STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
MHL092-610		B. WING		06/	03/2025		
	PROVIDER OR SUPPLIER Y HOME EXTENSION	I-PKEDS HOUSE	907 FRAN	DRESS, CITY, SICES DRIVE	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY SC IDENTIFYING INFORM.	ES 'FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	ΓS		V 000			
	This facility is licens category: 10A NCA Living for Adults with This facility is licens census of 3. The suaudits of 3 current of Sister facilities will be and sister facility B.	sed for the following C 27G .5600A Supe h Mental Illness. sed for 6 and current rvey sample consistients. e identified in this repoe identified as sister Clients and staff will letter of the facility a	service rvised tly has a ted of port. The r facility A ll be				
V 289	provides residential home environment these services is the rehabilitation of individuals, a developm or a substance abusupervision when in (b) A supervised live the facility serves eegine (1) one or more (2) two or more (2) two or more (2) two or more (3) two or more (4) two or more (5) two or more (6) two or more (7) two or more (8) two or more (9) two or more (10) two or more (11) two or more (12) two or more (13) two or more (14) two or more (14) two or more (15) two or mor	on SCOPE  ag is a 24-hour facilit  services to individu  where the primary p  e care, habilitation of  viduals who have a  ental disability or dis  se disorder, and who  the residence.  ving facility shall be I	als in a surpose of promental sabilities, to require sicensed if the beas	V 289			

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL092-610	B. WING		06/0	3/2025
	PROVIDER OR SUPPLIER  Y HOME EXTENSION	-PKEDS HOUSE 907 FRAN	DRESS, CITY, S ICES DRIVE , NC 27529	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 289	illness but may also (2) "B" design serves minors whose developmental disa diagnoses; (3) "C" design serves adults whose developmental disa diagnoses; (4) "D" design serves minors whose substance abuse do other diagnoses; (5) "E" design serves adults whose substance abuse do other diagnoses; (6) "F" design private residence, we three adult clients we mental illness but no disabilities, or three clients whose primate developmental disa other disabilities whose family provides the exempt from the folication (1)(A),(B),(E),(F),(G),(C),(C),(C),(C),(C),(C),(C),(C),(C),(C	have other diagnoses; nation means a facility which se primary diagnosis is a bility but may also have other nation means a facility which e primary diagnosis is a bility but may also have other nation means a facility which se primary diagnosis is ependency but may also have nation means a facility which e primary diagnosis is ependency but may also have nation means a facility which e primary diagnosis is ependency but may also have nation means a facility in a which serves no more than whose primary diagnoses is nay also have other adult clients or three minor	V 289			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL092-610	B. WING		06/	03/2025
	PROVIDER OR SUPPLIER  Y HOME EXTENSION	I-PKEDS HOUSE 907 FI	r address, city, s RANCES DRIVE ER, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 289	Continued From pa	ge 2	V 289			
	interview the facility (#1, #2, #3) had a had the primary purpose care and rehabilitate mental illness. The Review on 5/23/25 - Admitted 8/13/2 - Diagnoses of Sipolar Disorder, Disorder, Generaliz Autism Spectrum Disorder, Generaliz Autism Spectrum Disorder, History of Review on 5/23/25 - Admitted 6/14/2 - Diagnoses of Sipolar Disorder, Generaliz Autism Spectrum Disorder, Generalization Disorder, Generalization Disorder, Generalization Disorder, Generalization Disorder, Disorder, Generalization Disorder, Disorder, Generalization Disorder, Generalization Disorder, Generalization Disorder, Disorder, Generalization