PRINTED: 07/18/2025
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL049-169	A. BUILDING: _____ B. WING _____	R 06/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOLICK HOME	248 GRANDVIEW DRIVE STATESVILLE, NC 28677

(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 follow up survey was completed on June 30, 2025. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC .5600F Supervised Living for Alternative Family Living. This facility is licensed for 2 and has a current census of 1. The survey sample consisted of audits of 1 current client.	V 000	Issues noted V117: -The facility failed to maintain pharmacy packaging labels as required for each prescription dispensed -Physician's orders included: 2/6/25 chlorhexidine gluconate (oral health) rinse mouth with 15 milliliters (ml) for 30 seconds in the morning and evening after brushing, then spit. Also, 4/7/25 norgestimate/ethinyl estradiol (contraception) 0.25/0.035 milligrams (mg) 1 by mouth (PO) daily. Neither the chlorhexidine gluconate nor the norgestimate/ethinyl estradiol contained a pharmacy label detailing the client's name, the prescriber's name, the medication dispensing date, the medication expiration date, the name, address, and phone number of the pharmacy, or the name of the dispensing practitioner Root Cause: -The AFL provider failed to obtain an label detailing the client's name, the prescriber's name, the medication dispensing date, the medication expiration date, the name, address, and phone number of the pharmacy, or the name of the dispensing practitioner for the chlorhexidine gluconate (oral health). -The AFL provider failed to maintain the labeled packaging that contained the individual packets of the norgestimate/ethinyl estradiol (contraception) detailing the client's name, the prescriber's name, the medication dispensing date, the medication expiration date, the name, address, and phone number of the pharmacy, or the name of the dispensing practitioner. -The QP failed to review the medication orders against the MAR correctly during the completion of the MAR review tool. Corrective Actions: -A label detailing the client's name, the prescriber's name, the medication dispensing date, the medication expiration date, the name, address, and phone number of the pharmacy, or the name of the dispensing practitioner for the chlorhexidine gluconate (oral health) was obtained from the pharmacy on 7/18/25. -A label detailing client's name, the prescriber's name, the medication dispensing date, the medication expiration date, the name, address, and phone number of the pharmacy, or the name of the dispensing practitioner for norgestimate/ethinyl estradiol (contraception) was obtained from the pharmacy on 7/22/25 and will be affixed to the packaging of the drug by 7/30/2025.	
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 (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	V 117		7/18/2025 7/30/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Ashley Sims, BA/QP TITLE Regional Manager (X6) DATE 7/28/25

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V 117	Continued From page 1 practitioner. This Rule is not met as evidenced by: Based on observation, record reviews, and interviews, the facility failed to maintain pharmacy packaging labels as required for each prescription dispensed for 1 of 1 client (Client #1). The findings are: Review on 6/23/25 of Client #1's record revealed: -Date of Admission: 12/28/22. -Diagnoses: Mild Intellectual Developmental Disability; Neurodevelopmental Disorder. -Physician's orders included: -2/6/25 chlorhexidine gluconate (oral health) rinse mouth with 15 milliliters (ml) for 30 seconds in the morning and evening after brushing, then spit. -4/7/25 norgestimate/ethinyl estradiol (contraception) 0.25/0.035 milligrams (mg) 1 by mouth (PO) daily. Observation of Client #1's medications on 6/24/25 at approximately 9:00am-9:25am revealed: -Neither the chlorhexidine gluconate nor the norgestimate/ethinyl estradiol contained a pharmacy label detailing the client's name, the prescriber's name, the medication dispensing date, the medication expiration date, the name, address, and phone number of the pharmacy, or the name of the dispensing practitioner. Interview on 6/24/25 with the Alternative Family Living (AFL) Provider revealed:	V 117	Corrective Actions Continued: -The AFL will re-take Medication Administration training by 7/30/25. -The QP has retaken the Medication Administration training for supervisors. This was completed on 7/8/25. - The AFL provider will receive coaching regarding improper record keeping. Documentation of AFL coaching will be completed by 7/30/25. -The QP will receive coaching regarding failure to complete medication reviews appropriately. Documentation of QP coaching will be completed by 7/30/25. -AFL DSP is required to call QP to report off on any doctor visit. Documentation will occur during AFL contractor monitoring and QP supervision that this is required by 7/30/25. -RN-led medication reconciliation reviews will be incorporated into the RM/PD and PD/QP one-on-one meetings. The SRM will conduct periodic spot checks to monitor and ensure ongoing compliance with this process. The forms were updated on 7/28/2025. Preventative Measures: -The AFL will be required to re-take Medication Administration training. This was completed by 7/30/25. -The QP has retaken the Medication Administration training for supervisors. This was completed on 7/8/25. -The RN will complete a full review of the medication orders and MARs to ensure the AFL provider is administering medications appropriately. This was completed on 7/22/2025. -AFL shifting to Tarrytowm pharmacy which is a affiliate pharmacy of Abound Health -Tarrytown pharmacy is a "cycle fill pharmacy that maintains physician orders". AFL is scheduled to begin Tarrytown Pharmacy on 8/1/2025. -During monthly supervision meetings, the QP will conduct a comprehensive review of all medications, physician orders, and the current MAR. A licensed nurse will participate virtually to collaboratively review these items with the QP, ensuring accuracy and compliance. At the conclusion of the six-month period, the RN will discontinue virtual participation in the collaborative review of these items with the QP, having ensured their accuracy and compliance. Any issues noted by QP will be promptly addressed. Documentation will occur during AFL contractor monitoring and QP supervision that this is required by 7/30/25.	7/30/2025 7/8/2025 7/30/2025 7/30/2025 7/30/2025 7/28/2025 7/30/2025 7/8/2025 7/22/2025 7/30/2025

