STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		A. BUILDING.				
	MHL051-203	B. WING		l l	C 08/12/2025	
SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
4 DE 1104	3310 NC 2	210 HWY				
ULTIMATE FAMILY CARE HOME SMITHI			77			
MARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)	
		PREFIX TAG			COMPLÉTE DATE	
00 INITIAL COMMENTS		V 000				
A complaint survey was completed on 8/12/25. The complaint was substantiated (Intake #NC00232773). Deficiencies were cited.						
0A NCA	C 27G .5600A Supervised					
6. The su	rvey sample consisted of					
Privilegi	ng/Training Professionals	V 109				
D PROFITE PROF	ESSIONALS AND ESSIONALS no privileging requirements for als or associate professionals. It is					
	SUPPLIER ARE HON MARY STADEFICIENCY TORY OR LS DMMENT at survey aint was 2773). De y is licens 10A NCAA Adults wit y is licens 6. The su current of Privilegin 227G .02 D PROFE FE PROF shall be r rofession ed profes als shall e es require h time as nt system ied profes als shall e estence sh core skills cal knowl al awaren cal skills; con-making crisonal sk unication I skills. ed profes 6 .0104 (quiremen	MHL051-203 SUPPLIER STREET AD ARE HOME 3310 NC 2 SMITHFIE MMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL TORY OR LSC IDENTIFYING INFORMATION) DMMENTS Int survey was completed on 8/12/25. aint was substantiated (Intake 2773). Deficiencies were cited. If is licensed for the following service 10A NCAC 27G .5600A Supervised Adults with Mental Illness. If is licensed for 6 and has a current 6. The survey sample consisted of current client. Privileging/Training Professionals C 27G .0203 COMPETENCIES OF D PROFESSIONALS AND TE PROFESSIONALS AND TE PROFESSIONALS and associate als shall demonstrate knowledge, skills as required by the population served. In time as a competency-based In time as a c	MHL051-203 SUPPLIER STREET ADDRESS, CITY, S 3310 NC 210 HWY SMITHFIELD, NC 275 MARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL TORY OR LSC IDENTIFYING INFORMATION) OMMENTS OMMENTS V 000 It survey was completed on 8/12/25. Iaint was substantiated (Intake 1773). Deficiencies were cited. It is licensed for the following service 10A NCAC 27G .5600A Supervised Adults with Mental Illness. It is licensed for 6 and has a current 6. The survey sample consisted of current client. Privileging/Training Professionals C 27G .0203 COMPETENCIES OF D PROFESSIONALS Shall be no privileging requirements for rofessionals and associate als shall demonstrate knowledge, skills is required by the population served. In time as a competency-based Int system is established by rulemaking, ied professionals and associate als shall demonstrate competence. It ime as a competency-based Int system is established by rulemaking, ied professionals and associate als shall demonstrate competence. It ime as a competency-based Int system is established by rulemaking, ied professionals and associate als shall demonstrate competence. It ime as a competency-based It is including: Cal knowledge; In awareness; Cal skills; In on-making; In on-m	SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NC 210 HWY SMITHFIELD, NC 27577 MARCHOME ARE HOME 3310 NC 210 HWY SMITHFIELD, NC 27577 MARCHOME MARCHOME MARCHOME 3310 NC 210 HWY SMITHFIELD, NC 27577 MARCHOME MAR	SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 310 NC 210 HWY SMITHFIELD, NC 27577 MMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY PULL TORY OR LSC IDENTIFYING INFORMATION) DIMMENTS at survey was completed on 8/12/25. aint was substantiated (Intake 77/37). Deficiencies were cited. y is licensed for the following service 10A NCAC 27G .5600A Supervised dutts with Mental Illness. y is licensed for 6 and has a current 6. The survey sample consisted of current client. Privileging/Training Professionals C 27G .0203 COMPETENCIES OF D PROFESSIONALS AND TE PROFESSIONALS Ashall be no privileging requirements for rofessionals or associate professionals. et als shall demonstrate knowledge, skills is required by the population served. h time as a competency-based at swalls; n-making; resonal skills; unication skills; and I skills, ed professionals as specified in 10A 3.0104 (18)(a) are deemed to have quirements of the competency-based	

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL051-203	B. WING		I	C 12/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
III TIMAT	E FAMILY CARE HON	3310 NC 2	210 HWY			
OLITIVIA	LIAMILI CARLITON	SMITHFIE	LD, NC 2757	77		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 109	MH/DD/SAS. (f) The governing because of the initiation of a plan upon hiring each (g) The associate propulation served for the initiation of a plan upon hiring each (g) the associate propulation served for the governing the g	ge 1 pody for each facility shall ment policies and procedures an individualized supervision ch associate professional. professional shall be alified professional with the or the period of time as 104 of this Subchapter.	V 109			
	failed to ensure tha (Co-owner/Register competency. The find the Review on 8/8/25 of personnel record record of the Date of hire: 5/5 Education: Ass	view and interview, the facility t 1 of 1 staff red Nurse (RN)) demonstrated ndings are: f the Co-owner/RN's evealed:				
	Services (EMS) Par - incident dated: - primary importance - protocols u exposure/exhaustic - "the envir	sed: environmental-heat on - adults only conment the patient is in is re is no AC (air conditioning) Outside air temp is near 100				

