| | MHL092-686 | B. WING | R 07/29/2025 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| VICTORY HEALTHCARE SERVICES, INC | 3716 SUMMER PLACE RALEIGH, NC 27604 |

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| V 000 | INITIAL COMMENTS<br><br>An annual, complaint and follow up survey was completed on 7/29/25. The complaint was unsubstantiated (intake #NC00230409). Deficiencies were cited.<br><br>This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.<br><br>This facility is licensed for 6 and has a current census of 5. The survey sample consisted of audits of 4 current clients. | V 000 | RECEIVED<br>AUG 29 2025<br>DHSR-MH Licensure Sect | |
| V 108 | 27G .0202 (F-I) Personnel Requirements<br><br>10A NCAC 27G .0202 PERSONNEL REQUIREMENTS<br>(f) Continuing education shall be documented.<br>(g) Employee training programs shall be provided and, at a minimum, shall consist of the following:<br>(1) general organizational orientation;<br>(2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B;<br>(3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and<br>(4) training in infectious diseases and bloodborne pathogens.<br>(h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, | V 108 | V108 Personnel Requirements<br>As of 8/20/25 Current staff have been trained/inserviced on Medication Administration, Diabetes Care and Management, Insulin Administration, Treatment goals/PCP Development and Implementation, Crisis Plans and Implementation, Client Rights, Introduction to Mental Health, Managing, Documentation, Incident Reporting, Managing Conflicts. Going forward all new hires will be trained in these areas a QP, Administrator and/or other designated professional (RN, Pharmacist, etc.) prior to working alone in the group home. The administrator will include this training in the new hire training curriculum and schedule the training with the appropriate professional, e.g. QP, Administrator, RN or Pharmacist prior to staff working independently in the home. The training will be conducted at least quarterly over the next 12 months. | |

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| V 108 | Continued From page 1<br>the American Heart Association or their equivalence for relieving airway obstruction.<br>(i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to ensure 1 of 3 paraprofessional staff (#2) received training to meet the MH/DD/SA needs of the clients. The findings are:<br><br>Review on 7/1/25 of staff #2's record revealed:<br>- Hire date: 5/12/25<br>- Original hire date: 1/1/18<br>- No documentation of training on the needs of the clients including but not limited to treatment plans and strategies and implementation of crisis plans<br><br>Interview on 6/13/25 staff #2 reported:<br>- "Worked for Victory for about 4 years...about 5 years ago" and "been at the facility" since 5/28/25<br>- Was not trained on diabetes management for client #1 including checking his blood sugar and that he had diabetes<br><br>Interview on 6/19/25 staff #2 reported:<br>- "Just started back at Victory (Licensee) a few weeks ago"<br>- Left the Licensee's company in 2020 and was rehired when "[Licensee] called me to come back | V 108 | | |

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| V 108 | Continued From page 2<br>to work"<br>- No one provided information or training prior to rehire<br>- Never received training on the clients at the facility<br>- Was only told "one (client) talked a lot and one (client) stayed in bed all the time" and "two (clients) go to day program" and "one (client) asks for cigarettes all the time"<br>- "I went and read up on the guys (clients) on my own"<br>- Was not provided any orientation or initial training about the facility and clients<br><br>Interview on 7/8/25 staff #2 reported:<br>- When started at the facility, staff #1 "just gave me the rundown on everyone"<br>- Was told that "only one client (#4) was on insulin" and the others (clients #1 and #3) were on Metformin<br>- Was told that blood sugar checks were in the morning and evening<br>- Never met the Qualified Professional (QP) for the facility and did not receive any training from the QP<br><br>Interview on 7/3/25 staff #1 reported:<br>- The Licensee trained new staff about the clients and needs in the facility<br><br>Interview on 6/19/25 the QP reported:<br>- Was responsible for training the staff on communication, client rights, and interactions<br><br>Interview on 7/11/25 the QP reported:<br>- "It would be either me or [Licensee]" who trained the staff on treatment plans and client goals<br>- Tried to talk to staff about the treatment plans and client goals but did not remember the last | V 108 | | |

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| V 108 | Continued From page 3<br>time she had spoken with the staff to inform them on the treatment plans and goals<br><br>Interview on 7/22/25 the Licensee reported:<br>- "If somebody coming to take over for staff, that staff (outgoing) is supposed to brief the incoming staff" on the clients and the facility<br>- "When I finish (at the office) I will go straight there and speak with the staff to make sure [staff #1] shared everything"<br>- Showed incoming staff the Medication Administration Record and where they record administration of medication<br>- Showed incoming staff the blood sugar logs and how to record the results of the blood sugar check<br>- Was "not aware that [staff #1] had not briefed fill-in staff (#2)" when staff #2 arrived at the facility<br>- "[QP] is supposed to brief the staff "on treatment plans and client goals<br>- "It is the responsibility of the QP to let all staff know about changes to the PCP (Person Centered Profile)" and client goals<br>- It "would be my responsibility" to complete all training for fill-in staff, aside from the briefing from the current facility staff | V 108 | V112 Assessment/Treatment/ Habilitation Plan<br>All clients have been reassessed and current needs as identified by the team have been addressed in the treatment plans. Guardians who were unable to attend were given the opportunity to provide input and that information was entered into the PCP if information was provided by the guardian or other team member. Additionally all staff have been trained on the finished PCP and goals contained within the PCP. Going forward the staff will be trained on identification of needs and goal implementation via participation in the treatment team, goal development stage and subsequently monthly for the next months and then quarterly thereafter. | |
| V 112 | 27G .0205 (C-D)<br>Assessment/Treatment/Habilitation Plan<br><br>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN<br>(c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days.<br>(d) The plan shall include: | V 112 | | |

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| V 112 | Continued From page 4<br>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;<br>(2) strategies;<br>(3) staff responsible;<br>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;<br>(5) basis for evaluation or assessment of outcome achievement; and<br>(6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review and interview, the facility failed to develop a plan in partnership with the client or legally responsible person and failed to develop and implement goals and strategies to meet the needs of 3 of 3 audited clients (#1, #3, and #4). The findings are:<br><br>Review of client #1's record on 6/12/25 revealed:<br>- Admitted 8/23/16<br>- Diagnoses: Major Depressive Disorder, Recurrent; Severe Psychosis, Alcohol Use Disorder Severe,Hypertension, Diabetes Type II, Hyperlipidemia, Seborrheic Dermatitis, Gastroesophageal reflux disease (GERD)<br>- Treatment plan dated 11/20/24 had no goals | V 112 | | |

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| V 112 | Continued From page 5<br>or strategies in the treatment plan to address blood sugar (BS) check refusals<br>- No signatures on signature page to verify consent or agreement with the plan<br><br>Review on 7/9/25 of client #1's BS logs from 10/1/24 through 7/9/25 revealed:<br>- No actual results documented with "refusal" documented in the space of results<br><br>Review on 6/19/25 of client #1's daily progress notes revealed:<br>- Documented in 19 notes between 5/1/25 and 6/17/25 that client #1 refused BS checks<br><br>Interview on 6/19/25 client #1 reported:<br>- Had diabetes but "I've always been like borderline"<br>- Didn't get BS checked<br>- "I ain't gonna let this lady (staff #1) - they (staff) don't have to ask me no more" to have his BS checked<br>- Did not have problems with his BS<br><br>Review of client #3's record on 6/12/25 revealed:<br>- Admitted 9/3/24<br>- Diagnoses: Major Depressive Disorder, Diabetes, Arthritis<br>- Treatment plan dated 9/3/24 with no signatures on signature page to verify consent or agreement with the plan<br>- No goal in the treatment plan to address urinating and defecating on the floor and refusals to shower<br><br>Review on 7/3/25 of the Emergency Medical Services report dated 6/30/25 revealed:<br>- Client #3 died 6/30/25<br><br>Interview on 7/21/25 client #3's brother reported: | V 112 | | |

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| V 112 | Continued From page 6<br>- The cause of death on client #3's death certificate was heart failure<br><br>Review on 6/19/25 of client #3's daily progress notes revealed:<br>- 20 documented instances of client #3 refusing to shower between February 2025 and June 2025<br>- 1 documented instance of client #3 defecating on the floor<br><br>Interview on 6/1/25 and 6/18/25 client #3's brother reported:<br>- Refusing to shower was typical behavior for client #3<br>- Client #3 defecated on the floor and expected someone else to clean it up<br><br>Review of client #4's record on 6/12/25 revealed:<br>- Admitted 11/5/18<br>- Diagnoses: Schizoaffective Disorder Bipolar Type, Cocaine and Cannabis Use Disorders, GERD<br>- No documented progress towards goals or implementation of goal related to unsupervised time of one hour in the community daily<br><br>Review of client #4's treatment plan dated 11/14/24 provided by the Licensee and reviewed on 6/13/25 revealed:<br>- No signatures on signature page to verify consent or agreement with the plan<br>- Goal: "[Client #4] will navigate community independently for 1 hour daily, confidently, and safely, while maintaining mental and emotional well-being, utilizing appropriate coping strategies, and accessing necessary support systems when needed without incident over the next 6 months."<br><br>Interview on 6/13/25 client #4 reported: | V 112 | | |

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| V 112 | Continued From page 7<br>- Was not able to use unsupervised time and had "not been able to go to [local store] to buy drinks and things"<br>- The Licensee took away his "pass (unsupervised time)" four months ago<br>- Did not do anything to lose his unsupervised time but "he's (Licensee) not going to give me my pass back"<br><br>Interview on 7/1/25 client #4 reported:<br>- Still was not able to use unsupervised time<br>- Had been "on probation" for 6 months, ever since client #5 "went out at night and got hit by a car"<br>- Did not respond when asked who revoked his unsupervised time<br><br>Interview on 6/17/25 staff #1 reported:<br>- Client #1 refused BS checks every time<br>- "No one goes out" and "they (clients) all stay home (facility)"<br>- "I don't allow them (clients) to go to the store"<br>- Client #4 doesn't walk to the store<br>- No clients had gone to the store on their own<br><br>Interview on 7/3/25 staff #1 reported:<br>- Client #3 would defecate on the floor daily and would urinate on the floor or his bed at least two times daily since he was admitted<br><br>Interview on 6/13/25 and 6/19/25 staff #2 reported:<br>- Had worked at the facility for about 2 weeks<br>- Client #3 had only showered twice since she started at the facility<br>- When she first started at the facility, client #3 had no treatment plan in his record<br>- Did not remember if any of the other clients had current treatment plans in their record<br>- Client #4 was "frustrated because they | V 112 | | |