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V 117	Continued From page 2 -"I'm not sure what happened to the labels." -"I didn't even think about it (chlorhexidine gluconate) being a med (medication) since it's a mouthwash." Interview on 6/23/25 and 6/24/25 with the Qualified Professional (QP) revealed: -She visited the facility at least quarterly and reviewed client MARs. -Planned to ensure all client medications were labeled as required during each MAR review.	V 117	Who will monitoring and How often: -Abound Health QP will conduct a monthly site monitoring for the next 6 months ensuring all medication requirements are met. Quarterly site monitoring will resume following the 6 month period if the AFL continued to maintain all corrective measures that were put in place. Documentation will occur during AFL contractor monitoring and QP supervision that this is required by 7/30/25. Timetable for correction: All of the issues noted above were addressed and corrections were put into place on or before 7.30.2025 Issues noted V118: -Physician's orders included:2/6/25 chlorhexidine gluconate (oral health) rinse mouth with 15 milliliters (ml) for 30 seconds in the morning and evening after brushing, then spit. Also, 4/7/25 aripiprazole (mood stabilizer) 15 milligrams (mg) 1 by mouth (PO) daily in the evening.	7/30/2025 7/30/2025
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the	V 118	-No physician's order to discontinue chlorhexidine gluconate, or aripiprazole. -Chlorhexidine gluconate was not listed on the April-June 2025 MARs. -Aripiprazole 15 mg 1 PO daily in the evening was typed onto the June 2025 MAR and "D/C (discontinue) was handwritten in the signature blocks allotted for the 10th and 11th day of the month and a line was drawn across the blocks for the 12th-30th of the month. -Further down on the same page of the June 2025 MAR, Aripiprazole was handwritten with the same instructions of 15 mg 1 PO daily in the evening and had a line drawn through the signature blocks allotted for the 1st-16th of the month. -No documentation of aripiprazole having been administered from 6/10/25-6/16/25 Root cause: -The AFL provider failed to obtain discontinued orders for of chlorhexidine gluconate (oral health). -The AFL provider failed to obtain a physician order indicating the discontinuation of aripiprazole (mood stabilizer) on 6/10/2025 and replace with Caplyta. -The AFL provider failed to obtain a physician order resuming the use of aripiprazole (mood stabilizer) on 6/17/2025 due to insurance not covering Caplyta. -The QP failed to review the medication orders against the MAR correctly during the completion of the MAR review tool.	

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V 118	Continued From page 3 drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure MARs were kept current for 1 of 1 client (Client #1). The findings are: Review on 6/23/25 of Client #1's record revealed: -Date of Admission: 12/28/22. -Diagnoses: Mild Intellectual Developmental Disability; Neurodevelopmental Disorder. -Physician's orders included: -2/6/25 chlorhexidine gluconate (oral health) rinse mouth with 15 milliliters (ml) for 30 seconds in the morning and evening after brushing, then spit. -4/7/25 aripiprazole (mood stabilizer) 15 milligrams (mg) 1 by mouth (PO) daily in the evening. -No physician's order to discontinue chlorhexidine gluconate, or aripiprazole. Review on 6/23/25 and 6/24/25 of Client #1's MARs dated 4/1/25-6/24/25 revealed: -Chlorhexidine gluconate was not listed on the April-June 2025 MARs. -Aripiprazole 15 mg 1 PO daily in the evening was typed onto the June 2025 MAR and "D/C" (discontinue) was handwritten in the signature blocks allotted for the 10th and 11th day of the	V 118	Corrective Actions: -A physician order indicating the discontinuation of chlorhexidine gluconate (oral health) was obtained 7/25/25. -Medication error was completed on 7/28/25 due to AFL not following order properly. -A physician order indicating the discontinuation of aripiprazole (mood stabilizer) on 6/10/2025 and replace with Caplyta will be obtained by 7/30/25. -A physician order resuming the use of aripiprazole (mood stabilizer) on 6/17/2025 due to insurance not covering Caplyta will be obtained by 7/30/25. -The AFL will re-take Medication Administration training by 7/30/2025. -The QP has retaken the Medication Administration training for supervisors. This was completed on 7/8/25. - The AFL provider will receive coaching regarding improper record keeping. Documentation of AFL coaching will be completed by 7/30/25. -The QP will receive coaching regarding failure to complete medication reviews appropriately. Documentation of QP coaching will be completed by 7/30/25. -AFL DSP is required to call QP to report off on any doctor visit. Documentation will occur during AFL contractor monitoring and QP supervision that this is required by 7/30/25. -RN-led medication reconciliation reviews will be incorporated into the RM/PD and PD/QP one-on-one meetings. The SRM will conduct periodic spot checks to monitor and ensure ongoing compliance with this process. The forms were updated on 7/28/25. Preventative Measures: -The AFL will be required to re-take Medication Administration training. This was completed by 7/30/25. -The QP has retaken the Medication Administration training for supervisors. This was completed on 7/8/25. -The RN will complete a full review of the medication orders and MARs to ensure the AFL provider is administering medications appropriately. This was completed on 7/22/2025. -AFL shifting to Tarrytowm pharmacy which is a affiliate pharmacy of Abound Health -Tarrytown pharmacy is a "cycle fill pharmacy that maintains physician orders". AFL is scheduled to begin Tarrytown Pharmacy on 8/1/2025.	7/25/2025 7/28/2025 7/30/2025 7/30/2025 7/30/2025 7/8/2025 7/30/2025 7/30/2025 7/30/2025 7/28/2025 7/30/2025 7/8/2025 7/22/2025