Division of Health Service Regulation

STATE FORM 6899 RQAL11 If continuation sheet 2 of 22

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		MHL051-203	B. WING		08/1	2/2025
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ULTIMAT	E FAMILY CARE HO	ME 3310 NC 2				
_	T	SMITHFIE	LD, NC 275			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 109	Continued From pa	ge 2	V 109			
V 103	- "Treatment taken to nearest fire water via body bags shivering present. It immersion. He rem temperature reached mentation improved (local emergency reduced - incident dated: - primary implements of the primary implements of the Pt this evening in the residence with conditioning had been that they couldn't go found to be extrements in the residence with conditioning had been that they couldn't go found to be extrements in otted to be some been ormal for the progroup home staff of ever since he came was taken outside as where he could be environment. during state that he started of the residence during was transported to protocol throughout noted." Review on 8/8/25 of temperatures online Temperatures (21, 2025: - July 21: Highter that he started of the testing the protocol throughout noted."	as documented. Patient is estation and immersed in ice. He is never noted to have He is monitored for duration of ains in ice water until his es 98 degrees and his s. Patient is transported to boom)" 7/29/25 pression: fever ispatched out to a 64 years of it is noted to be coming from a set noted to have been seen at ast several daysUpon arrivaling it is found to be 90 degrees the staff stating that the air seen out for several days and get anybody out to fix it Pt is ely hopt (hot) to the touch and sewhat altered which is noted to the tates that he has had a fever es back from the hospital. Pt and placed onto the stretcher assessed and treated in a cool grassessment Pt is noted to do to feel much better once out the tolerand hospital and treated per it transport with improvement of the local weather erevealed: (local) during the week of July other 195°F				
	is noted to be some be normal for the p group home staff si ever since he came was taken outside a where he could be environment. during state that he started of the residence du was transported to protocol throughout noted." Review on 8/8/25 of temperatures online Temperatures (ewhat altered which is noted to t. tates that he has had a fever e back from the hospital. Pt and placed onto the stretcher assessed and treated in a cool g assessment Pt is noted to d to feel much better once out e to ambient temperature. Pt [local hospital] and treated per t transport with improvement of the local weather e revealed:				
		gh of 90°F gh of 88°F				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			,
		MHL051-203	B. WING		08/1	2/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ULTIMA	TE FAMILY CARE HOI	ME 3310 NC 2 SMITHFIE	210 HWY ELD, NC 275	77		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
V 109	- July 25: High - July 26: High - July 27: High - July 27: High - "The highe July was 99°F on July 21st - July heatwave with heat dangerous levels. A issued for the area degrees F and a heat degrees." Interview on 7/30/2 - hadn't been lividen he shared a rooden heat had not storm "a couple of the air had not storm "a couple of it was getting swhere you could seshirt - he would changed any money to buy any mone offered - the last couple days, they did not heat had his owr the air not working it was hot in the if you sit still, you moving again you go he stayed in his he tried to keep	gh of 96°F gh of 98°F gh of 99°F est temperature recorded in uly 27." y 30th was marked by a t index values reaching An extreme heat warning was , including a temperature of 95 eat index of up to 107 5 Client #2 reported: ing in facility that long om with client #6 been working since the last Mondays ago" o hot that he was sweating ee the sweat going down his ge clothes about 3 or 4 times a ught a fan but he didn't have a fan (client #6) brought a fan, but in his roommate to buy him a fan of weeks, even on the real hot have any air 5 Client #3 reported: he facility for a year a room that wasn't affected by he kitchen and the dining room ou can cool off but if you start	V 109			

