

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL091-107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/05/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HOUSE OF BLESSINGS II	STREET ADDRESS, CITY, STATE, ZIP CODE 48 CHEATHAM LANE HENDERSON, NC 27537
--	--

(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	<p>INITIAL COMMENTS</p> <p>An annual and follow up survey was completed on 9/5/25. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.</p> <p>This facility is licensed for 6 and has a current census of 4. The survey sample consisted of audits of 3 current clients.</p>	V 000		
V 105	<p>27G .0201 (A) (1-7) Governing Body Policies</p> <p>10A NCAC 27G .0201 GOVERNING BODY POLICIES</p> <p>(a) The governing body responsible for each facility or service shall develop and implement written policies for the following:</p> <p>(1) delegation of management authority for the operation of the facility and services;</p> <p>(2) criteria for admission;</p> <p>(3) criteria for discharge;</p> <p>(4) admission assessments, including:</p> <p>(A) who will perform the assessment; and</p> <p>(B) time frames for completing assessment.</p> <p>(5) client record management, including:</p> <p>(A) persons authorized to document;</p> <p>(B) transporting records;</p> <p>(C) safeguard of records against loss, tampering, defacement or use by unauthorized persons;</p> <p>(D) assurance of record accessibility to authorized users at all times; and</p> <p>(E) assurance of confidentiality of records.</p> <p>(6) screenings, which shall include:</p> <p>(A) an assessment of the individual's presenting problem or need;</p> <p>(B) an assessment of whether or not the facility can provide services to address the individual's needs; and</p>	V 105		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL091-107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/05/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HOUSE OF BLESSINGS II	STREET ADDRESS, CITY, STATE, ZIP CODE 48 CHEATHAM LANE HENDERSON, NC 27537
--	--

(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 105	Continued From page 1 (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL091-107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/05/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HOUSE OF BLESSINGS II	STREET ADDRESS, CITY, STATE, ZIP CODE 48 CHEATHAM LANE HENDERSON, NC 27537
--	--

(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 105	<p>Continued From page 2</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop and implement adoption of standards that assure operational and programmatic performance meeting applicable standards of practice for the use of a glucometer instrument including the Clinical Laboratory Improvement Amendments (CLIA) waiver. The findings are:</p> <p>Review on 9/4/25 of client #4's record revealed:</p> <ul style="list-style-type: none"> - Admitted: 11/16/18 - Diagnoses: Schizophrenia; Hypertension; Type 2 Diabetes; Hyperlipidemia; Depression; Gastroesophageal Reflux Disease; Chronic Kidney Disease; Hyperthyroidism; Bipolar; Aortic Aneurysm - Physician order dated 8/15/25: Accu-touch Test Strips, Use to test blood sugar (BS) daily <p>Interview on 9/4/25 client #4 reported:</p> <ul style="list-style-type: none"> - Staff checked her BS "everyday" <p>Interview on 9/4/25 staff #1 reported:</p> <ul style="list-style-type: none"> - Staff checked BS for client #4 <p>Interview on 9/5/25 staff #2 reported:</p> <ul style="list-style-type: none"> - Client #4 "is borderline diabetic" and staff did a "finger prick and check her blood sugar levels every morning" <p>Interview on 9/4/25 the Qualified Professional (QP) reported:</p> <ul style="list-style-type: none"> - Client #4 had diabetes and "gets finger sticks" to check her BS - The Licensee was responsible for completing the CLIA waiver application 	V 105		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL091-107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/05/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HOUSE OF BLESSINGS II	STREET ADDRESS, CITY, STATE, ZIP CODE 48 CHEATHAM LANE HENDERSON, NC 27537
--	--

(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 105	Continued From page 3 - Found out from the Licensee that the CLIA waiver application had not been submitted Interview on 9/4/25 the Licensee reported: - Client #4 had diabetes and staff checked her BS - She forwarded the CLIA waiver application to the QP to submit so "thought they (facility) had it (waiver)" This deficiency has been cited 3 times since the original cite on 8/15/23 and must be corrected within 30 days.	V 105		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (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;	V 113		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL091-107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/05/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HOUSE OF BLESSINGS II	STREET ADDRESS, CITY, STATE, ZIP CODE 48 CHEATHAM LANE HENDERSON, NC 27537
--	--