Disorder, Disorder, Generalization Disorder, Disorder, Generalization Disorder, Disorder, Disorder, Disorder, Generalization Disorder, Generalizat	ion, record review and realled to ensure 3 of 3 clier forme-like environment where of their services were the ion of individuals who have findings are:  of client #1's record revealed to the findings are:  of client #1's record revealed to the findings are:  of client #1's record revealed to the findings are:  of client #1's record revealed to the findings are:  of client #2's record revealed to the findings are the findings ar	e a d: se s d: ed, d			
	- Admitted 7/18/ - Diagnoses of B Personality Disorde Diabetes, Arthritis, Intellectual Develop Glaucoma, Hyperlip	bipolar Disorder, Borderline er, Hypertension (HTN), Typ Hyperthyroidism, Severe omental Disability (IDD), bidemia, Dermatitis, Mixed ontinence, Chronic Headack	e II			
	Observation on 5/2 3:30pm revealed:	1/25 between 11:32am -				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		MHL092-610		B. WING		06/	03/2025
	PROVIDER OR SUPPLIER  EY HOME EXTENSION	I-PKEDS HOUSE	907 FRAN	DRESS, CITY, S ICES DRIVE NC 27529	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 289	- Clients #2, #3, in the facility - Two twin size bedroom - Client #6B had clean undergarmer #1's bedroom  Interview on 5/21/2 - Staff #1A brougher from sister faciliat the facility for molecular the facility #6B and few days ago - She had her ow slept in there - She now share - Client #7B was bedroom while client #7B was bedroom while client from staying at the facility - The clients from staying at the facility - She and client for "a couple of night had facility for a year and client #facility for a year and client #facility for a year - Clients #6B and from sister facility E	#4A, #5A, #6B and # eds were located in entry two small grocery bants located on the flood to client #2 reported: ght clients #4A and #3 ity A and they've bee on the d #5A were sharing and lity d #7B arrived at the fiven bedroom, but client d a bedroom with client sleeping in client #1 not #1 was out of town client #3 reported: m sister facility A had y for a "little while" m sister facility B had y for "too long" #2 were sharing her hts"  5 client #4A reported 5A moved from siste they had been staying	client #3's ags with or of client  5A with n staying an empty facility a ant #6B ent #3 's been n't been bedroom  r facility A ag at the an in the facility go	V 289			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION  G:		(X3) DATE SURVEY COMPLETED	
		MHL092-610	B. WING		06/	03/2025
	PROVIDER OR SUPPLIER  Y HOME EXTENSION	I-PKEDS HOUSE 90	REET ADDRESS, CITY, 7 FRANCES DRIVE ARNER, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULI SC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 289	- Was living in the #4A were able to go - Staff #1A brough awhile and he and the facility for a "ha - He had clothes clothes at sister facility A linterview on 5/21/2 - Had been stayi - He slept in client was out of town linterview on 5/21/2 - Had been stayi - He brought a comedications with his facility - Client #2 move he could sleep in client #2 move he facility with client because the facility - Clients #4A and bedroom in the facility - Clients #4A and bedroom in the facility - Client #7B slept client #1 was out of - Client #2 kept he and would retrieve whenever client #7	te facility until he and clies back to sister facility A ght him to live in the facility A ght him to live in the facilicient #4A had been stay If a year"  in the facility, but he alsolity A 'and "waiting" to go back to	ity for ring at to had to had to had to the m so ove to 2025 staff tity two while and #3 droom			
	Interview on 5/21/2	5 the Director/Owner rep	orted:			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7. BOILDING.			
