STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601575	A. BUILDING: _____ B. WING _____	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRACLE HOUSES EAGLE PEAK	6120 EAGLE PEAK DRIVE CHARLOTTE, NC 28214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and complaint survey was completed on 1/7/26. The complaint was unsubstantiated (Intake #NC00235002). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for 3 and has a current census of 3. The survey sample consisted of audits of 2 current clients and 1 former client.	V 000		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and	V 118		

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V 118	Continued From page 1 (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 reviews and interviews, the facility failed to keep the MAR current affecting 2 of 3 audit clients (#1,#2). The findings are: Review on 1/6/26 of Client #1's record revealed: - Admission date 8/18/25; - Age 10 years old; - Diagnoses: Disruptive Mood Dysregulation Disorder (DMDD); Other Reactions to Stress; Attention Deficit Hyperactive Disorder (ADHD), Combined Type; Conduct Disorder, Childhood-Onset Type; - Physician's Order dated 8/29/25 Clonidine HCL (hydrochloride) 0.1 mg(milligram) tablet (ADHD), Take 1 tablet by mouth daily at bedtime Take 1 tablet by mouth daily at bedtime; - 9/2/25 Cetirizine HCL 5mg tablet (Allergies), Take 1 tablet by mouth every day at bedtime; - 11/4/25 Hydroxyzine HCL 10mg oral tablet (Anxiety), Take 1 tablet by mouth daily at 3pm. Review on 1/6/26 and 1/7/26 of Client #1's MARs from October 1, 2025- January 7, 2026 revealed: - No staff initials for administration of medication for Clonidine HCL 0.1 mg on 1/5-1/6/26; - No staff initials for administration of medication	V 118		

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V 118	Continued From page 2	V 118		

for Cetirizine HCL 5mg on 1/5-1/6/26;
- No Staff initials for administration of medication for Hydroxyzine HCL 10mg on 1/1-1/6/26.

Review on 1/6/26 of Client #2's record revealed:
- Admission date 8/14/25;
- Age 6 years old;
- Diagnosis: Post Traumatic Stress Disorder;
- Physician's Order dated 9/10/25 Risperidone 2mg (antipsychotic), Take one tablet by mouth once daily at bedtime;
- 11/18/25 Desmopressin Acetate 0.2mg (bedwetting), Take one tablet by mouth once daily at bedtime.

Review on 1/6/26 and 1/7/26 of Client #2's MARs from October 1, 2025-January 7, 2026 revealed:
- No staff initials for administration of medication for Risperidone 2mg on 1/6/26;
- No staff initials for administration of medication for Desmopressin Acetate 0.2mg on 1/6/26.

Interview on 1/7/26 with Client #1 revealed:
- Was administered medications daily;
- "I need my 3pm (medication)" was stated during the interview at approximately 3:27pm.

Interview on 1/7/26 with Client #2 revealed:
- Was administered medications daily.

Interview on 1/7/26 with the House Manager revealed:
- Reviewed the MARs twice a week;
- "I created a new MAR (for Client #1) because someone had made a black mark on the MAR and I don't like for my MARs to look messed up. When I made the new MAR, I forgot to sign off on it;"
- "I am the one who gives him (Client #1) his 3 o'clock (medication) each day;"

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V 118	Continued From page 3 - "This is my fault, I forgot to sign the new MAR;" - "The MAR wasn't signed off last night (1/6/26), because we were expecting you (Division Health Service Regulation surveyor) to come here. I'm not sure why it wasn't signed." Interview on 1/6/26 with the Qualified Professional revealed: - The House Manager created the MARs; - Reviewed the MARs weekly; - Staff completed a count of the medications daily.	V 118		
V 295	27G .1703 Residential Tx. Child/Adol - Req. for A P 10A NCAC 27G .1703 REQUIREMENTS FOR ASSOCIATE PROFESSIONALS (a) In addition to the qualified professional specified in Rule .1702 of this Section, each facility shall have at least one full-time direct care staff who meets or exceeds the requirements of an associate professional as set forth in 10A NCAC 27G .0104(1). (b) The governing body responsible for each facility shall develop and implement written policies that specify the responsibilities of its associate professional(s). At a minimum these policies shall address the following: (1) management of the day to day day-to-day operations of the facility; (2) supervision of paraprofessionals regarding responsibilities related to the implementation of each child or adolescent's treatment plan; and (3) participation in service planning meetings.	V 295		