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V 118	Continued From page 4 month and a line was drawn across the blocks for the 12th-30th of the month. -Further down on the same page of the June 2025 MAR, Aripiprazole was handwritten with the same instructions of 15 mg 1 PO daily in the evening and had a line drawn through the signature blocks allotted for the 1st-16th of the month. -No documentation of aripiprazole having been administered from 6/10/25-6/16/25. Interview on 6/24/25 with Client #1 revealed: -Could not name her prescribed medications. -Medications were administered by the Alternative Family Living (AFL) Provider. Interview on 6/24/25 with the AFL Provider revealed: -"I didn't even think about it (chlorhexidine gluconate) being a med (medication) since it's a mouthwash." -Client #1 had not missed any doses of prescribed medications. Interview on 6/23/25 and 6/24/25 with the Qualified Professional (QP) revealed: -Responsible for reviewing client's MARs. -Client #1's MAR for June 2025 had not been reviewed yet. -Planned to get an updated list of all prescribed medications and discontinued medications from Client #1's physician. Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician. This deficiency constitutes a recited deficiency and must be corrected within 30 days.	V 118	--During monthly supervision meetings, the QP will conduct a comprehensive review of all medications, physician orders, and the current MAR. A licensed nurse will participate virtually to collaboratively review these items with the QP, ensuring accuracy and compliance. At the conclusion of the six-month period, the RN will discontinue virtual participation in the collaborative review of these items with the QP, having ensured their accuracy and compliance. Any issues noted by QP will be promptly addressed. Documentation will occur during AFL contractor monitoring and QP supervision that this is required by 7/30/25. Who will monitoring and How often: -Abound Health QP will conduct a monthly site monitoring for the next 6 months ensuring all medication requirements are met. Quarterly site monitoring will resume following the 6 month period if the AFL continued to maintain all corrective measures that were put in place. Documentation will occur during AFL contractor monitoring and QP supervision that this is required by 7/30/25. Timetable for correction: - All of the issues noted above were addressed and corrections were put into place on or before 7.30.2025.	7/30/2025 7/30/2025 7/30/2025

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V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on observation, record reviews, and interviews, the facility failed to maintain coordination between the facility operator and the	V 291	Issues noted V291: -Caplyta (antipsychotic) 21 milligrams (mg) 1 by mouth (PO) every evening prescribed 6/9/25. -Phentermine (appetite suppressant) 37.5 mg 1 PO every morning prescribed 10/24/24. -Lisdexamfetamine (stimulant) 30 mg 1 PO in the morning prescribed 6/9/25. -Wegovy (weight management) 0.25 mg/0.5 milliliters (ml) inject 0.25 mg every week by subcutaneous route prescribed 10/24/24. -No physician's orders to discontinue the administration of Caplyta, phentermine, lisdexamfetamine, or Wegovy. -Caplyta was listed on the June 2025 MAR and initialed as being administered 6/10/25-6/16/25. The notation "D/C" (discontinue) was handwritten in the signature blocks corresponding to 6/17/25 and 6/18/25 with A line drawn through the blocks for 6/19/25-6/31/25. -Phentermine was listed on the April 2025 MAR and initialed as being administered 4/1/25-4/30/25. Phentermine was not listed on the May 2025, or the June 2025 MARs. -Lisdexamfetamine was not listed on the June 2025 MAR. -Wegovy was not listed on the April 2025, May 2025, or June 2025 MARs -The Caplyta, phentermine, lisdexamfetamine, and Wegovy were not in the facility. -The Caplyta was given to Client #1 as a "sample medication." -The phentermine had been discontinued. -Documentation was not available to demonstrate communication between the facility and the prescribing physician regarding the inability to obtain the prescribed medications.	

