STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-642	A. BUILDING: _____ B. WING _____	R 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C R E S T GROUP HOME #4	224 RANDOLPH AVENUE FAYETTEVILLE, NC 28311

(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, complaint and follow up survey was completed on September 19, 2025. The complaint was unsubstantiated (intake #NC00233355). 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 6 and has a current census of 4. The survey sample consisted of audits of 3 current clients.	V 000		
V 107	27G .0202 (A-E) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (a) All facilities shall have a written job description for the director and each staff position which: (1) specifies the minimum level of education, competency, work experience and other qualifications for the position; (2) specifies the duties and responsibilities of the position; (3) is signed by the staff member and the supervisor; and (4) is retained in the staff member's file. (b) All facilities shall ensure that the director, each staff member or any other person who provides care or services to clients on behalf of the facility: (1) is at least 18 years of age; (2) is able to read, write, understand and follow directions; (3) meets the minimum level of education, competency, work experience, skills and other qualifications for the position; and (4) has no substantiated findings of abuse or	V 107		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-642	A. BUILDING: _____ B. WING _____	R 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C R E S T GROUP HOME #4	224 RANDOLPH AVENUE FAYETTEVILLE, NC 28311

(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 107	Continued From page 1 neglect listed on the North Carolina Health Care Personnel Registry. (c) All facilities or services shall require that all applicants for employment disclose any criminal conviction. The impact of this information on a decision regarding employment shall be based upon the offense in relationship to the job for which the applicant is applying. (d) Staff of a facility or a service shall be currently licensed, registered or certified in accordance with applicable state laws for the services provided. (e) A file shall be maintained for each individual employed indicating the training, experience and other qualifications for the position, including verification of licensure, registration or certification. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to have complete personnel records affecting three of three audited paraprofessional staff (staff #1, staff #2, Residential Supervisor) and one of one qualifed professional staff (Executive Director/Qualified Professional (QP)). The findings are: Review on 9/16/25 of staff #1's personnel record revealed: -Date of hire: 6/4/25. -Job title: Direct Support Staff. -No documentation of a written job description	V 107		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-642	A. BUILDING: _____ B. WING _____	R 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C R E S T GROUP HOME #4	224 RANDOLPH AVENUE FAYETTEVILLE, NC 28311

(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 107	Continued From page 2	V 107		

signed by staff member and the supervisor.
-No documentation of educational verification/qualification.

Review on 9/16/25 of staff #2's personnel record revealed:
-Date of hire: 4/21/25.
-Job title: Direct Support Staff.
-No documentation of a written job description signed by staff member and the supervisor.
-No documentation of educational verification/qualification.

Review on 9/16/25 of the Residential Supervisor's personnel record revealed:
-Date of hire: 7/3/24.
-Job title: Residential Supervisor.
-No documentation of a written job description signed by staff member and the supervisor.
-No documentation of educational verification/qualification.

Review on 9/16/25 of the Executive Director/QP's personnel record revealed:
-Date of hire: 4/23/18.
-Job title: Executive Director/QP.
-No documentation of a written job description signed by staff member and the supervisor.

Interview on 9/16/25 the Office Manager stated:
-She was responsible for staff personnel records.
-Staff had not "brought back their signed job descriptions and education experience."
-She would make sure the signed job description and education verification/qualification were in the record.

Interview on 9/16/25 the Executive Director/QP stated:
-The Office Manager was responsible for staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-642	A. BUILDING: _____ B. WING _____	R 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C R E S T GROUP HOME #4	224 RANDOLPH AVENUE FAYETTEVILLE, NC 28311

(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 107	Continued From page 3 records. -He would ensure the records were complete as required.	V 107		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to access the Health Care Personnel Registry (HCPR) before hiring one of three audited paraprofessional staff (#2) The findings are: Record review on 9/16/25 for staff #2 revealed: -Date of hire: 4/21/25. -Date of the HCPR accessed: 4/25/25. Interview on 9/16/25 the Office Manager stated: -She was responsible for accessing the HCPR for staff. -She accessed the HCPR for staff #2 on the first day of orientation on 4/25/25. -She understood that the HCPR should be accessed prior to offer of employment.	V 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-642	A. BUILDING: _____ B. WING _____	R 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C R E S T GROUP HOME #4	224 RANDOLPH AVENUE FAYETTEVILLE, NC 28311

