

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL043-103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 12/17/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER PEACH FARM ROAD	STREET ADDRESS, CITY, STATE, ZIP CODE 1391 PEACH FARM ROAD LILLINGTON, NC 27546
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	<p>INITIAL COMMENTS</p> <p>A complaint and follow up survey was completed on December 17, 2025. The complaint was unsubstantiated (intake #NC00234300). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.</p> <p>This facility is licensed for 4 and has a current census of 4. The survey sample consisted of audits of 3 current clients.</p>	V 000		
V 131	<p>G.S. 131E-256 (D2) HCPR - Prior Employment Verification</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to complete Health Care Personnel Registry (HCPR) check prior to hire for 2 of 3 audited staff (#1, #2). The findings are:</p> <p>Finding #1: Review on 12/17/25 of staff #1's personnel record revealed:</p>	V 131		

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

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL043-103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 12/17/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER PEACH FARM ROAD	STREET ADDRESS, CITY, STATE, ZIP CODE 1391 PEACH FARM ROAD LILLINGTON, NC 27546
--	---

(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	<p>Continued From page 1</p> <ul style="list-style-type: none"> - Hire date: 3/13/25 - Position: Direct Support Professional - HCPR accessed: 6/19/25 <p>Finding #2: Review on 12/17/25 of staff #2's record revealed:</p> <ul style="list-style-type: none"> - Hire date: 9/26/25 - Position: Direct Support Professional - No documentation that HCPR was accessed prior to hire. <p>Interview on 12/17/25 the Program Director stated:</p> <ul style="list-style-type: none"> - She understood all relevant trainings and documentation should be completed before staff work with clients. - She would make sure that she had HCPR checks were completed prior to date of hire. <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 131		
V 366	<p>27G .0603 Incident Response Requirements</p> <p>10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS</p> <p>(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:</p> <ol style="list-style-type: none"> (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 	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL043-103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 12/17/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER PEACH FARM ROAD	STREET ADDRESS, CITY, STATE, ZIP CODE 1391 PEACH FARM ROAD LILLINGTON, NC 27546
--	---

(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	<p>Continued From page 2</p> <p>specified timeframes not to exceed 45 days;</p> <p>(5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;</p> <p>(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</p> <p>(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.</p> <p>(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.</p> <p>(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 by:</p> <p>(1) immediately securing the client record by:</p> <p>(A) obtaining the client record;</p> <p>(B) making a photocopy;</p> <p>(C) certifying the copy's completeness; and</p> <p>(D) transferring the copy to an internal review team;</p> <p>(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:</p>	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL043-103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 12/17/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER PEACH FARM ROAD	STREET ADDRESS, CITY, STATE, ZIP CODE 1391 PEACH FARM ROAD LILLINGTON, NC 27546
--	---

(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	<p>Continued From page 3</p> <p>(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;</p> <p>(B) gather other information needed;</p> <p>(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</p> <p>(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 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</p> <p>(3) immediately notifying the following:</p> <p>(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;</p> <p>(B) the LME where the client resides, if different;</p> <p>(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;</p> <p>(D) the Department;</p> <p>(E) the client's legal guardian, as applicable; and</p> <p>(F) any other authorities required by law.</p>	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL043-103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 12/17/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER PEACH FARM ROAD	STREET ADDRESS, CITY, STATE, ZIP CODE 1391 PEACH FARM ROAD LILLINGTON, NC 27546
--	---

(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	<p>Continued From page 4</p> <p>This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to document their response to level II and level III incidents. The findings are:</p> <p>Refer to V367 regarding specific incident report related to the following: - In response to an injury to client #2's jaw, he stated the injury had occurred after he fell outside, after he fell in his room, and after two unknown individuals from "the woods" came into his room and caused it.</p> <p>Review on 12/17/25 of the facility records from 9/01/25 - present revealed: - There were no level II incident reports for police contact. - There were no level III incident reports for allegations of abuse by unknown individuals.</p> <p>Interview on 12/17/25 the Program Director stated: - Due to a mental health concern, law enforcement were contacted in October and escorted client #2 to a local hospital. -When questioned during the assessment at the hospital, client #2 responded "yes" to a question about recent falls and stated he had hurt his jaw. - Client #2 gave 3 variations of how he had hurt his jaw. - He stated that he injured his jaw after falling outside, after falling in his room, and after two individuals came from the woods and caused the</p>	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL043-103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 12/17/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER PEACH FARM ROAD	STREET ADDRESS, CITY, STATE, ZIP CODE 1391 PEACH FARM ROAD LILLINGTON, NC 27546
--	---