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| V 112 | Continued From page 8<br>(facility staff) took his free time away to walk to the store"<br>- "It (revoking client #4's unsupervised time) happened before I got here" so she didn't know why it had been taken away or who had taken it away<br><br>Interview on 6/19/25 the Qualified Professional (QP) reported:<br>- Was responsible for developing and obtaining consent for the clients' treatment plans<br>- Received input from staff, guardians, and clients when developing the treatment plans<br>- She or the Licensee were responsible for getting the treatment plans signed by participants<br>- Client #4 had one hour of unsupervised time to go to the store or visit friends in the neighborhood<br>- Client #4's unsupervised time had never been revoked and she had "not heard anything about him (client #4) not being allowed to go out on his unsupervised time"<br><br>Interview on 7/11/25 the QP reported:<br>- Was "not aware" that client #1 refused BS checks but "it should be in the plan"<br>- Was never told that client #3 refused showers or urinated and defecated on the floor<br><br>Interview on 6/12/25 and 6/17/25 the Licensee reported:<br>- Client #1 refused all BS checks but "I don't think I've mentioned that to the QP"<br>- Client #3 didn't like taking showers and refused<br>- Client #3 "is sometimes too lazy to walk to the bathroom" and "will use the pull-up (adult incontinence brief) and not want to change it"<br>- Client #3 "don't like taking showers" so "I will come out and will shower him" | V 112 | | |

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| V 112 | Continued From page 9<br>- The Licensee sometimes had to come help client #3 shower<br>- Had discussed client #3's refusals to shower with the QP and did not know why it was not in the treatment plan<br>- Client #4 had unsupervised time in the community and was allowed to go to the store to buy cigarettes<br>- "There's no reason why he (client #4) cannot go to the store"<br>- The QP was responsible for and developed the treatment plans and sent them to him to put in the client records<br>- "This time I forgot to print print them (treatment plans) out and put them in" the records<br>- "I don't know if thr QP talk with them (clients and guardians)" about the client goals and treatment plans and to make sure the plans were signed.<br><br>This deficiency has been cited 3 times since the original cite on 12/5/22 and must be corrected within 30 days. | V 112 | V113 Client Records<br>Effective 8/15/25, the QP has been inserviced on documentation, which includes documenting outcomes as it relates to progress on individualized goals, behavioral events, incidents that aren't consistent with that person's baseline, medication refusals and noncompliance, medical concerns and developing person centered goals. The QP or appropriate personnel will providing training to all new hires and current staff on goal development and implementation. This documentation will be reflective on individual goals as specified in the PCP. All documentation of staff training will be maintained in their individual records under "supervision." The administrator will ensure that all information including PCPs, supervision Assessments, etc.. are logged in the file as they are completed. This will be reviewed during the quarterly quality assurance meeting. | |
| V 113 | 27G .0206 Client Records<br><br>10A NCAC 27G .0206 CLIENT RECORDS<br>(a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to:<br>(1) an identification face sheet which includes:<br>(A) name (last, first, middle, maiden);<br>(B) client record number;<br>(C) date of birth;<br>(D) race, gender and marital status;<br>(E) admission date;<br>(F) discharge date;<br>(2) documentation of mental illness, developmental disabilities or substance abuse | V 113 | | |

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| V 113 | Continued From page 10<br>diagnosis coded according to DSM IV;<br>(3) documentation of the screening and assessment;<br>(4) treatment/habilitation or service plan;<br>(5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician;<br>(6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician;<br>(7) documentation of services provided;<br>(8) documentation of progress toward outcomes;<br>(9) if applicable:<br>(A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM);<br>(B) medication orders;<br>(C) orders and copies of lab tests; and<br>(D) documentation of medication and administration errors and adverse drug reactions.<br>(b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to maintain a complete record for 3 of 3 audited clients (#1, #3, and #4). The findings are:<br><br>Review on 6/12/25 of client #1's record revealed: | V 113 | | |

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| V 113 | Continued From page 11<br>- Admitted 8/23/16<br>- Diagnoses: Major Depressive Disorder, Recurrent; Severe Psychosis, Alcohol Use Disorder Severe,Hypertension, Diabetes Type II, Hyperlipidemia, Seborrheic Dermatitis, Gastroesophageal reflux disease (GERD)<br>- Treatment plan dated 11/20/24 with goals to:<br>- Gain better insight into his mental illness through discussions focused on independent living<br>- Demonstrate effective communication/advocacy skills and participate in activities<br>- No documentation of progress towards goal outcomes<br><br>Review on 6/19/25 of the Qualified Professional's (QP) progress notes for client #1 from 4/1/25 through 6/19/25 revealed:<br>- "4/7/2025 QP note: QP met with consumer (client #1) and staff. Takes medications as prescribed. States doing fine. Will continue to monitor."<br>- "5/15/2025 QP note: QP met with consumer (client #1) and staff. Consumer states doing fine. Medication compliant. Will continue to monitor"<br>- No QP progress notes for June 2025<br>- No documentation regarding refusals for blood sugar checks<br><br>Review on 6/12/25 of client #3's record revealed:<br>- Admitted 9/3/24<br>- Diagnoses: Major Depressive Disorder, Diabetes, Arthritis<br>- Treatment plan dated 9/3/24 with goals to<br>- Take medications as prescribed daily<br>- Demonstrate effective communication/advocacy skills and participate in activities<br>- No documentation of progress towards goal | V 113 | | |

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| V 113 | Continued From page 12<br>outcomes<br><br>Review on 7/3/25 of the Emergency Medical Services report dated 6/30/25 revealed:<br>- Client #3 died 6/30/25<br><br>Interview on 7/21/25 client #3's brother reported:<br>- The cause of death on client #3's death certificate was heart failure<br><br>Review on 6/19/25 of the QP progress notes for client #3 revealed:<br>- Notes for 4/7/25, 5/15/25, and 6/5/25 that QP met with staff and client #3. Client #3 attended PSR (Psychosocial Rehabilitation). Client #3 took medication as prescribed. "Will continue to monitor"<br>- No documentation of concerns related to hygiene refusals and behaviors<br><br>Review on 7/29/25 of the facility appointment calendars for client #4 for April, May, and June 2025 revealed:<br>- Appointment with Primary Care Physician: 6/24/25<br>- Dentist Appointment: 7/10/25<br><br>Review on 6/12/25 of client #4's record revealed:<br>- Admitted 11/5/18<br>- Diagnoses: Schizoaffective Disorder Bipolar Type, Cocaine and Cannabis Use Disorders, GERD<br>- No treatment plan in the record<br>- No documentation of medical appointments<br>- No documentation of dentist appointments<br>- No documentation of progress towards goal outcomes<br><br>Review of client #4's treatment plan dated 11/14/24 provided by the Licensee and reviewed | V 113 | | |

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| V 113 | Continued From page 13<br>on 6/13/25 revealed:<br>- Goals to:<br>- Identify two necessary expenses and stay within budget<br>- Participate daily in facility discussions and share independent living task completed<br>- Navigate community independently daily<br>- No documentation of progress towards goal outcomes<br><br>Review on 6/19/25 of the QP progress notes for client #4 revealed:<br>- Notes dated for 4/7/25, 5/15/25, and 6/5/25 that "QP met with consumer and staff." Client #4 "states doing fine." Attended PSR weekly as scheduled. No concerns noted. Medication compliant. "Will continue to monitor."<br><br>Interview on 6/13/25 and 6/19/25 staff #2 reported:<br>- Had worked at the facility for about 2 weeks and client #3 had only showered twice<br>- Client #4 attended a day program daily<br>- When she first started at the facility, client #3 did not have a treatment plan in his record<br>- Had seen plans for clients #1, #2, and #4 but did not recall what the dates were for the treatment plans<br><br>Interview on 7/11/25 the QP reported:<br>- The Licensee was responsible for maintaining client records<br>- Had never noticed anything missing in the client records<br>- Was not aware of client #1's BS check refusals<br>- Was not aware of client #3's refusals for hygiene<br>- Was not aware of client #4's high BS levels until "a couple of months ago" when the Licensee | V 113 | | |

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| V 113 | Continued From page 14<br>talked with her<br>- Progress towards treatment plan goals was documented by "me or the staff"<br>- Checked the daily progress notes of staff on each visit but had not noticed anything in them because "they're kind of vague"<br>- Tried to make her notes specific to the goal the client was working on<br>- Did not know why there was no information in her notes or the daily progress notes addressing progress towards treatment plan goals<br>- She wrote up the treatment plans and sent them to the Licensee "who is responsible for getting them signed and into the chart"<br><br>Interview on 7/22/25 the Licensee reported:<br>- Was responsible for maintaining client records<br>- "The QP does the treatment plans. Sometimes when she does that, she will send it to my email, I will print it out and put it in there. This time I forgot to print them out and put them in"<br>- Client #3 never attended a day program or PSR<br>- "I don't know how she (QP) does that (ensure clients were meeting their goals)" because "I've never gone through her notes to see" | V 113 | | |
| V 114 | 27G .0207 Emergency Plans and Supplies<br><br>10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES<br>(a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available<br>to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes. | V 114 | V114 Emergency Plans and Supplies<br>As of 8/15/25 staff members were inserviced on procedures and protocols for conducting fire & disaster drills. Each will be completed by the residential staff on no less than a monthly basis and will be completed on all shifts within the quarter.<br>The administrator will ensure drills have been completed on a monthly basis and will co-sign the form during the administrator's subsequent visit to the group home. | |

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| V 114 | Continued From page 15<br>(b) The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.<br>(c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift.<br>Drills shall be conducted under conditions that simulate the facility's response to fire emergencies.<br>(d) Each facility shall have a first aid kit accessible for use.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure fire and disaster drills were conducted to simulate real emergencies. The findings are:<br><br>Review on 7/24/25 of the facility fire and disaster drills from 11/1/24 through 7/24/25 revealed:<br>- No fire or disaster drills completed during sleeping hours<br>- Disaster drills documented as one drill completed each month for either heat, thunderstorms, or an ice storm with notation that clients were advised to stay inside on each occasion<br><br>Interview on 6/12/25 and 7/24/25 client #1 reported:<br>- Was "not sure" how long he'd been at the facility but "it's been several years"<br>- Did a fire drill on 7/23/25<br>- Knew to "get out the house" for a fire | V 114 | | |