(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 113	<p>Continued From page 4</p> <p>(6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician;</p> <p>(7) documentation of services provided;</p> <p>(8) documentation of progress toward outcomes;</p> <p>(9) if applicable:</p> <p>(A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM);</p> <p>(B) medication orders;</p> <p>(C) orders and copies of lab tests; and</p> <p>(D) documentation of medication and administration errors and adverse drug reactions.</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain complete records affecting 3 of 3 audited clients (#1, #2, #4). The findings are:</p> <p>Review on 9/4/25 of client #1's record revealed:</p> <ul style="list-style-type: none"> - Admitted: 7/7/20 - Diagnoses: Major Depressive Disorder; Borderline Personality; Hearing Problem; Alcohol Use Disorder - No documentation of lab tests or services provided for medical care <p>Review on 9/4/25 of client #2's record revealed:</p> <ul style="list-style-type: none"> - Admitted: 1/25/23 - Diagnoses: Bipolar Disorder; Hypertension; 	V 113		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL091-107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/05/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HOUSE OF BLESSINGS II	STREET ADDRESS, CITY, STATE, ZIP CODE 48 CHEATHAM LANE HENDERSON, NC 27537
--	--

(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 113	<p>Continued From page 5</p> <p>Hyperglycemia; Urinary Incontinence; Alcohol Abuse; Pre-Diabetes; Vitamin D Deficiency</p> <ul style="list-style-type: none"> - No documentation of lab tests or services provided for medical care <p>Review on 9/4/25 of client #4's record revealed:</p> <ul style="list-style-type: none"> - Admitted: 11/16/18 - Diagnoses: Schizophrenia; Hypertension; Type 2 Diabetes; Hyperlipidemia; Depression; Gastroesophageal Reflux Disease; Chronic Kidney Disease; Hyperthyroidism; Bipolar; Aortic Aneurysm - No documentation of lab tests or services provided for medical care <p>Interview on 9/5/25 client #1 reported:</p> <ul style="list-style-type: none"> - Lived at the facility for 5 years - Staff transported him to his doctor's appointments <p>Interview on 9/5/25 client #2 reported:</p> <ul style="list-style-type: none"> - Been at the facility for 2 years - Went with staff to all of his medical appointments - Went to the doctor's office "past Tuesday (8/26/25) for bloodwork" <p>Interview on 9/5/25 client #4 reported:</p> <ul style="list-style-type: none"> - Been at the facility for "almost 10 years" - Staff took her to all of her medical appointments - Went to the doctor for an "issue with ear last week" <p>Interview on 9/4/25 staff #1 reported:</p> <ul style="list-style-type: none"> - Started at the facility on 12/1/18 - She "doesn't get anything from the doctors" when she went with clients #1, #2, and #4 to their appointments 	V 113		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL091-107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/05/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HOUSE OF BLESSINGS II	STREET ADDRESS, CITY, STATE, ZIP CODE 48 CHEATHAM LANE HENDERSON, NC 27537
--	--

(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 113	<p>Continued From page 6</p> <p>Interview on 9/5/25 staff #2 reported:</p> <ul style="list-style-type: none"> - Worked at the facility for 2 months - Staff took clients to their appointments and were responsible for getting documentation from each appointment - She put all documentation from each doctor's appointment in clients #1, #2, and #4's travel folders <p>Interview on 9/4/25 the Qualified Professional reported:</p> <ul style="list-style-type: none"> - Staff "should be bringing it (after-visit summary) back" from each appointment - Staff were responsible for ensuring all after-visit summaries and lab work results were in the client charts - Was not aware the lab results and after-visit summaries were not in the clients' charts <p>Interview on 9/4/25 the Licensee reported:</p> <ul style="list-style-type: none"> - Staff were responsible to "get note from doctor and put it in their (client's) record" - Did not know the after-visit summaries and lab results were not in the clients' charts 	V 113		
V 114	<p>27G .0207 Emergency Plans and Supplies</p> <p>10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES</p> <p>(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.</p> <p>(b) The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.</p>	V 114		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL091-107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/05/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HOUSE OF BLESSINGS II	STREET ADDRESS, CITY, STATE, ZIP CODE 48 CHEATHAM LANE HENDERSON, NC 27537
--	--

