AND DUAN OF CORRECTION IN TREMETICATION NUMBER.		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL032-415	B. WING		08/1	5/2025
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
MICHAE	L'S PLACE		CADILLA ST , NC 27703	REET		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETE DATE
V 000	INITIAL COMMEN	rs	V 000			
	An annual survey w 2025. Deficiencies	as completed on August 15, were cited.				
	category: 10A NCA	sed for the following service C 27G .5600C Supervised h Developmental Disabilities.				
		sed for 3 and has a current urvey sample consisted of clients.				
V 118	27G .0209 (C) Med	ication Requirements	V 118			
	only be administered order of a person a drugs. (2) Medications shat clients only when a client's physician. (3) Medications, included administered only builties only builties only builties only builties on the privileged to prepare (4) A Medication Acall drugs administered current. Medication recorded immediate MAR is to include the (A) client's name; (B) name, strength,	inistration: non-prescription drugs shall ad to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be by licensed persons, or by a trained by a registered nurse, regally qualified person and re and administer medications. Iministration Record (MAR) of red to each client must be kept s administered shall be ely after administration. The ne following: and quantity of the drug;				
	(C) instructions for (D) date and time the	administering the drug; ne drug is administered; and of person administering the				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

DIVISION	of Health Service Re	guiation				
	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL032-415	B. WING		08/1	5/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MICHAE	L'S PLACE		CADILLA ST , NC 27703	REET		
(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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 1	V 118			
	checks shall be rec	for medication changes or orded and kept with the MAR appointment or consultation				
	interviews the facilit	et as evidenced by: views, observation and by failed to keep the MARs e of three audited clients (#1).				
	-Admission date of -Diagnoses of Inter Schizophrenia - Un Disability. -Physician's order of	of Client #1's record revealed: 5/26/23. mittent Explosive Disorder, specified, and Mild Intellectual lated 7/24/25 for Olanzapine lligram (mg)- Take one tablet				
	2025 through Augur -July: -Olanzapine 5 r -August: -Olanzapine 5 r -There were no star	of Client #1's MAR for July 1, st 15, 2025 revealed: mg was not listed. mg was not listed. ff initials indicating Olanzapine ninistered for the months of				
	Observation on 8/1 of Client #1's medic					

AND DI AN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
74401 2744	OF CONTRECTION	IDENTIFICATION NOMBER.	A. BUILDING:			LLILD
		MHL032-415	B. WING		08/1	5/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MICHAE	L'S PLACE		CADILLA ST NC 27703	REET		
(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 118	Continued From pa	ge 2	V 118			
	Interview on 8/15/2 -She received her r -She had never had her medications.	5 with Client #1 revealed: medications from staff. d an issue regarding getting 5 with the Director revealed:				
	-She had had some MAR a few days agresolved itClient #1's Olanza by her doctor at the -She had administer #1, but was not recollanzapine 5 mg relectronic MAR after program.	e issues with the electronic go, but thought she had pine had just been prescribed e end of July. ered the Olanzapine to Client				
V 364	§ 122C-62. Addition Facilities. (a) In addition to the 122C-51 through Gowho is receiving tree 24-hour facility kees (1) Send and receivances to writing massistance when no services.	ve sealed mail and have aterial, postage, and staff	V 364			
	and at no cost to the physicians, and prividevelopmental disaprofessionals of his (3) Contact and cothere is a client adv	e facility, legal counsel, private vate mental health, ibilities, or substance abuse schoice; and insult with a client advocate if				