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V 291	Continued From page 6 qualified professionals responsible for the client's treatment/habilitation for 1 of 1 client (Client #1). The findings are: Review on 6/23/25 of Client #1's record revealed: -Date of Admission: 12/28/22. -Diagnoses: Mild Intellectual Developmental Disability; Neurodevelopmental Disorder. -Physician's orders included: -Caplyta (antipsychotic) 21 milligrams (mg) 1 by mouth (PO) every evening prescribed 6/9/25. -Phentermine (appetite suppressant) 37.5 mg 1 PO every morning prescribed 10/24/24. -Lisdexamfetamine (stimulant) 30 mg 1 PO in the morning prescribed 6/9/25. -Wegovy (weight management) 0.25 mg/0.5 milliliters (ml) inject 0.25 mg every week by subcutaneous route prescribed 10/24/24. -No physician's orders to discontinue the administration of Caplyta, phentermine, lisdexamfetamine, or Wegovy. Review on 6/23/25 and 6/24/25 of Client #1's MARs dated 4/1/25-6/24/25 revealed: -Caplyta was listed on the June 2025 MAR and initialed as being administered 6/10/25-6/16/25. The notation "D/C" (discontinue) was handwritten in the signature blocks corresponding to 6/17/25 and 6/18/25 with A line drawn through the blocks for 6/19/25-6/31/25. -Phentermine was listed on the April 2025 MAR and initialed as being administered 4/1/25-4/30/25. Phentermine was not listed on the May 2025, or the June 2025 MARs. -Lisdexamfetamine was not listed on the June 2025 MAR. -Wegovy was not listed on the April 2025, May 2025, or June 2025 MARs.	V 291	Root cause: -The AFL provider failed to comply with process for obtain discontinued orders. -The AFL provider failed to maintain the labeled packaging for medications. -The QP failed to review the medication orders against the MAR correctly during the completion of the monthly MAR review tool. -There was a failure in the handoff between the RN review and the team for obtaining new and D/C timely. Corrective Action: -A physician order indicating to begin taking Caplyta (antipsychotic) as of 6/10/2025 to replace Abilify will be obtained by 7/30/25. -A physician order indicating the discontinuation of Caplyta (antipsychotic) as of 6/16/2025 due to insurance not covering will be obtained by 7/30/25. -A physician order indicating the discontinuation of Phentermine (appetite suppressant) as of 11/22/2025 due medication only able to be taken for 90 days will be obtained by 7/30/25. -A physician order indicating to begin taking Phentermine (appetite suppressant) as of 3/31/25 will be obtained by 7/30/25. -A physician order indicating the discontinuation of Phentermine (appetite suppressant) as of 4/30/25 will be obtained by 7/30/25. -A physician order indicating to begin taking Lisdexamfetamine (stimulant) as of 7/7/2025 will be obtained by 7/30/25. -A physician order indicating the discontinuation of Lisdexamfetamine (stimulant) as of 9/5/24 due to insurance not covering will be obtained by 7/30/25. -A physician order indicating a new order with prior authorization sent 6/12/2025 for Wegovy (weight management) will be obtained by 7/30/25. -A physician order indicating the discontinuation of Wegovy as of 4/11/25 due to insurance not covering will be obtained by 7/30/25. -The AFL will re-take Medication Administration training by 7/30/2025. -The QP has retaken the Medication Administration training for supervisors. This was completed on 7/8/25. - The AFL provider will receive coaching regarding improper record keeping. Documentation of AFL coaching will be completed by 7/30/25. -The QP will receive coaching regarding failure to complete medication reviews appropriately. Documentation of QP coaching will be completed by 7/30/25.	7/30/2025 7/30/2025 7/30/2025 7/30/2025 7/30/2025 7/30/25 7/30/2025 7/30/2025 7/30/2025 7/30/2025 7/8/2025 7/30/2025 7/30/2025

