

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-938	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/22/2025
NAME OF PROVIDER OR SUPPLIER PAUL'S LOVING CARE, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3406 FERN PLACE GREENSBORO, NC 27408		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
V 000	INITIAL COMMENTS An annual and follow up survey was completed on August 22, 2025. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 5 and has a current census of 2. The survey sample consisted of audits of 2 current clients.	V 000			
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.	V 111	Correction: Paul's Loving Care has the completed the assessment prior to admission (had been completed but not in file) and filed in client record. Prevention: The owner will provide retraining to QP complete assessment prior to the delivery of services and filed. Who will monitor/how often: The owner and/or designee will monitor prior to an admission that the assessment is completed and filed in client record. The completed assessment will be monitored by owner/designee prior to admission, Quality check after 6 months and annual record review and updates.	9/11/2025	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Charissa Paul CEO - 9-12-25

STATE FORM

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Z17511

If continuation sheet 1 of 13

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DHSR-MH Licensure Sect

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V 111	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure an assessment was completed for each client prior to the delivery of services affecting 1 of 2 audited clients (Client #1). The findings are: Review on 8/22/25 of Client #1's record revealed: -Admission date of 1/9/25. -Diagnoses of Intellectual Developmental Disability, Bipolar Disorder and Anxiety. -An assessment dated 4/17/24 and completed by another provider. -No facility assessment was documented for Client #1. Interview on 8/21/25 with Client #1 revealed: -He resided in a group home prior to his January 2025 admission. -He moved to the facility because the former group home closed. -He needed staff assistance with medication administration, meal preparation, and independent living skills. Interview on 8/22/25 with the Owner/Licensee revealed: -She thought Client #1 had a completed	V 111		

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V 111	Continued From page 2 assessment in his record. -She would follow up and make sure there was a completed facility assessment for each client being considered for admission.	V 111			
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (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. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (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.	V 112	Correction: Paul's Loving Care has developed the Person Center Plan and has staff strategies and QP trained staff. Prevention: The owner will provide retraining to QP to ensure that staff strategies are developed with the person- centered plan within 30 days of admission. Who will monitor/how often: The owner and/or designee will monitor client record after 30 days of admission, quality check after 6 months and annual record review and updates.	9/2/2025	

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V 112	Continued From page 3 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure each client's treatment plan had staff strategies which supported client treatment goals affecting 1 of 2 audited clients (Client #2). The findings are: Review on 8/22/25 of Client #2's record revealed: -Admission date of 12/27/24. -Diagnoses of Autism Spectrum Disorder, Bipolar Disorder, and Attention-Deficit Hyperactivity Disorder. -1/3/25 treatment plan had a goal of Client #2 would receive assistance with Activities of Daily Living (ADLs), medication administration, nutrition as needed and explore ongoing interests and continue to develop independent living skills. -No documentation of staff strategies to support Client #2 in achieving his treatment goal. Interview on 8/21/25 with Client #2 revealed: -Staff #1 assisted him with medication administration, meal preparation, supervision at the facility and in the community, and coping strategies. -The Owner/Licensee assisted with scheduling his medical appointments. Interview on 8/22/25 with the Qualified Professional (QP) revealed: -She developed Client #2's treatment plan. -Her goal was to help Client #2 to speak up to have his needs met. -She and direct care staff encouraged Client #2 to communicate his thoughts, feelings and concerns. -She and staff encouraged him to read and write	V 112		

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V 112	Continued From page 4 to help him self-regulate when he became overstimulated. -The Group Home Manager transported Client #2 to appointments and to the store. Interview on 8/22/25 with the Owner/Licensee revealed: -She would follow up with the QP on Client #2's treatment plan to include staff strategies. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 112			
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes. (b) The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate the facility's response to fire emergencies. (d) Each facility shall have a first aid kit accessible for use. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire and disaster drills were held	V 114	Correction: Paul's Loving Care has completed fire and disaster drills completed monthly/each shift per quarter. The drill log was updated to reflect the actual drills with times (per shift). Prevention: The owner and or designee will provide retraining on the requirements for fire and disaster drills and the frequency of how they are to be done and documented. Who will monitor/how often: The owner and/or designee will be notified each month after the fire and disaster and other drills.	9/11/2025	

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V 114	Continued From page 5 quarterly and repeated for each shift. The findings are: Review on 8/22/25 of the fire and disaster drill log for the 1st quarter (January-March 2025), 2nd quarter (April, May, June 2025) and 3rd quarter (July and August 2025) revealed: -2nd quarter was missing 1 fire drill. -Due to the failure to accurately document the time or shift a fire and disaster drill was held, it could not be determined when the drills were held. Interview on 8/21/25 with Client #1 revealed: - "We do them once in a while." - "I don't remember the last fire drill." - "We haven't practiced that (disaster drill) yet, but I think we plan to." Interview on 8/21/25 with Client #2 revealed: - Denied he had practiced a fire or disaster drill during his admission. Interview on 8/22/25 with Staff #1: - There was a former direct care staff who worked at the facility every other weekend. - The former staff relieved her around 12:00 noon on Fridays. - The former staff left his position on or about 8/11/25. - She was the only direct care staff working at the facility. - Moving forward, she would make sure the fire and disaster drills were recorded with AM (morning) or PM (evening) beside the time or identified by shift. Interview on 8/22/25 with the Owner/Licensee revealed: - No clients were served during October 2024,	V 114			

