STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
74121 2741	or contraction	ISERTI IO/MIGNITIONISER.	A. BUILDING: _			
		092-516	B. WING		R 08/21/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MARY'S N	IANOR II	501 BUNN				
	OUR MARK OT		, NC 27597			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 000	INITIAL COMMENTS		V 000			
		up survey was completed Deficiencies were cited.				
		d for the following service 27G .5600A Supervised Mental Illness.				
	-	d for 6 and has a current rey sample consisted of ents.				
V 111	27G .0205 (A-B) Assessment/Treatme	nt/Habilitation Plan	V 111			
	10A NCAC 27G .020 TREATMENT/HABILI PLAN	5 ASSESSMENT AND TATION OR SERVICE				
	client, according to go	hall be completed for a overning body policy, prior to es, and shall include, but not				
	of admission, except detoxification or other	that a client admitted to a 24-hour medical program				
	shall have an establis admission; (4) a pertinent socia	I, family, and medical history;				
	and (5) evaluations or as	sessments, such as				
	vocational, as approp	e abuse, medical, and riate to the client's needs.				
	(b) when services are establishment and im	e provided prior to the plementation of the				
		or service plan, hereafter				
	referred to as the "pla	n," strategies to address the oblem shall be documented.				

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:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING:		COMI LETED
		092-516	B. WING		R 08/21/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MARY'S N	IANOR II	501 BUNN ZEBULON,			
	OLIMANA DV. OT			DDOWNERS DIAM OF CORRECTIO	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 111	Continued From page	÷ 1	V 111		
	failed to ensure an ac available and comple services for 3 of 3 aud The findings are: Review on 8/21/25 of -Admission date of 12 -Diagnoses of Disorga Cocaine, and Borderl	ew and interview, the facility imission assessment was ted prior to delivery of dited clients (#1, #2 and #3). client #1's record revealed:			
	-Admission date of 5/ -Diagnoses of Schizo Essential Hypertensic substance use, uncor asthma, uncomplicate	phrenia unspecified, on, Other psychoactive nplicated, Unspecified			
	-Admission date of 12 -Diagnoses of Schizo Essential Hypertension				

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STATE FORM 6899 CB2D11 If continuation sheet 2 of 13

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _	COMPLETED			
					R	
		092-516	B. WING		08/21/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE	-	
TO WILL OF T	NOVIDER OR GOLF EIER	501 BUNN		12, 211 0002		
MARY'S N	MANOR II		I, NC 27597			
	OUR MADY OT		·	DD0/4DED10 DLAM 05 00DD507101		
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 111	Continued From page	e 2	V 111			
	V 111 Continued From page 2 asthma, uncomplicated, and ConstipationThere was no documentation of an admission assessment.					
	Interview on 8/20/25 with the Owner revealed: -"I did the assessment, but I can't find it." -"I'm going to get all the charts updated." -She confirmed the facility failed to provide documentation of an admission assessment for clients #1, #2, and #3 prior to delivery of services.					
V 114	27G .0207 Emergeno	cy Plans and Supplies	V 114			
	AND SUPPLIES (a) Each facility shall and a disaster plan a these plans available to the county emerge request. The plans sh procedures and route (b) The plans shall be and evacuation procedures in the facility. (c) Fire and disaster of shall be held at least repeated for each shill.	ncy services agencies upon hall include evacuation es. e made available to all staff edures and routes shall be drills in a 24-hour facility quarterly and shall be ft. eted under conditions that response to fire				
	facility failed to ensur	as evidenced by: ews and interviews the e fire and disaster drills were and on each shift. The				

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		COMI LETED	
		092-516	B. WING		R 08/21/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
MARY'S N	IANOR II	501 BUNN ZEBULON	STREET , NC 27597			
0.0.15	CHMMADY CT		·		1 000	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 114	Continued From page	e 3	V 114			
		facility's fire drill log from August 2025 revealed: lls documented.				
		facility's disaster drills log ough August 2025 revealed: er drills documented.				
	Interview on 8/21/25 with Client #1 revealed: -"I haven't done any fire or disaster drills since I have been here."					
	-"The staff were supp -"Honestly, I haven't l sure staff were doing -She confirmed the fa	with the Owner revealed: osed to be doing the drills." ooked at the chart to make the drills." cility failed to ensure fire re conducted quarterly on				
V 118	27G .0209 (C) Medica	ation Requirements	V 118			
	only be administered order of a person authorized drugs. (2) Medications shall clients only when authorized shall client's physician. (3) Medications, incluadministered only by unlicensed persons transpharmacist or other leprivileged to prepare					