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| V 114 | Continued From page 16<br>- No other types of drills were ever completed<br>- "I don't have a clue" what would do for a tornado<br><br>Interview on 6/18/25 and 7/24/25 client #2 reported:<br>- Had been "living there 7 years"<br>- A fire drill was completed "recently" but could not remember which day<br>- Went outside to the mailbox for a fire<br>- Had never done any other drills at the facility<br>- Would "get down on the ground and cover your head" for a tornado<br><br>Interview on 6/13/25 and 7/24/25 client #4 reported:<br>- Been at the facility for "years"<br>- "Did one (fire drill) yesterday"<br>- Went to the street at driveway and sidewalk for a fire<br>- No other types of drills were completed at the facility<br>- Would "go to the basement and get on our knees or something" for a tornado<br><br>Interview on 7/1/25 and 7/10/25 staff #1 reported:<br>- Woke up the clients at 6AM daily<br>- The clients were usually asleep by 10:30PM<br><br>Interview on 7/24/25 staff #1 reported:<br>- Conducted fire and disaster drills monthly<br>- Went outside for a fire<br>- Went in the back hallway for a tornado<br>- Staff was "a live-in staff" and "didn't have shifts"<br><br>Interview on 7/24/25 the Qualified Professional reported:<br>- Fire and disaster drills were "supposed to be one per shift per quarter" | V 114 | | |

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| V 114 | Continued From page 17<br>- "I thought they (fire and disaster drills) were" completed at the facility<br>- The Licensee was responsible for ensuring fire and disaster drills were completed at the facility<br><br>Interview on 7/29/25 the Licensee reported:<br>- It was his responsibility to check the fire and disaster drill logs<br>- Did not know the drills had not been completed during sleeping hours<br>- Did not know staff had only completed fire drills<br>- Would ensure fire and disaster drills were completed | V 114 | | |
| V 131 | G.S. 131E-256 (D2) HCPR - Prior Employment Verification<br><br>G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY<br>(d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure the Health Care Personnel Registry (HCPR) was accessed prior to hire for 1 of 3 paraprofessional staff (#2). The findings are: | V 131 | V 131 Prior Employment Verification: Effective 8/15/25, the QP has met with the administrator to discuss hiring process and requirements. The QP has requested that new hires have completed HCPR checks prior to beginning employment, initiation of working in the home and prior to working alone. This information is to be presented to the QP prior to any additional training taking place. Administrator is responsible for ensuring that this process is followed. | |

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| V 131 | Continued From page 18<br><br>Review on 7/1/25 of staff #2's personnel record revealed:<br>- Hire date: 5/12/25<br>- HCPR accessed 6/30/25<br><br>Interview on 6/19/25 staff #2 reported:<br>- Worked for the Licensee's company from 2018 to 2020<br>- Was called by the Licensee to come back to work "a few weeks ago" but could not remember the exact date<br><br>Interview on 7/11/25 the Qualified Professional reported:<br>- It was the Licensee's responsibility to access HCPR<br><br>Interview on 7/22/25 the Licensee reported:<br>- Staff #2 worked for the Licensee's company in the past and he "I think I let her go" but "I can't recall the date"<br>- He contacted staff #2 to come back to work at the facility and she was rehired on 5/12/25<br>- "She (staff #2) brought all the papers (staff #2 records)" but when "I checked her record and didn't see the check (HCPR)" he accessed HCPR | V 131 | | |
| V 133 | G.S. 122C-80 Criminal History Record Check<br><br>G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT.<br>(a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter.<br>(b) Requirement. - An offer of employment by a | V 133 | V 133- Criminal History Record Check Effective 8/15/25, all potential employees will undergo a criminal background check within 5 days of making a conditional offer of employment. The facility administrator will complete the background check and ensure that the information/report is entered into the personnel file. Each file will be audited by the facility administrator or designee (office assistant) at least quarterly to ensure that information is present in the employee's file. | |

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| V 133 | Continued From page 19<br>provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal 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 national criminal history record check be shared | V 133 | | |

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| V 133 | Continued From page 20<br>with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency.<br>(c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant:<br>(1) The level and seriousness of the crime.<br>(2) The date of the crime.<br>(3) The age of the person at the time of the conviction.<br>(4) The circumstances surrounding the commission of the crime, if known.<br>(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.<br>(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed. | V 133 | | |

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| V 133 | Continued From page 21<br>(7) The subsequent commission by the person of a relevant offense.<br>The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.<br>(d) Limited Immunity. - A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for:<br>(1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual.<br>(2) Failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section.<br>(e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious | V 133 | | |

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| V 133 | Continued From page 22<br>Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.<br>(f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor.<br>(g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met:<br>(1) The provider shall not employ an applicant | V 133 | | |

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| V 133 | Continued From page 23<br>prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10. (2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.)<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure a criminal record check was requested within 5 business days of making the conditional offer of employment for 1 of 3 paraprofessional staff (#2). The findings are:<br><br>Review on 7/1/25 of staff #2's personnel record revealed:<br>- Hire date: 5/12/25<br>- Criminal record check requested: 6/6/25<br><br>Interview on 6/19/25 staff #2 reported:<br>- Worked for the licensee company from 2018 to 2020<br>- Was called by the Licensee to come back to work "a few weeks ago" but could not remember the exact date<br><br>Interview on 7/11/25 the Qualified Professional reported:<br>- It was the Licensee's responsibility to request all criminal record checks | V 133 | | |

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| V 133 | Continued From page 24<br><br>Interview on 7/22/25 the Licensee reported:<br>- Staff #2 had worked for the company in the past and he "had let her go" but could not remember the exact date<br>- He contacted staff #2 to come back to work at the facility and she was rehired on 5/12/25<br>- "She (staff #2) brought all the papers (staff #2 records)" but on 5/29/25 "I checked her record and didn't see the record check (criminal) so I pushed it in the system to get the check done" | V 133 | | |
| V 290 | 27G .5602 Supervised Living - Staff<br><br>10A NCAC 27G .5602 STAFF<br>(a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs.<br>(b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time.<br>(c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present:<br>(1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or | V 290 | V290 Supervised Living Staff<br>The QP immediately updated all supervision assessments. Additionally, training was completed with the clients, administrator and staff on adhering to following rules regarding engaging in unsupervised time, reporting protocols for noncompliance/non-adherence to the expectation and consequences for failure to utilize time appropriately. Compliance will be monitored daily beginning and reported to the QP as they occur. | |

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|---|---|---|---|
| | MHL092-686 | A. BUILDING: _____ B. WING _____ | R 07/29/2025 |

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| VICTORY HEALTHCARE SERVICES, INC | 3716 SUMMER PLACE RALEIGH, NC 27604 |

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| V 290 | Continued From page 25<br>(2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body.<br>(d) In facilities which serve clients whose primary diagnosis is substance abuse dependency:<br>(1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and<br>(2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure 1 of 5 clients (#5) was capable of remaining in the community unsupervised. The findings are:<br><br>Review on 7/11/25 of client #5's record revealed:<br>- Admitted: 3/31/18<br>- Diagnoses of Bipolar, Alcohol Abuse, Chronic Obstructive Pulmonary Disease, Aortic Aneurysm, Aortic Valve Replacement, Hypertension<br>- Unsupervised time assessment signed by the Qualified Professional (QP) dated 10/20/23:<br>- "Client can have 45 min (minutes) unsupervised in the community"<br>- Unsupervised time assessment signed by the | V 290 | | |

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| V 290 | Continued From page 26<br>QP dated 11/7/24:<br>- "Client can have 1 hr (hour) unsupervised time in the community" and "only for 1 hour. During daytime"<br>- 11/14/24 - Updated: "On hold (unsupervised time) due to accident ...consumer hit by car"<br>- Treatment plan dated 11/7/24: "[Client #5] will successfully access the community unsupervised for one hour, demonstrating the ability to navigate public spaces safely, engage with community resources, and manage personal well-being independently over the next 90 days"<br>- Sign out sheet from 10/26/24 until 11/12/24:<br>- Was out of the facility for longer than one hour for each of his 11 outings: 10/26, 10/27 10/30, 10/31, 11/2, 11/4, 11/5, 11/7, 11/9, 11/10, and 11/11<br>- Returned after sunset nine times: 10/26, 10/30, 10/31, 11/2, 11/4, 11/5, 11/7, 11/10, and 11/11<br>- Signed out past sunset three times: 11/5, 11/10 and 11/12<br>- No updated assessment to ensure client #5 continued to be capable of remaining in the community without supervision following his non-compliance with the guidelines in his unsupervised time assessment<br><br>Review on 7/2/25 of the Incident Response Improvement System report dated 11/14/24 revealed:<br>- "On 11/12/24 at approximately 8:00 pm, consumer (client #5) informed staff (#1) that he was going to the store to purchase cigarettes. The staff asked consumer to wait for Administrator (Licensee) to come take him as it was late to be walking to the store. Staff called Administrator to come to the group home (facility) to take him to the store. Administrator told staff | V 290 | | |

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| V 290 | Continued From page 27<br>he was on the way to the group home. Consumer did not wait for Administrator to arrive and walked to the store on his own anyway. On the way to the store consumer was hit by a car. When consumer did not return to the group home within the time it took to walk to the store and back Administrator went to look for him. Administrator was unable to find consumer and called the police to help. Police called an hour or so later and said consumer was in the hospital because he was hit by a car. [Local hospital] PA (physician assistant) called Administrator on 11/13/24 and informed him that consumer was in the ICU (Intensive Care Unit) and was confused."<br><br>Review on 7/9/25 of the Emergency Medical Services (EMS) record dated 11/12/24 revealed:<br>- 911 call received at 7:59PM<br>- "[EMS] was dispatched to a street reference MVC (motor vehicle collision) Pedestrian. Upon arrival the pt (patient) (client #5) was found on his left side in the recovery position, conscious and breathing. The pt was the pedestrian in the MVC at estimated 45-50mph ...Once in the ambulance the pt was exposed to showing an closed fracture to the left leg"<br><br>Review on 7/23/25 of the Local Police report dated 11/12/24 revealed:<br>- "UNIT 1 (vehicle) WAS GOING STRAIGHT AND HAD A STEAD GREEN LIGHT. UNIT 2 (client #5) WAS RUNNING ACROSS THE ROAD AND FAILED TO YIELD TO THE VEHICLES AND WAS STRUCK BY UNIT 1."<br>- Authorized speed limit 45 miles per hour<br>- Diagram depicting the accident:<br>- Intersection with 10 lanes across for the north/south direction and 6 lanes in the east/west direction<br>- Car heading north through the | V 290 | | |

