		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL074-276	B. WING		07/1	0/2025	
NAME OF I	PROVIDER OR SUPPLIER		DRESS CITY S	STATE ZIP CODE	1 0771	0/2020	
	3776 COUNTRYAIRE DRIVE						
PARADIC	GM 4 KIDS 2	AYDEN, N	C 28513				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
V 000	INITIAL COMMENT	-S	V 000				
	An annual survey w 2025. Deficiencies	as completed on July 10, were cited.					
	This facility is licensed for the following service category: 10A NCAC 27G .5600B Supervised Living for Minors with Developmental Disabilities.						
		sed for 4 and has a current arvey sample consisted of clients					
V 114	27G .0207 Emerger	ncy Plans and Supplies	V 114				
	AND SUPPLIES (a) Each facility sha and a disaster plan these plans availab to the county emergrequest. The plans procedures and rou (b) The plans shall and evacuation proposted in the facility. (c) Fire and disaste shall be held at least repeated for each s	gency services agencies upon shall include evacuation tes. be made available to all staff cedures and routes shall be r drills in a 24-hour facility st quarterly and shall be hift. ucted under conditions that s response to fire					

Division of Health Service Regulation
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) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL074-276	B. WING		07/1	0/2025
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
PARADIGM 4 KIDS 2 3776 COUN AYDEN, NC				DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 114	This Rule is not me Based on record refacility failed to ensheld at least quarte The findings are: Review on 7/10/25 2024 thru June 202 - No documented fifor the July- Septem December 2024 an - No documented if weekend 8am-8pm quarter. - No documented dishifts for the July- Sthe January- March - No documented diduring the Octoberthe January- March - No documented dithe weekend shift 8 2025 quarter. Interview on 7/10/2 not respond or to quarter interview on 7/10/2 - All clients participated the facility. - Fire and disaster of monthly at the facility. - Fire and disaster of monthly at the facility. - Shifts at the facility at the facility at the facility. - Shifts at the facility at the facility at the facility at the facility.	et as evidenced by: view and interviews, the ure fire and disaster drills were rly and repeated on each shift. of facility records from July 25 revealed: re drills for the weekend shifts nber 2024, October- d April- June 2025 quarters. re drills for 3rd shift or the shift for the January- March isaster drills for the weekend September 2024 quarter and 2025 quarter. isaster drills for 3rd shift December 2025 quarter and 2025. isaster drills for 3rd shift and sam-8pm for the April- June 5 client #1, #3 and #4 would uestions when asked. 5 the House Manager stated: ated in fire and disaster drills drills were completed once ty. 25 the Qualified Professional lients were with 1:1 staff. y were 3pm-11pm and - Friday and 8am=8pm and	V 114			

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
			A. BUILDING:					
		MHL074-276	B. WING		07/1	0/2025		
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
PARADIGM 4 KIDS 2 3776 COUN AYDEN, NO				DRIVE				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE		
V 114	Continued From pa	ge 2	V 114					
	required to be held repeated on each s	at least quarterly and hift.						
V 736	27G .0303(c) Facili	ty and Grounds Maintenance	V 736					
	EXTERIOR REQUI (c) Each facility and maintained in a safe	RO3 LOCATION AND REMENTS If its grounds shall be e, clean, attractive and orderly e kept free from offensive						
		on and interview, the facility I in a clean and attractive						
	12:50pm revealed: - The window blinds visible heavy dust; 1 blind with 2 broke - The 3 bulb light fix had 1 inoperable but	cture above the dining table						
	- Client #2 bedroom walls in different co peeling from the wa 6 drawer dresser ha left side and the bo	n had various writing on all lors; clothes on the floor, paint all above the nightstand. The ad 3 drawers off track on the ttom drawer had an th metal bar hanging from						
	off track Client #3 and #4's fixture on the left side 1 bulb missing; 3 but	er dresser had the 2nd drawer bathroom had a 3 bulb light de with 1 inoperable bulb and ulb light fixture on the right sing and 1 inoperable bulb.						

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		MHL074-276	B. WING		07/	10/2025	
	NAME OF PROVIDER OR SUPPLIER PARADIGM 4 KIDS 2 STREET ADDRESS, CITY, STATE, ZIP CODE 3776 COUNTRYAIRE DRIVE AYDEN, NC 28513						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
V 736	- Client #4's top left missing the knob or side top drawer was side.	ge 3 drawer of his dresser was a the right side and the right side and the left the missing a knob on the left the Qualified Professional sineeded for repair.	V 736				

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