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STATE FORM 6899 CB2D11 If continuation sheet 4 of 13

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		TED
092-516		B. WING		R 08/21	1/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MARY'S N	IANOR II		STREET			
			N, NC 27597		1	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	Continued From page	e 4	V 118			
	all drugs administered current. Medications a recorded immediately MAR is to include the (A) client's name; (B) name, strength, a (C) instructions for ad (D) date and time the (E) name or initials of drug. (5) Client requests for checks shall be record	d to each client must be kept administered shall be after administration. The following:				
	orders affecting 3 of 3 findings are: Review on 8/21/25 of -Admission date of 12 -Diagnoses of Disorga	ews, observation and failed to have physician's B clients (#1, #2, #3). The client #1's record revealed: 2/16/23. anized Schizophrenia, ine Intellectual Disability.				
	Observation on 8/20/2 of client #1's medicati	tions were available for				

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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: _		
		092-516	B. WING		R 08/21/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
MARY'S N	MANOR II	501 BUNN			
	OLIMANA DV. OT		, NC 27597	DDO//DEDIG DI AN OF CODDECTIO	<u>, </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 118	Continued From page	e 5	V 118		
	-Cetirizine 10mg (Alle -Polyethylene Powde -Triamcinolone Ointm	ergies) r 238gm (Constipation) eent 0.5% ion 150mg (Birth Control)			
	Review on 8/20/25 of the June, July, and August 2025 MAR for client #1 revealed: -Staff administered the medication above to client #1 on 6/1 thru 8/20.				
	Review on 8/20/25 of client #2's record revealed: -Admission date of 5/23/25Diagnoses of Schizophrenia unspecified, Essential Hypertension, Other psychoactive substance use, uncomplicated, Unspecified asthma, uncomplicated, and ConstipationThere were no physician's orders for the medications below.				
	Observation on 8/20/2 AM of client #2's med	25 at approximately 10:35 lication bin revealed:			
	administration- -Symbicort Aer 160-4	Powder 3350 (Constipation) ntipsychotic)			
	2025 MAR for client #	the June, July, and August 2 revealed: e medication above to client			
	-Admission date of 12 -Diagnoses of Schizo				

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STATE FORM 6899 CB2D11 If continuation sheet 6 of 13

AND DIAN OF CORRECTION IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		092-516	B. WING		R 08/21/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	E, ZIP CODE	
MARY'S N	IANOR II		IN STREET		
	OLIMAN DV OT		ON, NC 27597	DDOWDEDIO DI AN OF CODDECTIO	
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 118	Continued From page	e 6	V 118		
	substance use, uncor asthma, uncomplicate -There were no physi- medications below.				
	Observation on 8/20/2 PM of client #3's med	25 at approximately 12:11 ication bin revealed:			
	The following medical administrationHaloper Dec Inj 100r -Docusate Sodium 10r -Loratadine 10mg (All	00mg (Laxative)			
	2025 MAR for client #	the June, July, and August f3 revealed: e medication above to client			
	-"I lost my mom in Ma mastectomy." -"I haven't been able -"That is not a good re updated."	with the Owner revealed: ay (2025) and had a double to keep the charts updated." eason why my charts aren't were no physician's orders			
	for clients #1, #2 and				
V 133	G.S. 122C-80 Crimina	al History Record Check	V 133		
	CHECK REQUIRED APPLICANTS FOR E (a) Definition As use "provider" applies to a program and any providevelopmental disabil				

