2024 (approximately 76 days total):</p> <ul style="list-style-type: none"> -Lamictal was refused for morning doses on 12/7/24 through 12/9/24, and 12/14/24 through 12/16/24 (6 days). -Lamictal was refused for evening doses on 12/7/24 through 12/12/24, 12/15/24 through 12/18/24, and 12/24/24 and 12/25/24 (12 days). -Metformin was refused on 12/17/24 and 12/18/24 (2 days). -Metformin was refused for evening doses on 12/8/24, and 12/16/24 through 12/18/24 (4 days). -Clonidine was refused for the morning dose on 12/1/24 through 12/12/24, and 12/14/24 through 12/16/24 (15 days). -Seroquel 100 mg was refused for the morning 	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	<p>Continued From page 99</p> <p>dose on 12/14/24 through 12/16/24 (3 days). -Seroquel 100 mg was refused for the evening doses on 12/10/24 through 12/18/24, 12/21/24 through 12/23/24, and 12/28/24 through 12/30/24 (14 days). -Seroquel 200 mg was refused for evening doses on 12/5/24, 12/7/24 through 12/11/24, 12/14/24 through 12/18/24, 12/21/24 through 12/23/24, and 12/30/24 (15 days). -Zoloft was refused for morning doses on 12/10/24, and 12/14/24 through 12/17/24 (5 days).</p> <p>November 2024 (approximately 5 days total): -Clonidine was refused for morning doses on 11/27/24, 11/28/24, and 11/30/24 (3 days). -Clonidine was refused for evening doses on 11/16/24 and 11/17/24 (2 days).</p> <p>Review on 2/10/25 of Medication Administration Records (MARs) for client #3 revealed:</p> <p>Client #3 refused medication for the following dates and times:</p> <p>-Clonidine was refused for morning dose on 1/16/24. -Depakote was refused for evening dose on 1/29/24. -Depakote was refused for morning and evening doses on 10/30/24.</p> <p>Review on 2/10/25 of Medication Administration Records (MARs) for client #4 revealed:</p> <p>Client #4 refused medication for the following dates and times:</p> <p>January 2025 (3 days total): -Prozac was refused for morning dose on 1/4/24</p>	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	<p>Continued From page 100</p> <p>through 1/6/24 (3 days).</p> <p>December 2024 (3 days): Prozac was refused for morning doses on 12/28/24 through 12/30/25 (3 days).</p> <p>Review on 2/7/25 of the facility's incident reports revealed:</p> <ul style="list-style-type: none"> -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. <p>Interview on 2/24/25 with the Licensee/QP revealed:</p> <ul style="list-style-type: none"> -Was not aware of the medication errors. -"I don't know what an explanation might be for why they (medications) were not given." -"I don't know why they (staff) left it (MAR) blank. I will have to check to see who was working. 'X' means refusal, it (medication) was definitely not taken." -Had not contacted clients' physician to report errors and did not know he was supposed to report error, "no I didn't know I was supposed to." -Had not documented Level 1 incident reports for medication errors. -Had not determined the cause of the incidents, no risk/cause analysis or corrective measures 	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	Continued From page 101 developed and implemented to prevent similar incidents. -Had not assigned person(s) to be responsible for implementing corrections and preventive measures. 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.	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 floor. -Client #2's rabbit was not in the cage and was not visible in the room. Interview on 2/10/25 with client #2 revealed:	V 736		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 736	<p>Continued From page 102</p> <p>-Rabbit was in the room, "under the bed...she's free-range."</p> <p>Interview on 2/24/25 with client #2 revealed: -"She's (rabbit) somewhere (in client #2's bedroom)."</p> <p>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."</p> <p>Interview on 2/24/25 with client #3 revealed: -"...the rabbit is nice, cute and fluffy; it stays in [client #2]'s room."</p> <p>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.</p> <p>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..."</p> <p>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 room...come out to do chores...content 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."</p> <p>Interview on 2/19/25 with the Clinical Director/Qualified Professional (QP) revealed:</p>	V 736		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER TURN AROUND		STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 736	<p>Continued From page 103</p> <p>- "The rabbit is not in her (client #2) treatment plan; I have no clue about shot records."</p> <p>- "The rabbit came through [Day Treatment Program], it appears healthy; the other clients, they love it."</p> <p>Interview on 2/13/25 and 2/24/25 with the Licensee/QP revealed:</p> <p>- "I do not have any shot records for the animals as the bunny (rabbit) was a gift from the Day Treatment.</p> <p>- Would notify client #2's Social Worker (SW) that if it is a "...violation to have animals, the animal will have to be removed immediately...or shot records provided..."</p> <p>- "I spoke with her (client #2) social worker (about the rabbit), she (SW) said she would reimburse me for the rabies shot, I just need to take her (rabbit)."</p> <p>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.</p> <p>This deficiency was cited 6 times on 3/13/23, 8/8/23, 11/29/23, 2/21/24, 4/22/24, 7/11/24.</p>	V 736		