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V 114	Continued From page 6 November 2024 and not until Client #2's admission on 12/27/24. -She would follow up with staff on their documentation of fire and disaster drills to ensure the drills were held quarterly and repeated for each shift.	V 114			
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on record review, observation and interview, the facility was not maintained in a safe and clean manner. The findings are: Review on 8/22/25 of the North Carolina Residential Building Code Section 310.2.1 revealed: -"Emergency Egress-Every sleeping room shall have at least one operable window or exterior door approved for emergency egress. The units must be operable without use of key or tool to a full clear opening. If a window is provided, the sill height may not be more than 44" above the floor. These must provide a clear opening of 4 square feet. The minimum height shall be 22 inches and minimum width is 20 inches (1996 Building Code). (For buildings built under the previous Residential Building Code the requirements allowed for a sill height of 48" and an opening of 432 square inches in area with a minimum dimension of 16")."	V 736	Correction: Each window in all sleeping rooms is operable without the use of a key or tool to a full clear opening. Handyman has made sure all windows are operable. Prevention: The owner has trained staff of what to monitor as needed and during weekly room checks. Who will monitor/how often: The owner and/designee will follow up on handman work, Quality check after 6 months and annually that all remains operable.	8/22/2025	

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V 736	Continued From page 7 Observation on 8/22/25 of the facility between 12:27 pm and 1:30 pm revealed: -A vacant client bedroom with 1 window which Staff #1 was unable to open. Additionally, there was black discoloration of the beige carpet in front of both bedroom closets and in front of a floor heat register which were approximately 4' x 4' in size. -In Client #1's bedroom, there was a 58-inch TV on top of a 4-drawer wood dresser which blocked egress from 1 of his bedroom windows while a wood platform bed with built-in drawers blocked his 2nd bedroom window and prevented egress outside in the event of an emergency. -In Client #2's shared bedroom with 1 vacant bed, there were at least 20 black-colored stains of various shapes on the beige carpet and ranged in size from 2" to 4" in size. Interviews on 8/22/25 with Client #1 revealed: -He moved his TV to a game room beside his bedroom and moved his dresser away from the window he had the TV on after learning from Staff #1 and #2 he was not to block his bedroom window in case of an emergency. Interview on 8/22/25 with Staff #1 revealed: -"I don't know why it (vacant client bedroom window) won't open." -Client #1 would be okay to have his television and dresser moved from in front of his bedroom window. -"He rearranges his room every so often." -Client #1's bed was "heavy," and he would need help moving his bed away from his bedroom window. -The carpet in the client bedrooms and hallway with multiple stains were "like this" since she started work at the facility. -The stains were from "normal wear" and "spills."	V 736	Correction: Each window is clear of anything blocking it, i.e. bed, TV etc. All furniture moved for clear path for egress in the event of emergency. Prevention: The owner and/designee has trained staff of what to monitor as needed and during weekly room checks. Who will monitor/how often: The owner and/designee will follow up on as needed and Quality check after 3 months (may change with weather) and annually that all remains operable.	8/22/2025

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V 736	Continued From page 8 Interview on 8/22/25 with the Owner/Licensee revealed: -All the client bedroom windows "always" opened. -She did not know what caused the vacant client bedroom window not to open. -She would have the vacant client bedroom window addressed "immediately" by the handyman to ensure the window opened. -She would make sure Client #1 moved his television and dresser away from his window to provide a clear path for emergency egress in his room. -She would "look into" what could be done about the condition of the carpet. Review on 8/22/25 of a Plan of Protection completed by the Owner/Licensee on 8/22/25 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? The staff assisted client 1 with removing items from in front of the window. Action already completed. Vacant bedroom window has been opened by staff. [Handyman] has been notified to check repairing the spring in the window also immediately. Describe your plans to make sure the above happens. [Handyman] will notify owner (Owner/Licensee) when he is on his way to the facility to make sure he has access. Staff also follow protocols to let me know when they arrive and when repairs are completed. Staff will monitor that all windows are accessible with weekly room checks." The facility served clients with diagnoses of Intellectual Developmental Disability, Bipolar Disorder, and Autism Spectrum Disorder.	V 736	Correction: Carpet will be removed or replaced. Spoke with landlord she said in the next 30 days. Prevention: The owner and/designee has trained staff of what to monitor as needed for cleaning or immediate repair. Who will monitor/how often: The owner and/designee will follow up on as needed and Quality check after 6 and annually that flooring remains without stain and in good repair.	10/3/2025

