Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-877	A. BUILDING: _____ B. WING _____	R-C 09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE HOME-PHILLIP STREET	1008 PHILLIP STREET GARNER, NC 27529

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on 9/4/25. The complaints were substantiated (Intake #NC00232045 and #NC00232126). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 6 and has a current census of 5. The survey sample consisted of audits of 2 current clients and 2 former clients. Sister facilities are identified in this report. The sister facilities will be identified as A and B. Clients will be identified using the letter of the facility and a numerical identifier.	V 000		
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, malden); (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	V 113	V113 Client Records The QP and administrator will conduct quarterly review of records and ensure that documentation is present for any client who elopes, misses medical appts or is hospitalized. Should a client be issued a notice of discharge for nonpayment of room and board this information will be available and included in the notice of discharge. The specific amounts of money, missed payments, etc.. will be included in that documentation. An IRIS report will be completed for any client who elopes, has contact with law enforcement or is hospitalized for mental health or substance issues.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Gloria Ross BA, QP 10/12/25

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V 113	Continued From page 1 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; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain complete records affecting 1 of 2 former clients (FC#6) who was a client of the facility on 6/25/25. The findings are: Review on 8/15/25 of FC#6's record revealed: - Admission date: 2/20/23 - Diagnoses: Schizoaffective Disorder Depressed Type, Attention Deficit Disorder by history, Cocaine Use Disorder, Polysubstance Abuse Disorder, Thyroid Disease by history	V 113		

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V 113	Continued From page 2 - Discharge date: 7/1/25 - No documentation of missed appointments - No documentation of room and board payments or missed payments Attempted review on 8/26/25 of police records from FC#6's elopement on 5/15/25 was unsuccessful as no documentation was available. Attempted review on 9/2/25 of documentation of FC#6's drug screenings while living in the facility was unsuccessful as no documentation was available. Attempted review on 9/2/25 of emergency medical services (EMS) and hospital records related to FC#6's hospitalization on 6/25/25 was unsuccessful as no records were at the facility. Review on 8/20/25 of local police department report dated 5/16/25 revealed: - Staff #1 called EMS at 12:48 am to report that FC#6 had left the facility at approximately 9:00 pm and not returned - A local police officer was dispatched to the facility to gather information about FC#6's elopement Review on 8/20/25 of local EMS records dated 6/25/25 revealed: - A call was placed from the facility at 1:55 am and EMS arrived at the facility at 2:03 am - FC#6 reported that he took 3000 milligrams of gabapentin and requested EMS transport to a local hospital - FC#6 was standing with a local police officer when EMS arrived - EMS transported FC#6 from the facility to the local hospital at 2:12 am	V 113		

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V 113	Continued From page 3 Review on 8/26/25 of local hospital emergency department records dated 6/25/25 revealed: - FC#6 "presents with EMS after gabapentin overdose. States he was attempting to get high. Denies self-harm. However, states his bipolar is worse than normal and would like to talk to a psychiatrist. Patient (FC#6) evaluated by BHC (behavioral health counselor) who recommends voluntary admission for mania and possible psychosis. Patient is agreeable. Plan for inpatient referral under voluntary status. If patient attempts to leave, he will be IVC'ed (involuntarily committed)." - "Patient shares 'it was not my medications. The dumb a*s group home left the medications out so I took them to get high.'" - FC#6 was scheduled for transfer to a local psychiatric hospital on 6/25/25 at 5:00 pm Interviews on 8/18/25 and 8/20/25 FC#6's Department of Social Services (DSS) legal guardian reported: - She had met with the Registered Nurse/Administrator/Owner (RN/Admin/Owner) and the Qualified Professional (QP) at the facility in May 2025 - At that meeting, she was provided paperwork from FC#6's most recent psychiatric hospitalization, including a drug test showing he was positive for cocaine and methamphetamine - It was determined during the meeting that FC#6 would need to attend all future doctor's appointments and undergo drug testing at those appointments - After that, FC#6 began refusing to attend doctor's appointments - FC#6 was responsible for paying his room and board and he wasn't paying as scheduled - The RN/Admin/Owner "wasn't very good with keeping up with records and she couldn't really	V 113		

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V 113	Continued From page 4 tell me when he paid or what he owed" - FC#6 also eloped from the facility and traveled to another state in May 2025 and she was notified by the facility on the night of his elopement - FC#6 was transported to a local hospital by EMS on 6/25/25 after taking gabapentin - She had had difficulty securing the records from the 6/25/25 hospitalization Interviews on 8/14/25, 8/15/25, 8/20/25, 8/26/25 and 9/4/25 the QP reported: - FC#6 was responsible for paying toward his cost of care and he had not paid since February 2025 and he refused to pay - FC#6 had been given a discharge date of 6/30/25 due to nonpayment of room and board - The RN/Admin/Owner was responsible for securing those payments and keeping those records - FC#6 had tested positive for cocaine and methamphetamine during a psychiatric hospital in March 2025 - She could not find the paperwork from the psychiatric hospital that included the positive drug screening - "I know we have something that showed a positive drug screening" - It was possible that paperwork had been given to FC#6's DSS legal guardian and the guardian had not returned it - FC#6 "disputed it and said he hadn't used drugs but I don't know what happened to those records" - It was decided FC#6 would be drug tested at upcoming doctors' appointments "but he got missing and left and refused to go to the appointment" - She did not have documentation for the missed appointments	V 113		