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Division o	of Health Service Regu	lation			FURIWI APPROVEL
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		
AND PLAN (ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	A. BUILDING:	
					R
		092-516	B. WING		08/21/2025
		002 0.0			1 00/21/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	ITE, ZIP CODE	
MARY'S N	IANOR II		N STREET		
		ZEBULO	N, NC 27597		
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 133	Continued From page	2 7	V 133		
	(b) Requirement Ar	offer of employment by a			
	provider licensed und				
	applicant to fill a posit	tion that does not require the			
	applicant to have an	occupational license is			
		nt to a State and national			
		d check of the applicant. If			
		n a resident of this State for			
		hen the offer of employment			
		sent to a State and national			
	-	d check of the applicant. The			
	national criminal histo	•			
		e applicant's fingerprints. If			
		n a resident of this State for			
	_	en the offer is conditioned			
		criminal history record			
	check of the applican				
		who refuses to consent to a			
	1	d check required by this			
		nerwise provided in this			
		business days of making			
		f employment, a provider t to the Department of			
	Justice under G.S. 11				
		d check required by this it a request to a private			
		ate criminal history record			
		s section. Notwithstanding			
		Department of Justice shall			
		ational criminal history			
		ployment positions not			
	covered by Public Lav				
,		and Human Services,			
	Criminal Records Che				
	business days of rece	eipt of the national criminal	1		

Division of Health Service Regulation

history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the

STATE FORM 6899 CB2D11 If continuation sheet 8 of 13

Division of	<u>of Health Service Regu</u>	lation			
		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		092-516	B. WING		08/21/2025
NAME OF D	DOVIDED OD SUDDI IED	etheet as	DDEEC CITY CTA	TE ZIR CODE	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	IE, ZIP GODE	
MARY'S N	IANOR II		N STREET		
			N, NC 27597		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(*)
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
V 133	Continued From page	. 0	V 133		
V 133	Continued From page	÷ 0	V 133		
	national criminal histo	ory record check be shared			
	with the provider. Pro	viders shall make available			
		tion that a criminal history			
	check has been comp	oleted on any staff covered			
	•	nty that has adopted an			
		nance and has access to			
		al Information data bank			
	,	alf of a provider a State			
		d check required by this			
		ovider having to submit a			
		ment of Justice. In such a			
	_	I commence with the State			
	-	d check required by this			
	section within five bus				
		nployment by the provider.			
		ormation received by the all and may not be disclosed,			
	· ·	nt as provided in subsection			
	(c) of this section. For	•			
		private entity" means a			
	business regularly en	· ·			
		d checks utilizing public			
	records obtained from	- ·			
		licant's criminal history			
		one or more convictions of			
		e provider shall consider all			
		s in determining whether to			
	hire the applicant:				
	(1) The level and seri-	ousness of the crime.			
	(2) The date of the cri	ime.			
	(3) The age of the per	rson at the time of the			
	conviction.				
	(4) The circumstance				
	commission of the cri				
	` '	en the criminal conduct of			
		b duties of the position to be			
	filled.				
	(6) The prison, jail, pr				
	rehabilitation, and em	ployment records of the			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		092-516	B. WING		R 08/21/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
MARY'S N	MANOR II	501 BUNN	STREET		
WARTS	IANONII	ZEBULON	, NC 27597		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 133	-	: 9 the crime was committed. ommission by the person of	V 133		
	a relevant offense.	•			
		of a relevant offense alone mployment; however, the			
		considered by the provider.			
		ifies an applicant after			
		elevant factors, then the information contained in			
		cord check that is relevant			
		but may not provide a copy			
	of the criminal history applicant.	record check to the			
	••	- A provider and an officer			
		rider that, in good faith,			
	complies with this sec	tion shall be immune from			
	(1) The failure of the				
		s of information provided in			
		cord check of the individual. n employee's history of			
	criminal offenses if the				
	history record check is compliance with this s	s requested and received in section.			
	` <i>'</i>	- As used in this section,			
		ans a county, state, or y of conviction or pending			
		whether a misdemeanor or			
		n an individual's fitness to			
		the safety and well-being of tall health, developmental			
	•	nce abuse services. These			
	crimes include the cri	minal offenses set forth in			
		rticles of Chapter 14 of the			
	Issuing Monetary Sub	cle 5, Counterfeiting and			
		ve and Legislative Officers;			
	Article 6, Homicide; A	rticle 7A, Rape and Other			
	Sex Offenses; Article	8, Assaults; Article 10,			