(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 114	<p>Continued From page 7</p> <p>(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.</p> <p>(d) Each facility shall have a first aid kit accessible for use.</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure fire and disaster drills were completed at least quarterly & repeated for each shift. The findings are:</p> <p>Review on 9/4/25 of the facility's fire and disaster drills book from 7/7/24 through 9/4/25 revealed:</p> <ul style="list-style-type: none"> - All fire drills except one were completed between the hours of 7:33AM and 7:25PM - All disaster drills were completed between the hours of 7:30AM and 7:30PM - One fire drill and no disaster drills completed during third shift <p>Interview on 9/4/25 client #1 reported:</p> <ul style="list-style-type: none"> - "Lived here - as of July 2nd was five years" - Did fire drills - No other types of drills were completed - For a tornado would "get out of here" but did not know where he would go - The staff did not wake them up at night to complete fire or disaster drills <p>Interview on 9/4/25 client #2 reported:</p> <ul style="list-style-type: none"> - Been at the facility for 2 years - Completed fire drills "once a month I think" - Had not done disaster drills - Did not know what he would do for a tornado - Did drills "always when already awake" 	V 114		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL091-107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/05/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HOUSE OF BLESSINGS II	STREET ADDRESS, CITY, STATE, ZIP CODE 48 CHEATHAM LANE HENDERSON, NC 27537
--	--

(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 114	<p>Continued From page 8</p> <p>Interview on 9/4/25 client #4 reported:</p> <ul style="list-style-type: none"> - Lived at the facility for "almost 10 years" - Did a fire drill last week and "usually do it every other month" - Had done a tornado drill "two months ago, I think" and the clients "get in the middle of the hall and get down on our knees and cover our heads" - Did not do other types of drills - The staff did not wake them up at night to complete drills <p>Interview on 9/4/25 staff #1 reported:</p> <ul style="list-style-type: none"> - Had worked at the facility since 12/1/18 - She worked the 1st through the 8th of each month - Did a fire drill "every month when I'm here" - Disaster drills were completed quarterly - Did not "act it (disaster drills) out" with clients but would "ask them questions and see what they know" - Did not know when was the "last time practiced a disaster drill" - "I can't say when was the last time" a tornado drill was completed - "I have not done nighttime" drills - Staff did not have a schedule just knew to complete the drills at "all different hours" - The Licensee was responsible for reviewing the fire and disaster drills <p>Interview on 9/5/25 staff #2 reported:</p> <ul style="list-style-type: none"> - Worked at the facility for 2 months - "I did one (fire drill) at 6:42 (AM), I think it was Friday morning" - Did not do disaster drills "because [staff #1] mainly does the other drill, the disaster drill" - No drills were completed "overnight" <p>Interview on 9/4/25 the Qualified Professional (QP) reported:</p>	V 114		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL091-107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/05/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HOUSE OF BLESSINGS II	STREET ADDRESS, CITY, STATE, ZIP CODE 48 CHEATHAM LANE HENDERSON, NC 27537
--	--

(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 114	<p>Continued From page 9</p> <ul style="list-style-type: none"> - The Licensee was responsible for fire and disaster drills - Asked the clients "where they would go and what they would do" for a fire or disaster "but never asked if they (drills) are being done" - Shifts for the facility were 7AM to 3PM, 3PM to 11PM, and 11PM to 7AM <p>Interview on 9/4/25 the Licensee reported:</p> <ul style="list-style-type: none"> - Staff completed fire and disaster drills - There was no schedule for when the drills were to be completed - The facility supervisor and the QP "review the drills book" - Shifts for the facility were 7AM to 3PM, 3PM to 11PM, and 11PM to 7AM <p>This deficiency has been cited 3 times since the original cite on 8/15/23 and must be corrected within 30 days.</p>	V 114		
V 118	<p>27G .0209 (C) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</p> <p>(c) Medication administration:</p> <p>(1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs.</p> <p>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.</p> <p>(3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications.</p> <p>(4) A Medication Administration Record (MAR) of</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL091-107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/05/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HOUSE OF BLESSINGS II	STREET ADDRESS, CITY, STATE, ZIP CODE 48 CHEATHAM LANE HENDERSON, NC 27537
--	--