(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 131	Continued From page 4 Interview on 9/16/25 the Executive Director/Qualified Professional stated: -The Office Manager was responsible for accessing the HCPR for staff. -He would ensure that the HCPR was accessed prior to offer of employment for all staff.	V 131		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the	V 132		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-642	A. BUILDING: _____ B. WING _____	R 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C R E S T GROUP HOME #4	224 RANDOLPH AVENUE FAYETTEVILLE, NC 28311

(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 132	Continued From page 5 investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the Health Care Personnel Registry (HCPR) was notified of all allegations against health care personnel. The findings are: Review on 9/16/25 of the facility's records revealed: -There was no evidence of the HCPR notification for the allegation that the Former Assistant Director/Qualified Professional (QP) exploited Client #1's funds when reported to the facility on 8/25/25. Review on 9/16/25 of the Former Assistant Director/QP's personnel record revealed: -Date of hire: 2/14/22. -Date of separation: 8/26/25. -Job title: Assistant Director/QP. Interview on 9/16/25 the Executive Director/QP stated: -The guardian of client #1 reported an allegation of exploitation against the Former Assistant Director/QP of client #1's funds on 8/25/25. -He was responsible for all the HCPR notifications against staff. -He had not reported to the HCPR for the allegation of exploitation against the Former Assistant Director/QP. -He understood that all allegations against health care personnel were to be reported to the HCPR.	V 132		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-642	A. BUILDING: _____ B. WING _____	R 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C R E S T GROUP HOME #4	224 RANDOLPH AVENUE FAYETTEVILLE, NC 28311

(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 366	Continued From page 6	V 366		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-642	A. BUILDING: _____ B. WING _____	R 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C R E S T GROUP HOME #4	224 RANDOLPH AVENUE FAYETTEVILLE, NC 28311

(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 366	Continued From page 7 by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-642	A. BUILDING: _____ B. WING _____	R 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C R E S T GROUP HOME #4	224 RANDOLPH AVENUE FAYETTEVILLE, NC 28311

(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 366	Continued From page 8 available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to implement policies governing their response to level III incidents as required. The findings are: Review on 9/16/25 of client #1's record revealed: -Date of admission: 5/31/21. -Diagnosis of Moderate Intellectual Developmental Disability. Review on 9/16/25 of the Former Assistant Director/Qualified Professional (QP)'s personnel record revealed: -Date of hire: 2/14/22. -Date of separation: 8/26/25.	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-642	A. BUILDING: _____ B. WING _____	R 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C R E S T GROUP HOME #4	224 RANDOLPH AVENUE FAYETTEVILLE, NC 28311

(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 366	Continued From page 9 -Job title: Assistant Director/QP. Review on 9/16/25 of the facility's records revealed: -There were no incident reports for the allegation of exploitation of client #1's funds by the Former Assistant Director/QP. -There was no evidence of internal review to determine risk/cause analysis or development or corrective measures to prevent similar incidents from happening in the future. Interview on 9/16/25 the Executive Director/QP stated: -He was responsible for attending to the health and safety needs of individuals involved in the incident, determining the cause of the incident, developing and implementing corrective measures and developing and implementing measures to prevent similar incidents. -Client #1's guardian reported an allegation of exploitation against the Former Assistant Director/QP with client #1's personal funds on 8/25/25. -The guardian alleged that the Former Assistant Director/QP had used the client's benefit card for personal use. -"I am in the process of doing an internal investigation for the allegation against [Former Assistant Director/QP]." -"I am working on determining the cause of the incident, developing corrective action and measures to prevent similar incidents." -"I understand my responsibility in the response to all incidents."	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-642	A. BUILDING: _____ B. WING _____	R 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C R E S T GROUP HOME #4	224 RANDOLPH AVENUE FAYETTEVILLE, NC 28311

(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 367	Continued From page 10 REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-642	A. BUILDING: _____ B. WING _____	R 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C R E S T GROUP HOME #4	224 RANDOLPH AVENUE FAYETTEVILLE, NC 28311

(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 367	Continued From page 11 obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-642	A. BUILDING: _____ B. WING _____	R 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C R E S T GROUP HOME #4	224 RANDOLPH AVENUE FAYETTEVILLE, NC 28311

(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 367	Continued From page 12	V 367		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to notify the Local Management Entity/Managed Care Organization (LME/MCO) of a level III incident as required. The findings are:

Review on 9/16/25 of the North Carolina Incident Response Improvement System (IRIS) revealed:
-No IRIS report had been submitted for the allegation of exploitation reported to facilty on 8/25/25 against the Former Assistant Director/Qualified Professional (QP) involving client #1's personal funds.