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V 113	Continued From page 5 - She was notified of the elopement incident with FC#6 on 5/16/25 but did not secure records from the police notification - Initially she believed FC#6 hospitalization on 6/25/25 was medical and it had been described to her as though he "had a seizure or something" - She did not secure the EMS or hospital records from that hospitalization Interview on 9/2/25 the RN/Admin/Owner reported: - FC#6 was not up to date on his room and board payments - She was not sure about having any records for that - She and the QP had met with FC#6 twice at the facility to discuss payments, as well as attending appointments - FC#6 was refusing to attend appointments and intentionally missing them - Not sure about any hospital or police records - She and the QP were responsible for keeping client records up to date	V 113		
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,	V 118	V118 Medication Requirements The administrator will ensure that all staff are inserviced on medication administration and documentation. This training should include protocols for contacting the appropriate prescriber when medications are missed or refused to notify them of this incident. After 3 consecutive missed administrations for medications that are expected to be administered, the QP will complete an incident report outlining missed medication,	

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V 118	Continued From page 6 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. This Rule is not met as evidenced by: Based on record review and interview the facility failed to administer medications on the written order of a physician and failed to keep the MARs current for 2 of 2 former clients (former client #6 and former client #7) who were clients of the facility on 6/25/25. The findings are: Finding A. Review on 8/15/25 of former client (FC#6)'s record revealed: - Admission date: 2/20/23 - Diagnoses: Schizoaffective Disorder Depressed Type, Attention Deficit Disorder by history, Cocaine Use Disorder, Polysubstance Abuse Disorder, Thyroid Disease by history - Discharge date: 7/1/25	V 118	reasons for missed medication and any instructions provided by the prescriber. The administrator will ensure that additional training is provided to ensure compliance when necessary. The administrator or QP will address any directions given by the physician and will ensure training is provided to the staff and client as appropriate.	

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V 118	Continued From page 7 - FL2 signed by a physician dated 3/11/25 for vitamin D2 1.25 milligram (mg) 5000 units take one capsule by mouth twice weekly (supplement) Review on 8/20/25 of FC#6's MARs from 4/1/25-6/25/25 revealed: - Vitamin D2 was scheduled for administration on Tuesday and Wednesday of each week - For April and May of 2025, there were no staff initials that indicated vitamin D2 was administered on 4/15/25, 4/16/25, 4/22/25, 4/23/25, 4/29/25, 5/14/25, 5/20/25, 5/21/25, 5/27/25, 5/28/25 - From June 1-25, 2025, there were no staff initials to indicate vitamin D2 was administered Interview on 8/20/25 staff #1 reported: - He had worked at the facility since May 2025 - FC#6 consistently took medication and only missed medication if he was not at the facility - If FC#6 did not take medication due to being at work or otherwise out of the facility, he left the MAR blank - He did not know to indicate why a medication was missed or not given on the MAR Interview on 8/20/25 the Qualified Professional (QP) reported: - For some of those dates, the facility was waiting on FC#6's vitamin D2 from the pharmacy - She had contacted the pharmacy regarding a refill and the pharmacy had to request a refill from the physician Finding B. Review on 8/15/25 of FC#7's record revealed: - Admission date: 6/7/23 - Diagnoses: Anxiety Disorder, Unspecified Psychosis, Multiple Sclerosis - Discharge date: 7/7/25 - FL2 dated 5/27/25 with the following:	V 118		

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V 118	Continued From page 8 - Gabapentin 300 mg take one capsule by mouth three times daily (nerve pain) - Baclofen 10 mg take two tablets by mouth three time daily (multiple sclerosis) Review on 8/20/25 of FC#7's MARs from 4/1/25-6/25/25 revealed: - No staff initials that indicated gabapentin and baclofen were administered for 2:00 pm dose on 5/11/25, 5/14/25, 5/22/25, 6/6/25, 6/7/25, 6/8/25, 6/11/25, 6/12/25, 6/13/25 Interview on 8/15/25 FC#7 reported: - He lived at the facility for about 2 years - He took his medication consistently - He had unsupervised time and would go to the gym or other places during the day Interview on 8/20/25 staff #1 reported: - There were "a couple of times" that FC#7 was out of the facility during his 2:00 pm dose of medication - FC#7 did not self administered medications, so he did not give FC#7 medication to take if he was going to be out of the facility at the time medications were scheduled to be given - FC#7 was consistent with his medication Interview on 8/20/25 the QP reported: - Staff #1 should have been noting on the MAR if a medication was not given and why - She provided additional training to staff #1 on accurate and complete medication documentation - She and the Registered Nurse/Administrator/Owner were responsible for checking MARs quarterly to ensure accurate documentation and to ensure orders matched the MARs - She did not realize that there were missing	V 118		

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V 118	Continued From page 9 initials on FC#6 and FC#7's MARs Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician	V 118		
V 119	27G .0209 (D) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction. (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge.	V 119	119 Medication Requirements Medication training will be provided immediately by the administrator or designee. As of 9/8/25 medication training was completed for the staff in this home. Expired and spilled/loose medications shall be disposed of by flushing into a septic or sewer system (with a witness), or by transfer to a local pharmacy for destruction. Any excess medication, overages, expired or discontinued medications will be collected by the administrator or QP on no less than a weekly basis or when staff makes notification that a medication needs to be removed from the facility.	