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| V 290 | Continued From page 28<br>intersection in the second from the right lane<br>- A pedestrian laying in the intersection in the path of the car heading north<br><br>Review on 7/9/25 of the Hospital Admission report for client #5 dated 11/12/24 revealed:<br>- "Visit Diagnoses:<br>- Hemorrhagic shock (primary)<br>- Pedestrian injured in traffic accident, initial encounter<br>- Multiple closed fractures of pelvis with unstable disruption of pelvic ring, initial encounter<br>- Closed fracture of left tibia and fibula, initial encounter<br>- Closed fracture of neck of left femur, initial encounter<br>- Retroperitoneal bleeding<br>- Laceration of spleen, initial encounter<br>- Acute respiratory failure following trauma and surgery"<br>- "The patient (client #5) presented as a trauma alert via EMS. He was a pedestrian struck by a vehicle at approximately 45 miles per hour. He was kept in spine precautions during transport and brought directly to [local hospital]. On arrival his primary complaints were left leg and back pain ...His initial manual systolic blood pressure was reported in the 60's. Blood transfusion was initiated ... Additional IV (intravenous) access was obtained ...The patient remained hypotensive and massive transfusion protocol was initiated. He received a total of 3u (3 units) RBC's (red blood cells) and 1 u (unit) FFP (fresh frozen plasma)...The patient remained normotensive and given splenic injury with blush and large left retroperitoneal hematoma"<br><br>Review on 7/9/25 of the Hospital Discharge Summary for client #5 dated 12/6/24 revealed:<br>- "Admission diagnoses: Hemorrhagic shock | V 290 | | |

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| V 290 | Continued From page 29<br><br>...Retroperitoneal bleeding ...Closed fracture of left tibia and fibula ...Pedestrian injured in traffic accident ...Laceration of spleen ...Closed fracture of neck of left femur ...Multiple closed fractures of pelvis with unstable disruption of pelvic ring ..."<br>- "Injuries: Scalp hematomas, Nasal bone fx (fracture), L (left) clavicle fx, Tiny L apical PTX (pneumothorax), R (right) 1-2 rib fx, Pulmonary contusions, ?Aortic arch aneurysm ?chronic, Grade III splenic laceration with active extravasation, T4 (fourth thoracic vertebrae) compression fx, T10/11 (tenth and eleventh thoracic vertebrae) endplate fx and distraction injury with ALL (anterior longitudinal ligament) disruption, Large L RP (Retroperitoneal) hematoma, L femoral neck fx, L superior and inferior rami fx extending into L acetabulum/iliac bone/SI (Sacroiliac) joint, R superior and inferior rami fx, S1 VB (vertebra) extending into S1 lamina, L sacral ala fx, L tib (tibia)/fib (fibula) fx, urethral injury"<br><br>Interview on 7/21/25 client #5 reported:<br>- "They (facility staff) let me have my unsupervised time...I went to the store and bought some stuff and went back to the house (facility)"<br>- Went to one of two stores when using his unsupervised time: store #1 was closer to the facility but did not sell cigarettes but store #2 did sell cigarettes<br>- Went to store #2 every three to four days for cigarettes<br>- Would leave the facility "in the daytime" and "had to be back before suppertime" which was "about 6" PM<br>- Had no restrictions for how long he could be out of the facility<br>- Was never told he could only be away from the facility for an hour or any specific amount of | V 290 | | |

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| V 290 | Continued From page 30<br>time<br>- Was only told that for "the unsupervised time you got, use it wisely"<br>- Would be out "maybe a couple of hours and then I'd go home (facility)"<br>- "I had to write down the times I left and the times I came back"<br>- "Sometimes I'd get back late" which only happened "about five or six times" and after dark "about three or four times"<br>- The Licensee told him "a few times" he needed to be back to the facility by 8PM<br>- "I was in an accident" on 11/12/25<br>- "I was going home (facility) and this car came from out of nowhere and ran over my foot"<br>- "I was laying in a ditch for about an hour before they found me"<br>- "I'm banged up pretty bad"<br>- "I was walking to [store #2]" when he got hit by a car and "I landed in the ditch"<br>- Someone saw him and called an ambulance<br>- The staff at the facility knew he was going out because he "had to sign a book to make sure I was back on time"<br>- He left after dinner<br>- Staff #1 was working that night and did not say anything except "to sign out and make sure to put the time you sign out and when you got back to make sure you put the right time to sign in"<br>- No one from the facility told him to wait or not go<br><br>Interview on 7/10/25 a nurse at the rehabilitation center reported:<br>- Verified that client #5 still received physical rehabilitative treatment at their facility<br><br>Interview on 7/3/25 and 7/10/25 staff #1 reported: | V 290 | | |

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| V 290 | Continued From page 31<br><br>- On 11/12/25 the clients had already eaten dinner and taken medications before client #5 said he wanted to go to the store to buy cigarettes<br>- "I told him (client #5) to wait...we can go tomorrow" because it was "almost night" but "he refused and left."<br>- She "called 911 immediately when he (client #5) didn't come back and I call [Licensee]"<br>- "I didn't check times...he's (client #5) supposed to come back (to facility)..it's like 30 minutes to an hour" and when client #5 didn't return "I called 911 and then I called [Licensee]"<br>- "[Licensee] came to look for him (client #5)"<br>- The police arrived before the Licensee and "I gave them a picture" of client #5<br>- "After some hours the police called and said that he (client #5) was in the hospital" because he "had an accident"<br>- When client #5 used his unsupervised time, "he would use the one hour and come back"<br>- "[Licensee] didn't tell me that this is the time I should give them (clients) to come back" to the facility<br>- "They (Licensee) didn't give us a time (of day) they (clients) can go out and come back"<br>- "They (clients) have a sheet to sign before they go out...when they (clients) come back they also sign"<br>- "If we tell them (clients) to use one hour, they don't listen"<br>- Each time client #5 "didn't come back within the hour" she would call the Licensee and "[Licensee] told her he (client #5) might have been at a friends house"<br><br>Interview on 7/11/25 the QP reported:<br>- Client #5 was approved to go to store #1 that was near the facility but not to go to store #2 that was across the highway (10-lane road) | V 290 | | |

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| V 290 | Continued From page 32<br>- Had not been told that client #5 had not been following the guidelines for his unsupervised time by leaving later and for longer and going to a store farther from the facility than approved in his unsupervised time assessment<br>- If had known that client #5 was not adhering to the guidelines in the unsupervised time assessment, she "would have talked to [client #5] about it (not abiding by guidelines) and stopped it (approval for unsupervised time) if he couldn't follow it (guidelines)"<br><br>Interview on 7/22/25 the Licensee reported:<br>- Client #5 was approved for 1 hour of unsupervised time<br>- Staff #1 called him if client #5 was not back from his unsupervised time within an hour<br>- Client #5 signed out and sometimes did not tell staff #1 that he was leaving and "sometimes [client #5] would leave when she (staff #1) was working in another client's room" but when asked how often this occurred responded that "[client #5] does not listen"<br>- "Sometimes he (client #5) would go out before dinner after the day program, sometimes he (client #5) would go out after dinner"<br>- Had told client #5 to not cross "the highway" but store #2 "sells cigarettes cheap" and he had to cross the highway to get there<br>- We told client #5 to tell us when he wanted to go to store #2 and sometimes client #5 called but sometimes "he walked out" of the facility<br>- Client #5 had told the Licensee that he understood that he could not cross the highway but also responded that he knew what he was doing<br>- "We (facility staff) knew that (client #5 had been leaving the facility at unapproved times) but whenever you tell him, he would just use the F word and cuss you out for trying to restrict his | V 290 | | |

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| V 290 | Continued From page 33<br>movements"<br>- "[Staff #1] never called me except if he was not back at the time he was supposed to be back, like around-during medications" at 7:00 PM<br>- Did not talk to the QP about client #5 staying out longer and later than approved<br>- It was during medication time on 11/12/25 that staff #1 had known that client #5 "was not around" so he called 9-1-1 and told them "that one of the residents left the house (facility) and didn't come back" and provided a description of him<br>- "Less than 30 to 45 minutes later" an officer called back and said that client #5 had been in an accident and was in the hospital<br>- Client #5 was sent "to rehab (rehabilitation) for the injuries on the leg" when he was discharged from the hospital<br><br>Review on 7/29/25 of the Plan of Protection written and signed by the Licensee on 7/29/25 revealed:<br>"What immediate action will the facility take to ensure the safety of the consumers in your care?<br>- 1) To ensure the safety of the consumers, the staff and Administrator will be trained more often.<br>2) The Administrator will communicate with QP and the Doctors for any serious concern.<br>Describe your plans to make sure the above happens.<br>- The staff and the Administrator will continue to check/monitor clients at all times and notified the QP if needs be. The Administrator and QP will implements plans immediately to avoid any future incident. QP will develop new plans immediately."<br><br>This deficiency has been cited 3 times since the original cite on 12/5/22.<br><br>Client #5 had diagnoses of Bipolar, Alcohol | V 290 | | |

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| V 290 | Continued From page 34<br><br>Abuse, Chronic Obstructive Pulmonary Disease, Aortic Aneurysm, Aortic Valve Replacement, and Hypertension. The Qualified Professional (QP) completed an unsupervised time assessment on 11/7/24 for client #5 that approved him for 1 hour of unsupervised time in the community during daytime hours. Client #5 signed out after sunset three times, returned after sunset nine times, and was out of the facility for longer than one hour for all of his eleven outings from 10/26/24 until 11/12/24. The Licensee was aware that client #5 was not adhering to the guidelines of his unsupervised time assessment but had not discussed it with the QP. On 11/12/24, client #5 signed out at 7:48PM to go to the store. At 7:59PM emergency services received a call regarding a motor vehicle-pedestrian collision involving client #5. Client #5 was struck by a car that was going about 45 miles per hour which resulted in multiple injuries including hemorrhagic shock, retroperitoneal bleeding, closed fracture of left tibia and fibula, laceration of spleen, closed fracture of neck of left femur, and multiple closed fractures of pelvis with unstable disruption of pelvic ring. The Licensee neglected to notify the QP about client #5's non-adherence to the guidelines in his unsupervised time assessment which resulted in client #5 not being reassessed for his capability of remaining in the community without supervision and being hit by a car and sustaining multiple injuries.<br><br>This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. | V 290 | | |
| V 291 | 27G .5603 Supervised Living - Operations<br><br>10A NCAC 27G .5603 OPERATIONS | V 291 | | |