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MHL051-203 MHL051-203 MHL051-203 STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NC 210 HWY SMITHFIELD, NC 27577 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPTICENCY MUST BE PRECEDED BY FULL FREGULATORY ORLSC DENTIFYING INFORMATION) FREED (EACH DEPTICENCY MUST BE PRECEDED BY FULL FREED (EACH DEPTICENCY) V 109 V 109 V 109 V 109 V 109 Interview on 7/30/25 Client #4 reported: - been living in the facility for a year - the air had been out "seems like the past two months or so" - he had his own room where the air continued working - "It was kind of mug, a little muggy in the kitchen" - "It was exceptionally muggy for living in a house" - he stayed in his room a lot with the air - eating dinner in the dining room, "it was okay" - sometimes he "scarfed" down his food to get back in his room with the air Interview on 7/30/25 Client #5 reported: - been living in the facility for 3 years - the air hadn't been working for about a month - he told staff #1 that it was hot in the room and she said that someone would be coming to fix the air - he told her this when it first started getting hot - his sister brought him a fan because he was sweating a lot and was hot - it was really hot over the weekend (this past weekend)	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NC 210 HWY SMITHFIELD, NC 27577 MAILY CARE HOME SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION CRACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREPRINT TAG REGULATORY OR LSC IDENTIFYING INFORMATION PREPRINT TAG REGULATORY OR LSC IDENTIFYING INFORMATION PREPRINT TAG REGULATORY OR LSC IDENTIFYING INFORMATION PREPRINT TAG REACH CORRECTIVE ACTION SHOULD BE COMPLETED TO HEAPPROPRIATE DAY IN TAG REACH CORRECTIVE ACTION SHOULD BE COMPLETED TO HEAPPROPRIATE DAY IN TAG REACH CORRECTIVE ACTION SHOULD BE COMPLETED TO HEAPPROPRIATE DAY IN TAG REACH CORRECTIVE ACTION SHOULD BE COMPLETED TO HEAPPROPRIATE DAY IN TAG REACH CORRECTIVE ACTION SHOULD BE COMPLETED TO HEAPPROPRIATE DAY IN TAG REACH CORRECTIVE ACTION SHOULD BE COMPLETED TO HEAPPROPRIATE DAY IN TAG REACH CORRECTIVE ACTION SHOULD BE COMPLETED TO HEAPPROPRIATE DAY IN TAG REACH CORRECTIVE ACTION SHOULD BE COMPLETED TO HEAPPROPRIATE DAY IN TAG REACH CORRECTIVE ACTION SHOULD BE COMPLETED TO HEAPPROPRIATE DAY IN TAG REACH CORRECTIVE ACTION SHOULD BE COMPLETED TO HEAPPROPRIATE DAY IN TAG REGULATORY OR LANGE THE ACTION SHOULD BE COMPLETED TO HEAPPROPRIATE DAY IN TAG REGULATORY OR LANGE THE ACTION SHOULD BE COMPLETED TO HEAPPROPRIATE DEPORTED TO HEAPP	ANDILAN	OF CONTROL OF THE CON	IDENTIFICATION NOWIDER.	A. BUILDING:				
SUMMARY STATEMENT OF DEFICIENCY SMITHFIELD, NC 27577			MHL051-203	B. WING				
CAM ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (CAS) ID PROVIDER'S PLAN OF CORRECTION SHOULD BE CACH DEPICIENCY MUST BE PRECEDED BY FULL PEGLIATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CONSENTED TO THE APPROPRIATE COMPLETE DATE	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) V 109 Continued From page 4 - If he kept his door opened, it would get hot because of the side of the house that didn't have air - he was not sure when the air stopped working Interview on 7/30/25 Client #4 reported: - been living in the facility for a year - the air had been out "seems like the past two months or so" - he had his own room where the air continued working - "It was kind of mug, a little muggy in the kitchen" - "It was exceptionally muggy for living in a house" - he stayed in his room a lot with the air eating dinner in the dining room, "It was okay" - sometimes he "scarfed" down his food to get back in his room with the air Interview on 7/30/25 Client #5 reported: - been living in the facility for 3 years - the air hadn't been working for about a month - he told staff #1 that it was hot in the room and she said that someone would be coming to fix the air - he told her this when it first started getting hot - it sisster brought him a fan because he was sweating a lot and was hot - it was really hot over the weekend (this past weekend)	ULTIMAT	E FAMILY CARE HO	VI L		77			
- if he kept his door opened, it would get hot because of the side of the house that didn't have air - he was not sure when the air stopped working Interview on 7/30/25 Client #4 reported: - been living in the facility for a year - the air had been out "seems like the past two months or so" - he had his own room where the air continued working - "it was kind of mug, a little muggy in the kitchen" - "it was exceptionally muggy for living in a house" - he stayed in his room a lot with the air - eating dinner in the dining room, "it was okay" - sometimes he "scarfed" down his food to get back in his room with the air Interview on 7/30/25 Client #5 reported: - been living in the facility for 3 years - the air hadn't been working for about a month - he told staff #1 that it was hot in the room and she said that someone would be coming to fix the air - he told her this when it first started getting hot - his sister brought him a fan because he was sweating a lot and was hot - it was really hot over the weekend (this past weekend)	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF	HOULD BE	COMPLETE	
Interview on 7/30/25 Client #6 reported: - been living in the facility for about a month - it was hot in his room the last couple of weeks - "it was pretty hot" - he purchased a fan from a local store	V 109	- if he kept his debecause of the side air - he was not sure working Interview on 7/30/2 - been living in the the air had been months or so" - he had his own working - "it was kind of a kitchen" - "it was exception house" - he stayed in his eating dinner in sometimes he back in his room working in the the air hadn't been living in the he told staff #1 she said that some air - he told her this his sister broug sweating a lot and the it was really howekend) Interview on 7/30/2 - been living in the weekend) Interview on 7/30/2 - been living in the it was hot in his weeks - "it was pretty here."	oor opened, it would get hot e of the house that didn't have e when the air stopped 5 Client #4 reported: he facility for a year on out "seems like the past two room where the air continued mug, a little muggy in the onally muggy for living in a seroom a lot with the air on the dining room, "it was okay" "scarfed" down his food to get ith the air 5 Client #5 reported: he facility for 3 years een working for about a month that it was hot in the room and one would be coming to fix the when it first started getting hot ght him a fan because he was was hot tover the weekend (this past of the facility for about a month one facility for about a month one would be coming to fix the swas hot tover the weekend (this past of client #6 reported: 5 Client #6 reported: he facility for about a month or room the last couple of ot"	V 109				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		MHL051-203	B. WING		08/1	2/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		3310 NC 2	210 HWY			
ULIIMAI	E FAMILY CARE HON	ME SMITHFIE	LD, NC 275	77		
(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 APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
				52.10.2.10.7		
V 109	Continued From pa	ge 5	V 109			
	kitchen and dining room - he stayed in his room a lot with the fan Interview on 7/30/25 Staff #1 reported: - the air had not been working since this past					
	Saturday and she c	alled the repairman man) fixed the air but only one				
	side was working - she noticed that client #1's room was hot when the air was not working - the "guys" (clients) told her that they needed					
	fans because they were hot - client #1 went to the hospital this past weekend for a fall					
	Interview on 7/30/25 the Supervisor in Charge (SIC) reported: - been having an issue with the air conditioning					
	for the past week "a					
	kitchen, a bathroom					
	diagnosed with hea	o the hospital 7/26/25 and was t exhaustion 7/27/25, client #1 "was out of				
	_	and forth and couldn't keep				
	 staff #1 took client #1 to her room where it was cooler staff #1 was directed to call 911 					
	- client #1 didn't had a fan that was	n 8/7/25 Staff #1 reported: have a fan but his roommate only facing him nt #1 if he wanted a fan and he				
		the Co-owner/RN reported: ner first started having 25				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
THE PERIOD CONTROL OF THE	BENTI IOMITENTI NOMBER.	A. BUILDING:			
	MHL051-203	B. WING		08/1	2/2025
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ULTIMATE FAMILY CARE HON	ME 3310 NC 2 SMITHFIE	210 HWY LD, NC 275	77		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
very well the air condition and was working "o she called a tec needed a new unit she was told by without air had fans she didn't know having a fan client #1 was in but client #1 did not she confirmed to not have personal faworking the night that clishe told staff that the conditioners Interview on 8/5/25 air conditioning com the original serv the unit needed the house Interview on 8/5/25 fire department report he responded to Sunday night/early lended up having there was no canight he and EMS was said "boy it's hot in lended with the thermometed degrees at 1:00am	ner was not completely broken on and off" chnician who told her that she of the SIC that both rooms is anything about client #2 not in the same room with client #5 it have his own fan that client #1 and client #2 did tans while the air was not lient #1 went to the hospital, ney could get portable air the technician with the local inpany reported: vice call was 7/21/25 if to be replaced on that side of the Lieutenant for the local orted: or an emergency call late Monday morning 7/27/25 call for a sick person and client in grever all about client #1 falling that alked in together and they both	V 109			

