STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-937	A. BUILDING: _____ B. WING _____	R 02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE HEALTHCARE INC	627 DONALD ROSS DRIVE RALEIGH, NC 27610

(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, complaint and follow up survey was completed on February 26, 2025. The complaint was unsubstantiated (intake #NC00227378). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 6 and has a current census of 5. The survey sample consisted of audits of 2 current clients and 1 former client.	V 000	[redacted]	
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; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (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.	V 112	V112 Assessment/Treatment/ Habilitation Plan The team developed additional strategies to address the client's behaviors and to provide training and assistance to the staff on how to address behaviors using team approved strategies for consistency and uniformity for all staff. As of 3/15/25, the QP has inserviced the staff on the updated plan/strategies.	

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V 112	Continued From page 1	V 112		

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to implement 1 of 3 audited client's treatment plan (#2). The findings are:

Review on 2/24/25 of client #2's record revealed:
- admitted 3/22/24
- diagnoses: Schizoaffective (Bipolar type) and Hypertension
- a treatment plan dated 3/22/24 with the following crisis plan:
- "...listen, listen and listen again to her concerns. Talk to her in a calm manner. Validate her thoughts or ideas if that's appropriate. Monitor closely when she...seems to increasingly active when this is not the expectation. You don't have to agree with her but don't disagree when she is angry or upset...encourage client to call her daughter or son, safe friend..."

An attempted survey on 2/24/25 with client #2 revealed:
- was agitated, cursed several times as she attempted to explain incidents didn't relate to the questions

During interview on 2/24/25 client #3 reported:
- she recalled an incident when client #2 was sent to her bedroom
- client #2 "showed off at the program"

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V 112	Continued From page 2 - client #2 held a door at the program that prevented client #3's entrance - when she (client #3) was able to enter the room, she pushed client #2 to the side - this caused client #3 to become upset - client #2 cursed at the Director and case manager (CM) - the Director called staff #1 on client #2 - when client #2 arrived at the facility, staff #1 sent client #2 to her bedroom - client #2 had to stay in her bedroom for about 30 minutes - client #2 was upset and talked loud in her bedroom During interview on 2/24/25 staff #1 reported: - client #2 "only" exhibited behaviors after she returned from the program - recalled an incident this year (2025) client #2 had a behavior at the program - the Director made her aware of the behavior - client #2 arrived at the facility she was agitated - when she was agitated, it was hard to calm her down - she requested client #2 go to her room and calm down - there was no certain amount time client #2 had to stay in her bedroom "just until she calmed down" During interview on 2/26/25 the Qualified Professional reported: - client #3 informed her yesterday (2/25/25) staff #1 sent client #2 to her bedroom for a behavior - requested staff #1 to follow client #2's treatment plan - "sending [client #2] to her bedroom was not part of the treatment plan"	V 112		

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V 112	Continued From page 3 - planned to come up with other strategies to address client #2's behaviors when she returned from the program agitated	V 112		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders;	V 113	V113 Client Records The administrator and staff are responsible for assembling a record for each new admission. When a person is discharged that information should be maintained in the facility and may be moved from a book/record to an envelope labeled with the client's name. The facility will not release any original paperwork to anyone outside of the employment of this facility. QP has inserviced the staff and administrator on maintaining files belonging to individuals admitted to this facility on these premises at all times. Other options were explored which include: faxing information to the hospital, upon request of the hospital, staff writing/listing diagnoses and medications for EMS upon or prior to arrival or making a request to the pharmacy to share medication records with the hospital. This practice will be monitored by the QP.	

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V 113	Continued From page 4 (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on record review and interview the facility failed to maintain an individual client record for 1 of 1 former client (FC#6). The findings are: Review on 2/24/25 of FC#6's record revealed: - an identification face sheet with no admission date - no documentation of the following: - date of birth - gender - admission/discharge date - mental illness, developmental disabilities or substance abuse - screening and assessment During interview on 2/24/25 staff #1 reported: - FC#6 had been at the facility a short period of time - In January 2025 she contacted emergency services (EMS) for FC#6 - she gave the original copies to EMS - management informed her the original copies of the clients' records should not be given to EMS During interview on 2/25/25 the Qualified	V 113		

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V 113	Continued From page 5 Professional reported: - staff #1 informed her there was not ink for the printer - she gave the original copies of FC#6's record to EMS	V 113		
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. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure a psychotropic drug regimen review was completed every 6 months (client #4). The findings are: Review on 2/24/25 of client #4's record revealed: - admitted 4/24/18 - diagnoses: Schizophrenia, Hearing Impaired and Obesity - FL2 dated 3/14/24 had the following medications:	V 121	V121 Medication Requirements The QP met with the staff and administrator on 3/15/25 to review drug review protocols. The Drug/Medication reviews are completed quarterly by the contracted pharmacy's licensed pharmacist. The facility staff or administrator will request these reviews on no less than a quarterly basis. These will be filed in the Medication Administration Records or the individual client's file. Compliance will be monitored by the QP, no less than quarterly.	