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| V 291 | Continued From page 35<br>(a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity.<br>(b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management.<br>(c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals.<br>(d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern.<br><br>This Rule is not met as evidenced by:<br>Based on record review, observation, and interview, the facility failed to maintain coordination between the facility operator and the qualified professionals who are responsible for treatment/habilitation affecting 3 of 3 audited clients (#1, #3, and #4). The findings are: | V 291 | V 291 Supervised Living Operations<br>The facility has contracted with a nurse to provide training on Diabetes Care & Management. Ongoing training will focus on managing and reporting high and low blood sugar levels. During the next medical visits for each of the clients diagnosed with diabetes, the staff or administrator will obtain written guidelines for when and how to make contact with that provider in the event of an emergency. Those guidelines will be implemented 100 % of the time. Any staff person who fails to contact the medical provider will be relieved of responsibilities. Consequences may include termination from this particular facility. Additionally, the administrator has implemented a daily communication log and will maintain daily communication regarding any issues of concerns. Will specifically address blood sugars, managing appointments, coordination of care with providers (dentists, Drs, S Ws, Programs, etc..). This was implemented immediately and training will be done at least monthly for the first quarter and quarterly thereafter. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| V 291 | Continued From page 36<br><br>Review on 6/12/25 of client #1's record revealed:<br>- Admitted 8/23/16<br>Diagnoses: Major Depressive Disorder, Recurrent; Severe Psychosis, Alcohol Use Disorder Severe,Hypertension, Diabetes Type II, Hyperlipidemia, Seborrheic Dermatitis, Gastroesophageal reflux disease (GERD)<br><br>Review on 6/12/25 of client #3's record revealed:<br>- Admitted 9/3/24<br>- Diagnoses of MDD, Diabetes, Arthritis<br><br>Review on 7/3/25 of the Emergency Medical Services report dated 6/30/25 revealed:<br>- Client #3 died 6/30/25<br><br>Interview on 7/21/25 client #3's brother reported:<br>- The cause of death on client #3's death certificate was heart failure<br><br>Review on 6/12/25 of client #4's record revealed:<br>- Admitted 11/5/18<br>- Diagnoses of Schizoaffective Disorder Bipolar Type, GERD, Cocaine and Cannabis Use Disorders<br><br>Finding A: An example of how the facility failed to coordinate with the Primary Care Physicians (PCP #1 and #2) for clients #1, #3, and #4:<br><br>Review on 6/12/25 of client #1's record revealed:<br>- FL-2 dated 2/11/25: "True Metrix test strip use to test blood sugar (BS) twice a day" (BID) signed by PCP #2<br>- Order dated 1/26/25 for "True Metrix Glucose Test Strip" and "Directions: 1 (one) Each two times daily" signed by PCP #1<br><br>Review on 7/9/25 of client #1's BS log 10/1/24 | V 291 | | |

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| V 291 | Continued From page 37<br>through 7/9/25 revealed:<br>- Number of BS check opportunities: 563<br>- 477 entries had "refusal" documented in the BS results<br>- The other 86 spaces were blanks<br><br>Interview on 6/19/25 client #1 reported:<br>- "I've always been like borderline" for diabetes<br>- Did not get his BS checked<br>- "I'm not having a problem" with his BS<br>- "I ain't gonna let this lady (staff #1). They (staff) don't have to ask me no more" to have his BS checked<br><br>Interview on 6/18/25 the medical assistant for PCP #2 for client #1 reported:<br>- Client #1 was first seen at their office in August of 2022<br>- Client #1's most recent appointment was on 2/11/25 and his A1C was 5.3<br>- There was not an order for client #1's BS to be checked<br><br>Review on 6/12/25 of client #3's record revealed:<br>- FL-2 signed by PCP #1 dated 9/12/24: BS test strips to check blood sugar twice daily<br><br>Review on 7/9/25 of client #3's BS logs for April, May, and June 2025 revealed the number of entries between:<br>- 200-299: 41<br>- 300-399: 4<br>- 400-499: 2<br><br>Review on 6/12/25 of client #4's record revealed:<br>- FL-2 signed by PCP #1 dated 2/4/25: Accu-check strip, use one twice daily<br><br>Review on 7/24/25 of client #4's BS logs for April, May and June 2025 revealed the the number of | V 291 | | |

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| V 291 | Continued From page 38<br>entries between:<br>- 200-299: 72<br>- 300-399: 45<br>- 400-499: 12<br>- 500-599: 0<br><br>Review on 7/24/25 of client #4's glucometer results between 4/1/25 and 6/30/25 revealed the following BS results between:<br>- 200-299: 77<br>- 300-399: 48<br>- 400-499: 10<br>- 500-599: 1<br><br>Interview on 6/13/25 client #4 reported:<br>- "I was taking it (BS) twice daily, but" staff #2 had not been checking his BS<br>- Last checked BS "within a couple of weeks," but could not remember date<br>- Did not know why staff #2 did not check his BS<br><br>Interview on 7/9/25 client #4 reported:<br>- "I think I'm doing well" with his diabetes<br><br>Interview on 6/16/25 medical records staff at PCP #1's office reported:<br>- PCP #1 was client #1's PCP but client #1 had not been seen at their office since 2022<br>- Had no documentation that the facility had called regarding high BS levels for client #3 or client #4<br>- Client #3 was last seen on 3/31/25 and his A1C was 8.5<br>- Client #4 was last seen on 5/27/25 and his A1C was 10.4<br><br>Interview on 6/19/25 PCP #1 reported:<br>- "I think they (facility) mentioned it (client #1's BS check refusals) to me one time" but PCP #1 | V 291 | | |

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| V 291 | Continued From page 39<br>hadn't seen client #1 for an appointment since April 2022<br>- "Looks like we did send the prescription for client #1's BS test strips BID in January 2025"<br>- The guideline he gave the facility was that if the BS reading was above 200 "they are supposed to let me know"<br>- The last time any of client #4's high BS readings had been reported to him was "six to eight weeks ago", but he could not remember the exact date<br>- The facility had contacted him in the past when client #4's BS readings were high but did not know that clients #3 and #4 had BS readings over 200 in April, May, and June 2025<br>- "High (blood) sugar can lead to complications like kidney damage, heart condition, dehydration" and a diabetic coma<br><br>Interview on 6/17/25 staff #1 reported:<br>- Worked at the facility "like one year"<br>- Clients #1, #3, and #4 had BS checked by staff<br>- If the "blood sugar is high, I have to call 911 to come get them"<br>- "If it's 350 I will call the ambulance to come take them" or when it was less than 75<br>- Never called the PCP as "The owner of this place (Licensee) is the one that would call the primary doctor"<br>- Client #1 "refuses every time" to have his BS checked<br>- If a client refused BS checks "I call the owner (Licensee)" and "I put 'refused'" on the BS log<br><br>Interview on 6/13/25 staff #2 reported:<br>- Been at the facility for about two weeks<br>- No one told her that client #1 needed his BS checked<br>- Client #3 had his BS checked "in the morning | V 291 | | |

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| V 291 | Continued From page 40<br>and at night"<br>- Checked client #3's BS "maybe about 5 times" since she started at the facility<br>- Was never given instruction or trained by facility regarding what to do for high BS readings or refusals<br><br>Interview on 6/19/25 the Qualified Professional reported:<br>- Was never told that client #1 refused BS checks<br>- Was not told that client #4's BS readings were high until "maybe two months ago"<br>- Did not ask about refusals on the BS logs<br>- The Licensee wrote the FL-2s and was responsible for having the PCP review and sign them<br>- The Licensee handled all of the clients' medical appointments<br><br>Interview on 6/12/25 and 6/17/25 the Licensee reported:<br>- Clients #1, #3, and #4 had BS checked by staff<br>- Client #1 had "refused treatment, that's why [PCP #1] released from treating him" and the Licensee had found him a new PCP (#2)<br>- "If it's (BS) 300 it's on the high side" and "if it's like 150-200 then we let the pharmacist know and we call the doctor"<br><br>Interview on 7/22/25 and 7/24/25 the Licensee reported:<br>- When there were "issues in the home (facility)" staff told him and he would "go and address it (issue in the facility)"<br>- "I never call [QP] to complain that this client is doing this or this client is doing that"<br>- Could not remember if he had told the QP that client #1 refused BS checks | V 291 | | |

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| V 291 | Continued From page 41<br>- Could not remember if he had told the QP that client #4 had high BS readings<br>- Wrote the FL-2s and met with the PCP to have them reviewed and signed<br>- Did not notice that the order for BS test strips for client #1 was from the former PCP<br>- Did not discuss client #1's BS refusals with PCP #2 because "my fear was that I if tell them he was refusing treatment from the other doctor (PCP #1), they would reject him" like PCP #1 had<br><br>Finding B: An example of how the facility failed to coordinate with the dentist for client #4:<br><br>Review on 7/25/25 of client #4's dental records obtained from the dental office revealed:<br>- Appointment on 10/24/23 for periodic exam and x-rays with the following recommendations<br>- 3 extractions<br>- 2 root canals<br>- 9 core buildup<br>- 9 full crown<br>- 9 crown delivery<br>- Upper partial resin with base; lower partial resin with base<br>- Appointment 12/12/23 for limited evaluation and x-rays<br>- Appointment 7/10/25 for comprehensive exam<br>- Provider notes from dentist for 7/10/25 appointment: "Pt. (Patient) presents to clinic for NPE (New Patient Exam). Medical Hx (history) and medications reviewed, no contraindications to tx. (treatment)<br>CC (Chief Complaint): I have a bunch of bad teeth.<br>Exam:<br>EOE (Extra Oral Exam): WNL (Within Normal Limits)<br>IOE (Intra Oral Exam): WNL | V 291 | | |