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V 295	Continued From page 4 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to employ an Associate Professional (AP) who provided services to the facility on a full-time basis. The findings are: Review on 1/5/26 of the facility's client and staff census form revealed: - Staff #2 was listed as the AP; Interview on 1/6/26 with the Executive Director revealed: - There was a mistake on the census, Staff #2 was not the AP; - Provided another staff member's name that was not listed on the census as the AP. Review on 1/6/26 of the facility's client and staff census form revealed: - The AP name was added to the census form. Review on 1/6/26 of the AP's personnel record revealed: - Hire date 4/12/24; - Job Title- AP. Interview on 1/7/26 with Staff #2 revealed: - AP worked 2-3 days per week; - AP mainly worked on the weekends at night. Interview on 1/7/26 with the House Manager revealed: - AP "sometimes work 3rd shift and sometimes work 2nd shift; - "She worked on Monday (1/5/26) and then again on this Friday."	V 295		

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V 295	Continued From page 5 Interview on 1/7/26 with the AP revealed: - "I work part time;" - "I work 2nd and 3rd shift;" - "I work 3rd shift Friday- Sunday, I just started third shift in September but on the weekends;" - "I guess, I would have them (House Manager, Executive Director) to put me back on 2nd shift so I can meet the requirements of an AP but to get off by 10pm." Interview on 1/6/26 with the Qualified Professional revealed: - The AP worked at least 30 hours each week; - The AP schedule changed each week depending on the need of the facility.	V 295		
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,	V 366		

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V 366	Continued From page 6 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 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	V 366		

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V 366	Continued From page 7 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 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.	V 366		

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V 366	Continued From page 8 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement written policies governing their response to level I and level II incidents. The findings are: Review on 1/7/26 of the facility's incident reports from October 1, 2025- January 6, 2026 revealed: - No report was completed for Client #1's behavior on 12/22/25; - No report was completed for Client #1's behavior on 12/30/25. Review on 1/5/26 and 1/7/26 the North Carolina Incident Response Improvement System (NC IRIS) from October 1, 2025-January 7, 2026 revealed: - An incident occurred on 12/22/25; - The provider learned of the incident on 12/22/25; - The provider commented-"QP continues to gather information concerning the incident on 12/22/25;" - On 1/6/26, Provider Comment-" ...Despite continued staff support, [Client #1] agitation persisted throughout dinner and his nightly routine. He refused to eat, continued directing profanity and derogatory language toward staff, and made repeated verbal threats, stating he would hit staff if she did not leave and that he would hit the house manager, expressing disregard for redirection or consequences. Staff continued to utilize de-escalation strategies, therapeutic communication, and increased supervision in an effort to reduce escalation. During a brief moment when one staff member stepped away, [Client #1] barricaded himself inside his room. When staff entered to ensure safety, [Client #1] escalated to physical	V 366		

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V 366	Continued From page 9 aggression, yelling and screaming, overturning furniture, moving his dresser, and striking staff in the head with a case. Due to the immediate safety risk to [Client #1] and others, staff implemented a therapeutic hold in accordance with policy to prevent further harm. Following the intervention, staff attempted to process the incident with [Client #1] and provided emotional support while monitoring his ability to regain emotional regulation. The house manager was notified and stated she would come in to provide additional support and intervention. [Client #1] was then directed to remain in his room for the remainder of the night to promote safety and stabilization. Following this, [Client #1] remained awake, continued manipulating items in his room, intermittently exited his room, and verbalized that staff were "messing with him." Staff maintained increased monitoring, consistent structure, and a supportive presence throughout the remainder of the shift to ensure safety and reduce the risk of further escalation." - An incident occurred on 12/30/25; - The provider learned of the incident on 12/30/25; - The provider commented- "QP continues to gather information concerning the incident on 1/1/26;" - On 1/6/26, Provider Comment-" ... [Client #1] became increasingly angry during processing. Staff continued to provide support and redirection while [Client #1] completed his in-room intervention. Following this, [Client #1] exhibited defiant and aggressive behaviors toward staff, including kicking a staff member and throwing a fan. For safety reasons, staff removed the fan from the area. Due to continued escalation, [Client #1] was placed in a therapeutic hold to allow him time to regain emotional regulation. After release, [Client #1] began kicking his	V 366		

