AND PLAN OF CORRECTION		ITATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		MHL096-282	B. WING			R 02/2025
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
LAIBO	RNE PLACE GROUP I	HOME	JTH CLAIBORN BORO, NC 275			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
V 000	INITIAL COMMENT	rs	V 000			
		w up survey was completed ficiencies were cited.				
		sed for the following service C 27G .5600A Supervised th Mental Illness.				
	This facility is licensed for 6 and has a current census of 6. The survey sample consisted of audits of 3 current clients					
V 112	27G .0205 (C-D) Assessment/Treatn	nent/Habilitation Plan	V 112			
	PLAN (c) The plan shall be assessment, and in legally responsible of admission for clie receive services be (d) The plan shall i (1) client outcome(achieved by provision projected date of act (2) strategies; (3) staff responsible (4) a schedule for the annually in consultar responsible person (5) basis for evaluar outcome achievement (6) written consent responsible party, construction (5) staff responsible party, construction (6) written consent responsible party, construction (6) staff responsible party, construction (7) staff	ILITATION OR SERVICE be developed based on the in partnership with the client or person or both, within 30 days ents who are expected to eyond 30 days. Include: (s) that are anticipated to be on of the service and a chievement; le; review of the plan at least ation with the client or legally or both; ation or assessment of				

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Division	of Health Service Re	egulation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPLE	
		MHL096-282	B. WING		R 05/02	/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CLAIBOI	RNE PLACE GROUP I	HOME	TH CLAIBOR ORO, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 112	This Rule is not me Based on record re interview, the facilit consent or agreeme party, or a written s stating why such co affecting 2 of 3 aud findings are: Review on 5/2/25 o - Admission date of - Diagnoses of Sch Chronic Kidney Dis - Person-Centered - No signature by co party. Review on 5/2/55 o - Admission date of - Diagnoses of Sch Developmental Dis - PCP dated 4/1/25 - No signature by co party. Interview on 5/2/25 stated they participa planning.	et as evidenced by: view, observation, and y failed to obtain written ent by the client or responsible tatement by the provider onsent could not be obtained ited clients (#1 and #3). The f client #1's record revealed: *8/1995. izophrenia, Reflux, Diabetes, ease. Profile (PCP) dated 4/29/25. lient #1 or the responsible f client #3's record revealed: *8/2013. izophrenic; Intellectual ability-Mild. lient #1 or the responsible client #1 and client #3 both ated in their treatment 23 staff #1 stated she thought	V 112			
	the signature pages plans. ealth Service Regulation	s were filed with the PCP				

Division of Health Service Regulation STATE FORM

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STATEMEN	of Health Service Re TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		MHL096-282	B. WING			R 02/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	RNE PLACE GROUP I	404 SOU	ITH CLAIBORN	NE PLACE		
	KNE FLACE GROOF I	GOLDSE	BORO, NC 275	30		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT)		(X5) COMPLET
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO T	HE APPROPRIATE	DATE
				DEFICIENC	Y)	
V 112	Continued From pa	ge 2	V 112			
		-				
	Interview on 07/05/	23 the Licensee stated Client				
		PCP's would be signed on				
	5/12/25.	-				
	This deficiency con	stitutes a re-cited deficiency				
	and must be correct	,				
V 118	27G .0209 (C) Med	ication Requirements	V 118			
	10A NCAC 27G .02	209 MEDICATION				
	REQUIREMENTS	inistration				
	(c) Medication adm (1) Prescription or r	non-prescription drugs shall				
		ed to a client on the written				
	5	uthorized by law to prescribe				
	drugs.					
		all be self-administered by				
	client's physician.	uthorized in writing by the				
		cluding injections, shall be				
		y licensed persons, or by				
		trained by a registered nurse	3			
		legally qualified person and				
		e and administer medications Iministration Record (MAR) of				
		red to each client must be kep				
	-	s administered shall be				
		ely after administration. The				
	MAR is to include the	he following:				
	(A) client's name;					
	.,	and quantity of the drug; administering the drug;				
		he drug is administered; and				
		of person administering the				
	drug.					
		for medication changes or				
	checks shall be rec	orded and kept with the MAR				