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V 119	Continued From page 10 This Rule is not met as evidenced by: Based on record review and interview the facility failed to dispose of medications in a manner that guards against diversion or accidental ingestion affecting 3 of 4 former clients (FC#7, FC#8 and FC#9) and failed to dispose of the remainder of discharged clients' medication supplies affecting 2 of 4 former clients (FC#8 and FC#9). The findings are: Review on 8/15/25 of FC#7's record revealed: - Admission date: 6/7/23 - Discharge date: 7/7/25 Review on 8/20/25 of FC#8's record revealed: - Admission date: 3/11/21 - Discharge date: 7/27/21 Review on 8/19/25 of FC#9's record revealed: - Admission date: 6/5/20 - Discharge date: 4/10/25 Review on 8/20/25 of a picture taken by FC#7 and timestamped 6/25/25 at 1:30 am revealed: - Pharmacy blister medication card with 30 sealed blisters that contained white round tablets and a pharmacy label that included: - FC#7's name - "Baclofen 20 mg (milligrams) tablet" - "Take 1 tablet by mouth three times daily for pain" - Filled: 7/14/2023 - Discard after: 7/14/2024 Review on 8/27/25 of a picture taken by FC#7	V 119		

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V 119	Continued From page 11 and timestamped 6/25/25 at 3:56 pm revealed: - Pharmacy blister medication card lying on the ground with visible blades of grass that showed 6 sealed blisters containing 1 and 1/2 brown oval tablets each, number and content of additional blisters unknown due to not being visible in this picture and a pharmacy label that included: - FC#8's name - "Citalopram HBR (hydrobromide) 20 mg tablet" - "Take 1 and 1/2 tablets by mouth every day for mood" - "Filled: 12/26/2020" - "Discard after: 12/26/2021" Review on 8/27/25 of a picture taken by FC#7 and timestamped 6/25/25 at 1:31 am revealed: - Pharmacy blister medication card with 36 sealed blisters that contained 1 brown and beige capsule each, 24 empty blisters, and 2 blisters not visible with a pharmacy label that included: - FC#8's name - "Gabapentin 300 mg capsule" - "Take one capsule by mouth three times daily with meals" - "Filled: 10/2/2020" - "Discard after: 10/2/2021" Review on 8/27/25 of a picture taken by FC#7 and timestamped 6/25/25 at 3:50 pm revealed: - Pharmacy blister medication card with at least 19 sealed blisters containing 2 small blue oval tablets each, number and content of additional blisters unknown due to not being visible and a pharmacy label that included: - FC#9's name - "Olanzapine 15 mg tablet" - "Take two tablet by mouth at bedtime" - "Filled: 9/25/2019" - "Discard after: 9/19/2020"	V 119		

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V 119	Continued From page 12 Review on 8/20/25 of local emergency medical services (EMS) records dated 6/25/25 revealed: - A call was placed from the facility at 1:55 am and EMS arrived at the facility at 2:03 am - FC#6 reported that he took 3000 mg of gabapentin and requested EMS transport to a local hospital - EMS transported FC#6 from the facility to the local hospital at 2:12 am Review on 8/26/25 of local hospital emergency department records dated 6/25/25 revealed: - FC#6 "presents with EMS after gabapentin overdose. States he was attempting to get high. Denies self-harm..." - "Patient (FC#6) shares 'it was not my medications. The dumb a*s group home left the medications out so I took them to get high.'" Interview on 8/28/25 FC#6 reported: - He was "a hard drug addict" with a history of cocaine and methamphetamine use - On 6/25/25, he took 3000 mg of gabapentin - He found the medication in a trash bag that was in an unlocked outdoor storage room at the facility - He sorted through all the medication and found gabapentin - He left some medications in the trash bag in the outdoor storage room and only took what he wanted - "There were all kinds of pills in there. They were old" - Informed client #1 and FC#7 that he had taken the gabapentin and they helped him "get rid of those drugs" by flushing them - "That dose of gabapentin got me really manic and my blood pressure was very high" - 6/25/25 was not the first time he took any of	V 119		

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	MHL092-877	A. BUILDING: _____ B. WING _____	R-C 09/04/2025

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V 119	Continued From page 13 the expired medication that he found, but he did not remember when he initially discovered the expired medication in the unlocked outdoor storage room Interview on 8/14/25 client #1 reported: - He had lived at the facility since 12/31/24 - "Sometime in June" 2025, FC#6 took "old medicine" and "tried to overdose" - FC#6 got the medication from an unlocked outdoor storage room where it was being stored with other medication - The Qualified Professional (QP) had since picked up the medication and returned it to the pharmacy - FC#6 informed him and FC#7 that he had taken the medication - The medication FC#6 took "was [FC#7's] old medication" - He did not know the expired medication was in the unlocked outdoor storage room until FC#6 told him - FC#6 "came and said he thought he needed to go to the hospital because he had taken too much medication" - FC#6 "handed him a bookbag full of old medicine" - FC#6 "said he took it because he wanted them (facility staff) to know how easy it was to get to the medication" Interview on 8/28/25 client #1 reported: - He "assumed [the QP] removed the medication from that closet (outdoor storage room) because she is normally the one that takes old medication to the pharmacy" but he did not see her remove it Interviews on 8/15/25 and 8/20/25 FC#7 reported: - He lived at the facility for about 2 years	V 119		

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V 119	Continued From page 14 - The facility had stored expired medication in an unlocked outdoor storage room - The expired medication was not removed until FC#6 "got ahold of it and overdosed on it" - On 6/25/25, FC#6 took gabapentin and told client #1 he wasn't feeling well because he had taken expired medication - The gabapentin that FC#6 took was not prescribed to him or FC#6 - He took pictures of the medication that FC#6 had as well as the medication that was still in the unlocked storage closet - FC#6 gave him and client #1 the remainder of the medication FC#6 had and asked them to flush it - FC#6 asked client #1 to call EMS and when they arrived, he told them he had taken expired gabapentin - The Registered Nurse/Administrator/Owner (RN/Admin/Owner) and the QP knew that the medication was at the facility and that it was in an outside storage room - The medication was removed from the facility by the QP after FC#6 had gone to the hospital Interview on 8/18/25 FC#6's Department of Social Services (DSS) legal guardian reported: - FC#6 had a history of methamphetamine and cocaine abuse - FC#6 was discharged from the facility after he took another client's expired medication - FC#6 reported the medication he took was gabapentin - FC#6 reported he got the medication from an unlocked outdoor storage room - FC#6 felt he took too much and went to the hospital - The QP notified her that FC#6 took gabapentin from a client's room at the facility and that the medication was expired	V 119		