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V 291	Continued From page 7 Observation of Client #1's medications on 6/24/25 at approximately 9:00am-9:25am revealed: -The Caplyta, phentermine, lisdexamfetamine, and Wegovy were not in the facility. Interview on 6/24/25 with the Alternative Family Living (AFL) Provider revealed: -The Caplyta was given to Client #1 as a "sample medication." -The phentermine had been discontinued. -Client #1 had not missed any doses of prescribed medications. Interview on 6/24/25 with the Qualified Professional (QP) revealed: -"Caplyta was a sample med (medication)." -Client #1's insurance refused to pay for the lisdexamfetamine, or for the Wegovy. -Documentation was not available to demonstrate communication between the facility and the prescribing physician regarding the inability to obtain the prescribed medications for Client #1. -" ...I'm going to go to the doctor and get a new prescription (order) for everything." Attempted interviews on 6/25/25 and 6/27/25 with Client #1's physician were unsuccessful due to no response to phone calls. This deficiency constitutes a recited deficiency and must be corrected within 30 days.	V 291	Corrective Actions Continued: -AFL DSP is required to call QP to report off on any doctor visit. Documentation will occur during AFL contractor monitoring and QP supervision that this is required by 7/30/25. -RN-led medication reconciliation reviews will be incorporated into the RM/PD and PD/QP one-on-one meetings. The SRM will conduct periodic spot checks to monitor and ensure ongoing compliance with this process. The forms were updated on 7/28/25. Preventative Measures: -The AFL will be required to re-take Medication Administration training. This was completed by 7/30/25. -The QP has retaken the Medication Administration training for supervisors. This was completed on 7/8/25. -The RN will complete a full review of the medication orders and MARs to ensure the AFL provider is administering medications appropriately. This was completed on 7/22/2025. -AFL shifting to Tarrytowm pharmacy which is a affiliate pharmacy of Abound Health -Tarrytown pharmacy is a " cycle fill pharmacy that maintains physician orders". AFL is scheduled to begin Tarrytown Pharmacy on 8/1/2025. --During monthly supervision meetings, the QP will conduct a comprehensive review of all medications, physician orders, and the current MAR. A licensed nurse will participate virtually to collaboratively review these items with the QP, ensuring accuracy and compliance. At the conclusion of the six-month period, the RN will discontinue virtual participation in the collaborative review of these items with the QP, having ensured their accuracy and compliance. Any issues noted by QP will be promptly addressed. Documentation will occur during AFL contractor monitoring and QP supervision that this is required by 7/30/25. Who will monitoring and How often: -Abound Health QP will conduct a monthly site monitoring for the next 6 months ensuring all medication requirements are met. Quarterly site monitoring will resume following the 6 month period if the AFL continued to maintain all corrective measures that were put in place. Documentation will occur during AFL contractor monitoring and QP supervision that this is required by 7/30/25. Timetable for correction: - All of the issues noted above were addressed and corrections were put into place on or before 7.30.2025	7/30/2025 7/28/2025 7/30/2025 7/8/2025 7/22/2025 7/30/2025 7/30/2025 7/30/2025
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	V 736		

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	MHL049-169	A. BUILDING: _____ B. WING _____	R 06/30/2025

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V 736	Continued From page 8 manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility was not maintained in a safe, attractive and orderly manner. The findings are: Observation on 6/24/25 at approximately 8:28am-9:00am revealed: -From the left side of the driveway, a paved path led to a screened porch at the left side of the facility. The doorway which provided egress from the screened porch was blocked on the inside with furniture and large bird cages. -There was no walkway leading to the front door of the facility. -The garage door was opened. There was a clearing in the garage that was approximately 18" - 24" wide which ran from the driveway to the door leading to the inside of the facility. The remainder of the garage floor was covered with numerous household items haphazardly stacked approximately 2'-5' high which included cardboard boxes of various sizes piled on top of one another, a full-size mattress, bed rails, lamps, storage totes, laundry baskets with clothes hangers, suitcases, and two motorcycles with boxes piled on top of each seat. -A heavy-duty extension cord was placed across the 18"-24" clearing which resulted in a trip hazard. -A brown colored water stain which was approximately the size of a basketball was on the living room ceiling near the front door. A hole approximately the size of a quarter in diameter was in the center of the stain and exposed a mesh-like material. -An additional brown colored water stain	V 736	Issues noted: (V736): -The doorway which provides egress from the screened porch was blocked on the inside with furniture and large bird cages. -There was no walkway leading to the front door of the facility. -There was a clearing in the garage that was approximately 18"-24" wide which ran from the driveway to the door leading to the inside of the facility. The garage was in disarray with items haphazardly stacked 2'-5' high with various items. -There was a heavy duty extension cord across the 18"-24" clearing which resulted in a trip hazard. -A brown colored water stain approximately the size of a basketball on the living room ceiling near the front door. A hole the size of a quarter in diameter was in the center of the stain exposing a mesh-like material. -An additional brown colored water stain approximately 12" in length was on the ceiling above the kitchen table. -The in ground pool at the back of the facility was not fully enclosed and one portion of the fence was damaged with 6 of 15 balusters missing and the other 9 were bent and mangled leaving an opening wide enough for an individual to enter. -The garage, screened porch and water stains all remained the same as identified during the observation on 6/24/25 at approximately 8:28am-9:00am. -The width of the upper level patio area was approximately 8'-10' wide and approximately 14'-18' long. The upper level led to a 36" drop to the middle level with a hot tub. The cover to the hot tub was not secured shut. The middle level was 6'-8' wide and approximately 14'-18' long. The middle level led to a 24" drop directly into an in ground pool. -The gate was open and unsecured at the time of the observation. -The 56" high metal fence continued around night-hand side of the pool, directly opposite the facility. There was a missing section of the fence which measured 72" wide.	