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STATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL096-282	B. WING			R 02/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE		
CLAIBO	RNE PLACE GROUP	HOME	JTH CLAIBORN BORO, NC 275			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
V 118	Continued From pa	ige 3	V 118			
	file followed up by a with a physician.	appointment or consultation				
	Based on record re facility failed to kee audited clients (#1, Finding #1 Review on 5/2/25 c	et as evidenced by: eviews and interviews the p the MARs current for 3 of 3 #4). The findings are: of client #1's record revealed:				
	Chronic Kidney Dis	izophrenia, Reflux, Diabetes,				
	dated 10/4/24 reve - Carvedilol 3.12mg - Divalproex 500mg - Famotidine 20mg - Flunisolide Spray each nostril twice d - Melatonin 10mg (- Quetiapine 100mg - Risperidone 1mg, daily	aled: g, (Hypertension) 1 twice daily g, (bipolar) 1 twice daily. , (acid reflux)1 twice daily. 0.25%, (allergies) 2 sprays- laily. insomnia), 1-2 at bedtime g, (antipsychotic) 1 twice daily (antipsychotic) 1 three times				
	bedtime.	g, (cholesterol) 1 daily at 100mg, (constipation) 1 daily	,			
	and April 2025 MA	ndicate the medication was				

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If continuation sheet 4 of 9

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		MHL096-282	B. WING			R 02/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	RNE PLACE GROUP	404 SOL	ITH CLAIBORN	IE PLACE		
	RNE PLACE GROUP	GOLDSE	BORO, NC 275	30		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC [\]	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pa	ige 4	V 118			
	 Divalproex 500mg 8:00pm Famotidine 20mg 8:00pm Flunisolide Spray twice daily, 2/28/25 Melatonin 10mg, 7 8:00pm. Quetiapine 100mg 8:00pm. Risperidone 1mg, 8:00pm 	e daily, 2/28/25 at 8:00pm. g, 1 twice daily, 2/28/25 at , 1 twice daily, 2/28/25 at 0.25%, 2 sprays- each nostril at 8:00pm. 1-2 at bedtime, 2/28/25 at g, 1 twice daily, 2/28/25 at 1 three times daily, 2/28/25 a g, 1 daily at bedtime, 2/28/25 a				
	4/30/25.	100mg, 1 daily, 4/29/25 - 0.025%, 2 sprays each nostril at 8:00pm.				
	- Admission date of	izophrenic; Intellectual				
	 Admission date of Diagnoses of Sch 	izoaffective Disorder-Bipolar ageal Reflux Disease, Sinus ary Microadenoma,				
	dated 10/28/24 rev	f client #4's physician orders ealed: (muscle movement) 1 twice				

Division of Health Service Re TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	E SURVEY
ND PLAN OF CORRECTION	DENTIFICATION NUMBER:	A. BUILDING:			PLETED
	MHL096-282	B. WING			R 02/2025
IAME OF PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
LAIBORNE PLACE GROUP	HOME 404 SOU	TH CLAIBORN	NE PLACE		
	GOLDSE	SORO, NC 275	530		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118 Continued From pa	age 5	V 118			
 GNP Clearlax Porin 8 ounces liquid c Haloperidol 5mg, Lithium Carb 1500 Lorazepam 1mg, Melatonin 3mg, (I Mirtazapine 15mg bedtime. Pantoprazole 40n Propranolol 10mg 2:00pm and 6:00pr Clozapine 100mg morning. Review on 5/2/25 c and March 2025 M No staff initials to ir administered for th February 2025 Benztropine 1mg, 8:00pm. Clozapine 100mg 8:00am. Lithium Carb 1500 8:00pm. Propranolol 10mg 6:00pm, 2/14/25 at and 2/20/25 at 6:00 March 2025 Benztropine 1mg, 8:00pm. Clozapine 100mg 6:00pm, 2/14/25 at Benztropine 1mg, 8:00pm. Clozapine 100mg 8:00pm. Clozapine 100mg 8:00pm. Clozapine 100mg 8:00pm. Clozapine 100mg 8:00pm. Clozapine 100mg 	(schizophrenia) 3 at bedtime. mg, (bipolar) 1 twice daily. (anxiety) 1 twice daily. (anxiety) 1 twice daily. (antidepressant) 1 daily at ng (acid reflux) 1 daily. g, (tremors) 1 at 6:00am, n , (schizophrenia) 1 in the of client #4's February 2025 MRs revealed: ndicate the medication was e following:: 1 twice daily, 2/20/25 at , 1 in the morning, 2/28/25 at mg, 1 twice daily, 2/20/25 at g, 1 at 6:00am, 2:00pm and 6:00am, 2:00pm and 6:00pm				