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	MHL092-837	A. BUILDING: _____ B. WING _____	R 02/26/2026

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V 121	Continued From page 6 - Risperidone 3mg (milligrams) bedtime (schizophrenia) - Trazodone 150mg bedtime (depression) - Setraline 25mg 2 everyday (depression) - Clozapine 200mg 2 bedtime & Clozapine 50mg twice a day (Schizophrenia) - last documentation of a drug regimen review was 4/19/24 During interview on 2/24/25 staff #1 reported: - she was supposed to contact the pharmacist every 6 months for the drug regimen review - she contacted the pharmacist 2/24/25 to complete the drug regimen review During interview on 2/25/25 the Qualified Professional reported: - the staff or the Licensee was responsible for the current drug regimen reviews being in the clients' records	V 121		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home	V 132	V132 Notifications, Allegations & Protections The QP assumes all responsibility for reporting any and all allegations of abuse, neglect or exploitation to the HCPR within 24 hours of receiving that information.	

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V 132	Continued From page 7 care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure the Health Care Personnel Registry (HCPR) was notified of an allegation of abuse. The findings are: Review on 2/24/25 of client #2's record revealed: - admitted 3/22/24 - diagnoses: Schizoaffective (Bipolar type) and Hypertension During interview on 2/24/25 client #2's guardian reported: - client #2 made abuse allegations against staff #1 sometime after Christmas 2024 - she and the Qualified Professional (QP) made a visit to the facility to interview client #2 - client #2 denied the abuse allegations During interview on 2/24/25 & 2/25/25 the QP reported: - she was informed by the Department of	V 132		

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V 132	Continued From page 8 Social Services (DSS) in January 2025 that client #2 alleged abuse against staff #1 in January 2024 - client #2 was not at the facility in January 2024 - the DSS worker was supposed to get back with her after she confirmed the dates - had not heard back from the DSS worker, therefore she did not complete the investigation, did not remove staff #1 from the work shift and did not complete the HCPR During interview on 2/24/25 the Licensee reported - the Director from the day program called her the end of last year (2024) and informed her client #2 alleged staff #1 hit her - an internal investigation was completed by she and the (QP) - the QP should have a copy of the investigation - the QP should have notified HCPR	V 132		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time.	V 290	V290 Supervised Living As of 3/25/25 all clients will be reassessed to determine the level of supervision needed to attend the Drop In Center. Any client who is determined to need greater supervision than is provided in the Drop In Center setting will be referred to a PSR program where more supervision is provided. Going forward the administrator and staff will get input from the QP prior to referring the clients to a program.	

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V 290	Continued From page 9 (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 2 of 3 audited clients (#2 & #4) treatment plan documented they were capable of remaining in the community unsupervised for specified periods of times. The findings are:	V 290		

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V 290	Continued From page 10 Review on 2/24/25 of client #2's record revealed: - admitted 3/22/24 - diagnoses: Schizoaffective (Bipolar type) and Hypertension - treatment plan dated 3/22/24 with no documentation of unsupervised time Review on 2/24/25 of client #4's record revealed: - admitted 4/24/18 - diagnoses: Schizophrenia, Hearing Impaired and Obesity - treatment plan dated 4/20/24 with no documentation of unsupervised time During interview on 2/26/25 the Director of the day program reported: - clients were "free" to sign in and out of the day program - staff provided minimal supervision to the clients During interview on 2/26/25 client #2's guardian reported: - was not aware "clients could come and go as they please" - there was no discussion with the Qualified Professional (QP) regarding unsupervised time for client #2 - that day program would not be an appropriate place for client #2 if she could could sign herself in and out - planned to speak with the QP regarding a psychosocial rehabilitation (PSR) day program for client #2 During interview on 2/26/25 the QP reported: - she spoke with client #2's guardian - they planned to get client #2 in a more structured day program "like a PSR"	V 290		

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V 366	Continued From page 11	V 366		
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 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	V 366	V366 Incident Response Requirements The QP will ensure that all Level 2 Incident are entered into IRIS within 72 hours. If the incident involves an allegation of abuse, neglect or exploitation then it will be reported to HCPR within 24 hours. The investigation will begin immediately once QP is notified and will be completed within 5 calendar days). All level II and III incidents will be entered into IRIS within 72 *hours.*	