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
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			D WING			
		MHL051-203	B. WING		08/1	2/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DDESS CITY S	STATE, ZIP CODE		
NAME OF I	- NOVIDEN ON SUFFEIEN			STATE, ZIF GODE		
ULTIMAT	E FAMILY CARE HO	лE 3310 NC 2				
0		SMITHFIE	LD, NC 275	77		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
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TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				DEFICIENCY)		
V 109	Continued From pa	ge 7	V 109			
V 100	Continued From pa	ge 7	V 100			
	they had to help hir	n up and help him move"				
	- he was not resp	oonding and could not walk				
		acility that had the AC had				
		air was unable to circulate to				
	other areas					
	- as soon as the	y got client #1 in the				
		AC, he was able to talk more				
		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
	Interview on 8/8/25 with Client #5's sister					
	reported:					
		t the air not working because				
	she visited her brot					
		and another sister went to				
		lient #5 some items and he				
	_					
	came out with his s					
		er that they didn't have any air				
	and it was hot					
		nt #5 if he wanted her to buy				
	him a fan and he sa					
		e fan the same day because				
		e and she didn't want him to				
	overheat					
V 118	27G .0209 (C) Med	ication Requirements	V 118			
	(-)	•				
	10A NCAC 27G .02	209 MEDICATION				
	REQUIREMENTS					
	(c) Medication adm	inistration:				
		non-prescription drugs shall				
		ed to a client on the written				
		uthorized by law to prescribe				
	•	diffortized by law to prescribe				
	drugs.	all be self administered by				
		all be self-administered by				
		uthorized in writing by the				
	client's physician.	Landa and a Committee of the Committee o				
		cluding injections, shall be				
		y licensed persons, or by				
		trained by a registered nurse,				
	pharmacist or other legally qualified person and					

