

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL073-080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/09/2025
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HOUSE OF PHYLL EMPOWERS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 425 SOUTH MAIN STREET ROXBORO, NC 27573
--	---

(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 complaint survey was completed on 9/9/25. The complaint was substantiated (intake #NC00232718). Deficiencies were cited.

This facility is licensed for the following service category: 10A NCAC 27G .5600B Supervised Living for Minors with Developmental Disability.

This facility is licensed for 6 and has a current census of 3. The survey sample consisted of audits of 2 current clients and 1 former client.

V 000

VIII
Director will perform initial assessment when renewing the case for placement. The initial assessment will include clients presenting problem, needs and strengths, admitting diagnosis, social, family, medical history and assessments. The administrative assistant will verify that it has been completed and filed in residents binder before date of admission.

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

V 111

RECEIVED
OCT 03 2025
DHQR-MH Licensure Sect

Division of Health Service Regulation
LABORATORY DIRECTOR'S USE PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Cortney Hill* DIRECTOR/OWNER: _____ DATE: 10/1/2025

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL073-080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/09/2025
NAME OF PROVIDER OR SUPPLIER HOUSE OF PHYLL EMPOWERS, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 425 SOUTH MAIN STREET ROXBORO, NC 27573		
(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 111	<p>Continued From page 1</p> <p>client's presenting problem shall be documented.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure an admission assessment for 1 of 1 former clients (FC#3) was completed prior to delivery of services. The findings are:</p> <p>Review on 9/8/25 of FC#3's record revealed:</p> <ul style="list-style-type: none"> - Admission date: 5/9/25 - Diagnoses: Autism Spectrum Disorder, Mild Intellectual Developmental Disability, Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder - Discharge date: 8/16/25 - No documentation of an admission assessment <p>Interview on 9/8/25 the House Manager/Qualified Professional (HM/QP) reported:</p> <ul style="list-style-type: none"> - She was the QP for the facility - She had not yet completed admission assessments for new clients entering the facility - The Director/Co-Owner and the Administrator/Co-Owner were responsible for completing admission assessments - She did not know if the admission assessment was completed for FC#3 	V 111		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL073-080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/09/2025
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HOUSE OF PHYLL EMPOWERS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 425 SOUTH MAIN STREET ROXBORO, NC 27573
---	---

(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 111	<p>Continued From page 2</p> <p>Email received from the Director/Co-Owner on 9/9/25 revealed:</p> <ul style="list-style-type: none"> - "We can not locate the original initial assessment (for FC#3) but one was done because the admissions team meets before accepting a new resident. It seems the document was misplaced." <p>Interview on 9/9/25 the Administrator/Co-Owner reported:</p> <ul style="list-style-type: none"> - An admission assessment had been completed for FC#3 but they were unable to locate it - There is a committee that meets prior to new client admissions to review the referral and determine appropriateness - She "decided that we are going to remedy this by putting committee meeting notes on the assessment form" 	V 111		
V 112	<p>27G .0205 (C-D) Assessment/Treatment/Habilitation Plan</p> <p>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN</p> <p>(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.</p> <p>(d) The plan shall include:</p> <ol style="list-style-type: none"> (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 	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL073-080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/09/2025
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HOUSE OF PHYLL EMPOWERS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 425 SOUTH MAIN STREET ROXBORO, NC 27573
--	---

(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 112

Continued From page 3
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

V112
Informed consent is included in our intake packet. we will edit the informed consent statement to be more easily identified. we use a person centered plan as our plan of treatment. we will train the gp to update PCP goals within the first week of treatment.

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed obtain written consent from client guardians and failed to develop and implement goals and strategies to meet the needs for 3 of 3 audited clients (#1, #2 and former client #3). The findings are:

- Review on 9/8/25 of client #1's record revealed:
- Admission date: 6/16/25
 - Diagnoses: Autism Spectrum Disorder (ASD), Post-traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder (ADHD), Children's Arthritis
 - Treatment plan dated 3/18/25 revealed:
 - No goals or strategies identified for implementation by this facility
 - No written consent from guardian

- Review on 9/8/25 of client #2's record revealed:
- Admission date: 5/17/25
 - Diagnoses: ASD, ADHD, Oppositional Defiant Disorder (ODD)

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL073-080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/09/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HOUSE OF PHYLL EMPOWERS, L.L.C	STREET ADDRESS, CITY, STATE, ZIP CODE 425 SOUTH MAIN STREET ROXBORO, NC 27573
---	---