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V 366	Continued From page 12 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 preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not	V 366		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-937	A. BUILDING: _____ B. WING _____	R 02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE HEALTHCARE INC	627 DONALD ROSS DRIVE RALEIGH, NC 27610

(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 13 available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) Immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record review and interview the facility failed to implement written policies governing their response to a level II incident. The findings are: Review on 2/24/25 of the facility's record revealed: - no documentation of the following: - risk/cause analysis of the described incident - the health & safety needs of the client - determining the cause of the incident - implementing corrective measures & measures to prevent similar incidents During interview on 2/24/25 the Licensee reported	V 366		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 366	Continued From page 14 - the Director from the day program called her the end of last year (2024) and informed her client #2 alleged staff #1 hit her - an internal investigation was completed by she and the Qualified Professional (QP) During interview on 2/25/25 & 2/26/25 the QP reported: - she was informed by the Department of Social Services in January 2025 that client #2 alleged abuse by staff #1 in January 2024 - client #2 was not at the facility in January 2024 - the DSS worker was supposed to get back with her after she confirmed the dates - had not heard back from the DSS worker, therefore she did not investigate the incident	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and	V 367	V367 Incident Reporting Requirements The QP has provided an extensive training to the direct care staff and the administrator. Training included examples of level I, II and III incidents. Level of reporting will be decided by the QP . All incidents will be completed & entered into IRIS within 72 hours. HCPR notification must be submitted within 24 hours of learning of the incident. The QP is responsible for entering all Level II and III incident reports into IRIS.	

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V 367	Continued From page 15 identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).	V 367		

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PEACE HEALTHCARE INC	827 DONALD ROSS DRIVE RALEIGH, NC 27610

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V 367	Continued From page 16 (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure a level II incident report was complete and submitted to the local management entity/managed care organization (LME/MCO). The findings are: Review on 2/19/25 of the Incident Response Improvement System (IRIS) revealed: - no level II incident reports	V 367		

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V 367	Continued From page 17 Review on 2/24/25 of client #2's record revealed: - admitted 3/22/24 - diagnoses: Schizoaffective (Bipolar type) and Hypertension During interview on 2/25/25 client #2's guardian reported: - client #2 made abuse allegations against staff #1 sometime after Christmas 2024 - she and the Qualified Professional (QP) made a visit to the facility to interview client #2 - client #2 denied the abuse allegations During interview on 2/25/25 & 2/26/25 the QP reported: - she was informed by the Department of Social Services in January 2025 that client #2 alleged abuse by staff #1 in January 2024 - client #2 was not at the facility in January 2024 - the DSS worker was supposed to get back with her after she confirmed the dates - had not heard back from the DSS worker, therefore she did not complete the level II incident report During interview on 2/25/25 the Licensee reported - the Director from the day program called her the end of last year (2024) and informed her client #2 alleged staff #1 hit her - an internal investigation was completed by she and the QP - the QP should have completed the level II incident report	V 367		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS	V 736		

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V 736	Continued From page 18 (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 maintain in a safe, clean, attractive and orderly manner. The findings are: Observation on 2/24/25 at 2:58pm of the facility revealed: - a wooden kitchen table that leaned to one side - the rubber lining inside the refrigerator door was detached and hung to the floor - client #1 and client #4's bathroom sink had undrained water - had a foul sewer odor in the bathroom During interview on 2/24/25 staff #1 reported: - the Licensee was aware of the needed repairs, however had not informed her of the refrigerator's door Observation on 2/25/25 at 9:32am revealed the following: - maintenance was currently at the facility - a strong sewer odor throughout the facility - the tile peeled near the bathroom tub - the hallway bathroom's toilet was unstable due to a missing screw - the Licensee put on gloves and moved the toilet from side to side - the bathroom's door did not latch properly During interview on 2/25/25 the Licensee reported: - she was not aware the sink was clogged - was not aware the rubber lining was	V 736	V736 Facility Grounds & Maintenance As of 3/27/25 the facility contractor will have all repair or replace all areas in need of being repaired or replaced. These include: refrigerator, drawers, cabinets, tables, sinks, toilets, etc.. The plumbing issue in the bathroom was addressed on 2/28/25. All sinks are open (no clogs). The broken bathroom door was repaired on 2/26/25. Going forward the facility administrator will complete a monthly inspection of the facility and will make get her contractor to make repairs or replace items as needed.	

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V 736	Continued From page 19 detached from the refrigerator's door - was not aware of the hallway's bathroom issues - staff was supposed to notify management regarding the facility repairs This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		

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