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DIVISION	of Health Service Re	egulation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:		COIVIE	LETED
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		MHL051-203	D. WINO		08/1	2/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ULTIMATE FAMILY CARE HOME 3310 NC						
SMITHFIE			LD, NC 275	77		
(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 page 8		V 118			
	(4) A Medication Ad all drugs administer current. Medication recorded immediate MAR is to include the (A) client's name; (B) name, strength, (C) instructions for (D) date and time the (E) name or initials drug. (5) Client requests checks shall be recorded.	e and administer medications. Iministration Record (MAR) of red to each client must be kept is administered shall be ely after administration. The ne following: and quantity of the drug; administering the drug; and of person administering the for medication changes or orded and kept with the MAR appointment or consultation				
	failed to administer order of a physician	et as evidenced by: view and interview, the facility medications on the written and failed to demonstrate ng 1 of 6 clients (#1). The				
	 Admitted: 3/5/2 Diagnoses: Sch Dyslipidemia, Cons Physician's ord Tylenol Ext capsules (cap), cap 	client #1's record revealed: 4 nizophrenia, Hypothyroidism, tipation, Seborrheic Dermatitis er dated 2/12/25 revealed: ra Strength 500 milligram (mg) s 1-2 by mouth every 6 hours or headache, fever or pain				

Review on 8/7/25 of client #1's July 2025 MAR

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		A. BUILDING.		1 ,	С	
	MHL051-203	B. WING			12/2025	
NAME OF PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE			
ULTIMATE FAMILY CARE HON	ΛF	210 HWY ELD, NC 275	77			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
tablet (tabs), take 1 hours as needed for pain no staff initials a administered during. Interview on 7/30/28 client #1 had a 7/27/25 and she gares she did not give she called the concentrate of the concentration of t	in (AC) Non-Aspirin 500mg -2 tabs by mouth every six r headache, for fever, or for as medication being g the month of July 5 staff #1 reported: fever of 100 degrees on ve him some cold water e him any Tylenol co-owner/registered nurse d her to call 911 in 8/7/25 staff #1 reported: to deal with client #1 not falling alking back and forth so she him any medication for his the Supervisor In Charge pain relievers and fever at staff #1 didn't give client #1 ecause everything was staff #1 really knew what to the Co-owner/RN reported: call from staff #1 saying that er of 103 degrees aff #1 to give client #1 Tylenol	V 118				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(V2) MULTIPL	E CONSTRUCTION	T(V2) DATE	CLIDVEV	
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
						C
		MHL051-203	B. WING		08/12/2025	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
147 UVIL 01 1	TO VIDER OR GOLF EIER	3310 NC 2		517 (12, 2.11 ° 00B2		
III TIMATE FAMILY CARE HOME			LD, NC 275	77		
	OUR MAA DV OTA					
(X4) ID PREFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD)		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
\/ 139	27G 0404 (F-L) Or	perations During Licensed	V 139			
V 100	Period	Defations During Licensed	V 133			
	Fenou					
	10A NCAC 27G .04	104 OPERATIONS				
	DURING LICENSE					
		duct inspections of facilities				
	without advance no					
		cilities that have not served				
	any clients during the previous 12 months shall not be renewed. (h) DHSR shall conduct inspections of all 24-hour facilities an average of once every 12 months, to occur no later than 15 months as of					
	July 1, 2007.					
	(i) Written requests	s shall be submitted to DHSR				
	a minimum of 30 da	ays prior to any of the following				
	changes:					
		tion of a new facility or any				
	renovation of an ex					
		or decrease in capacity by				
	program service typ					
		n program service; or				
	` '	n location of facility.				
	U/	otification must be submitted				
		m of 30 days prior to any of				
	the following chang (1) Change ir	n ownership including any				
	change in partnersh					
		n name of facility.				
		ee plans to close a facility or				
		ce, written notice at least 30				
		all be provided to DHSR, to all				
		d when applicable, to the				
		persons of all affected clients.				
		Idress continuity of services to				
	clients in the facility					
		expire unless renewed by				
		onal period. Prior to the				
		ise, the licensee shall submit				
	to DHSR the follow					