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V 366	Continued From page 10 dresser and attempted to exit the back door in an effort to AWOL. Staff intervened promptly and prevented elopement. To reduce further risk of property damage, staff redirected [Client #1] to the common area and provided continued [Client #1] became increasingly angry during processing. Staff continued to provide support and redirection while [Client #1] completed his in-room intervention. Following this, [Client #1] exhibited defiant and aggressive behaviors toward staff, including kicking a staff member and throwing a fan. For safety reasons, staff removed the fan from the area. Due to continued escalation, [Client #1]was placed in a therapeutic hold to allow him time to regain emotional regulation. After release, [Client #1] began kicking his dresser and attempted to exit the back door in an effort to AWOL. Staff intervened promptly and prevented elopement. To reduce further risk of property damage, staff redirected [Client #1] to the common area and provided continued." Interview on 1/7/26 with the House Manager revealed: - Incident reports are filled out on a form on the computer and sent to the Qualified Professional (QP); - The QP was responsible for IRIS reports. Interview on 1/6/26 with the QP revealed: - Was responsible for level II incident reports; - "I completed the last one (IRIS report) on the 30th and completed two updates (in IRIS) today."	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS	V 367		

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V 367	Continued From page 11 (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 obtained regarding the incident, including: (1) hospital records including confidential	V 367		

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V 367	Continued From page 12 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		

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V 367	Continued From page 13	V 367		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to report all level II incident in the Incident Response Improvement System (IRIS), failed to notify the Local Management Entity (LME)/Managed Care Organization (MCO) responsible for the catchment area where services were provided within 24 hours and 72 hours of becoming aware of the incident. The findings are:

Review on 1/5/26 and 1/7/26 of the IRIS from October 1, 2025-January 6, 2026 revealed:
- An incident occurred on 12/2/25;
- The provider learned of the incident on 12/2/25;
- The report was submitted on 12/6/25;
- Provider Comments " [Client #1] became visibly upset when prompted to follow routine directions and began demonstrating increased difficulty with compliance within the facility. The consumer's affect escalated rapidly, presenting with loud vocalizations, heightened irritability, and refusal to respond to staff's redirection attempts. Staff implemented verbal de-escalation strategies, including offering choices, providing space, and using calm-tone communication; however, the consumer continued to escalate. As the dysregulation intensified, the consumer attempted to engage in property destruction by flipping over dressers and throwing items toward staff, creating safety concerns within the environment. Staff continued efforts to redirect the consumer, maintain a safe distance, and minimize environmental hazards while encouraging the use

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	MHL0601575	A. BUILDING: _____ B. WING _____	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRACLE HOUSES EAGLE PEAK	6120 EAGLE PEAK DRIVE CHARLOTTE, NC 28214