(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 112	<p>Continued From page 4</p> <ul style="list-style-type: none"> - Treatment plan dated 1/29/25 revealed: <ul style="list-style-type: none"> - No goals or strategies identified for implementation by this facility - No written consent from guardian <p>Review on 9/8/25 of former client (FC#3)'s record revealed:</p> <ul style="list-style-type: none"> - Admission date: 5/9/25 - Diagnoses: ASD, ADHD, ODD, Mild Intellectual Developmental Disability - Treatment plan dated 1/28/25 revealed: <ul style="list-style-type: none"> - No goals or strategies identified for implementation by this facility - No written consent from guardian <p>Interview on 9/8/25 the House Manager/Qualified Professional reported:</p> <ul style="list-style-type: none"> - Her duties at the facility included developing treatment plans and attending child and family team meetings - She thought the facility had 4 months after admission to update client treatment plans - The Director/Co-Owner gave her those timeframes - She was working on updating the treatment plan for client #2 - Client #1 had a treatment plan at admission and the facility had not "gotten to the point of needing to update it yet" <p>Interview on 9/9/25 the Administrator/Co-Owner reported:</p> <ul style="list-style-type: none"> - She was not sure of the timeframes for having client treatment plans updated - She agreed that some goals and strategies specific to the facility could have better prepared staff to address clients' needs and prevented some behaviors and incidents - She would ensure that the facility was completing and updating treatment plans 	V 112		
-------	--	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL073-080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/09/2025
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HOUSE OF PHYLL EMPOWERS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 425 SOUTH MAIN STREET ROXBORO, NC 27573
---	---

(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 112 Continued From page 5
appropriately moving forward

V 112

V 114 27G .0207 Emergency Plans and Supplies

V 114

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 completed quarterly and on each shift. The findings are:

- Review on 9/8/25 of the facility's fire and disaster drills from 11/1/24-9/8/25 revealed:
- No day shift fire or disaster drills during the 4th quarter of 2024 (October-December)
 - No overnight shift fire drills during the 1st quarter of 2025 (January-March)
 - No day shift fire drills during the 2nd quarter of 2025 (April-June)

V114
we will update our fire drill/disaster sheet to include one drill for each shift quarterly. The current shift schedule does not have one for every shift. we will retrain the shift leaders on checking once a month to ensure drills are completed.

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL073-080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/09/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HOUSE OF PHYLL EMPOWERS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 425 SOUTH MAIN STREET ROXBORO, NC 27573
---	---

(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 6</p> <p>Interview on 9/8/25 client #1 reported:</p> <ul style="list-style-type: none"> - Did not remember how long he had lived at the facility - The facility did fire and disaster drills - The facility staff woke him up for a tornado drill by banging on his door and it made him really angry - There were maps around the facility to direct him where to go for a fire - For a fire, he would go out the front door <p>Interview on 9/8/25 client #2 reported:</p> <ul style="list-style-type: none"> - He did not recall how long he had lived at the facility - The facility practiced fire and disaster drills <p>Interview on 9/8/25 the Direct Support Professional Lead reported:</p> <ul style="list-style-type: none"> - He had worked at the facility since April 2025 - The facility practiced fire and disaster drills - Drills were completed monthly - The facility staff completed announced and unannounced drills - Announced drills were typically between 4:00 pm and 8:00pm and unannounced drills were typically when clients were sleeping <p>Interview on 9/8/25 the House Manager/Qualified Professional reported:</p> <ul style="list-style-type: none"> - She had worked at the facility since it opened - Drills were supposed to be done on each shift during each quarter - There was a outline the facility staff used to ensure all drills were completed and the staff picked a day and time to complete drills - She had talked to the Director/Co-Owner about revising how drills were completed and scheduling out dates staff was to complete them 	V 114		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL073-080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/09/2025
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HOUSE OF PHYLL EMPOWERS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 425 SOUTH MAIN STREET ROXBORO, NC 27573
---	---

(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	Continued From page 7 Interview on 9/9/25 the Administrator/Co-Owner reported: - The facility had the following shifts: - During summer: day shift was 9:00 am - 9:00 pm and overnight shift was 9:00 pm - 9:00 am - During school year: day shift was 3:00 pm - 9:00 pm and overnight shift was 9:00 pm - 9:00 am - Weekend shifts were 9:00 am - 9:00 pm for day shift and 9:00 pm - 9:00 am for overnight shift year-round - Staff was responsible for completing drills and she thought the system they used was working - She would talk to staff about revising their system	V 114		
V 117	27G .0209 (B) Medication Requirements 16A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name;	V 117		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL073-080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/09/2025
NAME OF PROVIDER OR SUPPLIER HOUSE OF PHYLL EMPOWERS, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 425 SOUTH MAIN STREET ROXBORO, NC 27573	
(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 117	<p>Continued From page 8</p> <p>(C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner.</p> <p>This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure 1 of 2 audited current client's (#1) medications had packaging labels. The findings are:</p> <p>Review on 9/8/25 of client #1's record revealed:</p> <ul style="list-style-type: none"> - Admission date: 6/16/25 - Diagnoses: Autism Spectrum Disorder, Post-traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder, Children's Arthritis - Physician's orders dated 8/15/25 for the following: <ul style="list-style-type: none"> - Aripiprazole 10 milligrams (mg) take 1 tablet by mouth twice daily (mood) - Olanzapine 10 mg take 1 tablet by mouth nightly (anger) <p>Observation at approximately 2:43 pm on 9/8/25 revealed:</p> <ul style="list-style-type: none"> - A bottle of aripiprazole 10 mg with no pharmacy label - A clear resealable plastic bag with client #1's initials and "PM meds (medications)" handwritten 	V 117	<p><i>V117</i></p> <p>We will retrain staff on disposing of single pills that are returned from therapeutic leave. House manager and shift leads will conduct weekly audits on medication closets to make sure there are labels on all medications and no single pills out of labeled packages.</p>