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V 119	Continued From page 15 Interview on 9/3/25 FC#6's DSS legal guardian reported: - FC#6 told her he took the expired medication from the medication closet at the facility and the closet was unlocked Interviews on 8/14/25 and 8/20/25 staff #1 reported: - He had worked at the facility since May 2025 - All medication was stored in the locked medication closet - When a medication was discontinued or expired, he wrote "discharged" on it and put it aside in the medication closet until the QP returned it to the pharmacy - Discontinued or expired medication was regularly removed by the QP and there had not been any excess supply of expired medication - Never made aware of any medication that was stored in an outside storage room - Had never been in the outdoor storage room until 8/20/25 - If anything had been stored in the outdoor storage room and removed prior to 8/20/25, he would not be aware of it - On 6/25/25, he was sleeping and client #4 woke him up because EMS and the local police department were at the facility - Client #1 had called EMS for FC#6 - He knew FC#6 went to the hospital but did not know any of information about what happened Interview on 8/26/25 former staff (FS#2) reported: - She had worked at the facility for a year and left around October of 2024 - FC#6 and FC#7 lived at the facility while she worked there - She had not returned to the facility since she	V 119		

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V 119	Continued From page 16 left - When she worked at the facility, "there was some old medication but I had locked it in the med (medication) closet" - The medication was in a black trash bag and she did not inform the RN/Admin/Owner or the QP that it was in the medication closet - The medication in the black trash bag was still in the medication closet when her employment at the facility ended Interview on 8/14/25 the QP reported: - She was initially told that FC#6 went to the hospital on 6/25/25 because "he may have had a seizure or something" - Today, client #1 changed the details of the story and told her that FC#6 had "a bag of all types of drugs in his bookbag" - Client #1 also told her that FC#6 got the medication from the outdoor storage room - Client #1 claimed he had shown her the medication in the outdoor storage room, but this was the first she had heard of it - The facility did not store medication in an outdoor storage room and had a locked medication closet where all medications were stored - "There is no way we would leave medication, expired or otherwise, in the shed (outdoor storage room) when we have a double locked door to store that stuff (clients' medications)" - The outdoor storage room was not often checked for content because nothing was ever placed in there - Client #1 told her today that FC#6 had taken expired gabapentin but that he also had a bookbag full of other old medications he took from the outdoor storage room Interviews on 8/20/25 and 8/29/25 the QP	V 119		

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V 119	Continued From page 17 reported: - FC#8 had lived at the facility in 2021 - There was no reason his medication would still be at the facility - "Once you said [FC#8], I gave up" - "If that medicine was in that closet (outdoor storage room), I never knew and I have no idea where it went" - "I never went in that closet and took anything out" - "He's (FC#8) been gone so long I don't know if maybe the pharmacy delivered them (FC#8's medication). No idea why they would be in another location other than a locked closet" - She did not tell FC#6's DSS legal guardian that he had taken another client's expired medication because she did not know until 8/14/25 - She had been in the outdoor storage room "once or twice months ago because a client had left and we went looking for their clothing" - She did not know if the outdoor storage room locked but did not remember needing a key when she accessed it - Confirmed that FC#9 had lived at the facility and had discharged 4/10/25 Interviews on 9/2/25 and 9/4/25 the QP reported: - It was her and the RN/Admin/Owner's responsibility to remove expired, discontinued and discharged clients' medication from the facility - Facility staff were to notify her or the RN/Admin/Owner of any expired or discontinued medication at the facility - "If I had known that medication was there, we would have been taken that medication out of there" - "I think we're (her and the RN/Admin/Owner) going to go through and search the house	V 119		

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V 119	Continued From page 18 (facility) again because there's another shed out there" - "This (the medication being in the outdoor storage room) was wrong and I know it's wrong. I expected it to be worse" Interview on 9/2/25 the RN/Admin/Owner reported: - She and the QP were responsible for removing medications from the facility - "Sometimes staff packs them (medications) up and the pharmacy comes and gets them" - All medications for the facility were stored in the locked medication closet, including expired medication - Was aware of EMS being called for FC#6 but did not recall the date - It was suspected that FC#6 had taken something, but she did not know what happened - Heard that FC#6 said he had gotten medication from the outdoor storage room but she did not have any knowledge of medications being there or when they would have been put there or by whom - The outdoor storage room was not used to store old or expired medication - "No idea how the medication issues would have happened" - "I have no idea how medications that were there for so long would be there" - "I don't like extra medications around to avoid any confusion " - "I go and clean up and remove everything and I like meds to be really organized and clean to reduce confusion" - "If I take any medicine from the med closet, it will go straight to my car" This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements	V 119		

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V 119	Continued From page 19 (V120) for a Type A1 and must be corrected within 23 days.	V 119		
V 120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure all medications were stored securely affecting 5 of 5 current clients (#1 - #5) and 2 of 2 former clients (FC#6 and FC#7) who were clients of the facility on 6/25/25. The findings are:	V 120	V120 Medication Requirements Effective immediately, any current, discontinued or expired medications will be properly stored in a locked storage area, double locked storage box (as appropriate). At no time will any medications be stored away from the designated locked storage closet. If any medication is delivered to the facility that is not prescribed for a member of that group home, then the staff shall not accept the delivery of that medication. Additionally, when a client is discharged the medications will be removed from the facility at the time of that person's discharge. It will be sent with the client, guardian, other designated person or delivered to the contracted pharmacy for disposal.	