(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 5 injury. -There were no visible injuries present and client #2 had not complained of jaw pain. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	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 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	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL043-103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 12/17/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER PEACH FARM ROAD	STREET ADDRESS, CITY, STATE, ZIP CODE 1391 PEACH FARM ROAD LILLINGTON, NC 27546
--	---

(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	<p>Continued From page 6</p> <p>report recipients by the end of the next business day whenever:</p> <p>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or</p> <p>(2) the provider obtains information required on the incident form that was previously unavailable.</p> <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <p>(1) hospital records including confidential information;</p> <p>(2) reports by other authorities; and</p> <p>(3) the provider's response to the incident.</p> <p>(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).</p> <p>(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:</p> <p>(1) medication errors that do not meet the definition of a level II or level III incident;</p> <p>(2) restrictive interventions that do not meet the definition of a level II or level III incident;</p> <p>(3) searches of a client or his living area;</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL043-103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 12/17/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER PEACH FARM ROAD	STREET ADDRESS, CITY, STATE, ZIP CODE 1391 PEACH FARM ROAD LILLINGTON, NC 27546
--	---

(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	<p>Continued From page 7</p> <p>(4) seizures of client property or property in the possession of a client;</p> <p>(5) the total number of level II and level III incidents that occurred; and</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure critical incident reports were submitted to the Local Management Entity (LME)/Managed Care Organization (MCO) within 72 hours as required. The findings are:</p> <p>Review on 12/17/25 of the North Carolina Incident Response Improvement System (IRIS) website revealed no Level II or Level III incident reports had been submitted to the LME/MCO from 9/01/25 - 12/17/25.</p> <p>Review on 12/17/25 of client #2's record revealed: -Admission date of 10/28/23. -Diagnoses of mild intellectual developmental disability, fetal alcohol syndrome, schizoaffective disorder, and adjustment disorder.</p> <p>Review on 12/17/25 General Event Report dated 10/17/25 revealed:</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL043-103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 12/17/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER PEACH FARM ROAD	STREET ADDRESS, CITY, STATE, ZIP CODE 1391 PEACH FARM ROAD LILLINGTON, NC 27546
--	---

(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	<p>Continued From page 8</p> <ul style="list-style-type: none"> - Describe what happened before the event: "We was all outside me and 2 other staff members, and all of the Residents was outside and we was roasting marshmallows making smores outside. [Client #2] started flipping out running saying that a bear was chasing him, and he was running around the house. And saying people was trying to kill him, [client #2] ran up the front 2 steps and tripped then he ran inside of the house and called 911 saying that the bear was chasing him and growling at him. Staff tried to talk to him he was scared of us and didn't want to talk to us because people was after him and the bear was trying to kill him" - Summary: "I don't know what happened to [client #2] he just started tripping out like someone and a bear was really after him. And he wanted to go to the hospital or get help" <p>Interview on 12/17/25 client #2 stated:</p> <ul style="list-style-type: none"> - He had lived at the facility for 3 years. - He loved living at the facility and was treated well by staff. - He had never been hurt by anyone at the facility and had never seen anyone hurt by staff at the facility. - He had not been hurt by any outside individuals while living at the facility. - He had hurt his jaw "a couple of months ago" when he fell down in his room and hit his night stand. - His mouth was sore and he was taken to the hospital to get checked out and was fine. - He was fine and had no pain following the event. - He had no concerns. <p>Interview on 12/17/25 the Program Director stated:</p> <ul style="list-style-type: none"> - Due to a mental health concern, law enforcement were contacted in October and 	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL043-103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 12/17/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER PEACH FARM ROAD	STREET ADDRESS, CITY, STATE, ZIP CODE 1391 PEACH FARM ROAD LILLINGTON, NC 27546
--	---

(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	<p>Continued From page 9</p> <p>escorted client #2 to a local hospital.</p> <p>-When questioned during the assessment at the hospital, client #2 responded "yes" to a question about recent falls and stated he had hurt his jaw.</p> <p>- Client #2 gave 3 variations of how he had hurt his jaw.</p> <p>- He stated that he injured his jaw after falling outside, after falling in his room, and after two individuals came from the woods and caused the injury.</p> <p>-There were no visible injuries present and client #2 had not complained of jaw pain.</p> <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 367		
-------	--	-------	--	--