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V 736	Continued From page 9 There was 1 vacant client bedroom with 1 window which did not open to allow for emergency egress. Additionally, Client #1's bedroom had 2 windows. 1 window was blocked by his bed and the 2nd window was blocked by a 58" TV and 4-drawer dresser which prevented a clear path for egress in the event of an emergency. This deficiency constitutes a Type A2 rule violation for substantial risk of serious harm and must be corrected within 23 days.	V 736		
V 752	27G .0304(b)(4) Hot Water Temperatures 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (4) In areas of the facility where clients are exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to maintain the water temperature between 100-116 degrees Fahrenheit in areas of the facility where clients were exposed to hot water. The findings are: Observation on 8/22/25 of the facility between 12:27 pm and 1:30 pm revealed: -At the kitchen sink, the hot water temperature was 130 degrees Fahrenheit at 12:30 pm. -At the shared client bathroom sink which was used by Clients #1 and #2, the hot water	V 752	Correction: Water heater has been repaired and water temps posted for water checks and what to do when outside the acceptable degrees. Handyman had been working on since 8/8/2025. To correct issue. Part came on 8/22/2025. Prevention: The owner has trained staff in what are acceptable temperatures to monitor daily and who to contact immediately if the temperature is outside of the window. Who will monitor/how often: The owner and/designee will follow up on as needed and Quality check with submission of temperature logs as requested and no less than monthly submission of temp logs.	8/22/2025

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V 752	Continued From page 10 temperature was 130 degrees Fahrenheit at 12:50 pm. -At the shared client bathtub which was used by Clients #1 and #2, the hot water temperature was 132 degrees Fahrenheit at 12:52 pm. Further observation on 8/22/25 of the hot water temperature between 3:21 pm and 3:55 pm revealed: -The kitchen sink temperature was 134 degrees Fahrenheit at 3:21 pm. -The shared client bathroom was 130 degrees Fahrenheit at 3:55 pm. Interview on 8/22/25 with Staff #2 revealed: -She was the Group Home Manager. -"I don't know why the water temperature is that high (130 and 140 degrees Fahrenheit)." -Confirmed the landlord had worked on the hot water heater "recently" because the water temperature was "not getting hot and he (handyman) may have turned it up too high." -The handyman came out and adjusted the water temperature within the past hour. -"The water heater may need to be replaced" in response to the fluctuation in water temperatures. Review on 8/22/25 of the facility's water temperature log for 2025 revealed: -Water temperature was documented daily from 7/1/25 to 8/22/25 without documented times. -The facility location where the water temperature was checked was not documented on the log. -8/16/25 to 8/22/25, the water temperature was documented daily at 140 degrees Fahrenheit. Interview on 8/21/25 with Client #1 revealed: -"It's not too hot or too cold. I can turn the water (temperature) where I need it when I shower and wash my hands."	V 752		

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V 752	Continued From page 11 Interview on 8/21/25 with Client #2 revealed: -"No problem" in response to whether the water temperature was too hot or too cold when he showered or washed his hands. Interview on 8/22/25 with Staff #1 revealed: -She was a Direct Support staff. -The landlord turned the hot water up "about a month ago" because it was not hot enough. -She checked the water temperature each morning at the kitchen sink and recorded the temperature on a daily log. Interview on 8/22/25 with the Owner/Licensee revealed: -She knew the handyman came one day last week to turn the hot water up because the temperature had dropped. -She would have the handyman to "immediately" address the hot water temperature. Review on 8/22/25 of a Plan of Protection completed by the Owner/Licensee on 8/22/25 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? I have contacted [Handyman] he is the repairman for the landlord. He was contacted earlier and came out to turn the hot water heater down. He stated that the hot water heater was on 116. He said hot water heater must have a malfunction. I have contacted him back since [Division of Health Service Regulation surveyor] rechecked the water temperature. Requested that he come out immediately to correct this issue. Staff will be responsible for regulating water temperature for all clients. Describe your plans to make sure the above	V 752			

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V 752	Continued From page 12 happens. [Handyman] will notify owner (Owner/Licensee) when he is on his way to the facility to make sure he has access. Staff also follow protocols to let me know when they arrive and when repairs are completed. Staff will monitor water temperature closely with new thermometer." The facility served clients with diagnoses of Intellectual Developmental Disability, Bipolar Disorder, and Autism Spectrum Disorder. The water temperatures in areas where clients had access to hot water ranged from 130-134 degrees Fahrenheit. Client #1 and Client #2 were exposed to hot water temperatures above 116 degrees Fahrenheit which placed the clients at substantial risk of harm. This deficiency constitutes a Type A2 rule violation for substantial risk of serious harm and must be corrected within 23 days.	V 752			