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V 120	Continued From page 20 CROSS REFERENCE: 10A NCAC 27G .0209 Medication Requirements (V119). Based on record review and interview the facility failed to dispose of medications in a manner that guards against diversion or accidental ingestion affecting 3 of 4 former clients (FC#7, FC#8 and FC#9) and failed to dispose of the remainder of discharged clients' medication supplies affecting 2 of 4 former clients (FC#8 and FC#9). Review on 8/14/25 of client #1's record revealed: - Admission date: 12/31/24 - Diagnoses: Unspecified Bipolar Disorder, Attention Deficit Hyperactivity Disorder, Mild Intellectual Developmental Disorder Review on 8/14/25 of client #2's record revealed: - Admission date: 8/14/24 - Diagnoses: Major Depressive Disorder, Agoraphobia with Panic Disorder, Generalized Anxiety Disorder, Hypertension Review on 9/4/25 of client #3's record revealed: - Admission date: 8/1/25 - Diagnoses: Major Depressive Disorder, Nontraumatic Intracerebral Hemorrhage, Dysphagia, Aphasia, Osteoarthritis of the right knee, Hyperlipidemia, History of Alcohol Abuse, History of Psychoactive Substance Abuse Review on 9/4/25 of client #4's record revealed: - Admission date: 5/1/25 - Diagnosis: Schizoaffective Disorder Review on 9/4/25 of client #5's record revealed: - Admission date: 6/4/20 - Diagnoses: Chronic Undifferentiated Schizophrenia, Hypertension, Increased cholesterol	V 120		

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V 120	Continued From page 21 Review on 8/15/25 of FC#6's record revealed: - Admission date: 2/20/23 - Diagnoses: Schizoaffective Disorder Depressed Type, Attention Deficit Disorder by history, Cocaine Use Disorder, Polysubstance Abuse Disorder, Thyroid Disease by history - Discharge date: 7/1/25 Review on 8/15/25 of FC#7's record revealed: - Admission date: 6/7/23 - Diagnoses: Anxiety Disorder, Unspecified Psychosis, Multiple Sclerosis - Discharge date: 7/7/25 Review on 8/19/25, 8/20/25 and 8/27/25 of pictures taken by FC#7 with no timestamp revealed: - Multiple medications inside a black trash bag that included: - The back of a multi-dose pre-sorted medication package that had no visible pharmacy label with approximately 7 visible blisters with 4 medications in each including a blue and beige capsule, a green and beige capsule and 2 round white tablets, 14 blisters visible but of unknown content, and the number and content of additional blisters was unknown due to not being visible in this picture - The front of 8 blisters from a multi-dose pre-sorted medication package with a pharmacy label that was unreadable - An open box of an unknown medication with no visible pharmacy label - 2 brown pharmacy pill bottles with unknown contents and no visible pharmacy label - The back of 2 pharmacy blister medication cards of an unknown medication that had no visible pharmacy label, approximately 26 sealed blisters, and number and content of remaining blisters was unknown as they were not	V 120		

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V 120	Continued From page 22 visible in this picture - The side view of a pharmacy blister medication card with an least 5 empty blisters, 5 that remained sealed, no visible pharmacy label and the number and content of the remaining blisters was unknown as they were not visible in this picture - A gloved hand that was holding an open brown pharmacy pill bottle with at least 11 white capsules and no visible pharmacy label - A small clear plastic resealable bag with an unreadable pharmacy label and 2 individual blister pill packets inside, including one that remained sealed with a small white oval tablet and one that was empty, and 7 individual blister pill packets lying outside the bag that all remain sealed with small white oval tablet - A bowl of a toilet with approximately one-third of the surface of the water covered with brown and beige capsules - A blue reusable shopping bag with the following inside: - A multi-dose pre-sorted medication roll with at least 4 sealed blisters and no visible pharmacy label - The back of a multi-dose pre-sorted medication package with 5 empty blisters, no visible pharmacy label and number and content of remaining blisters unknown due to not being visible in this picture - The front of a pharmacy blister medication card with 4 empty blisters, no visible pharmacy label and number and content of remaining blisters unknown due to not being visible in this picture - The back of a pharmacy blister medication card with 1 empty blister, no visible pharmacy label and number and content of remaining blisters unknown due to not being visible in this picture	V 120		

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V 120	Continued From page 23 - 2 pharmacy blister medication cards with approximately 29 empty blisters, no visible pharmacy label and number and content of remaining blisters unknown due to not being visible in this picture - A blue reusable shopping bag inside a black trash back that was lying on a plywood floor, next to a plywood wall and beneath a wooden shelf that included a pharmacy blister medication card with no visible pharmacy label and number and content of remaining blisters unknown due to not being visible in this picture - A pharmacy blister medication card with at least 21 empty blisters that included: - FC#7's name - "Gabapentin 300 milligrams (mg) capsule" - "Take twice daily for neuropathy" - "3/21/24 may refill" - Number and content of remaining blisters unknown due to not being visible in this picture - A pharmacy blister medication card with an unreadable pharmacy label that contained 30 sealed blisters with small white round tablets - A pharmacy blister medication card with no visible pharmacy label that contained at least 14 empty blisters and number and content of remaining blisters unknown due to not being visible in this picture - A brown pharmacy pill bottle with the lid attached, contents unknown and no visible pharmacy label - A pharmacy blister medication card with an unreadable pharmacy label that contained 30 sealed blisters with brown and beige capsules, 22 empty blisters and number and content of remaining blisters unknown due to not being visible in this picture - Pharmacy blister medication card with no visible pharmacy label and at least 14 empty	V 120		