		MHL092-610	B. WING		06/03/2025	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BRADLE	Y HOME EXTENSION	N-PKFDS HOUSF	NCES DRIVE , NC 27529			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 289	Continued From pa	age 5	V 289			
	- She instructed clients #4A and #5/ - Clients #6B an stay on 5/19/25 - The facility had to stay there becauded to stay there becauded bedroom - Clients #2 and bedroom - Client #6B slept client #7B sleept in control of the stay of the	the staff #1A to move her and A to the facility in April 2025 d #7B came to the facility to d enough beds for #6B and #7B use client #1 was out of town #3 were sharing client #3's of the client #1's bedroom and client #2's bedroom d #5A were sharing an empty ility ith clients #4A, #5A, #6B & facility was "temporary" and uation" because she didn't have for this facility or sister facility ents #4A, #5A, #6B & #7B to facility once she hired new cess of hiring new staff for the acility B, and the new staff was on 5/24/25				
V 291	27G .5603 Supervi 10A NCAC 27G .56	sed Living - Operations  OPERATIONS	V 291			
	(a) Capacity. A factorial six clients when the developmental disason June 15, 2001, than six clients at the provide services at licensed capacity. (b) Service Coordination of the profession treatment/habilitation six clients at the provide services at licensed capacity.	cility shall serve no more than e clients have mental illness or abilities. Any facility licensed and providing services to more hat time, may continue to no more than the facility's nation. Coordination shall be en the facility operator and the hals who are responsible for on or case management. If the Family or Legally				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		MHL092-610		B. WING		06/	03/2025
	PROVIDER OR SUPPLIER  Y HOME EXTENSION	I-PKEDS HOUSE	907 FRAN	DRESS, CITY, S ICES DRIVE , NC 27529	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM.	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 291	provided the opport relationship with he means as visits to the facility. Reports annually to the pare legally responsible Reports may be in conference and shaprogress toward me (d) Program Activitiactivity opportunitie needs and the treat Activities shall be dinclusion. Choices or legal system is in	n. Each client shall tunity to maintain and or or his family throughe facility and visits a shall be submitted ent of a minor reside person of an adult rewriting or take the foall focus on the client eeting individual goalies. Each client shall shall be been been to foster commay be limited when the aprimary concertion.	ongoing gh such outside at least ent, or the esident. orm of a t's als. all have choices, an. mmunity on the court alth or	V 291			
	interview the facility six clients were ser	et as evidenced by: ion, record review ar realled to ensure no ved at a time when to s or developmental o	more than the clients				
	- Admitted 8/13/ - Diagnoses of S Bipolar Disorder, D Disorder, Generaliz Autism Spectrum D Reflux Disease (GE	of client #1's record 12 schizoaffective Disor epression, Impulse ( red Anxiety Unspecif bisorder, Gastroesop ERD), Chronic Kidne Alcohol Abuse and	der, Control fied, bhageal ey Disease				
	- Admitted 6/14/0	of client #2's record )2 schizophrenia Undiffe					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		MHL092-610		B. WING			06/03/2025	
	PROVIDER OR SUPPLIER  Y HOME EXTENSION	-PKEDS HOUSE	907 FRAN	DRESS, CITY, SICES DRIVE NC 27529	STATE, ZIP CODE			
(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 C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC)	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 291	Review on 5/23/25 - Admitted 7/18/ Diagnoses of B Personality Disorde Diabetes, Arthritis, Intellectual Develop Glaucoma, Hyperlip Fecal & Urinary Inc and Generalized Pa  Review on 5/23/25 revealed: - Admitted into s - Diagnoses of S Paranoid Type, GE  Review on 5/23/25 revealed: - Admitted into s - Diagnoses of In Borderline Personal Hyperlipidemia, Tou  Review on 5/23/25 revealed: - Admitted into s - Diagnoses of M Mood Adjustment, I Impediment/Disturb Colostomy and HTI  Review on 5/23/25 - Admitted into s - Diagnoses of S HTN, GERD, Brady	of client #3's record 14 sipolar Disorder, Border, Hypertension (HT) Hyperthyroidism, Secondar Disability (ID) bidemia, Dermatitis, Iontinence, Chronic Hain of client #4A's record sister facility A on 6/18 schizophrenia, Heber RD, HTN and Severe of client #5A's record sister facility A on 11/2 mpulse Control Disor lity Disorder, HTN, urette Syndrome and of client #6B's record sister facility B on 8/13 fajor Depressive Dis Psychosis, Speech bances, Traumatic Bi	derline N), Type II vere D), Mixed Headache d 3/23 bhrenia, e IDD d 24/04 der, Enuresis d 3/12 order, rain Injury, evealed: 8/98 oid Type, demia	V 291				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL092-610	B. WING		06/03/2025	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BRADLE	Y HOME EXTENSION	-PKFDS HOUSE	CES DRIVE NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRESS OF THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