Review on 9/16/25 of client #1's record revealed:
-Date of admission: 5/31/21.
-Diagnosis of Moderate Intellectual Developmental Disability.

Review on 9/16/25 the Former Assistant Director/QP's personnel record revealed:
-Date of hire: 2/14/22.
-Date of separation: 8/26/25.
-Job title: Assistant Director/QP.

Interview on 9/16/25 the Executive Director/QP stated:
-He was responsible for the submission of all IRIS reports.
-The guardian of client #1 reported an allegation of exploitation against the Former Assistant Director/QP of client #1's funds on 8/25/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-642	A. BUILDING: _____ B. WING _____	R 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C R E S T GROUP HOME #4	224 RANDOLPH AVENUE FAYETTEVILLE, NC 28311

(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 367	Continued From page 13 -The guardian alleged that the Former Assistant Director/QP had used the client's benefit card for personal use. -He had not completed an IRIS report for the allegation of exploitation. -"...I just did not have the time and opportunity to follow through what we needed to do as far as reporting." -He understood that an IRIS report was required for all allegations of exploitation within 24 hours. -He would submit an IRIS report "later today."	V 367		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances	V 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-642	A. BUILDING: _____ B. WING _____	R 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C R E S T GROUP HOME #4	224 RANDOLPH AVENUE FAYETTEVILLE, NC 28311

(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 500	Continued From page 14 under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure all instances of alleged	V 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-642	A. BUILDING: _____ B. WING _____	R 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C R E S T GROUP HOME #4	224 RANDOLPH AVENUE FAYETTEVILLE, NC 28311

(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 500	Continued From page 15 exploitation were reported to the local Department of Social Services (DSS). The findings are: Review on 9/16/25 of the facility's records from 8/1/25-9/16/25 revealed no reports of allegations of exploitation to the local DSS. Review on 9/16/25 of client #1's record revealed: -Date of admission: 5/31/21. -Diagnoses of Moderate Intellectual Developmental Disability. Review on 9/16/25 the Former Assistant Director/Qualified Professional (QP)'s personnel record revealed: -Date of hire: 2/14/22. -Date of separation: 8/26/25. -Job title: Assistant Director/QP. Interview on 9/16/25 the Executive Director/QP stated: -On 8/25/25 client #1's guardian reported an allegation of exploitation against the Former Assistant Director/QP regarding client #1's personal funds. -The guardian alleged that the Former Assistant Director/QP had used the client's benefit card for personal use. -He had not reported the allegation of exploitation made on 8/25/25 by client #1's guardian to DSS. -He understood he was required to report all allegations of exploitation to the local DSS.	V 500		
V 752	27G .0304(b)(4) Hot Water Temperatures 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed,	V 752		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-642	A. BUILDING: _____ B. WING _____	R 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C R E S T GROUP HOME #4	224 RANDOLPH AVENUE FAYETTEVILLE, NC 28311

(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	Continued From page 16 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 interviews, the facility's water temperature was not maintained between 100-116 degrees Fahrenheit. The findings are: Observation on 9/16/25 at approximately 10:15 am - 10:45 am revealed: -The hot water temperature at the kitchen sink was 124 degrees Fahrenheit. -The hot water temperature at the sink in the half bathroom was 121 degrees Fahrenheit. -The hot water temperature in the bathroom with the walk in shower was 122 degrees Fahrenheit at the sink and 117 degrees Fahrenheit at the shower. -The hot water temperature in the bathroom with the shower/bathtub combination was 117 degrees Fahrenheit at the sink. Review on 9/16/25 of the facility's water temperature log form revealed: "Instructions: Water temperature should be checked twice daily....Acceptable temperature range: 105 degrees Fahrenheit to 120 degrees Fahrenheit...." Interview on 9/17/25 client #1 stated: -"The hot water is good, it's alright." -He was able to adjust the water temperature.	V 752		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-642	A. BUILDING: _____ B. WING _____	R 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C R E S T GROUP HOME #4	224 RANDOLPH AVENUE FAYETTEVILLE, NC 28311