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL073-080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/09/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HOUSE OF PHYLL EMPOWERS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 425 SOUTH MAIN STREET ROXBORO, NC 27573
---	---

(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 117	<p>Continued From page 9</p> <p>on it and inside was one white oval tablet that looked identical to the tablets inside the blister pack medication card for client #1's olanzapine 10 mg</p> <p>Interview on 9/8/25 the House Manager/Qualified Professional reported:</p> <ul style="list-style-type: none"> - She and the Director/Co-Owner were responsible for reviewing medications for compliance - The bottle of aripiprazole 10 mg in client#1's medication bin was something he brought with him at admission - His mother wanted him to finish using all medications in bottles prior to switching to the blister pack medication cards - She did not consider that there was no pharmacy label visible on it - The single tablet in the resealable bag was a medication that his parents returned after therapeutic leave - She thought his parents had popped the tablet out of the blister pack mistakenly and placed it in the resealable bag - Facility staff was "supposed to put it back in the pack" <p>Interview on 9/9/25 the Administrator/Co-Owner reported:</p> <ul style="list-style-type: none"> - It had "been a process with [client #1's] medication. - They had difficulty getting medication orders from client #1's mother when he admitted to the facility - When client #1 admitted to the facility, all his medication was in bottles and the facility used blister pack medication cards so everything had been switched over - She thought "the pill in the bag was when he (client #1) went on therapeutic leave and it came 	V 117		
-------	--	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL073-080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/09/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HOUSE OF PHYLL EMPOWERS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 425 SOUTH MAIN STREET ROXBORO, NC 27573
---	---

(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 117	Continued From page 10 back to us like that" - "That is not the way we send medication with him for therapeutic leave" - "I'll investigate and see what happened and find a solution"	V 117		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (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. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (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. (4) A Medication Administration Record (MAR) of 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: (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. (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.	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL073-080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/09/2025
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HOUSE OF PHYSICIAN EMPOWERS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 425 SOUTH MAIN STREET ROXBORO, NC 27573
---	---

(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> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to keep the MARs current for 2 of 2 current audited clients (#1 and #2). The findings are:</p> <p>A. Review on 9/8/25 of client #1's record revealed:</p> <ul style="list-style-type: none"> - Admission date: 6/16/25 - Diagnoses: Autism Spectrum Disorder (ASD), Post-traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder (ADHD) and Children's Arthritis - Physician's orders dated 8/7/25 for the following: <ul style="list-style-type: none"> - New chapter all flora probiotic gummy take 1 gummy by mouth twice daily (supplement) - Kids gummy multivitamin take 1 gummy by mouth twice daily (supplement) - Physician's order dated 8/15/25 for clonidine hydrochloride (HCl) 0.1 milligram (mg) take 1 tablet by mouth twice daily (ADHD) - Physician's order dated 7/23/25 for aripiprazole 10 mg take 1 tablet by mouth at night (mood) - Physician's orders dated 7/25/25 for the following: <ul style="list-style-type: none"> - Fluticasone 50 micrograms (mcg) take 2 puffs twice daily in each nostril (asthma) - Dulera inhaler 50 mcg take 2 puffs by mouth twice daily (asthma) <p>Review on 9/8/25 of client #1's MARs from 8/17/25 - 8/31/25 revealed:</p>	V 118		
-------	--	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL073-080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/09/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HOUSE OF PHYLL EMPOWERS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 425 SOUTH MAIN STREET ROXBORO, NC 27573
---	---