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| V 291 | Continued From page 42<br>Cancer Screening: Negative<br>Hard Tissue: Findings documented in EHR (Electronic Health Record)<br>Perio: See hygiene note<br>Radiographic exam: Radiographs reviewed. Findings documented in EHR.<br>The pt. was informed of the findings and presented with treatment options as documented in EHR.<br>Discussed ext (extraction) of the remaining teeth and fabrication of a C/C (cobalt/chrome) denture.<br>Reviewed denture fabrication timeline with the pt.<br>Risks and benefits of treatment were discussed and pt. agreed to txp (treatment plan).<br>OHI (Oral Hygiene Instructions) was reviewed with pt. Pt. encouraged to continue brushing 2x (two times) daily and flossing 1x (one time) daily.<br>Encouraged to reduce the amount of fortified carbs. (carbohydrates)<br>No complications with today`s apt. (appointment)<br>NV (Next Visit): Impressions after exts. (extractions)"<br><br>Review on 7/3/25 of dental records faxed on 7/3/25 by client #4's Co-Guardian/Sister revealed:<br>- Appointment 10/24/25 - same dental records as provided by dental office noted above<br><br>Review on 7/29/25 of the facility appointment calendars for 2023, 2024, and 2025 revealed:<br>- No dental appointments for client #4 until 7/10/25<br><br>Observation of a phone call between the Licensee and an unknown person on 7/1/25 between 1:45PM and 2:15PM revealed:<br>- The unknown person said that client #4 had reported pain in his mouth and teeth<br>- The unknown person wanted the Licensee to get client #4 an appointment with the dentist | V 291 | | |

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| V 291 | Continued From page 43<br>- The Licensee called the dentist and made an appointment for 7/10/25<br><br>Interview on 6/13/25 client #4 reported:<br>- "I got a lot of work (dental procedures) to be done"<br><br>Interview and observation on 7/9/25 client #4 reported:<br>- "I need some teeth pulled out" because "I need some space" pointing to his mouth<br>- Not any of the dental procedures had been completed<br>- Was last seen at the dentist "about a year ago," when he was told what dental work needed done, but could not remember the date of the appointment<br>- "They (dentist office) told me it (dental procedures) was a lot of money" and "they (facility) didn't want to do it"<br><br>Interview on 7/3/25 client #4's Co-Guardian/Sister reported:<br>- She and client #4's mother were co-guardians for client #4<br>- She took client #4 to the dentist "about 2 or more years ago because they (facility) hadn't taken him" but could not remember the exact date<br>- She had the after-visit paperwork for client #4's dentist appointment<br>- There was a lot of dental work that needed to be done<br>- The work hadn't been completed due to client #4 "not wanting to cooperate" and the facility "not enforcing" the dental work<br>- Client #4 was "supposed to go to the dentist every 2 to 3 months", but he hadn't gone to the dentist before or since she took him, and he "has teeth that are rotting in his mouth...cutting the | V 291 | | |

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| V 291 | Continued From page 44<br>inside of his mouth"<br><br>Interview on 6/19/25 the QP reported:<br>- The Licensee handled all of the clients' dental appointments<br><br>Interview on 7/22/25 Licensee reported:<br>- "I took him (client #4) to the dentist the other day, last week" on 7/10/25<br>- Had asked the dentist what was wrong and "they (dentist) said that they just did x-rays" and "everything is fine"<br>- There was no plan to fill cavities or for teeth to be extracted<br>- The dentist said "they would get in touch with next appointment"<br>- Client #4's prior dental appointment "was like 3 months ago" when "he (client #4) started complaining to the mother his teeth were hurting"<br>- Immediately scheduled an appointment for client #4 but when asked did not remember the date and commented that the office didn't have any immediate appointments available<br>- Clients had routine dental appointments scheduled and as needed for a toothache or emergencies<br>- All appointments for clients were written on a calendar at the facility<br><br>Finding C: An example of how the facility failed to correctly document blood sugar checks for clients #1, #3, and #4:<br><br>Review on 7/9/25 of client #1's BS log for 10/1/24 through 7/9/25 revealed:<br>- Number of BS check opportunities: 563<br>- Number of spaces without documentation: 86<br><br>Review on 7/9/25 of client #3's BS logs for 4/1/25 through 6/29/25 revealed: | V 291 | | |

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| V 291 | Continued From page 45<br>- Number of BS check opportunities: 180<br>- Number of spaces without documentation: 35<br><br>Review on 7/24/25 of client #4's BS logs and glucometer readings for 4/1/25 through 6/30/25 revealed the following results:<br>- Number of BS check opportunities: 182<br>- Number of opportunities for BS checks that were not documented: 43<br>- Number of glucometer readings that were not documented on client #4's BS log: 4<br>- Number of entries on client #4's BS log but were not displayed in the glucometer: 1<br>- Number of total discrepancies between client #4's glucometer readings and what was documented on the BS logs: 26<br>- 4/7/25 - BS reading of 347 was displayed in the glucometer but not documented on the BS log<br>- 4/27/25 - 242 was documented for AM BS check, but the glucometer reading was 354<br>- 4/28/25 - 354 was documented for the AM BS check, but the glucometer reading was 242<br>- 4/30/25<br>- 279 was documented for the AM BS check, but the glucometer reading was 297<br>- 295 was documented for the PM BS check, but no data was shown in the glucometer<br>- 5/1/25 - 334 was documented for AM BS check, but the glucometer reading was 219<br>- 5/17/25 - 226 was documented for AM BS check, but the glucometer reading was 304<br>- 5/22/25 - 250 was documented for AM BS check, but the glucometer reading was 212<br>- 5/23/25<br>- 182 was documented for AM BS check, but the glucometer reading was 296<br>- 219 was documented for PM BS check, but the glucometer reading was 209 | V 291 | | |

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| V 291 | Continued From page 46<br>- 5/24/25<br>- 232 was documented for AM BS check, but the glucometer reading was 208<br>- 255 was documented for PM BS check, but the glucometer reading was 213<br>- 5/25/25 - 181 was documented for AM BS check, but the glucometer reading was 275<br>- 5/29/25 - BS reading of 189 was displayed in the glucometer but not documented on the BS log<br>- 6/6/25 - BS reading of 295 was displayed in the glucometer but not documented on the BS log<br>- 6/15/25 - 411 was documented for PM BS check, but the glucometer reading was 511<br>- 6/17/25<br>- 255 was documented for AM BS check, but the glucometer reading was 250<br>- 215 was documented for PM BS check, but the glucometer reading was 313<br>- 6/18/25<br>- 211 was documented for AM BS check, but the glucometer reading was 210<br>- 205 was documented for PM BS check, but the glucometer reading was 305<br>- 6/19/25 - 255 was documented for PM BS check, but the glucometer reading was 238<br>- 6/21/25 - 225 was documented for PM BS check, but the glucometer reading was 265<br>- 6/22/25 - BS reading of 219 was displayed on the glucometer but not documented on the BS log<br>- 6/24/25 - 305 was documented for PM BS check, but the glucometer reading was 302<br>- 6/27/25 - 264 was documented for PM BS check, but the glucometer reading was 245<br>- 6/29/25 - 220 was documented for PM BS check, but the glucometer reading was 273<br><br>Interview on 7/25/25 staff #1 reported: | V 291 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| V 291 | Continued From page 47<br>- "Maybe it (discrepancies in BS logs and glucometer readings) was a mistake" and "maybe I put in on my sheet wrong"<br><br>Interview on 6/19/25 the QP reported:<br>- The Licensee was responsible for reviewing BS logs<br>- Had looked at the BS logs briefly, but never reviewed them completely or asked about blank spaces<br><br>Interview on 6/17/25 and 6/18/25 the Licensee reported:<br>- Staff documented refusals for BS checks and for high BS readings<br>- "[PCP #1] recommended before breakfast and dinner for blood sugar checks" so that was when clients' BS was checked<br>- Was responsible for reviewing BS logs for accuracy and completeness<br>- Had never asked staff about the spaces without documentation on the BS logs<br><br>Review on 7/29/25 of the Plan of Protection written and signed by the Licensee on 7/29/25 revealed:<br>"What immediate action will the facility take to ensure the safety of the consumers in your care?<br>- 1) Staff of the facility will receive more trainings - in a months time.<br>2) Monitor and check the clients at all times to ensure of their safety immediately.<br>3) Reports to the QP and Doctors for any incident - immediately."<br>"Describe your plans to make sure the above happens.<br>- 1) Staff will continue to check and monitor the clients to prevent any future incidents.<br>2) Will communicate/notify QP and Doctors.<br>3) QP will implement new and updated plans | V 291 | | |

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| V 291 | Continued From page 48<br>immediately to ensure clients safety."<br><br>This deficiency has been cited 3 times since the original cite on 12/5/22.<br><br>The facility served clients with Major Depression Disorder, Recurrent, Severe Psychosis, Alcohol Use Disorder, Severe, Diabetes, Hyperlipidemia, Gastroesophageal reflux disease, Schizoaffective Disorder Bipolar Type, and Cocaine and Cannabis Use Disorders. Client #1 had an order signed by PCP #1 that he had not seen since April 2022 for BS checks and an FL-2 signed by PCP #2 that was written by the Licensee that included the BS checks. From October 2024 through June 2025 client #1 refused all 477 documented BS checks out of 563 opportunities. The Licensee did not coordinate with client #1's former and current PCPs to ensure client #1 needed to continue having his BS checked and regarding client #1's refusals to have his BS checked which resulted in client #1 continuing to refuse BS checks for a minimum of 10 months. The facility did not notify PCP #1 for any BS readings above 200 and 47 of client #3's and 136 of client #4's BS readings were above 200. High BS levels had health risks including kidney damage, heart condition, dehydration, and a diabetic coma. The Licensee did not report high BS readings for April, May, and June of 2025 to PCP #1 which resulted in PCP #1 not being able to address the high BS readings for clients #3 and #4.<br>Client #4 was seen by the dentist in October and December 2023 where it was recommended that 3 extractions, 2 root canals, 9 core buildup, 9 full crown, 9 crown delivery, an upper partial resin with base and a lower partial resin with base be completed. Client #4 did not have any additional dentist appointments documented until 7/10/25. | V 291 | | |