Division of Health Service Regulation						
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					С	
		MHL051-203	B. WING			2/2025
		WITE031-203			00/1	2/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		3310 NC 2	210 HWY			
ULIIMAI	E FAMILY CARE HON	^{/IE} SMITHFIE	LD, NC 275	77		
(V4) ID	SHMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)N	(Y5)
(X4) ID PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
				DEFICIENCY)		
V 139	Continued From pa	ge 11	V 139			
	-					
	(1) Annual Fe					
		on of any changes in the				
		t written notification was				
	submitted;					
		rent fire inspection report;				
		anitation inspection report, with				
		day/night or periodic service				
	that does not handle food for which a sanitation inspection report is not required; and (5) The names of individuals who are					
	\ /					
		shareholders holding an				
		olling interest of 5% or more of				
	the applicant entity.					
	This Rule is not me	et as evidenced by:				
		view and interview, the facility				
	failed to provide the					
		mergency relocation of clients				
		of Health Service Regulations				
	(DHSR). The findin					
	, ,	<u> </u>				
	Review on 8/8/25 o	f a hotel receipt revealed:				
	- check in date 8	time: 7/29/25 2:51am				
		f DHSR's facility folder				
	revealed:					
		ocation application was				
	provided by the fac	ility.				
		5 the Supervisor in Charge				
	(SIC) reported:					
		t have air conditioning on one				
	side of the facility	A Heli al analis de la Prima				
		nt #5's shared bedroom did not				
	have air conditionin					
	- client #2 & clier	nt #6's shared bedroom did not				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		C	
MHL051-203					2/2025	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ULTIMAT	E FAMILY CARE HO	ME 3310 NC 2 SMITHFIE	210 HWY LD, NC 275	77		
(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 139	have air conditionir - the facility had the air conditioning - the same day thospital, the Co-Owmoved client #2, clifor the day until the conditioners for the Interview on 8/8/25 - she had the client #1 went - the air conditioners sometime Further interview or reported: - she had never relocation	been having a problem with for "at least" the past week hat client #1 went to the vner/Registered Nurse (RN) ient #5 and client #6 to a hotel by purchased the portable air efacility the Co-owner/RN reported: ents go to a hotel the morning to the hospital ner first started having e in July 2025 n 8/12/25 the Co-owner/RN heard of an emergency of get them (clients) out of the	V 139			
V 366	10A NCAC 27G .06 RESPONSE REQUIRESPONSE REQUIRESPONSE REQUIRESPONSE AND (a) Category A and implement written presponse to level I, shall require the proful attending of individuals involving (2) determining (3) developing measures according timeframes not to 6 (4) developing	JIREMENTS FOR D B PROVIDERS I B providers shall develop and policies governing their II or III incidents. The policies povider to respond by: to the health and safety needs wed in the incident; ng the cause of the incident; ag and implementing corrective ag to provider specified	V 366			

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		B. WING		С		
MHL051-203				08/1	2/2025	
NAME OF PROVIDER OR SUPPL	R STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
ULTIMATE FAMILY CARE I	OME 3310 NC 2	210 HWY				
OLIMAILI AMILI GARLI	SMITHFIE	LD, NC 275	77			
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
V 366 Continued From	page 13	V 366				
specified timefra (5) assign for implementat preventive meas (6) adheri set forth in G.S. 42 CFR Parts 2 164; and (7) mainta Subparagraphs (b) In addition to Paragraph (a) o shall address in regulations in 42 (c) In addition to Paragraph (a) o providers, exclu develop and imp their response to while the provide or while the clien The policies shall by: (1) immed by: (A) obtaini (B) makin (C) certify (D) transfer review team; (2) conver review team with internal review to who were not in were not response with direct profeservices at the to	mes not to exceed 45 days; ng person(s) to be responsible on of the corrections and	V 300				

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Division of Health Service Regulation STATE FORM

RQAL11 If continuation sheet 14 of 22

DIVIDION	or riealth Service IN	zgulation				
	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					ے ا	、
		MIII 054 202	B. WING		00/4	
		MHL051-203	B. WING	·····	08/1	2/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		3310 NC 2	210 HWY			
ULTIMAT	E FAMILY CARE HON	ΛF	LD, NC 275	77		
(X4) ID		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG	•	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP		DATE
		·		DEFICIENCY)		
1/000	0 " 1=		11000			
V 366	Continued From pa	ge 14	V 366			
	(A) review the	copy of the client record to				
	determine the facts	and causes of the incident				
	and make recomme	endations for minimizing the				
	occurrence of future					
	(B) gather oth	ner information needed;				
		ten preliminary findings of fact				
		days of the incident. The				
		of fact shall be sent to the				
		hment area the provider is				
		ME where the client resides,				
	if different; and	,				
		nal written report signed by the				
		months of the incident. The				
		sent to the LME in whose				
		provider is located and to the				
		nt resides, if different. The				
		shall address the issues				
		ernal review team, shall				
		ocuments pertinent to the				
		make recommendations for				
		urrence of future incidents. If				
		led for the report are not				
		ee months of the incident, the				
		provider an extension of up to				
		omit the final report; and				
		ely notifying the following:				
		esponsible for the catchment				
	` ,	vices are provided pursuant to				
	Rule .0604;	vices are provided pursuant to				
	,	where the client resides, if				
	different;	พาเอเซ แเซ เมเซมเนเซมเนซิ้ง, ม				
	,	der agency with responsibility				
		updating the client's				
		fferent from the reporting				
	provider;					
	(D) the Depar					
	. ,	s legal guardian, as				
	applicable; and					
	(F) any other	authorities required by law.				

Division of Health Service Regulation

STATE FORM 6899 RQAL11 If continuation sheet 15 of 22

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	MHL051-203		B. WING		C 08/12/2025		
					00/1	2/2025	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
ULTIMAT	E FAMILY CARE HOM	ME 3310 NC 2		77			
	OLIMANA DV. OTA		LD, NC 275		ON.	0.5	
(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 366	Continued From pa	ge 15	V 366				
	failed to document incident. The finding Review on 7/30/25 - Admitted: 3/5/2 - Diagnoses: Sch Dyslipidemia, Cons Review on 8/5/25 C Services (EMS) Para - incident dated: - primary important sunstroke - incident dated: - primary important part of client #1 - determining - developing to prevent similar in sunstroke - incident dated: - primary important important important incident dated: - primary important i	view and interview, the facilty their response to a Level II gs are: client #1's record revealed: Anizophrenia, Hypothyroidism, tipation, Seborrheic Dermatitis client #1's Emergency Medical tient Care Record revealed: 7/26/25 pression: heatstroke and 7/29/25 pression: fever and "patient e touch" in the residence at the time of MS of the facility records revealed: ion for client #1's emergencies of the health and safety needs g the cause of the incident and implementing corrective and implementing measures acidents					
	- assigning p	ncidents persons to be responsible for he corrections and preventive					