(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	Continued From page 17 Interview on 9/16/25 client #2 stated: -"The hot water feels incredible, it helps rest my body.... I can adjust the temperature to make sure nothing is too hot or too cold." Interview on 9/16/25 client #3 stated: -"The hot water is just right. I know how to turn (adjust) the water to make it feel just right." Interview on 9/16/25 staff #1 stated: -"The clients have not complained to me about the hot water." -Staff checked the hot water temperatures twice a day. -"I noticed for the past two months that it was hotter than normal. It was reading at 116-118 when I first started now it is reading at 121-123 (degrees Fahrenheit)." -"I don't know of any staff reporting the hot water being too hot to maintenance." -All clients were able to adjust the water temperatures. Interview on 9/16/25 staff #2 stated: -Staff checked the hot water temperatures twice a day. -No client had complained about the hot water being "too hot." -All clients were able to adjust the water temperatures. Interview on 9/16/25 the Residential Supervisor stated: -No client had complained about the hot water being "too hot." -All clients were able to adjust the hot water temperatures. -Staff measured hot water temperatures twice daily. -"The water log form showed acceptable	V 752		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-642	A. BUILDING: _____ B. WING _____	R 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C R E S T GROUP HOME #4	224 RANDOLPH AVENUE FAYETTEVILLE, NC 28311

(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	Continued From page 18 temperature ranges from 105 degrees Fahrenheit and 120 degrees Fahrenheit." -"I will make the adjustment to the water log today. I will request maintenance to come out and adjust the hot water." Interview on 9/16/25 the Executive Director/QP stated: -"I gave [Residential Supervisor] training on what DHSR (Division of Health Service Regulation) expects, I told him about the temperatures 1 week ago." -The Residential Supervisor sent a maintenance order in today for the hot water temperature adjustment. -He would follow up with the Residential Supervisor to ensure the hot water was between 100-116 degrees Fahrenheit. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 752		
V 774	27G .0304(d)(7) Minimum Furnishings 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (d) Indoor space requirements: Facilities licensed prior to October 1, 1988 shall satisfy the minimum square footage requirements in effect at that time. Unless otherwise provided in these Rules, residential facilities licensed after October 1, 1988 shall meet the following indoor space requirements: (7) Minimum furnishings for client bedrooms shall include a separate bed, bedding, pillow, bedside table, and storage for personal belongings for each client.	V 774		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-642	A. BUILDING: _____ B. WING _____	R 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C R E S T GROUP HOME #4	224 RANDOLPH AVENUE FAYETTEVILLE, NC 28311

(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 774	Continued From page 19	V 774		

This Rule is not met as evidenced by:
Based on observation and interviews the facility failed to have minimum furnishings for a client bedroom which included a separate bed, bedding, pillow, bedside table and storage for personal belongings. The findings are:

Observation on 9/16/25 from approximately 10:15 am - 10:45 am revealed:
-Vacant bedroom #1 did not have a bed, bedding, pillow, bedside table or storage for personal belongings.
-Client #2's bedroom did not have a bed frame, the box spring and mattress was on the floor.

Interview on 9/16/25 with client #2 was unsuccessful due to he did not answer questions about his bed. He looked around the room and stated random sentences.

Interview on 9/16/25 staff #1 stated:
-Client #2's bed had been broken for "a month or two."
-She did not know how the bed got broken.
-She reported the broken bed to the Residential Supervisor.

Interview on 9/16/25 staff #2 stated:
-"We (staff) fixed it (bed frame), but for some reason the boards under the bed would still sink in."
-The bed had been broken about a month or two.
-"I did talk to another staff and he said that [client #2] prefers to sleep on the floor."

Interview on 9/16/25 the Residential Supervisor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-642	A. BUILDING: _____ B. WING _____	R 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C R E S T GROUP HOME #4	224 RANDOLPH AVENUE FAYETTEVILLE, NC 28311

(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 774	Continued From page 20 stated: -Client #2's broken bed frame was in a storage room. -"The bed frame had been broken since July or August (2025)". Interview on 9/16/25 the Executive Director/Qualified Professional stated: -"[Client #2] did not want a regular bed, he used a box spring and mattress, to my understanding that is his preference." -"I know that if a client is in the room they need the basic furnishing, as we admit clients we make sure they have the minimum furnishing." -He would ensure that all client bedrooms had the minimum furnishing required.	V 774		