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| V 291 | Continued From page 49<br><br>The Licensee did not make appointments with client #4's dentist for the recommended dental work to be completed which resulted in client #4 not seeing a dentist until 7/10/25 and not getting the dental work completed.<br>Clients #1, #3, and #4 had orders from PCP #1 for BS to be checked. From October 2024 through June 2025 client #1 BS logs had 86 spaces with no documentation out of 563 opportunities. Client #3 had 35 spaces with no documentation out of 180 opportunities on the BS logs for April through June 2025. Client #4 had 43 spaces with no documentation out of 182 opportunities on the BS logs for April through June 2025. Client #4 had 26 total discrepancies between the BS readings in his glucometer and what staff #1 wrote on the BS log for April through June 2025.<br><br>This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. | V 291 | | |
| V 512 | 27D .0304 Client Rights - Harm, Abuse, Neglect<br><br>10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION<br>(a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66.<br>(b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter.<br>(c) Goods or services shall not be sold to or purchased from a client except through established governing body policy.<br>(d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by | V 512 | V512 Client Rights – Harm, Abuse, Neglect<br>All staff will be retrained in CPR/First Aid and emergency protocols by the certified trainer. Staff #1 has been given the opportunity for retraining. The instructor who did the training believes that the staff person was properly trained in life saving techniques. She completed competency based assessments, demonstrated the proper skills and was certified. Unfortunately client #3 had already expired when the staff located him. | |

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| V 512 | Continued From page 50<br>governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter.<br>(e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.<br><br>This Rule is not met as evidenced by:<br>Based on record review, observation and interview 1 of 2 staff (#1) neglected 1 of 3 audited clients (#3). The findings are:<br><br>Review on 7/1/25 of client #3's record revealed:<br>- Admitted 9/3/24<br>- Diagnoses: Major Depressive Disorder, Diabetes, Arthritis<br><br>Review on 7/1/25 of staff #1's record revealed:<br>- Hire date: 5/6/24<br>- CPR and First Aid training completed 5/20/25<br><br>Review on 7/1/25 of the Incident Response Improvement System report dated 6/30/25 revealed:<br>- "On June 30, 2025, at approximately 6:00 AM, the Administrator (Licensee) received a call from on-duty staff (#1) reporting that a consumer (client #3) was found unresponsive and lying face down on the floor in his bedroom. The Administrator responded immediately and upon arrival at the group home, entered the consumer's room, turned him onto his back, and contacted emergency services (911). While on | V 512 | | |

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| V 512 | Continued From page 51 | V 512 | | |

the phone with 911, the Administrator initiated CPR and continued until emergency medical personnel arrived on the scene. Despite resuscitation efforts, the consumer was later pronounced deceased. All appropriate notifications were made, and the situation was handled in accordance with agency policy and emergency protocols."

Review on 7/23/25 of the audio to 911 Communications regarding client #3 for 6/30/25 revealed:
- Call received at 6:31:41AM
- The Licensee was the caller
- A client was "not breathing and not responsive"

Review on 7/3/25 of the Emergency Medical Services report dated 6/30/25 revealed:
- Call received 6/30/25 at 6:30:50AM
- Arrived on scene at 6:38:10AM
- Dispatched to a cardiac arrest
- Upon arrival client #3 was "pulseless and apneic. Rigor mortis and lividity present upon assessment"
- Time of death 6:39AM

Review on 7/9/25 of the local Police Department report dated 6/30/25 revealed:
- "A resident (client #3) of the group home was found deceased next to his bed."
- Staff #1 Narrative: "I last saw him at around 2230hrs (hours) (10:30PM last night. He was up and going to the bathroom. When I came in this morning, I found him face-down on the ground. I couldn't tell if he was breathing or not, so I called [Licensee]."
- Licensee Narrative: "[Staff #1] called me at 0614hrs (6:14AM) and said that one of the residents (client #3) was on the ground. I asked

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| V 512 | Continued From page 52<br>her (staff #1) if he (client #3) was breathing and she said she wasn't sure if he was breathing or not. I came over right away and called 911. He (client #3) was originally face-down, but I rolled him over. I tried to do CPR on him."<br>- Officer Narrative: "On 6/30/25, I responded to a code blue at 3716 Summer Place. Call comments stated that a resident was deceased ...On arrival, I went to one of the ground floor bedrooms and found the complainant, [Licensee], performing CPR on the decedent, [Client #3], who was stiff, cold, and obviously deceased ...I spoke with [Licensee], who told me that he was called out to the location by the live-in care provider, [Staff #1]. [Licensee] said that [Staff #1] called him at 0614hrs (6:14AM), stating that [Client #3] was unconscious and unresponsive on the floor. When [Licensee] asked if he was breathing, [Staff #1] allegedly said that she was not sure if he was breathing or not. [Licensee] then drove out to the group home and found [Client #3] face-down on the ground. [Licensee] called 911 and, determining that [Client #3] was not breathing, rolled [Client #3] over and began performing CPR per dispatch's instructions ...[Staff #1] said that she last saw [Client #3] at around 2230hrs (10:30PM) when he went to bed. When she went to wake him up for breakfast, [Staff #1] found [Client #3] on the floor next to his bed. Unsure if he was breathing or what to do, she called [Licensee]."<br><br>Observation on 7/22/25 at 11:51AM of staff #1's cell phone call logs revealed:<br>- A call to the Licensee on 6/30/25 at 6:08AM<br><br>Observation on 7/22/25 at 2:14PM of the Licensee cell phone call logs revealed:<br>- Calls received from staff #1 on 6/30/25 at 6:09AM and 6:14AM | V 512 | | |

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| V 512 | Continued From page 53<br><br>Interview on 7/1/25 client #1 reported:<br>- "The guy (client #3) passed away"<br>- Didn't know anything about client #3's death<br>- Was asleep and woke up about 6:00AM and "when I come down (stairs), they (staff) had started talking, the lady (staff #1) had just found him"<br>- On 6/30/25 "staff (#1) didn't try anything before [Licensee] got there"<br><br>Interview on 7/1/25 client #2 reported:<br>- Shared a bedroom with client #3<br>- On 6/30/25 around 6:00AM client #3 "was trying to get out of bed and he fell" and "he (client #3) died right there"<br>- Client #3 was rocking in his bed and went head first to the floor<br>- Client #3 "didn't call for help"<br>- No staff was in the room when client #3 fell, but staff #1 was in the facility<br>- Staff #1 "didn't try anything before [Licensee] got there"<br>- Staff #1 came into room the same time as the Licensee<br>- The Licensee "came in and tried to do CPR but it didn't work"<br>- Client #3 "never fell before"<br><br>Interview on 7/1/25 client #4 reported:<br>- "A man (client #3) died early the other morning"<br>- "I don't know anything about it (death of client #3)"<br>- "He (client #3) fell off the bed and died" and "the staff (#1) told me what happened"<br>- Woke up at 6:00AM and "the police came about 6:30 (AM), I think"<br>- When client #4 "got downstairs the police were already there" | V 512 | | |

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| V 512 | Continued From page 54<br>- "He (client #3) was dead about 5 o'clock (AM) I think"<br>- Staff #1 was working at the facility that morning<br><br>Interview on 7/1/25 staff #1 reported:<br>- During observation of bedroom at 11:45AM on 7/1/25:<br>- Found client #3 on the floor, face down on the left side of the bed between the bed and the door<br>- Door was closed when she approached the room<br>- On 6/29/25 she went to bed at 10PM and fell asleep around midnight after she listened for the clients<br>- On 6/30/25 checked on the clients around 6:00AM to wake them up for their day programs<br>- Got to client #3's room around 6:05AM and saw him on his side on the floor facing the bed<br>- Was "shocked, never seen someone dying before"<br>- "I just started to do CPR" and "started pushing on [client #3]'s chest"<br>- Called the Licensee immediately around 6:09AM<br>- The Licensee arrived in "like 6 to 10 minutes" and she and the Licensee "began CPR together"<br>- The Licensee called 911 "within minutes of arriving" and EMS came 6 to 10 minutes later<br>- Was trained in CPR and first aid and knew the standard practices<br>- "I knew to call 911 but I was panicked and was confused and called [Licensee]"<br>- Responded she "was panicked and pressing on his chest" when asked if she checked client #3 for a pulse or if he was breathing<br>- No clients called for help during the night<br><br>Interview on 6/30/25 the Licensee reported: | V 512 | | |

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| V 512 | Continued From page 55<br>- "About 6:00AM this morning (6/30/25), the supervisor (staff #1) at the home (facility) called me that he (client #3) had passed on"<br>- Told staff #1 to check if client #3 was breathing but "she (staff #1) seemed to be nervous and panicking so I rushed over"<br>- Arrived "about 6:20 (AM)" and called 911 immediately from the facility phone but did not know what time he made the call<br>- When he arrived, Staff #1 was trying to reposition client #3 so "I asked her if he was facing down, she said he was so she was trying to get him face up"<br>- Explained the situation to 911 operator and was told to reposition him and start CPR until EMS arrived<br>- Administered CPR on client #3 until EMS arrived which was before 6:20AM<br>- EMS confirmed client #3 was deceased at the facility<br>- Did not know the cause of death<br><br>Interview on 7/22/25 the Licensee reported:<br>- On 6/30/25 was still in bed when staff #1 called and said she had gone into client #3's room and found client #3 on the floor<br>- "She (staff #1) didn't know if [Client #3] was alive or dead" so he told staff #1 to check client #3 for signs of life<br>- Staff #1 was "panicked" so the Licensee left his house and went to the facility which was "about 5-7 minutes drive from my house"<br>- When staff #1 called "she was confused and didn't know what to do at that particular time"<br>- He told staff #1 that he was coming and "that's why she (staff #1) didn't call 9-1-1, because she was focused on my coming"<br>- Arrived at the facility as staff #1 called a second time at "about 6:14AM"<br>- Staff #1 was crying and saying "I don't know if | V 512 | | |

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| V 512 | Continued From page 56<br>he's alive or dead"<br>- Upon arrival he grabbed the facility phone and called 911<br>- "At first, I shook him (client #3) a little to see if he would move" but client #3 did not respond so the Licensee called 911<br>- "He (client #3) was on the floor beside his bed...laying mostly on one side (of his body), mostly facing the bed"<br>- "I had to move him face-up to allow for the chest compressions"<br>- "They (911 communications) asked if he was breathing, I said I wasn't sure"<br>- "I started CPR" and "the lady (911 communications) was counting with me"<br>- Administered CPR until EMS arrived at "6:20 or 6:24"AM<br>- Was not sure if staff #1 tried to move client #3 because "that was the position he was in when I got to the room...she (staff #1) said she was trying to see if she could get him (client #3) up, but I don't know what she was doing"<br><br>Interview on 7/3/25 the CPR instructor reported:<br>- Trained staff #1 in First Aid and CPR on 5/20/25<br>- Was certain staff #1 knew the procedures and steps for basic life saving methods<br>- Initial steps if someone was found unresponsive were to check the pulse, position body to begin CPR, contact 911 at first opportunity, and continue CPR until someone gets there<br>- "The first minutes are vital"<br>- "If a person is nonresponsive, got to have oxygen going to the brain"<br>- Waiting to begin CPR or contact emergency services right away had risks including "brain damage, death. Those are the main things"<br>- "The longer you wait (to start CPR and | V 512 | | |