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					С	
		MHL051-203	B. WING		1	2/2025
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ULTIMAT	E FAMILY CARE HO	ME 3310 NC 2 SMITHFIE	210 HWY LD, NC 275	77		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 366	Continued From pa	ge 16	V 366			
	measures - maintainino	g documentation				
	reported:	5 the Supervisor In Charge th was declining and had been				
	for months - they had discus health	ssed client #1's declining				
	 air conditioners were purchased after client #1 went to the hospital confirmed no documentation of debriefing of client #1's emergency room visits this past weekend 					
	Interview on 8/7/25 the QP reported: - client #1 went to the hospital for a fall - confirmed no documentation of debriefing of client #1's emergency room visits this past weekend					
	Nurse reported: - the portable air after client #1 went - confirmed no d	the Co-owner/Registered conditioners were purchased to the hospital ocumentation of debriefing of ncy room visits this past				
V 367	27G .0604 Incident	Reporting Requirements	V 367			
	level II incidents, ex the provision of billa consumer is on the	UIREMENTS FOR				

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Division of Health Service Regulation STATE FORM

NAME OF PROVIDER OR SUPPLIER ULTIMATE FAMILY CARE HOME STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NC 210 HWY SMITHFIELD, NC 27577 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NC 210 HWY SMITHFIELD, NC 27577 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 17 to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail,						С	
ULTIMATE FAMILY CARE HOME 3310 NC 210 HWY SMITHFIELD, NC 27577 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 17 to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail,		MHL051-203		B. WING		1	
CALCE CALC	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 17	ULTIMA [*]	TE FAMILY CARE HO	ИE				
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 17 to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail,		T					
to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail,	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETE
90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail,	V 367	Continued From pa	ige 17	V 367			
means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy	V 367	to whom the provid 90 days prior to the responsible for the services are provid becoming aware of be submitted on a f Secretary. The rep in person, facsimile means. The report information: (1) reporting identification inform (2) client ider (3) type of ind (4) description (5) status of the cause of the incided (6) other indirectly or responding. (b) Category A and missing or incomples shall submit an upon report recipients by day whenever: (1) the provided erroneous, misleadd (2) the provided erroneous, misleadd (2) the provided erroneous and upon request by the obtained regarding (1) hospital reinformation; (2) reports by (3) the provided erroneous by the obtained regarding (1) hospital reinformation;	er rendered any service within a incident to the LME catchment area where ed within 72 hours of the incident. The report shall form provided by the port may be submitted via mail, a or encrypted electronic shall include the following provider contact and nation; nitification information; cident; and viduals or authorities notified. I B providers shall explain any ete information. The provider lated report to all required the end of the next business der has reason to believe that ad in the report may be ling or otherwise unreliable; or der obtains information dent form that was previously I B providers shall submit, a LME, other information the incident, including: ecords including confidential of other authorities; and der's response to the incident.	V 367			

Division of Health Service Regulation

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MHL051-203 B. VIING	STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER ULTIMATE FAMILY CARE HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 18 Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a cilent death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of cilent death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C 0.300 and 10A NCAC 27E - D104(e)/18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level III or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level III and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1)							,
CALL DESCRIPTION COMMENT CARE HOME SUMMARY STATEMENT OF DEFICIENCIES			MHL051-203	B. WING		08/1	2/2025
CALL DEPTIMENT PAMILY CARE HOME SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROPERLY TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 367 Continued From page 18 V 367 V 367 Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (6) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1)	NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CALID CALI	ULTIMAT	E FAMILY CARE HOM	ΛF		77		
Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1)	PRÉFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETE
		Mental Health, Dev Substance Abuse Secoming aware of providers shall send incidents involving a Health Service Reg becoming aware of client death within sor restraint, the proimmediately, as reconstructed as a second and 10A NCA (e) Category A and report quarterly to the catchment area who The report shall be by the Secretary via include summary in (1) medication definition of a level (2) restrictive the definition of a level (2) restrictive the definition of a level (3) searches (4) seizures (4) seizures (5) the total mincidents that occur (6) a statement been no reportable incidents have occumeet any of the crit (a) and (d) of this Residue and the summary of the crit (a) and (d) of this Residue and the summary of the crit (a) and (d) of this Residue and the summary of the crit (a) and (d) of this Residue and the summary of the crit (a) and (d) of this Residue and the summary of the crit (a) and (d) of this Residue and the summary of the crit (a) and (d) of this Residue and the summary of the crit (a) and (d) of this Residue and the summary of the crit (a) and (d) of this Residue and the summary of the crit (a) and (d) of this Residue and the summary of the crit (a) and (d) of this Residue and the summary of the crit (a) and (d) of this Residue and the summary of the crit (a) and (d) of this Residue and the summary of the crit (a) and (d) of this Residue and the summary of the crit (d) and (d) of this Residue and the summary of the crit (d) and (d) of this Residue and the summary of the crit (d) and (d) of this Residue and the summary of the crit (d) and (d) of this Residue and the summary of the crit (d) and (d) of this Residue and the summary of the crit (d) and (d) of this Residue and the summary of the crit (d) and (d) of this Residue and the summary of the crit (d) and (d) of this Residue and the summary of the crit (d) and (d) of this Residue and the summary of the crit (d) and (d) of this Residue and the summary of the crit (d) and the summary of the crit (d) and the summary of the crit (d) and the summ	elopmental Disabilities and Services within 72 hours of the incident. Category A d a copy of all level III a client death to the Division of illation within 72 hours of the incident. In cases of seven days of use of seclusion vider shall report the death quired by 10A NCAC 26C AC 27E .0104(e)(18). B providers shall send a he LME responsible for the ere services are provided. Submitted on a form provided a electronic means and shall information as follows: In errors that do not meet the III or level III incident; Interventions that do not meet evel II or level III incident; of a client or his living area; of client property or property in a client; number of level II and level III red; and ent indicating that there have incidents whenever no urred during the quarter that eria as set forth in Paragraphs calle and Subparagraphs (1)		DEFICIENCY)		