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V 367	Continued From page 14 of coping strategies. Following these behaviors, the consumer suddenly AWOL'd from the facility, running toward the roadway without regard for personal safety. Staff immediately initiated AWOL protocol and maintained close line-of-sight supervision to ensure the consumer remained safe from traffic and environmental dangers. While attempting to prevent the consumer from entering the street-where oncoming vehicles were present-staff reached out to block the consumer's path and guide him away from danger. During this safety intervention, the consumer was inadvertently scratched on the neck as staff attempted to prevent imminent harm. After the consumer was redirected and returned to the facility, staff provided supportive time and allowed him to regain his composure. Once calm, staff engaged the consumer in therapeutic processing focused on his ability to remain safe, use coping strategies, and reduce risky behaviors across all settings. Staff discussed alternative ways to communicate frustration and reviewed steps to remain compliant with expectations. Due to the scratch on his neck, staff applied first aid according to agency protocol, monitored the area for additional irritation, and ensured the consumer felt supported throughout the intervention. After consultation with the clinical team, the House Manager was instructed to transport the consumer to [local hospital] for additional medical evaluation and a formal medical review to ensure comprehensive follow-up care. Following the incident, the QP contacted the guardian and provided a detailed update, ensuring the guardian was fully informed of the events, the consumer's behaviors, and all interventions implemented to maintain safety;" - An incident occurred on 12/22/25; - The provider learned of the incident on 12/22/25;	V 367		

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V 367	Continued From page 15 - The provider commented-"QP continues to gather information concerning the incident on 12/22/25;" - On 1/6/26, Provider Comment-" ...Despite continued staff support, [Client #1] agitation persisted throughout dinner and his nightly routine. He refused to eat, continued directing profanity and derogatory language toward staff, and made repeated verbal threats, stating he would hit staff if she did not leave and that he would hit the house manager, expressing disregard for redirection or consequences. Staff continued to utilize de-escalation strategies, therapeutic communication, and increased supervision in an effort to reduce escalation. During a brief moment when one staff member stepped away, [Client #1] barricaded himself inside his room. When staff entered to ensure safety, [Client #1] escalated to physical aggression, yelling and screaming, overturning furniture, moving his dresser, and striking staff in the head with a case. Due to the immediate safety risk to [Client #1] and others, staff implemented a therapeutic hold in accordance with policy to prevent further harm. Following the intervention, staff attempted to process the incident with [Client #1] and provided emotional support while monitoring his ability to regain emotional regulation. The house manager was notified and stated she would come in to provide additional support and intervention. [Client #1] was then directed to remain in his room for the remainder of the night to promote safety and stabilization. Following this, [Client #1] remained awake, continued manipulating items in his room, intermittently exited his room, and verbalized that staff were "messing with him." Staff maintained increased monitoring, consistent structure, and a supportive presence throughout the remainder of the shift to ensure safety and reduce the risk of	V 367		

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V 367	Continued From page 16 further escalation." - An incident occurred on 12/30/25; - The provider learned of the incident on 12/30/25; - The provider commented- "QP continues to gather information concerning the incident on 1/1/26;" - On 1/6/26, Provider Comment-" ... [Client #1} became increasingly angry during processing. Staff continued to provide support and redirection while [Client #1] completed his in-room intervention. Following this, [Client #1] exhibited defiant and aggressive behaviors toward staff, including kicking a staff member and throwing a fan. For safety reasons, staff removed the fan from the area. Due to continued escalation, [Client #1] was placed in a therapeutic hold to allow him time to regain emotional regulation. After release, [Client #1] began kicking his dresser and attempted to exit the back door in an effort to AWOL. Staff intervened promptly and prevented elopement. To reduce further risk of property damage, staff redirected [Client #1] to the common area and provided continued [Client #1] became increasingly angry during processing. Staff continued to provide support and redirection while [Client #1] completed his in-room intervention. Following this, [Client #1] exhibited defiant and aggressive behaviors toward staff, including kicking a staff member and throwing a fan. For safety reasons, staff removed the fan from the area. Due to continued escalation, [Client #1]was placed in a therapeutic hold to allow him time to regain emotional regulation. After release, [Client #1] began kicking his dresser and attempted to exit the back door in an effort to AWOL. Staff intervened promptly and prevented elopement. To reduce further risk of property damage, staff redirected [Client #1] to the common area and provided continued."	V 367		