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| V 512 | Continued From page 57<br>contact emergency services), the worse it's gonna be"<br><br>Interview on 7/9/25 the Primary Care Physician for client #3 reported:<br>- The time it takes for rigor mortis to set in depends on the ambient temperature, what health the person was in, their state of hydration<br>- The stiffness of rigor mortis to a smaller part of the body "can set in within a few hours after death"<br>- Rigor mortis usually started setting in within "2 to 3 hours and then peaks around 8 to 12 hours" when the whole body becomes stiff<br><br>Interview on 7/21/25 client #3's brother reported:<br>- The cause of death on client #3's death certificate was heart failure<br><br>Review on 7/29/25 of the Plan of Protection written and signed by the Licensee on 7/29/25 revealed:<br>"What immediate action will the facility take to ensure the safety of the consumers in your care?<br>- Staff of Victory Healthcare Services will ensure proper check/monitor all clients at all time for their safety, will call emergency 911 for any life threatening in the facility and the use of CPR. QP (Qualified Professional) and Doctors will be notified<br>Describe your plans to make sure the above happens.<br>- Training and QP assessment will be conducted for adquate clients safety in a months time. Staff, Administrator will inform QP and Doctors for any challenges. Training and assessment will be done as soon as possible to ensure clients safety in the facility immediately." | V 512 | | |

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|---|---|
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| V 512 | Continued From page 58<br><br>Client #3 had diagnoses of Major Depressive Disorder, Diabetes, and Arthritis. On 6/30/25 around 6:05AM staff #1 found client #3 on the floor in his bedroom. Staff #1 called the Licensee at 6:08AM who came to the facility and called 911 using the facility phone at 6:30AM. At the instruction of 911 communications, the Licensee began CPR until EMS arrived at 6:38AM. Instead of immediately calling 911 and initiating CPR as trained, staff #1 called the Licensee, which resulted in a 25-minute delay for emergency care to be initiated. Client #3 was pronounced deceased after EMS arrived at the facility.<br><br>This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. | V 512 | | |
| V 513 | 27E .0101 Client Rights - Least Restrictive Alternative<br><br>10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE<br>(a) Each facility shall provide services/supports that promote a safe and respectful environment. These include:<br>(1) using the least restrictive and most appropriate settings and methods;<br>(2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others;<br>(3) providing choices of activities meaningful to the clients served/supported; and<br>(4) sharing of control over decisions with the client/legally responsible person and staff.<br>(b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the | V 513 | V513 Least Restrictive Interventions Client rights trainings were conducted 7/30/25, 8/6/25 and again on 8/15/25. Restrictions are not allowed unless they have been authorized by the guardian & team and a review of this restriction is reviewed weekly. At no time will anything that the client should have open access to be restricted unless the proper procedures are followed. At no time will a staff person or administrator make the decision to restrict access without talking with the guardian and QP and a proper assessment of the request and the benefits of the restriction have been discussed. Any restriction for a medical reason will involve the client's medical provider. This training will be done at least quarterly. | |

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| | MHL092-686 | A. BUILDING: _____ B. WING _____ | R 07/29/2025 |

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| V 513 | Continued From page 59<br>intervention. These include:<br>(1) using the intervention as a last resort; and<br>(2) employing the intervention by people trained in its use.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review, and interview, the facility failed to use the least restrictive and most appropriate method affecting 5 of 5 clients. The findings are:<br><br>Observation at 10:54AM on 6/12/25 revealed:<br>- Four kitchen cabinets containing food were locked using a hasp that locked 2 cabinets each and a padlock for each hasp<br><br>Interview on 6/18/25 client #2 reported:<br>- Clients had "no access to food" at night because staff locked the fridge and "freezer up at 8 at night"<br>- The kitchen food cabinets were locked and only staff could open them<br>- Couldn't get his drink from the refrigerator had to "suffer" until staff would get him what he wanted<br>- The kitchen cabinets had "never been locked during the day"<br><br>Interview on 6/17/25 staff #1 reported:<br>- Had been working at the facility for one year<br>- The locks on the kitchen cabinets had been unlocked when she returned to the facility on 6/15/25<br>- Staff had been locking the kitchen cabinets before but "there was no reason for it (cabinets) | V 513 | | |

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| V 513 | Continued From page 60<br>to be locked"<br><br>Interview on 6/19/25 the Qualified Professional reported:<br>- Had never noticed locked kitchen cabinets at the facility<br><br>Interview on 6/13/25 and 6/18/25 the Licensee reported:<br>- The kitchen cabinets were locked at night because a former client that had left about a year prior would get food and put it under his pillow<br>- Client #4 sometimes came to the kitchen at midnight and got food<br>- The fridge and kitchen cabinets were locked at night and unlocked at 6:00AM<br>- The kitchen cabinets were locked to "prevent clients from using cans and bottles as weapons against others"<br>- The facility staff locked the cabinets "in the morning before breakfast and after dinner"<br><br>Interview on 7/22/25 the Licensee reported:<br>- "I tell them (staff) to lock the top (cabinets) because we have some gravy, some bottles, we don't keep those kinds of things exposed to the clients because if they get crazy they could use them as weapons" | V 513 | | |
| V 736 | 27G .0303(c) Facility and Grounds Maintenance<br><br>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS<br>(c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.<br><br>This Rule is not met as evidenced by: | V 736 | V736 Facility and Grounds Maintenance<br>The facility administrator has purchased items needing repair or placement. The contractor initiate work on 8/16/25 and is expected to complete the repairs by 8/29/25.<br><br>The old mattresses have been removed from outside the home. All broken blinds were replaced by 8/15/25.<br><br>The house was cleaned immediately, will be cleaned professionally following all repairs. | |

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| V 736 | Continued From page 62<br><br>Interview on 6/18/25 and 6/30/25 client #2 reported:<br>- Had lived in the home for 7 years<br>- "The place is rundown and it's got a lot of problems"<br>- The "windshields are broken" in his bedroom and "they are just old"<br>- The front yard, "we need it cut. It's been some weeks now"<br>- There were problems with the roof leaking in the bathroom but couldn't remember for how long<br>- Had not noticed the peeling paint on his bedroom ceiling<br>- Staff #2 cleaned the house but Staff # 1 "is dirty"<br>- The icemaker had been broken "for like 3 months now"<br><br>Interview on 6/17/25 staff #1 reported:<br>- She had called the Licensee about the ceiling peeling in the bedroom of client #2 and client #3 but could not remember when<br>- The mattress had been put outside "two or three months ago"<br>- The kitchen drawers had broken recently and she sent a message to the Licensee "like a week ago" but could not remember the exact date<br>- She hadn't noticed the broken blinds<br>- There was a person that came to do repairs when it was needed but she didn't know who it was<br>- The Licensee coordinated all repairs in the home<br><br>Interview on 6/12/25 and 6/13/25 staff #2 reported:<br>- Began work at this facility on 5/28/25<br>- The facility had "been like this (unclean)" since she started<br>- Came to the facility and had to "clean it up" | V 736 | | |

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| V 736 | Continued From page 61<br>Based on observation and interview, the facility and it's grounds were not maintained in a clean, attractive, and orderly manner. The findings are:<br><br>Observation at 10:54AM on 6/12/25 revealed:<br>- Client #1's bedroom had an oval shaped water stain on the ceiling above the bed about 7 inches in diameter<br>- Client #2 and client #3's shared bedroom:<br>- Door blinds had 3 broken slats<br>- Window blinds had 4 bent slats, 1 broken slat, and 2 missing slats at the top<br>- Ceiling paint peeling between client beds in a triangular shape about 6 inches long<br>- Client #4's bedroom:<br>- There were 5 large trashbags full of clothes and an empty gift bag on the floor and clothes hanging on a microphone stand in front of the dresser<br>- Client #5's bedroom :<br>- 2 bathroom floor tiles that were diagonal to each other were each missing a 2-inch by 3-inch triangular shaped piece on the touching corners<br>- Bathroom mirror had a smeared gray residue across two-thirds of the glass<br>- Blinds for exterior door had 4 broken slats<br>- 2 of 8 kitchen drawers were missing<br>- 2 of 6 kitchen drawers had no handle<br>- A twin mattress leaned on a tree to the side of the house<br>- The lawn was approximately 8 inches tall in about three-fourths of the front yard<br><br>Interview on 6/12/25 client #1 reported:<br>- Had lived at the facility for several years<br>- The facility was "just okay" and he had no problems with it | V 736 | | |

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| V 736 | Continued From page 63<br>- Client #3's room smelled like urine<br>- She had to mop to get the urine smell out of the house<br><br>Interview on 6/19/25 the Qualified Professional reported:<br>- She visited the facility "a couple of times a month" and would walk through the facility<br>- The only thing she had ever noticed was a leak in the toilet that the Licensee was there working on fixing at the time<br>- The Licensee was responsible for all repairs at the facility<br><br>Interview on 6/12/25 and 6/17/25 the Licensee reported:<br>- He had bought new mattresses in May 2025 and had put the old mattress outside<br>- The blinds had been replaced recently and was "surprised to see the blinds" were broken<br>- It was his responsibility to make sure repairs were completed<br>- He checked the facility "almost every day<br>- Staff notified him if anything broke or needed repaired and he would "come down to look at it"<br>- He would call their handyman when repairs were needed<br>- The staff was responsible for ensuring the facility was cleaned<br>- If he saw the facility needed to be cleaned, he called the staff person and had them clean it<br><br>Interview on 7/22/25 the Licensee reported:<br>- He was not aware of any leaking but had already called maintenance to check the roof for leaks<br>- He had already spoken with someone about the repair to the ceiling paint in the bedroom of client #2 and client #3 but they needed to fix the leak before they could fix the ceiling | V 736 | | |

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| V 736 | Continued From page 64<br>- He had been in contact with the repairmen to change the roof, but had not received a date from them yet<br>- The icemaker had been fixed "up to four times" but client #2 kept "destroying it" and they were waiting on parts but the repair was scheduled for 8/16/25<br><br>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days. | V 736 | | |