V 291	- Clients #2, #3, in the facility  Interview on 5/21/22 - Staff #1A brougher from sister facility - Staff #1A, clien staying at the facility Interview on 5/21/25 - The clients from staying at the facility - The clients from staying at the facility - The clients from staying at the facility - FS #3 left the facility - FS #3 left the facility Interview on 5/21/25 - He and client # with staff #1A, and facility for a year an - Staff #1A was the facility - He brought some medications with his facility - Was living in the #4A were able to go - Staff #1A brought facility and they for a "half a year"	he only staff in the facility #4A, #5A, #6B and #7B were  5 client #2 reported: th clients #4A and #5A with tity A to live in the facility illing in as the staff because is left t #4A and client #5A had been by for months  5 client #3 reported: In sister facility A had been by for a "little while" In sister facility B hadn't been by for "too long" acility, but she didn't know  the only staff that worked in the  5 client #4A reported: 5 A moved from sister facility A they had been staying at the	V 291			

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  907 FRANCES DRIVE GARNER, NC 27239  D(A) ID PREFIX CEACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  100 PREFIX CEACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  100 PREFIX TAG  100 PREFIX CEACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  100 PREFIX TAG  100 PREFIX TAG  100 PREFIX TAG  100 PROVIDER'S PLAN OF CORRECTION  100 PREFIX TAG  100 PREFIX TAG  100 PROVIDER'S PLAN OF CORRECTION  100 PREFIX TAG  100 PREFIX TAG  100 PREFIX TAG  100 PROVIDER'S PLAN OF CORRECTION  100 PREFIX TAG  100 PREFIX TAG  100 PROVIDER'S PLAN OF CORRECTION  100 PROVIDER'S  100 PROVIDER'S PLAN OF CORRECTION  100 PROVID	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  BRADLEY HOME EXTENSION-PKEDS HOUSE  OF FRANCES DRIVE GARNER, NC 27529  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUARDORY OR I.S. IDENTIFYING INFORMATION)  PREFIX TAG  V 291  Continued From page 9  - Had been staying at the facility for two nights because there was no staff at sister facility B two nights ago because she moved out of state - He brought his clothes and medications with him when he was moved to the facility - Staff #1A was the only staff that worked in the facility - Lived at sister facility B - Came to the facility on 5/18/25 because FS #4B left sister facility B a few nights ago - Staff #1A was the only staff that with the clients in the facility Interview on 5/21/25 staff #1A reported: - Was the assigned staff for sister facility A - The Director/Owner instructed her to move to the facility with client #4A and #5A in March 2025 because FS #18 left the facility - Clients #6B and #7B were moved to the facility with client #4A and #5A in March 2025 because FS #18 left the facility - Clients #6B and #7B were moved to the facility with client #4A and #5A in March 2025 because FS #18 left the facility - The Director/Owner instructed her to move to the facility with client #4A and #5A in March 2025 because FS #3 left the facility - The Director/Owner instructed her to move to the facility with client #4A and #5A in March 2025 because FS #3 left the facility - The Director/Owner was "in the process of hiring a new staff" for the facility and sister facility B - The Director/Owner was "in the process of hiring a new staff" for the facility and sister facility B - The Director/Owner told her that she "hoped to have a staff hired by Monday (5/26/25)"  Interview on 5/21/25 the Director/Owner reported: - The facility didn't have an assigned staff								
PRADLEY HOME EXTENSION-PKEDS HOUSE   907 FRANCES DRIVE GARNER, NC 27529			MHL092-610		B. WING		06/0	03/2025
CAN ID   PROVIDER'S PLAN OF CORRECTION   PREFIX TAG	NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