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V 120	Continued From page 24 blisters and number and content of remaining blisters unknown due to not being visible in this picture - Pharmacy blister medication card with no visible pharmacy label that contained at least 2 sealed blisters with 1 and 1/2 beige oval tablets in each and number and content of additional blisters unknown due to not being visible in this picture Review on 8/20/25 of a picture taken by FC#7 and timestamped 6/25/25 at 3:53 pm revealed: - The back of a multi-dose pre-sorted medication package that included: - FC#A1's name - "Use by: 7/18/24" - Morning column of pre-sorted medication that showed 6 blisters that included: - "Tot (total) Qty (quantity): 6" - "1-duloxetine 30 mg dr (delayed release)" - "1-loratadine 10 mg" - "1-naltrexone hcl (hydrochloride) 50 mg" - "1-quetiapine 200 mg" - "1-topiramate 100 mg" - "1-Vit (vitamin) b-12 1000 mcg (micrograms) tab (tablet)" - Noon column of pre-sorted medication that showed 7 blisters that included: - "Tot Qty: 1" - "1-topiramate 100 mg" - Evening column of pre-sorted medication with 7 blisters that read "Unused" - Bedtime column of pre-sorted medication with 2 blisters of unknown content due to not being visible in this picture - Additional remaining blisters in each column was unknown due to not being visible in this picture	V 120		

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V 120	Continued From page 25 Review on 8/27/25 of a picture taken by FC#7 and timestamped 6/25/25 at 3:50 pm: - Pharmacy blister medication card with at least 3 sealed blisters that contained a small blue oval tablet, 8 empty blisters, number and content of additional blisters unknown due to not being visible in this picture and a pharmacy label that included: - FC#B1's name - "Olanzapine 15 mg tablet" - "Take one by mouth at bedtime" - "Filled: 2/1/2021" - "Discard After: 2/1/2022" - Handwritten at the top of the pharmacy label was "PM D/C (discontinue) 05/04/21" Review on 8/27/25 of a picture taken by FC#7 and timestamped 6/25/25 at 3:51 pm revealed: - Pharmacy blister medication card with at least 4 sealed blisters that contained a small blue oval tablet, number and content of additional blisters unknown due to not being visible in this picture and a pharmacy label that included: - FC#B1's name - "Olanzapine 15 mg tablet" - "Take one by mouth at bedtime" - "Filled: 5/1/2021" - "Discard After: 5/1/2022" Interviews on 8/26/25 and 8/28/25 the Qualified Professional (QP) reported: - FC#A1 had lived at sister facility A and had never lived at this facility - She had "no idea how her medication would have been stored at the facility - "If her medication was there, it could have been delivered by the pharmacy. It would have probably been the same pharmacy as the house (facility) she was at"	V 120		

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	MHL092-877	A. BUILDING: _____ B. WING _____	R-C 09/04/2025

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V 120	Continued From page 26 - FC#B1 had lived at sister facility B and had never lived at this facility - She did not know how his medication would have been stored at the facility Interviews on 9/2/25 and 9/4/25 the QP reported: - It was her and the Registered Nurse/Administrator/Owner (RN/Admin/Owner)'s responsibility to ensure medication was properly stored at the facility - "Still trying to figure it out. How would medication get there from 2 clients (FC#A1 and FC#B1) that had never even been to that house (facility)" Interview on 9/2/25 the RN/Admin/Owner reported: - She and the QP were responsible for ensuring medication was properly stored at the facility by facility staff - "No idea how clients that have never lived at that facility would have medication there" - "I've never heard of the pharmacy delivering meds (medication) there for a client at another facility" - "I don't take meds from one place to another for any reason. That would be extra driving. Why would I do that?" - "If I need to put them somewhere before taking them back (to the pharmacy), I would put them in my personal office" Review on 9/4/25 of the Plan of Protection written by the QP dated 9/4/25 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? - The facility Administrator (RN/Admin/Owner) and QP will do an extensive search of the entire facility in an effort to locate expired and excess medications. If any medications are found they	V 120		

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V 120	Continued From page 27 will be removed from the premises immediately and taken to the pharmacy. The person taking the meds from the facility will get a receipt from the receiver at the pharmacy of all meds to be disposed of. This will be completed by 9/5/25. Describe your plans to make sure the above happens. - The QP or Administrator will conduct a search of the facility at least monthly and document findings which will be stored in the medication administration record." This facility served clients with diagnoses that included, but were not limited to, Schizoaffective Disorder, Cocaine Use Disorder, Polysubstance Abuse Disorder, Unspecified Bipolar Disorder, Attention Deficit Hyperactivity Disorder, Mild Intellectual Developmental Disorder, Major Depressive Disorder, Agoraphobia with Panic Disorder, Generalized Anxiety Disorder, History of Alcohol Abuse and Multiple Sclerosis. The facility had expired and discontinued medication for former clients of this facility and at least 2 sister facilities stored in an unlocked outdoor storage room. On 6/25/25, FC#6 was transported to a local hospital due to an overdose on gabapentin he took from the unlocked outdoor storage room in an attempt to get high. In addition to FC#6, there were other clients with access to the medications and took pictures of the medication in black trash bags and medication poured into toilets for flushing. These unidenitifed medications in blister packs and medication bottles dated back to 2021. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 120		

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V 366	Continued From page 28	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	V366 Incident Response Requirements The QP is responsible for reporting level II and III incidents and entering them into IRIS. All level II and III incidents will be entered into IRIS within 72 hours.	