STATE FORM

STATEMEN	of Health Service Re TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		MHL096-282	B. WING			R 5/02/2025	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
CLAIBOI	RNE PLACE GROUP	HOME	TH CLAIBORN ORO, NC 275				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
V 118	Continued From pa	age 6	V 118				
	8:00pm and 3/31/2 - Lorazepam 1mg, 8:00pm. - Melatonin 3mg, 1 8:00pm. - Mirtazapine 15mg 8:00pm and 3/31/2 - Pantoprazole 40n - Propranolol 10mg 6:00pm, 3/19/25 at at 6:00pm and 3/31 - Quetiapine 100mg 8:00pm. - Trazodone 50mg, - Westab Plus 27-r 6:00pm and 3/31/2 Interview on 5/2/25 - Staff administered Interview on 5/2/25	1 twice daily, 3/31/25 at at bedtime, 3/31/25 at 5 at 8:00pm ng, 1 daily at bedtime, 3/18/25 at 5 at 8:00pm ng, 1 daily, 3/31/25 at 8:00pm. g, 1 at 6:00am, 2:00pm and 6:00am and 2:00pm, 3/27/25 1/25 at 6:00pm. g, 1 bedtime, 3/31/25 at 1 daily, 3/31/25 at 8:00pm. ng, 1 at 6:00pm, 3/27/25 at 5 at 6:00pm. 6 client #1 stated: d his medications daily. 6 client #4 stated: medications daily. 7 the Manager stated: en administered their					
	- Staff had forgotte - She would follow Interview on 5/2/25	en to sign initial the MAR. up with the responsible staff. the Licensee stated clients					
	medication adminis	o accurately document stration it could not be #2 received his medication as					
		nstitutes a re-cited deficiency cted within 30 days.					

Division of Health Service Regulation STATE FORM

	of Health Service Re NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		MHL096-282	B. WING			R 02/2025
IAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CLAIBO	RNE PLACE GROUP	HOME	JTH CLAIBORN BORO, NC 275			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 736	10A NCAC 27G .03 EXTERIOR REQU (c) Each facility and maintained in a saf manner and shall b odor. This Rule is not me Based on observat was not maintained orderly manner. Th Observation on 5/2 - The gray 3 seat se fabric that had peel the floor beside the - Client #6's bedrood inch light brown sta closet; brown reside approximately 2 fee baseboard and car - Client #5 had a 6 that had 2 knobs me drawer on the left I drawer on left side 6 drawer dresser he drawer missing, the handles missing. T knob at the top and missing 2 knobs or - Client #1's recline on both arms; lamp shade. - The hall bathroom	d its grounds shall be ie, clean, attractive and orderly be kept free from offensive et as evidenced by: ion and interview, the facility i in a clean, attractive and e findings are: /25 at 10:07am revealed: ofa in the sitting room had led off; fabric peelings were or e sofa and in the window sill. om had an approximately 12 ins in the carpet in front of the e had dropped down the wall et by the closet and on the pet; drawer dresser with a mirror issing on the top left; the 2nd had 3 knobs missing; another ad 4 knobs on the top left e 2nd drawer on the left had 2 The beside table was missing I another beside table was	1			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:			PLETED
		MHL096-282	B. WING			R 02/2025
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
LAIBOF	RNE PLACE GROUP	HOME				
	SUMMARY ST		BORO, NC 275	PROVIDER'S PLAN OF		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	COMPLET DATE
V 736	Continued From pa	age 8	V 736			
		ew furniture soon and that the installing new flooring ility.				
	minor repairs could major repairs requi	5 the Licensee stated only d be done by the facility and ired a work order. Work order the landlord about the carpet.	s			
		nstitutes a re-cited deficiency cted within 30 days.				