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Division of	of Health Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUP		(X1) PROVIDER/SUPPLIER/CLIA	1 ' '	CONSTRUCTION	(X3) DATE SURVE	Υ
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
				D WING		
		092-516	B. WING		08/21/20	25
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
MA DV((0.1	AANOD II	501 BUN	IN STREET			
MARY'S N	IANUR II	ZEBULO	N, NC 27597			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE CO	(X5) MPLETE DATE
V 133	Continued From page	e 10	V 133			
V 133	Kidnapping and Abdulnjury or Damage by Incendiary Device or and Other Housebrea Other Burnings; Article Robbery; Article 18, E False Pretenses and Obtaining Property or Fraudulent Use of Crandricle 19B, Financial Act; Article 20, Fraud 26, Offenses Against Decency; Article 26A, Article 27, Prostitution 29, Bribery; Article 31, Office; Article 35, Offensec; Article 36A, Rarticle 39, Protection Protection of the Familitoxication; and Article Time. These crimes sale of drugs in violat Controlled Substance 90 of the General State offenses such as sale violation of G.S. 18B-impaired in violation of G.S. 20-138.5. (f) Penalty for Furnish applicant for employing supplies, or otherwise an employment applic criminal history recordshall be guilty of a Cla (g) Conditional Employemploy an applicant of complex an employing an applicant of conditional Employing an employing an employing an employing an applicant of conditional Employing an employing	ction; Article 13, Malicious Use of Explosive or Material; Article 14, Burglary skings; Article 15, Arson and e 16, Larceny; Article 17, Embezzlement; Article 19, Cheats; Article 19A, Services by False or edit Device or Other Means; Transaction Card Crime s; Article 21, Forgery; Article Public Morality and Adult Establishments; r; Article 28, Perjury; Article public Morality and Adult Establishments; r; Article 28, Perjury; Article onses Against the Public iots and Civil Disorders; of Minors; Article 40, illy; Article 59, Public ele 60, Computer-Related also include possession or ion of the North Carolina as Act, Article 5 of Chapter tutes, and alcohol-related to underage persons in 302 or driving while of G.S. 20-138.1 through and False Information Any ment who willfully furnishes, a gives false information on cation that is the basis for a d check under this section ass A1 misdemeanor. Tyment A provider may conditionally prior to of a criminal history record applicant if both of the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			756.125162		R
		092-516	B. WING		08/21/2025
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STA	TE, ZIP CODE	
MARY'S N	IANOR II		N STREET N, NC 27597		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
V 133	prior to obtaining the criminal history record subsection (b) of this fingerprint cards as re (2) The provider shall criminal history record business days after the conditional employme 2001-155, s. 1; 2004-	not employ an applicant applicant's consent for d check as required in section or the completed equired in G.S. 114-19.10. submit the request for a d check not later than five ne individual begins	V 133		
	This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a criminal history record check was requested within five business days of making the conditional offer of employment affecting 1 of 3 audited staff (#1). The findings are:				
	Review on 8/21/25 of staff #1's personnel record revealed: -Hire date of 7/25/25She was hired as a Habilitation TechnicianThere was no documentation of the criminal background check.				
	background check. Interview on 8/21/25 with Staff #1 revealed: -"I started working for the company a few weeks ago." -"I'm not sure who does the personnel records." Interview on 8/21/25 with the Owner revealed: -"I thought the criminal background was in the chart."				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7415 / 2476 / 6574 / 2576			A. BUILDING:			
		092-516	B. WING		R 08/21/2025	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
MARY'S MANOR II ZEBULON, NC 27597						
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	ORRECTIVE ACTION SHOULD BE COMPLETE EFERENCED TO THE APPROPRIATE DATE	
V 133	-"I'm not sure why the completed." -She confirmed the facriminal history record within five business d conditional offer of en	e criminal background wasn't acility failed to ensure the dicheck was not requested ays of making the apployment for staff #1.	V 133			

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