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V 367	Continued From page 17 Interview on 1/7/26 with the House Manager revealed: - Incident reports are filled out on a form on the computer and sent to the Qualified Professional (QP); - The QP was responsible for IRIS reports. Interview on 1/6/26 with the QP revealed: - Was responsible for level II incident reports; - "I completed the last one (IRIS report) on the 30th and completed two updates (in IRIS) today."	V 367		
V 539	27F .0102 Client Rights - Living Environment 10A NCAC 27F .0102 LIVING ENVIRONMENT (a) Each client shall be provided: (1) an atmosphere conducive to uninterrupted sleep during scheduled sleeping hours, consistent with the types of services being provided and the type of clients being served; and (2) accessible areas for personal privacy, for at least limited periods of time, unless determined inappropriate by the treatment or habilitation team. (b) Each client shall be free to suitably decorate his room, or his portion of a multi-resident room, with respect to choice, normalization principles, and with respect for the physical structure. Any restrictions on this freedom shall be carried out in accordance with governing body policy. This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to ensure there was	V 539		

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V 539	Continued From page 18 an atmosphere conductive to uninterrupted sleep during scheduled sleeping hours and accessible areas for personal privacy affecting 1 of 3 current clients (#4). The findings are: Observation on 1/7/26 in the facility at approximately 4:01pm revealed: - Bathroom door was opened in Client #4's bedroom. Interview on 1/7/26 with Client #4 revealed: - Staff used the bathroom throughout the night while Client #4 was in the bedroom asleep; - "They don't bother me when they use the bathroom." Interview on 1/7/26 with Staff #2 revealed: - Denied using the bathroom in Client #4's bedroom while he was asleep; - "It's not really privacy for either of us (staff and client) if you have to 'go-go'." Interview on 1/7/26 with the Associate Professional revealed: - "We go into the bathroom while the client is in his room sleep, he never complained." Interview on 1/7/26 with the House Manager revealed: - Was not aware staff could not use the bathroom in a client's bedroom throughout the night; - Client #4's bedroom door was always open throughout the night; - Staff used the bathroom in Client #4's bedroom throughout the night; - Planned to put a sign on the bathroom door letting staff know to not use the bathroom.	V 539		

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V 736	Continued From page 19	V 736		
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 failed to maintain its grounds in a safe, clean, attractive and orderly manner. Observation on 1/7/26 at approximately 3:30pm of Client #1's bedroom revealed: - Brown stains at the top left wall and ceiling behind the door, when entering into the room; - Two cracks in the ceiling, where the wall and the corner of the closet meet, ranging from approximately 8 inches to 12 inches long; - An approximately 12 inch by 12 inch hole covered with white spackle but not completed on the wall beside the client's bed; - An approximately 5 inch by 8 inch hole covered with white spackle but not completed on the wall beside the client's bed. Observation on 1/7/26 at approximately 3:50pm of Client #2's bedroom revealed: - White spackle on the wall not completed for approximately 1 foot and 5 inches long above Client #2's bed; - Darker grey paint from the grey paint on the wall covering a hole at approximately 1.5 feet long and 2 feet wide; - Crack in the wall leading to the ceiling from the top of the door frame at approximately 1 foot long;	V 736		

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V 736	Continued From page 20 Observation on 1/7/26 at approximately 4:00pm of Client #4's bedroom revealed: - The whole wall behind Client #4's dresser was dirty and marked with winding, overlapping scruff marks. Interview on 1/7/26 with Client #1 revealed: - "I killed a bug on the wall that is why that brown stuff is on the wall;" - "I put that hole in the wall when I was upset, I think it was a few weeks ago." Interview on 1/7/26 with Client #4 revealed: - "I made those marks on the wall with my car, I didn't know it was going to do all of that (scruff marks)." Interview on 1/7/26 with the Associate Professional revealed: - Noticed the marks on the wall in Client 4's room right after Christmas; - Client #1's holes were patched in his room "late November or early December." Interview on 1/7/26 with the House Manager revealed: - Completed a walkthrough of the facility monthly and documented anything that required the attention of maintenance; - "The maintenance man was here already, fixing some things in the home;" - Client #4 made the scruff marks on the wall after Christmas with his car; - "We know we have to paint in [Client #1's] room to cover up those patches."	V 736		