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V 366	Continued From page 29 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		

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V 366	Continued From page 30 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 incidents as required. The findings are: Review on 8/15/25 of the Incident Response Improvement System (IRIS) revealed: - No level II reports from the facility for former clients (FC#6) Attempted review on 8/15/25 of the facility's incident reports for 6/25/25 was unsuccessful as no reports were provided. There was no evidence of internal review to determine risk/cause analysis or development or corrective measures to	V 366		

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V 366	Continued From page 31 prevent similar incidents from happening in the future. Review on 8/20/25 of local emergency medical services (EMS) records dated 6/25/25 revealed: - A call was placed from the facility at 1:55 am and EMS arrived at the facility at 2:03 am - FC#6 reported that he took 3000 milligrams (mg) of gabapentin and requested EMS transport to a local hospital - FC#6 was standing with the local police department when EMS arrived - EMS transported FC#6 from the facility to the local hospital at 2:12 am Review on 8/26/25 of local hospital emergency department records dated 6/25/25 revealed: - FC#6 "presents with EMS after gabapentin overdose. States he was attempting to get high. Denies self-harm. However, states his bipolar is worse than normal and would like to talk to a psychiatrist. Patient (FC#6) evaluated by BHC (behavioral health counselor) who recommends voluntary admission for mania and possible psychosis. Patient is agreeable. Plan for inpatient referral under voluntary status. If patient attempts to leave, he will be IVC'ed (involuntarily committed)." - "Patient shares 'it was not my medications. The dumb a*s group home left the medications out so I took them to get high.'" - FC#6 was scheduled for transfer to a local psychiatric hospital on 6/25/25 at 5:00 pm Interview on 8/28/25 FC#6 reported: - On 6/25/25, he went to the hospital because he took 3000 mg of gabapentin from an outdoor storage room that was unlocked Interview on 8/14/25 staff #1 reported:	V 366		

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V 366	Continued From page 32 - On 6/25/25, he was sleeping and client #4 woke him up because EMS and the local police department were at the facility - Client #1 had called EMS for FC#6 - He knew FC#6 went to the hospital but did not know any of information about what happened - He notified the Qualified Professional (QP) of the incident Interview on 9/3/25 the Department of Social Services (DSS) legal guardian for FC#6 reported: - On 6/25/25, she spoke with the QP and the QP informed her that FC#6 went to the hospital because he took expired medication from another client's room - She informed the QP that FC#6 reported he got the medication from the unlocked medication closet Interviews on 8/14/25, 8/15/25, 9/3/25 and 9/4/25 the QP reported: - Initially she believed FC#6's hospitalization on 6/25/25 was medical and it had been described to her as though he "had a seizure or something" - She did not secure the EMS or hospital records to confirm the reason for the hospitalization - She could not recall when she talked to FC#6's DSS legal guardian about the 6/25/25 hospitalization - FC#6's DSS legal guardian informed her that FC#6 had taken medication that was not his, but she did not recall when - She knew on 8/14/25 that FC#6 was reporting he took the medication from an unlocked outside storage room - She did not know how or when FC#6 could have gained access to other clients' medication - She had met with staff #1 to review the facility	V 366		

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V 366	Continued From page 33 system for disposing of expired and discontinued medication, as well as medication storage - The meeting with staff #1 was not documented - She was responsible for incident response and follow-up - She and the Registered Nurse/Administrator/Owner (RN/Admin/Owner) would do a full search of the facility on 9/5/25 and implement a monthly facility search that would be documented on the medication administration record	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT 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	V 367	367 Incident Reporting Requirements Level I and II incident reports will be completed and submitted by the QP or designee and will be submitted to the LME/MCO as required. Level II incidents will be submitted within 72 hours.	

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V 367	Continued From page 34 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 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	V 367		

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V 367	Continued From page 35 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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a level II incident report was submitted to the Local Management Entity (LME)/Managed Care Organization (MCO) within 72 hours as required. The findings are: Finding A. Review on 8/15/25 of former client (FC#6)'s record revealed: - Admission date: 2/20/23 - Diagnoses: Schizoaffective Disorder Depressed Type, Attention Deficit Disorder by history, Cocaine Use Disorder, Polysubstance Abuse Disorder, Thyroid Disease by history - Discharge date: 7/1/25 - Discharge summaries local psychiatric	V 367		

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V 367	Continued From page 36 hospitals with the following: - Admission 2/28/25 and discharge 3/12/25 - Admission 3/18/25 and discharge 3/27/25 Review on 8/20/25 of local police department report dated 5/16/25 revealed: - Staff #1 called emergency services at 12:48 am to report that FC#6 had left the facility at approximately 9:00 pm and not returned - A local police officer was dispatched to the facility to gather information about FC#6's elopement Review on 8/20/25 of local emergency medical services (EMS) records dated 6/25/25 revealed: - A call was placed from the facility at 1:55 am and EMS arrived at the facility at 2:03 am - FC#6 reported that he took 3000 milligrams of gabapentin and requested EMS transport to a local hospital - FC#6 was standing with the local police department when EMS arrived - EMS transported FC#6 from the facility to the local hospital at 2:12 am Review on 8/26/25 of local hospital emergency department records dated 6/25/25 revealed: - FC#6 "presents with EMS after gabapentin overdose. States he was attempting to get high. Denies self-harm. However, states his bipolar is worse than normal and would like to talk to a psychiatrist. Patient (FC#6) evaluated by BHC (behavioral health counselor) who recommends voluntary admission for mania and possible psychosis. Patient is agreeable. Plan for inpatient referral under voluntary status. If patient attempts to leave, he will be IVC'ed (involuntarily committed)." - "Patient shares 'it was not my medications. The dumb a*s group home left the medications	V 367		