Division of Health Service Regulation STATE FORM

6899 SXEQ11 If continuation sheet 3 of 10

DIVISION	of Health Service Re	egulation				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL032-415	B. WING		08/1	5/2025
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MIOLIAE	LIO DI AOF	2815 CAS	CADILLA ST	REET		
MICHAE	L'S PLACE	DURHAM,	NC 27703			
(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 SHOULD CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
V 364	Continued From pa	ge 3	V 364			
	restricted by the face exercise these right (b) Except as provof this section, each treatment or habilitatimes keeps the rig (1) Make and rece calls. All long distarthe client at the time collect to the receiv (2) Receive visitors a.m. and 9:00 p.m. hours daily, two houp.m.; however visitiover therapies; (3) Communicate a supervision with incupon the consent of (4) Make visits out unless: a. Commitment position the result of the client violent crime, includes assault with a dead respondent was for insanity or incapable. The client was committed to the facommitment to a collivision of Adult Collins and the commitment is beto proceed pursuant A court order may expendent was prohibited conditions prescribe (5) Be out of doors	cility and each adult client may its at all reasonable times. ided in subsections (e) and (h) in adult client who is receiving ation in a 24-hour facility at all that to: ive confidential telephone ince calls shall be paid for by the of making the call or made ing party; is between the hours of 8:00 for a period of at least six that are of which shall be after 6:00 ing shall not take precedence and meet under appropriate lividuals of his own choice of the individuals; is ide the custody of the facility is roceedings were initiated as and in a crime involving an ally weapon, and the individuality by reason of the or proceeding; it is of proceeding; it is of proceeding; it is of proceeding in the individual or cility while under order of the or proceeding in the individual or cility while under order of the or proceeding in the individual or cility while under order of the or proceeding in the individual or cility while under order of the or proceeding in the individual or cility while under order of the or				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(Y2) MI II TIDI	E CONSTRUCTION	(Y3) DATE	SLID//EV	
AND DIAN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		` ′		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:	A. BUILDING:		
			D WING	B. WING		
		MHL032-415	B. WING		08/1	5/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MICHAE	10 DI ACE	2815 CAS	CADILLA ST	REET		
MICHAE	L'S PLACE	DURHAM	NC 27703			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	FRIATE	DAIL
1/00/			1/ 00/			
V 364	Continued From pa	ge 4	V 364			
		ibited by law, keep and use				
		nd possessions, unless the				
		to determine capacity to				
	proceed pursuant to					
	(7) Participate in re					
	` '	d a reasonable sum of his				
	own money;	a licence, unless otherwise				
		s license, unless otherwise er 20 of the General Statutes;				
	and	er 20 or the General Statutes,				
		individual storage space for				
	his private use.	mannaan cicrage space is:				
		e rights enumerated in G.S.				
		.S. 122C-57 and G.S.				
	122C-59 through G	.S. 122C-61, each minor client				
		atment or habilitation in a				
		the right to have access to				
		ision and guidance. In				
		ninor's status as a developing				
	individual, the mino					
	emotionally, intelled	able him to mature physically,				
		of the physical, emotional,				
		naturity of the minor, the				
		I provide appropriate				
	•	on and control consistent with				
	the rights given to the	he minor pursuant to this Part.				
		o, where practical, make				
		o ensure that each minor				
		ment apart and separate from				
		the treatment needs of the				
	minor client dictate					
		ho is receiving treatment or				
		24-hour facility has the right to: and consult with his parents or				
	` '	ency or individual having legal				
	custody of him;	noy or individual having legal				
		nsult with, at his own expense				
		responsible person and at no				

Division of Health Service Regulation				I		
AND DI AN OF CODDECTION INDENTIFICATION NI IMPED:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
VIAD LEVIA	OI OUNILUTION	IDLIVIII IOATION NUMBER.	A. BUILDING:	A. BUILDING:		LLILD
		MHL032-415	B. WING 08		08/1	5/2025
		0.70557.40		NTATE 710 0005		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MICHAE	L'S PLACE		CADILLA ST	REET		
		DURHAM,	NC 27703			
(X4) ID	_	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
TAG	AG REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	INAIL	D/ ((E
				·		
V 364	Continued From pa	ge 5	V 364			
	cost to the facility, le	egal counsel, private				
		mental health, developmental				
		tance abuse professionals, of				
		sponsible person's choice; and				
		nsult with a client advocate, if				
	there is a client adv					
		I in this subsection may not be				
		cility and each minor client				
		rights at all reasonable times.				
		ided in subsections (e) and (h)				
		n minor client who is receiving				
		ation in a 24-hour facility has				
	the right to:	ation in a 2 1 mour racinty mac				
		ive telephone calls. All long				
		be paid for by the client at the				
		call or made collect to the				
	receiving party;					
		ve mail and have access to				
		ostage, and staff assistance				
	when necessary;					
	(3) Under appropri	ate supervision, receive				
	visitors between the	e hours of 8:00 a.m. and 9:00				
	p.m. for a period of	at least six hours daily, two				
	hours of which shal	I be after 6:00 p.m.; however				
	visiting shall not tak	te precedence over school or				
	therapies;					
		l education and vocational				
		nce with federal and State law;				
		daily and participate in play,				
		sical exercise on a regular				
	basis in accordance	•				
		ibited by law, keep and use				
		nd possessions under				
		sion, unless the client is being				
		apacity to proceed pursuant to				
	G.S. 15A-1002;					
	(7) Participate in re					
		individual storage space for				
	the safekeeping of	personal belongings;				