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V 736	Continued From page 9 approximately 12" in length was on the ceiling above the kitchen table. -The inground pool at the back of the facility was not fully enclosed and one portion of the fence was damaged with 6 of 15 balusters missing and the other 9 were bent and mangled leaving an opening wide enough for an individual to enter. Additional Observation on 6/27/25 at approximately 9:45am-10:40am revealed: -The garage, screened porch and water stains all remained the same as identified during the observation on 6/24/25 at approximately 8:28am-9:00am. -The driveway of the facility led to a grassy area of the backyard, which led directly onto a hardscaped patio with 3 levels which was divided into the upper level, the middle level, and the lower level. The width of the upper level patio area was approximately 8'-10' wide and approximately 14'-18' long. The upper level led to a 36" drop to the middle level with a hot tub. The cover to the hot tub was not secured shut. The middle level was 6'-8' wide and approximately 14'-18' long. The middle level led to a 24" drop directly into an inground pool. -The inground pool had a shallow end and a deep end. The water in the shallow end was approximately 3' deep. When standing at the shallow end of the pool looking outward toward the deeper end of the pool, the facility's deck and ramp were on the left side, and a 56" high black metal fence was on the far side of the pool opposite the observer. There was a 56" high metal gate which led to a stone staircase at the left-hand corner of the pool. The gate was open and unsecured at the time of the observation. -The 56" high metal fence continued around the right-hand side of the pool, directly opposite the facility. There was a missing section of fence	V 736	-The swimming pool was not fully enclosed and there was damage to the aluminum fencing that had an opening large enough for someone to access. This is not compliant with the rule. Take the necessary steps to enclose the entire pool with an access gate that can be secured and repair or replace the aluminum fencing. -Five bent balusters were strewn across the length of the stone steps. There was no fencing or method to secure the area of the pool on the shallow end adjacent to the middle level patio. -There was only a 12" distance between the furniture and the waterline of the pool which created a limited walking space. -Two pieces of outdoor lawn furniture had broken seats with holes. The woven straw seat of a wooden rocking chair was ripped with a hole in the center approximately the size of a volleyball. The fabric for the seating of a metal framed patio chair had two tears approximately 6" in length. -Off the deck, there was a ramp which had a 41" entry and was not secured. The ramp led to the pool. -At the time of the survey, it was observed that steps to the pool deck were replaced with a ramp that is not compliant with NCSBC (North Carolina State Building Code), one foot of run for every one inch of height. This ramp was 48 inches in height and does not have 48 feet of run. This is not compliant with the rule. -At the time of the survey it was observed that there was evidence of a leak at the living room ceiling at the front door.	

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V 736	Continued From page 10 which measured approximately 72" wide. -On the right-hand side of the pool, there were 5 stone steps which led up the incline of the property. Five bent balusters were strewn across the length of the stone steps. There was no fencing or method to secure the area of the pool on the shallow end adjacent to the middle level patio. -Surrounding the pool area were several pieces of outdoor furniture. The furniture was placed along the shallow end and deep end of the pool. The furniture was placed in such a manner that there was only a 12" distance between the furniture and the waterline of the pool which created a limited walking space. -Two pieces of outdoor lawn furniture had broken seats with holes. The woven straw seat of a wooden rocking chair was ripped with a hole in the center approximately the size of a volleyball. The fabric for the seating of a metal framed patio chair had two tears approximately 6" in length. -Off the deck, there was a ramp which had a 41" entry and was not secured. The ramp led to the pool. Review on 6/26/25 of North Carolina Residential Building Code R 311.8.1 Maximum Slope revealed: -"Ramps serving the egress door required by Section R 311.2 shall have a slope of not more than 1 unit vertical in 12 units horizontal (8.3 percent slope) ..." Review on 6/23/25 of the Division of Health Service Regulation's (DHSR) Construction Section's Statement of Deficiencies (SOD) for Bolick Home dated 11/21/24 revealed: -"DHSR Construction Section conducted a Biennial Survey on November 21, 2024 from 1:25 PM to 2:20 PM ...At the time of our visit, we cited	V 736	Root Cause: -Failure to ensure doorways and walkways were not blocked and free from items that may be potential trip hazards. -Failure to repair ceiling from a leak. -Failure to repair fencing that had become damaged. -Failure to maintain a gate with proper latching mechanism. - Upon, original licensure, stairs were present, AFL DSP had a ramp installed post licensure. Due to building oversight, ramp was not in compliance with building codes. -Failure to maintain a clear walkway around pool area. -Failure to remove furniture that had become broken or had tears. AFL DSP's failure to communicate DHSR citations to Abound Health. Corrective Action: -The Abound Health site monitoring tool and field guide has been updated to include pool enclosures and ramps. This was updated on 7/15/25. -Conducted coaching with the contractor on 6/27/25 regarding multiple areas of non-compliance, including facility standards, adherence to building codes, and grounds maintenance. Addressed the contractor's failure to notify the QP as required. -Initiated follow-up on-site supervision to verify that repairs meet building code requirements on 7/14/2025. An additional on-site supervision was completed by 7/22/25 to ensure the remaining deficiencies were corrected. -Temporarily increased monitoring frequency to ensure timely resolution of maintenance issues by the contractor. This was discussed with AFL verbally on 7/14/2025 and will documented during Contractor Monitoring by 7/30/25. -The walkway in the screened in porch and the doorway to the front door have been cleared of clutter. This was confirmed on 7/22/25. -The garage floor is free of stacked boxes, furniture, and other miscellaneous items. This was confirmed on 7/22/25. -The ceiling leak was repaired and completed. This was confirmed on 7/8/2025.	7/15/2025 6/27/2025 *** 7/30/2025 7/22/2025 7/22/2025 7/8/2025