(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 118	<p>Continued From page 10</p> <p>all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following:</p> <ul style="list-style-type: none"> (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. <p>(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.</p> <p>This Rule is not met as evidenced by: Based on record review, observation, and interview the facility failed to ensure medications were administered on the written order of a physician for 1 of 3 audited clients (#2). The findings are:</p> <p>Review on 9/5/25 of client #2's record revealed:</p> <ul style="list-style-type: none"> - Admitted 1/25/23 - Diagnoses: Bipolar Disorder; Essential Hypertension; Alcohol Abuse; Pre-Diabetes; Vitamin D Deficiency; Hyperglycemia; Urinary Incontinence - Physician medication orders dated 8/15/25: <ul style="list-style-type: none"> - Mobic 15 milligrams (mg) tablet, take one tablet by mouth every day for inflammation - Neurontin 300 mg Capsule, take one tablet by mouth every day for nerve pain - MAR for September 1 through 5, 2025: 	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL091-107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/05/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HOUSE OF BLESSINGS II	STREET ADDRESS, CITY, STATE, ZIP CODE 48 CHEATHAM LANE HENDERSON, NC 27537
--	--

(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 118	<p>Continued From page 11</p> <ul style="list-style-type: none"> - Mobic 15 mg tablet, take one tablet by mouth daily as needed for inflammation - Neurontin 300 mg Capsule, take one capsule by mouth 3 times a day as needed for nerve pain - No documentation of Mobic or Neurontin being administered - No physician orders to discontinue or change administration for Mobic or Neurontin <p>Observation on 9/5/25 of client #2's medications revealed:</p> <ul style="list-style-type: none"> - Mobic 15 mg tablet, take one tablet by mouth daily as needed for inflammation - Neurontin 300 mg Capsule, take one capsule by mouth 3 times a day as needed for nerve pain <p>Interview on 9/4/25 and 9/5/25 staff #1 reported:</p> <ul style="list-style-type: none"> - Worked at the facility since 12/1/18 - Only worked the 1st through 8th of each month - Did not know there was no order to change Mobic or Neurontin to as needed for client #2 - The information for client #2's medication was updated on the MAR when she began her shift on 9/1/25 so "thought" the order came in while she was not working <p>Interview on 9/5/25 the Qualified Professional reported:</p> <ul style="list-style-type: none"> - Completed medication reviews "maybe quarterly" because staff, the house supervisor, and the Licensee were responsible for monthly medication reviews - When a medication order is changed by a physician "the pharmacy should send a copy of the change request to the group home" and staff should put it in the chart - "Told staff today (9/5/25) that they need something from the pharmacy or the doctor" 	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL091-107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/05/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HOUSE OF BLESSINGS II	STREET ADDRESS, CITY, STATE, ZIP CODE 48 CHEATHAM LANE HENDERSON, NC 27537
--	--

(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 118	Continued From page 12 before changing the administration of any medication This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (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. (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. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (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 (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	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL091-107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/05/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HOUSE OF BLESSINGS II	STREET ADDRESS, CITY, STATE, ZIP CODE 48 CHEATHAM LANE HENDERSON, NC 27537
--	--

(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 290	<p>Continued From page 13</p> <p>need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body.</p> <p>(d) In facilities which serve clients whose primary diagnosis is substance abuse dependency:</p> <p>(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</p> <p>(2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that a client was capable of remaining in the home or community without supervision affecting 2 of 3 audited clients (#2, #4). The findings are:</p> <p>Review on 9/4/25 of client #2's record revealed:</p> <ul style="list-style-type: none"> - Admitted: 1/25/23 - Diagnoses: Bipolar Disorder; Hypertension; Hyperglycemia; Urinary Incontinence; Alcohol Abuse; Pre-Diabetes; Vitamin D Deficiency - Supervision assessment dated 11/15/24: "Moves about the neighborhood or community with continual staff supervision requiring staff to be within audible, visual and/or physical proximity of the individual" <p>Interview on 9/4/25 client #2 reported:</p> <ul style="list-style-type: none"> - Attended a day program "everyday Monday through Friday" - Used a local public rural transportation 	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL091-107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/05/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HOUSE OF BLESSINGS II	STREET ADDRESS, CITY, STATE, ZIP CODE 48 CHEATHAM LANE HENDERSON, NC 27537
--	--