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V 367	Continued From page 37 out so I took them to get high.'" - FC#6 was scheduled for transfer to a local psychiatric hospital on 6/25/25 at 5:00 pm Interview on 8/28/25 FC#6 reported: - On 6/25/25, he went to the hospital because he took 3000 mg of gabapentin from an outdoor storage room that was unlocked Interview on 9/3/25 the Department of Social Services (DSS) legal guardian for FC#6 reported: - On 6/25/25, she spoke with the Qualified Professional (QP) and the QP informed her that FC#6 went to the hospital because he took expired medication from another client's room - She informed the QP that FC#6 reported he got the medication from the unlocked medication closet - She was notified of the elopement on 5/16/25 by the QP on 5/16/25 Finding B. Review on 8/15/25 of FC#7's record revealed: - Admission date: 6/7/23 - Diagnoses: Anxiety Disorder, Unspecified Psychosis, Multiple Sclerosis - Discharge date: 7/7/25 - Discharge summary from a local psychiatric hospital with an admission date of 5/28/25 and discharge date of 6/4/25 Review on 8/15/25 of the Incident Response Improvement System (IRIS) revealed: - No level II reports from the facility for FC#6 or FC#7 Interview on 8/14/25 staff #1 reported: - He had been working at the facility since May of 2025 - There was an incident with FC#6 in "early	V 367		

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V 367	Continued From page 38 June" when he left the facility and did not return on time so the police were called - On 6/25/25, he was sleeping and client #4 woke him up because EMS and the local police department were at the facility - Client #1 had called EMS for FC#6 - He knew FC#6 went to the hospital but did not know any of information about what happened - He notified the Qualified Professional (QP) of both incidents Interviews on 8/14/25, 8/15/25, 8/20/25 and 8/26/25 the QP reported: - She was responsible for submitting IRIS reports for the facility - She had not completed any IRIS reports for FC#6 or FC#7 - FC#6's hospitalization on 2/28/25 was due to depression and bipolar symptoms - On 3/18/25, FC#6 was IVC'ed by his Department of Social Services (DSS) legal guardian - She was notified of the elopement incident with FC#6 on 5/16/25 - Initially she believed FC#6 hospitalization on 6/25/25 was medical and it had been described to her as though he "had a seizure or something" - She did not secure the EMS or hospital records to confirm the reason for the hospitalization - She could not recall when she talked to FC#6's DSS legal guardian about the 6/25/25 hospitalization - FC#6's DSS legal guardian informed her that FC#6 had taken medication that was not his, but she did not recall when - She knew on 8/14/25 that FC#6 was reporting he took the medication from an unlocked outside storage room	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-877	A. BUILDING: _____ B. WING _____	R-C 09/04/2025

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V 367	Continued From page 39 - The hospitalization for FC#7 started as a medical hospitalization, but resulted in a transfer to a local psychiatric hospital - She should have completed IRIS reports for the hospitalizations for FC#6 and FC#7, as well as the elopement for FC#6 Interview on 9/2/25 the Registered Nurse/Administrator/Owner reported: - The QP was responsible for submitting IRIS reports for the facility	V 367		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility and its grounds was not maintained in a safe, clean, attractive and orderly manner. The findings are: Observation on 8/14/25 at 10:32 am revealed: - A piece of vinyl on the outside front of the facility was bowed out and no longer attached to the structure - A kitchen drawer had a missing drawer from - Baseboards throughout the kitchen and dining rooms were covered in a black and brown substance - The stair rails leading down to the living room were loose - The blinds covering the living room windows had 9 broken slats	V 736	V736 Facility and Grounds Maintenance By 10/4/25 the administrator will ensure that all excess furniture is removed from the facility grounds. All blinds and drawers are replaced, railings outside the facility are replaced or repaired. Door frames are repaired and other areas	

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V 736	Continued From page 40 - The blinds covering the window in the bedroom of client #1 had 8 broken slats - A single high-pitched chirp every 60 seconds which originated from a smoke detector in the hallway - 2 couches upside down and leaned against the back of the facility - 1 mattress and 1 boxspring outside leaned against the right side of the facility Observation on 8/28/25 at 10:50 am revealed: - The front porch railing had approximately 8 missing pickets - The door frame around the lock on the inside of the staff office had approximately a 2 foot piece that was split and broken off and had been filled in with yellow foam sealant Interview on 8/14/25 client #1 reported: - He had lived at the facility since 12/31/24 - There were things at the facility that needed to be repaired, including the stair rail leading downstairs Interview on 8/14/25 staff #1 reported: - He had been working at the facility since May of 2025 - The door frame leading into the staff office was broken when he began working and no repairs had been done to it since he had been working at the facility - If he noticed repairs that were needed at the facility, he informed the Registered Nurse/Administrator/Owner (RN/Admin/Owner) and she sent someone out to make the repairs - He was waiting on the repairman to fix some things at the facility, such as the stair rail leading downstairs and the smoke detector Interview on 8/28/25 the Qualified Professional	V 736		

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V 736	Continued From page 41 reported: - The RN/Admin/Owner was responsible for having repairs at the facility completed - She did not recall damage to the staff office door frame or any repairs that were made to it Interview on 9/2/25 the RN/Admin/Owner reported: - She had someone that completed repairs at the facility - When repairs were needed, she would call the repairman and he quickly went to the facility to make the repairs - She did not remember when the staff office door frame was damaged - "Probably happened years ago" - She had someone to remove old furniture and she needed to remind him to get the couches and mattresses from the outside of the facility This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		