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V 736	Continued From page 11 deficiencies that require an acceptable plan of correction. All deficiencies listed were discussed with onsite staff (Alternative Family Living (AFL) Provider) during the exit interview ..." -" ...At the time of the survey, it was observed that the swimming pool was not fully enclosed and there was damage to the aluminum fencing that had an opening large enough for someone to access. This is not compliant with the rule. Take the necessary steps to enclose the entire pool with an access gate that can be secured and repair or replace the aluminum fencing." -" ...At the time of the survey, it was observed that steps to the pool deck were replaced with a ramp that is not compliant with NCSBC (North Carolina State Building Code), one foot of run for every one inch of height. This ramp was 48 inches in height and does not have 48 feet of run. This is not compliant with the rule. Take the necessary steps to repair this deficiency." -" ...At the time of the survey it was observed that there was evidence of a leak at the living room ceiling at the front door. This is not compliant with the rule. Take the necessary steps to repair the ceiling ..." Interview on 6/27/25 with DHSR's Construction Section's Surveyor who completed the 11/21/24 survey revealed: -She conducted the Biennial Survey for Bolick Home on 11/21/24. -During the survey, she informed the AFL Provider the ramp and the pool enclosure had to be fixed. "It was made clear to her (AFL Provider). I measured the ramp in front of her. There used to be a wall there and it was taken down. She even asked questions about it. I explained there was too high of a drop, and the need for the pool to be enclosed, and the requirement for a 48-foot ramp, or steps ..."	V 736	-The pool is fully enclosed with an access gate that can be secured. The hole in the fence was repaired on 6/27/25, a temporary gate and replacement fencing was installed above the ramp 6/27/25. Confirmation that the pool is fully enclosed on 7/14/25. -The ramp has been removed and replaced with steps that meet NCSBC 7/15/2025. - It was confirmed on 7/21/25, that the hot tub top is secured by the attached latches. -Confirmation on 7/22/25 that the patio furniture has been arranged to allow for ample walking space and patio furniture that was broken or had tears has been removed. Preventative Measures: -The AFL will ensure the maintenance of the home is kept up with and that any remodeling is done up to code. . - Additionally the AFL provider will ensure the doorways are not blocked and the walkways are free from items that may be potential trip hazards. - A clear floor space of at least 3 feet will be maintained throughout the garage to allow safe access and prevent stacking of items. -The AFL will continue monitoring the ceiling and will make the necessary repairs if any leaks occur. - The AFL will oversee that the pool remains properly enclosed, with the gate kept closed and secured when needed. - The AFL will ensure poolside furniture is arranged to maintain a clear walkway and that all lawn furniture remains in good condition, free of holes or tears. -AFL had been verbally coached on all preventative measures above prior to 7/22/25. A documented coaching will be conducted by 7/30/2025. Who will monitoring and How often: -Abound Health QP will conduct a monthly site monitoring for the next 6 months ensuring each facility and it's grounds are maintained in a safe, clean, attractive and orderly manner and are free from offensive odor. Quarterly site monitoring will resume following the 6 month period if the AFL continued to maintain all corrective measures that were put in place. This has been verbally discussed with QP and AFL prior to 7/22/25. Documentation will occur during AFL contractor monitoring and QP supervision that this is required by 7/30/25. Timetable for Correction: All of the issues noted above were addressed and corrections were put into place on or before 7.22.2025.	7/14/2025 7/15/2025 7/21/2025 7/22/2025 7/30/2025 7/30/2025 7/22/2025

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V 736	Continued From page 12 -The AFL Provider inquired as to why the issue had not been cited previously. During the prior Biennial Survey completed on 8/16/22, the wall was still present, and the ramp had not yet been installed. Review on 6/27/25 of DHSR's Initial Licensure Photographs in the Non Disclosed File dated 10/26/18 of Bolick Home revealed: -The photograph of the rear exterior of the facility revealed a deck with a set of steps which led from the deck to the lower patio and inground pool. The pool was completely enclosed. There was no evidence of a ramp at the facility. Interview on 6/25/25 with DHSR's Construction Section's Supervisor revealed: -"The ramp was cited due to residential building code R 311. If a ramp is 48" above grade, then code requires a slope of 1:12, so the ramp should be about 48'. If the patio area is 3' above grade, there should be a barrier, guardrail." Review on 6/25/25 of Abound Health NC, LLC's (Licensee) Policy #51 dated October 2016 revised March 2018, May 2020, November 2020, December 2020, June 2021, April 2022, March 2023 and June 2024 revealed: -" ...Swimming and Water Safety Protocols approval for licensed facilities ...Any pool at a licensed facility must receive approval from DHSR construction section ..." -" ...Clients must not be left unattended by Abound Health personnel while in or around any body of water ..." Review on 6/23/25 of Client #1's record revealed: -Date of Admission: 12/28/22. -Diagnoses: Mild Intellectual Developmental Disability; Neurodevelopmental Disorder.	V 736		