(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 290	<p>Continued From page 14</p> <p>system to take him to his day program</p> <ul style="list-style-type: none"> - Staff did not ride with him on the local public rural transportation system <p>Review on 9/4/25 of client #4's record revealed:</p> <ul style="list-style-type: none"> - Admitted: 11/16/18 - Diagnoses: Schizophrenia; Hypertension; Type 2 Diabetes; Hyperlipidemia; Depression; Gastroesophageal Reflux Disease; Chronic Kidney Disease; Hyperthyroidism; Bipolar; Aortic Aneurysm - Supervision assessment dated 10/2/24: "Moves about the neighborhood or community with continual staff supervision requiring staff to be within audible, visual and/or physical proximity of the individual" <p>Interview on 9/4/25 client #4 reported:</p> <ul style="list-style-type: none"> - Went "on a bus" to her day program - Staff did not go with her on the "bus" <p>Interview on 9/4/25 staff #1 reported:</p> <ul style="list-style-type: none"> - Each weekday, clients #2 and #4 attended separate day programs and used local public rural transportation systems to get there - No staff rode with clients #2 or #4 to their day programs <p>Interview on 9/5/25 staff #2 reported:</p> <ul style="list-style-type: none"> - "They have [local public rural transportation system]" for client #2 - "I don't know the name of the one that [client #4] uses but it's like [local public rural transportation system]" that client #2 uses - Staff did not ride with clients #2 or #4 to their day programs <p>Interview on 9/4/25 the Qualified Professional (QP) reported:</p> <ul style="list-style-type: none"> - Was responsible for unsupervised time 	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL091-107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/05/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HOUSE OF BLESSINGS II	STREET ADDRESS, CITY, STATE, ZIP CODE 48 CHEATHAM LANE HENDERSON, NC 27537
--	--

(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 290	<p>Continued From page 15</p> <p>assessments</p> <ul style="list-style-type: none"> - None of the clients had unsupervised time to "leave on their own" - "Thought staff were transporting (clients) to programs and groups" <p>Interview on 9/4/25 the Licensee reported:</p> <ul style="list-style-type: none"> - The QP was responsible for unsupervised time assessments - Was responsible for setting up the transportation for clients with the local public rural transportation systems - Told the QP about the transportation systems so "thought" the clients were approved to go to the day programs on their own <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 290		
V 752	<p>27G .0304(b)(4) Hot Water Temperatures</p> <p>10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT</p> <p>(b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors.</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure the temperature of the hot water was maintained between 100-116 degrees Fahrenheit (°F). The findings are:</p>	V 752		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL091-107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/05/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HOUSE OF BLESSINGS II	STREET ADDRESS, CITY, STATE, ZIP CODE 48 CHEATHAM LANE HENDERSON, NC 27537
--	--

(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 752	<p>Continued From page 16</p> <p>Observation on 9/4/25 at approximately 11:18AM of the facility's hot water temperatures revealed:</p> <ul style="list-style-type: none"> - Kitchen sink was 118°F - Client #4 and staff bathroom sink was 119°F and shower was 117°F <p>Review on 9/4/25 of the facility fire drill log revealed:</p> <ul style="list-style-type: none"> - Water temperatures documented monthly on fire drill form - All documented water temperatures were between 100-116°F <p>Interview on 9/4/25 client #1 reported:</p> <ul style="list-style-type: none"> - Been at the facility for 5 years - Set his own water temperature and it was "not hot" <p>Interview on 9/4/25 client #2 reported:</p> <ul style="list-style-type: none"> - Lived at facility for 2 years - He adjusted the water temperatures for his showers and the water temperature was "never too hot" <p>Interview on 9/4/25 client #4 reported:</p> <ul style="list-style-type: none"> - Been at the facility for "almost 10 years" - "Water temperature is pretty good" - "I take a warm shower in the morning" and she set her own water temperature - The water temperature had "never been too hot" <p>Interview on 9/4/25 staff #1 reported:</p> <ul style="list-style-type: none"> - Started at the facility on 12/1/18 - Did not know the water temperature was high - Checked water temperatures monthly and they were never "that high" - Clients did not complain about the temperature of the water 	V 752		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL091-107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/05/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HOUSE OF BLESSINGS II	STREET ADDRESS, CITY, STATE, ZIP CODE 48 CHEATHAM LANE HENDERSON, NC 27537
--	--

(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 752	<p>Continued From page 17</p> <p>Interview on 9/5/25 staff #2 reported:</p> <ul style="list-style-type: none"> - Worked at the facility for 2 months - Water temperature was checked about once a month - Water temperatures were "usually between 110 and 115 give or take" - Clients never complained about the water temperature <p>Interview on 9/4/25 the Quality Professional reported:</p> <ul style="list-style-type: none"> - Staff or the Licensee were responsible for hot water temperatures - No clients complained about water temperature at the facility <p>Interview on 9/4/25 the Licensee reported:</p> <ul style="list-style-type: none"> - Water temperature was checked monthly by staff - Did not know the hot water temperature "was high" - Clients did not complain about the water temperature 	V 752		