PRÉFIX TAG  REGULATORY OR USC IDENTIFYING INFORMATION)  V 291  Continued From page 9  - Had been staying at the facility for two nights because there was no staff at sister facility B  - FS #4B left sister facility B two nights ago because she moved out of state  - He brought his clothes and medications with him when he was moved to the facility  - Didn't know how long he was staying at the facility Interview on 5/21/25 client #7B reported:  - Lived at sister facility B  - Came to the facility on 5/18/25 because FS  #4B left sister facility B a few nights ago  - Staff #1A was the only staff that with the clients in the facility  Interview on 5/21/25 staff #1A reported:  - Was the assigned staff for sister facility A  - The Director/Owner instructed her to move to the facility with client #AA and #SA in March 2025 because FS #1B left the facility  - Clients #8B and #7B were moved to the facility two nights ago because there was no staff at sister facility B  - Was "under the impression" clients #6B and #7B weren't going to stay at the facility for "too long"  - The Director/Owner told her that she "hoped to have a staff 'for the facility and sister facility B  - The Director/Owner told her that she "hoped to have a staff hired by Monday (5/28/25)"  Interview on 5/21/25 the Director/Owner reported:  - The facility didn't have an assigned staff	BRADLE	Y HOME EXTENSION	I-PKEDS HOUSE					
- Had been staying at the facility for two nights because there was no staff at sister facility B - FS #4B left sister facility B two nights ago because she moved out of state - He brought his clothes and medications with him when he was moved to the facility - Didn't know how long he was staying at the facility - Staff #1A was the only staff that worked in the facility - Staff #1A was the only staff that worked in the facility Interview on 5/21/25 client #7B reported: - Lived at sister facility B - Came to the facility on 5/18/25 because FS #4B left sister facility B a few nights ago - Staff #1A was the only staff that with the clients in the facility  Interview on 5/21/25 staff #1A reported: - Was the assigned staff for sister facility A - The Director/Owner instructed her to move to the facility with client #4A and #5A in March 2025 because FS #3 left the facility - Clients #6B and #7B were moved to the facility wo nights ago because there was no staff at sister facility B - Was "under the impression" clients #6B and #7B weren't going to stay at the facility for "too long" - The Director/Owner was "in the process of hiring a new staff" for the facility and sister facility B - The Director/Owner told her that she "hoped to have a staff hired by Monday (5/26/25)"  Interview on 5/21/25 the Director/Owner reported: - The facility didn't have an assigned staff	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY	/ FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	COMPLETE
because FS #3 left the facility in April 2025 and staff #1A was currently filling in - She instructed staff #1A to move her and	V 291	- Had been stayi because there was - FS #4B left sist because she move - He brought his him when he was n - Didn't know how facility - Staff #1A was t facility Interview on 5/21/2 - Lived at sister f - Came to the far #4B left sister faciliti - Staff #1A was t clients in the facility Interview on 5/21/2 - Was the assign - The Director/Or the facility with clier because FS #3 left - Clients #6B and facility two nights agat sister facility B - Was "under the #7B weren't going to long" - The Director/Or hiring a new staff" f B - The Director/Or to have a staff hired Interview on 5/21/2 - The facility didn't because FS #3 left staff #1A was curred to the staff #1A was c	ng at the facility for the no staff at sister facility B two night dout of state clothes and medical noved to the facility whong he was staying the only staff that wo staying be called a facility B cility on 5/18/25 because the only staff that with the facility B cility on 5/18/25 because the facility B cility on 5/18/25 because the facility dhe only staff that with the facility dhe facility dhe facility dhe facility dhe facility dhe facility constay at the facility where was "in the profor the facility and sistent by Monday (5/26/2) of the Director/Owner that a cility in April 20 on thy filling in	cility B ats ago tions with ag at the arked in the d: ause FS oth the cility A to move to arch 2025 o the as no staff a#6B and for "too access of ster facility ar reported: staff 025 and	V 291			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3) DATE COMP			SURVEY PLETED	
		MHL092-610	B. WING 06/03/2025			03/2025
	PROVIDER OR SUPPLIER  Y HOME EXTENSION	I-PKEDS HOUSE 907 FRAI	DDRESS, CITY, S NCES DRIVE , NC 27529	STATE, ZIP CODE		
(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 DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 291	clients #4A and #5A facility - Clients #6B and facility because she - The "set up" wi #7B sleeping in the an "emergency situ any staff coverage B - Was in the production.	A from sister facility A to this d #7B were staying at the e terminated FS #3 on 5/19/25 th clients #4A, #5A, #6B & facility was "temporary" and ation" because she didn't have for this facility or sister facility cess of hiring new staff for the cility B, and the new staff was	V 291			

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