STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL0921010	B. WING		09/0	2/2025
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
TLC OPE	ERATIONS (ARBOR H	OUSF)	OR DRIVE , NC 27612			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	-S	V 000			
	An annual survey w Deficiencies were c	as completed on 9/2/25. ited.				
	category: 10A NCA	sed for the following service C 27G .5600C Supervised h Developmental Disability.				
		sed for 3 and has a current urvey sample consisted of clients.				
V 118	27G .0209 (C) Med	ication Requirements	V 118			
	only be administered order of a person and drugs.  (2) Medications shat clients only when and client's physician.  (3) Medications, included administered only bunlicensed persons pharmacist or other privileged to prepare (4) A Medication Administered administered only bunlicensed persons pharmacist or other privileged to prepare (4) A Medication Administered administered in Medication recorded immediated MAR is to include the (A) client's name;  (B) name, strength, (C) instructions for a	inistration: non-prescription drugs shall d to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be y licensed persons, or by trained by a registered nurse, legally qualified person and e and administer medications. ministration Record (MAR) of ed to each client must be kept s administered shall be ely after administration. The ne following: and quantity of the drug; administering the drug;				
	(D) date and time the	ne drug is administered; and of person administering the				

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

TITLE (X6) DATE

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL0921010	B. WING		09/	02/2025	
	PROVIDER OR SUPPLIER	OUSF) 3709 AR	BOR DRIVE	STATE, ZIP CODE			
	,	, RALEIGI	H, NC 27612				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
V 118	Continued From pa	ge 1	V 118				
	checks shall be rec	for medication changes or orded and kept with the MAR appointment or consultation					
	failed to have writte physician for a clier	et as evidenced by: view and interview the facility on authorization by the client's nt to self-administer his g 1 of 3 clients (#3). The					
	<ul> <li>Admitted: 8/26/</li> <li>Diagnoses: Authepatitis B</li> <li>Physician order Fumarate Extended tablet ER 24-hour, times a day for anx</li> <li>No written auth</li> </ul>	rism, Anxiety, Hypothyroidism, r dated 8/18/25 for Quetiapine d Release (ER) 300 milligrams Give 1 tablet by mouth three					
	pack the meds and - "I go on bus trip a lot" - When he return ask me" if he took t	facility in 2013 If medications" If medications away from the facility "staff I take them while I'm out" I take the community by myself I take the facility, "they (staff) I take the medication					
	Interview on 8/29/2	5 staff #1 reported:					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL0921010	B. WING 09/		2/2025	
	PROVIDER OR SUPPLIER ERATIONS (ARBOR H	OUSE) 3709 ARB	ORESS, CITY, S OR DRIVE , NC 27612	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE
V 118	he wanted and was weekdays for work  If client #3 wou "his self-administer Fumarate)" with him community  Interview on 9/2/25 Supervisor reported  Was not aware was required for climedications  Interview on 9/2/25 reported:  Client #3 "has a into the community  "Staff goes through the community  "Staff goes through the community  "Staff goes through the community  The staff had "Interviewed what med documented that in the community with client #3 in a transport of the community  Never had a med documented that in the community of the community	able to "come and go" when a away from the home most or his day program Id be gone all day, he took his ed medications (Quetiapine in when he left for the Id:  the Community Residential id: authorization from a physician ents to self-administer  the Qualified Professional in a pill travel thing" that he took if he was not back by 2PM bough and scans everything pels)" and the medication went ravel container returned to the facility staff lications were taken and in their medication system kept it (sending client #3's im) going from prior pany" eeting to discuss client #3	V 118			
V 131	G.S. 131E-256 (D2 Verification	) HCPR - Prior Employment	V 131			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		MHL0921010	B. WING		09/	02/2025
	PROVIDER OR SUPPLIER ERATIONS (ARBOR H	OUSE) 3709 ARB	DRESS, CITY, S OR DRIVE , NC 27612	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION I CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 131	REGISTRY (d2) Before hiring h health care facility of health care facility of Personnel Registry	ge 3 EALTH CARE PERSONNEL ealth care personnel into a or service, every employer at a shall access the Health Care and shall note each incident oropriate business files.	V 131			
	failed to ensure the Registry (HCPR) we employment for 1 of Community Reside findings are:	view and interview, the facility Health Care Personnel as accessed prior to f 3 audited staff (the ntial Supervisor (CRS)). The f CRS's personnel record f24 te: 6/29/24 16/24				
	Interview on 8/29/2 reported: - Rehired at the the standard and access HCF Interview on 9/2/25 Reported: - The HR departs accessing HCPR for	facility on 9/16/24 that Human Resources (HR) PR prior to her rehire the Qualified Professional ment was responsible for				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL0921010	B. WING 0		09/0	)2/2025	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY,	STATE, ZIP CODE	•		
TLC OPE	TLC OPERATIONS (ARBOR HOUSE)  3709 ARBOR DRIVE RALEIGH, NC 27612						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
V 131	Continued From pa	ige 4	V 131				
	the CRS prior to he	er employment					

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