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Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		(X3) DATE COMP	SURVEY LETED	
		MHL051-203	B. WING		08/1	2/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		3310 NC		,		
ULTIMAT	TE FAMILY CARE HON	MF	ELD, NC 275	77		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODEFICIENCY)	ILD BE	COMPLETE DATE
V 367	Continued From pa	ge 19	V 367			
	failed to ensure inci to the Local Manag	et as evidenced by: view and interview, the facility dent reports were submitted ement Entity (LME)/Managed (MCO) within 72 hours. The				
	Services (EMS) Par - incident dated: - primary imp sunstroke	pression: heatstroke and				
	 protocols used: environmental-heat exposure/exhaustion - adults only "the environment the patient is in is extremely hot. There is no AC (air conditioning) noted in the facilityOutside air temp is near 100 degrees at the time of the call." 					
	- "Treatment taken to nearest fire water via body bag. shivering present. I	as documented. Patient is e station and immersed in ice He is never noted to have He is monitored for duration of ains in ice water until his				
	temperature reache	es 98 degrees and his c.Patient is transported to nom)"				
	- "EMS 12 di age Pt (patient) tha	oression: fever spatched out to a 64 years of t is noted to be coming from a s noted to have been seen at				
	the ER within the pa to the Pt this evenir in the residence wit	ast several daysUpon arrival ng it is found to be 90 degrees h staff stating that the air en out for several days and				
	that they couldn ' to	get anybody out to fix it Pt is ely hopt (hot) to the touch and what altered which is noted to				

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Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			C	
MHL051-203		B. WING		 	1 <u>2/2025</u>		
NAME OF PROVIDER OR SUF	PLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
ULTIMATE FAMILY CAR	Е НО	ME 3310 NC 2 SMITHFIE	210 HWY ELD, NC 275	77			
PREFIX (EACH DEF	CIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
ever since he was taken ou where he coul environment. state that he sof the resider was transport protocol throunoted." Review on 7/3 Improvement - no entries emergencies Interview on 7 reported: - she did n - the Qualit Co-owner/Rethem - client #1's for months are hospital - they had health but did visits Interview on 8 - she and t - she didn'needed for cl - client #1's Interview on 8 fire department - he responsional	taff scameside ld be durin starte de durin starte durin sta	states that he has had a fever e back from the hospital. Pt and placed onto the stretcher assessed and treated in a cool ag assessment Pt is noted to ad to feel much better once out use to ambient temperature. Pt a [local hospital] and treated per at transport with improvement of the Incident Response em (IRIS) revealed: eference to client #1's ed to heat exposure IRIS reports crofessional (QP) and the red Nurse (RN) completed at was why he was going to the at was why he was going to the assed client #1's declining document the emergency room of the QP reported: a chowner/RN did IRIS reports a that an IRIS report was a that the hospital for a fall of the Lieutenant for the local	V 367				

AND BLAN OF CORRECTION TO TRENTIFICATION NUMBER:					SURVEY LETED		
						С	
MHL051-203			B. WING			2/2025	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
ULTIMA	TE FAMILY CARE HO	ME 3310 NC 2 SMITHFIE	210 HWY LD, NC 275	77			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
V 367	#1 ended up having there was no conight he and EMS was aid "boy it's hot in there were no pwindow units the thermometed degrees at 1:00am client #1 was "sthey had to help hir he was not res the side of he for their doors shut so other areas as soon as the	g fever all about client #1 falling that alked in together and they both	V 367				

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Division of Health Service Regulation STATE FORM