(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 12</p> <ul style="list-style-type: none"> - No staff initials to indicate administration of medications for the following: <ul style="list-style-type: none"> - New chapter all flora probiotic gummy for 8:00 pm dose on 8/30/25 and 8/31/25 - Kids gummy multivitamin for 8:00 pm dose on 7/12/25 and 7/19/25 - Clonidine HCl 0.1 mg for 8:00 am dose on 7/29/25 and 8/30/25 - Arpiprazole 10 mg on 8/17/25 - Fluticasone 50 mcg for 8:00 pm dose on 6/28/25, 6/29/25 and 7/25/25 - Dulera inhaler 50 mcg for 8:00 pm dose on 6/17/25, 6/20/25 and 7/25/25 <p>Interview on 9/8/25 client #1 reported:</p> <ul style="list-style-type: none"> - He did not remember how long he had lived at the facility - He took his medication daily and there were no issues with medication <p>B. Review on 9/8/25 of client #2's record revealed:</p> <ul style="list-style-type: none"> - Admission date: 5/17/25 - Diagnoses: ASD, ADHD and Oppositional Defiant Disorder - Physician's order dated 5/27/25 for Zyrtec 10 mg take 1 tablet at bedtime (allergies) - Physician's order dated 8/20/25 for clonidine HCl 0.2 mg take 1 tablet at bedtime - Physician's orders dated 7/29/25 for the following: <ul style="list-style-type: none"> - Invega extended release (ER) 1.5 mg take 1 tablet by mouth with 3 mg at bedtime (antipsychotic) - Invega ER 3 mg take 1 tablet by mouth with 1.5 mg at bedtime - Physician's order dated 6/25/25 for cyproheptadine HCl 4 mg take 1/2 tablet by mouth three times daily for appetite encouragement 	V 118		
-------	---	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL073-080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/09/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HOUSE OF PHYLL EMPOWERS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 425 SOUTH MAIN STREET ROXBORO, NC 27573
---	---

(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 13</p> <ul style="list-style-type: none"> - Physician's order dated 8/22/25 for focalin extended release (XR) 10 mg take 1 tablet by mouth every day with 30 mg (ADHD) <p>Review on 9/8/25 of client #2's MARs from 6/1/25 - 8/31/25 revealed:</p> <ul style="list-style-type: none"> - No staff initials to indicate administration of medications for the following: <ul style="list-style-type: none"> - Zyrtec 10 mg on 8/27/25 - Clonidine HCl 0.2 mg on 8/27/25 - Invega ER 1.5 mg on 7/17/25 - Invega ER 3 mg on 7/17/25 and 8/27/25 - Cyproheptadine HCl 4 mg for 8:00 am dose on 8/16/25 - Focalin XR 10 mg on 8/28/25 <p>Interview on 9/8/25 client #2 reported:</p> <ul style="list-style-type: none"> - He did not recall how long he had lived at the facility - Sometimes he "tries to say no" to taking his medication but he always took it - No issues with medication <p>Interview on 9/8/25 the Direct Support Professional Lead (DSP Lead) reported:</p> <ul style="list-style-type: none"> - He had worked at the facility since April 2025 - All client got their medication daily and on time - "We make sure of that" - He reviewed the MAR to ensure everyone was getting their medication - He noticed missing staff initials sometimes and he would follow-up with that staff so they could correct it on the MAR <p>Interview on 9/8/25 the House Manager/Qualified Professional (HM/QP) reported:</p> <ul style="list-style-type: none"> - She had worked at the facility since it opened - She and the Director/Co-Owner reviewed MARs weekly 	V 118		
-------	---	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL073-080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/09/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HOUSE OF PHYLL EMPOWERS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 425 SOUTH MAIN STREET ROXBORO, NC 27573
---	---

(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 14</p> <ul style="list-style-type: none"> - The MARs were reviewed for completion and accuracy - She did not notice the missing initials <p>Interview on 9/8/25 the Director/Co-Owner reported:</p> <ul style="list-style-type: none"> - She was a registered nurse - She and the HM/QP were responsible for checking MARs, which included ensuring everything was initialed as administered and making sure the MARs matched the physicians' order - She taught facility staff to use the "dot method" where they placed a dot to acknowledge a medication was prepared and ready to be administered, and then they initial once it has been administered <p>Interview on 9/9/25 the Administrator/Co-Owner reported:</p> <ul style="list-style-type: none"> - The DSP Lead, HM/QP and the Director/Co-Owner were all responsible for reviewing MARs and ensuring accurate completion - "Everyone has a role in making sure it gets done correctly" <p>Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician</p>	V 118	<p>we will retrain all staff on initialing boxed boxes after med administration by we will also retrain all 10/30 staff on making sure that a second staff member reviews the MAR after giving meds. some of the misted initials were omissions from a clients supplement being out of stock. his parent provide those supplement. we have asked the parents to purchase in bulk so that we do not run out. MARs will be renewed by the house manager weekly.</p>	
-------	---	-------	--	--