6899

DIVISION	of Health Service Re	egulation	1			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COIVIP	LETED
		MHL032-415	B. WING		08/1	5/2025
NAME OF I	PROVIDER OR SUPPLIER	etpeet AD	DDESS CITY S	STATE, ZIP CODE		
NAIVIE OF I	-ROVIDER OR SUPPLIER					
MICHAE	L'S PLACE		CADILLA ST	IREEI		
			NC 27703			
(X4) ID		TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL)		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
V 364	Continued From pa	go 6	V 364			
V 30 4	Continued From pa	ge o	V 304			
		and spend a reasonable sum				
	of his own money;					
		s license, unless otherwise				
		ter 20 of the General Statutes.				
		erated in subsections (b) or (d)				
	,	be limited or restricted except				
		fessional responsible for the lient's treatment or habilitation				
		ement shall be placed in the				
	•	ndicates the detailed reason				
		The restriction shall be				
		ated to the client's treatment or				
		A restriction is effective for a				
	period not to excee	d 30 days. An evaluation of				
	each restriction sha	Ill be conducted by the				
		al at least every seven days,				
		estriction may be removed.				
		a restriction shall be				
		client's record. Restrictions on				
	· ·	wed only by a written				
		by the qualified professional in nat states the reason for the				
		iction. In the case of an adult				
		peen adjudicated incompetent,				
		an initial restriction or renewal				
		ghts, an individual designated				
		ipon the consent of the client,				
		striction and of the reason for				
	it. In the case of a r	ninor client or an incompetent				
		ally responsible person shall				
		instance of an initial restriction				
		riction of rights and of the				
		ation of the designated				
		responsible person shall be				
	aocumented in writ	ng in the client's record.				

6899

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
				A. BUILDING:			
		MHL032-415	B. WING		08/1	5/2025	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
MICHAE	L'S PLACE		SCADILLA ST , NC 27703	REET			
(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 CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
V 364	Continued From pa	nge 7	V 364				
	Based on observatinterviews, the facil 3 audited clients (# their access to food Observation on 8/1 pm of the facility re-There were three on each of their doc-A combination was refrigerator. Review on 8/15/25 -Admission date of -Diagnoses of Inter Schizophrenia - Un Disability.	5/25 between 8:45 am to 2:00 vealed: refrigerators with a cable lock ors. s needed to open the					
	-No documentation	tion of food related behaviors. of detailed reason for the evaluation of the restriction.					
	-Admission date of -Diagnoses of Schi Intellectual Disabilit Disorder, History of Sialorrhea, Hypercl Urosepsis, History Disorder, Knee Arth -Treatment/habilitat include documentat -No documentation restriction and no e	of Client #2's record revealed: 11/6/08. zophrenia, Pica, Mild ty, Alzheimer, Seizure f Stroke, Risk of Aspiration, holesterolemia, History of of untreated Syphilis, Sexual protomy and Dysarthria tion plan dated 3/1/25 did not tion of food related behaviors. of detailed reason for the evaluation of the restriction.					
	-Admission date of						

Division of Health Service Regulation STATE FORM

6899 SXEQ11 If continuation sheet 8 of 10

AND DUAN OF CODDECTION DENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL032-415	B. WING		08/1	5/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
MICHAE	L'S PLACE		CADILLA ST	REET		
	OLIMANA DV. OTA		NC 27703	PROVIDERIO PLAN OF CORRECTIV	ON.	44-1
(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 APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
V 364	Continued From pa	ge 8	V 364			
	Moderate - Recurre Intermittent Explosi Retardation, and AI - Treatment/habilitati include documentati - There was a draft in plan written by Clienthe need to lock the Plan had not been a committee. Interview on 8/15/2: - She had been at the Food was good an enough for everyone - Food was locked under the staff know and they - She did not have obut staff would get it.	anything to eat, she would let would get it for her. spen access to the refrigerator, her food if she wanted. he combination for the cable				
	-Indicated he liked thowever, it was har his diagnoses.	5 with Client #2 revealed: the food at the facility; d to interview Client #2 due to able to answer complex				
	Unable to interview hospitalized.	Client #23 as she was				
	-She had just place refrigerators last we -She had been hav stealing food in con					

AND DUAN OF CODDECTION DENTIFICATION NUMBER.			E CONSTRUCTION	(X3) DATE COMP	SURVEY	
		MHL032-415	B. WING		08/1	15/2025
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MICHAE	L'S PLACE		CADILLA ST , NC 27703	TREET		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CORRECTION SHOULD BE					(X5) COMPLETE DATE
V 364	#3 indicating about but it had not been -Client #3's psychia plan indicating the rand food pantry as and stealing food fropantryThe behavioral plarights committee for -At the time of the sentence.	the locks in the refrigerator, signed. trist had develop a behavioral need to lock the refrigerator Client #3 had been sneaking om the refrigerator and food n was to be sent to disability	V 364			

6899