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V 736	Continued From page 13 Observation on 6/24/25 at approximately 9:11am-9:25am of Client #1 revealed: -At approximately 9:11 am Client #1 informed the AFL Provider and the Qualified Professional (QP) that she was going to wait outside for her ride to her day program. -The QP and the AFL Provider remained in the facility while Client #1 walked out of the kitchen toward the garage which led to the driveway and exterior of the facility. -At approximately 9:12 am, Client #1 was outside alone and unsupervised. -At approximately 9:25 am the AFL Provider glanced outside the window above the kitchen table to check whether Client #1 remained in the driveway and remarked aloud, to no one in particular, "she's (Client #1) still waiting." -During this timeframe, neither the AFL Provider nor the QP were present outside with Client #1, despite the pool area being unsecured and easily accessible. Observation and Interview on 6/24/25 at approximately 8:33am-8:36am with Client #1 revealed: -" ...We swim here (facility) ..." -Client #1 was preparing to leave for her day program and did not provide further details regarding swimming at the facility. Interviews on 6/23/25, 6/24/25 and 6/27/25 with the AFL Provider revealed: -Client #1 was the only client at the facility. -Client #1 "is unsure of herself ...[Client #1] needs support with everything ...needs assistance with most adaptive living skills ..." -When asked about Client #1's level of proficiency for swimming, she stated, "she's no athlete."	V 736		

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V 736	Continued From page 14 -The facility's inground pool was approximately 3'-7' in depth. -She had installed the ramp off the rear deck of the facility in 2023 because her grandchildren came to swim and they had been falling down the stairs and she believed the installation of the ramp would help prevent falls on the stairs. -The pool fence was damaged by someone mowing the lawn with a riding lawn mower in June or July 2024. -Acknowledged she had been informed in November 2024 during DHSR's Construction Survey that the pool fencing needed to be repaired and the pool needed to be secured. -She had not corrected the issues identified during the November 2024 DHSR Construction Survey because she "did not have the money to make the repairs." -The garage was used as the primary entrance and exit for the facility. -"There was a leak in the ceiling. It was the dormers that leaked before the last inspection (November 2024 DHSR Construction Section's Survey). It's been over a year since it has leaked." Interviews on 6/23/25, 6/24/25 and 6/27/25 with the QP revealed: -Responsible for residential site monitoring. -Visited the facility at least quarterly and completed walk-throughs of the interior and exterior of the facility. -She had not identified any safety issues with the facility. -Was "not sure" if the licensee had a policy for swimming pools. -Confirmed she was aware of DHSR's Construction Survey from November 2024 but did not receive the SOD. -Reported she made attempts in December 2024	V 736		

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V 736	Continued From page 15 and January 2025 to obtain a copy of DHSR's Construction Section's SOD, but after that the follow up "fell off." -During the current survey, she called DHSR Construction Section and received a copy of the November 2024 SOD on 6/25/25. -"Someone is coming out today (6/27/25) to do an estimate on the fence." Review on 6/27/25 of a Plan of Protection completed and submitted by the QP on 6/27/25 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? AFL (Provider) will install temporary fencing around pool and a barrier (temporary) at the ramp. Client will be moved to emergency placement if not completed today. Describe your plans to make sure the above happens. QP will ensure safety measures are taken to protect client by doing more visits/random pop ups" Client #1 was diagnosed with Mild Intellectual Developmental Disability and Neurodevelopmental Disorder. On November 21, 2024, DHSR's Construction Section verbally notified the AFL Provider that the facility was in violation of regulatory requirements. Specifically, the inground swimming pool was not fully enclosed due to damage to the aluminum fencing, which created an opening large enough to allow unauthorized access. Additionally, the original steps to the pool deck had been replaced with a non-compliant ramp that did not meet NCSBC standards. The AFL Provider utilized the garage as the primary entrance to the facility but did not maintain the area in a safe, and	V 736		

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V 736	Continued From page 16 unobstructed manner. There was also evidence of a ceiling leak in the living room near the front door. Despite being made aware of these deficiencies, the AFL Provider failed to address and correct the issues. The AFL Provider reported she did not have the money to make the necessary repairs. Client #1 was allowed to access the outside of the facility and the unsecured in-ground pool without the required staff supervision. The QP, who was responsible for monitoring the facility, conducted walkthroughs of both the interior and exterior of the facility but did not identify these safety concerns. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 736		