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
	MHL0411015	A. BUILDING: _____ B. WING _____	12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAYMARK GUILFORD RESIDENTIAL TREATME	5209 WEST WENDOVER AVENUE HIGH POINT, NC 27265

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on 12/31/25. One complaint was unsubstantiated (intake# NC00234416) and one complaint was substantiated (Intake # NC00234467). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .3400 Residential Treatment - Individuals with Substance Abuse Disorders and 10A NCAC 27G .5600E Supervised Living for Adults with Substance Abuse Dependency. This facility is licensed for 56 beds and has a current census of 28. The survey sample consisted of audits of 7 current clients and 2 former clients.	V 000		
V 106	27G .0201 (A) (8-18) (B) GOVERNING BODY POLICIES 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (8) use of medications by clients in accordance with the rules in this Section; (9) reporting of any incident, unusual occurrence or medication error; (10) voluntary non-compensated work performed by a client; (11) client fee assessment and collection practices; (12) medical preparedness plan to be utilized in a medical emergency; (13) authorization for and follow up of lab tests; (14) transportation, including the accessibility of emergency information for a client;	V 106	Immediate Action - Reviewed Client #5's record; medical evaluation and treatment for elevated blood pressure on 9/15/25 confirmed. A late entry note was completed to reflect transport, evaluation, and return. Client continues routine vital sign monitoring per physician orders. – **Completed 1/19/2026** All residential and nursing staff re-educated on policies and Medical Director–approved guidelines for elevated blood pressure management and documentation. Training covered standardized Elevated Blood Pressure Response Checklist for all readings meeting escalation criteria. Checklist includes required actions for elevated blood pressure readings, documentation requirements, including service notes, email notifications, and time-stamped vital sign entries. And, responsibility for documentation when a client is transported to a medical center and upon return notifications, maintained in client record in EHR. **Completed 1/21/2026: Ongoing monitoring**	1-19-26 1-21-26

			Ongoing Monitoring & Oversight -QI, CD, PD, and SPD will audit vital signs and service notes weekly for 90 days. Deficiencies will be addressed immediately through coaching or additional training.	

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

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V 106	Continued From page 2 (15) services of volunteers, including supervision and requirements for maintaining client confidentiality; (16) areas in which staff, including nonprofessional staff, receive training and continuing education; (17) safety precautions and requirements for facility areas including special client activity areas; and (18) client grievance policy, including procedures for review and disposition of client grievances. (b) Minutes of the governing body shall be permanently maintained. This Rule is not met as evidenced by: Based on record review and interview, the facilty failed to implement their policy regarding documenting services provided to clients with an elevated blood pressure reading affecting 1 of 7 audited current clients (client #5). The findings are: Review on 12/29/25 of client #5's record revealed: - An admission date of 5/16/25 - Diagnoses of Alcohol Use Disorder (D/O), Severe; Cocaine Use D/O, Severe; Major Depressive D/O, Single Episode, Moderate; Generalized Anxiety D/O and Hypertension Review on 12/30/25 of client #5's "Vital Sign Log" revealed: - Residential Worker #1 (RW#1) documented that client #5 had a blood pressure reading of "164 (systolic)/114 (diastolic)" on 9/15/25	V 106		

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V 106	Continued From page 3 - No time was listed to reflect when the reading was noted Review on 12/30/25 the guidelines facilty staff were to follow for clients with "high blood pressure" readings revealed: - The guidelines had been developed by the facility's Medical Director and included the following: "...Current Client Guidelines A. BP (Blood Pressure) 160-179 ____ 110-109. If there are at least 2 readings at this level and the client DOES have symptoms, client will need to be transported to the med (medical) center for evaluation. First, document readings on blood pressure log. Next, contact RW supervisor to give detail of readings and intent to transport. Next, email nursing staff (CC: Director and RW Supervisor) detailing readings, symptoms and intent to transport to med (medical) center. Last, complete service note detailing readings, email sent to nursing staff and intent to transport to med center. Staff will then transport client to med center for evaluation..." - "...Reminder: Please reminder to complete a service note when client returns to the facility and any information that client relayed to you regarding visit (new medications, follow up appt. (appointment), etc.) Also, be sure to email nursing staff about client's return to that they may follow up the next day..." Attempts on 12/30/25 and on 12/31/25 to review documentation regarding the events of 9/15/25 other than the "vital signs log" was unsuccessful as there was no other documents available for review. Interview on 12/19/25 with client #5 revealed: - Per agency protocol, she was taken a local medical center due to her blood pressure being	V 106		

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V 106	Continued From page 4 "160 over something." - Felt "ok" other than "maybe some swelling" around her rings - "Never felt like I couldn't function." - Treated at the medical center (testing and administered blood pressure medication) and returned to facility on the same day - Does not recall the exact date but believed it was in October 2025 Interview on 12/31/25 with the Quality Improvement Manager revealed: - No other documents were available for review regarding client #5 and the events of 9/15/25 - Acknowledgement that documentation should have been completed by either residential staff and/or nursing staff regarding client #5 and her transport to a medical center due to an elevated blood pressure on 9/15/25 - This was a failure by residential and/or nursing staff to follow agency protocol	V 106		
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.	V 118	Reviewed Client #5's record; medications were prescribed by a physician and remain appropriate. Center Director after reviewing with medical director reviewed administration practices around 9/13/25; no additional gaps identified. Client continues to receive medications as ordered; MARs verified accurate and complete. **Completed 1/12/2026** All residential and nursing staff will be re-educated on: Administering medications per physician orders, timely and accurate completion of MARs, proper use of the electronic heath records system with emphasis on documentation accountability and verification that entries are saved. **Completed 1/21/2026** **A**ttendance recorded. **Attached.** Center Director or designee will audits MARs weekly for 30 days to ensure compliance and accuracy. Findings will be documented; deficiencies corrected immediately with coaching. **Ongoing monitoring by CD, PD. SPD**	1-12-26 1-21-26

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V 123 V 123	Continued From page 5 27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. . This Rule is not met as evidenced by: Based on record review and interview, the facilty failed to ensure all medication errors were reported immediately to a physician or pharmacist affecting 3 of 7 audited current clients (clients #2, #6 and #7) and 2 of 2 audited former clients (FC #8 and FC #9). The findings are: Review on 12/29/25 of client #2's record revealed: - An admission date of 8/20/25 - Diagnoses of Alcohol Use Disorder (D/O), Severe; Cannabis Use D/O, Mild; Major Depression, Moderate; Post-Traumatic Stress D/O, Moderate; Tobacco Use D/O, Severe; Congestive Heart Failure; Coronary Artery Disease; Emphysema; Gastroesophageal Reflux Disease; Hypertension and Stented Coronary Artery - A Patient Medication List" (no date listed) which documented client #2 had last been	V 123 V 123	Records for Clients #2, #6, #7, and Former Clients #8 and #9 were reviewed. Nursing leadership confirmed all current clients are receiving medications as ordered, refills are tracked, and MARs are current. All nursing and residential staff were re-educated on the facility's medication error policy, including immediate notification to the physician or pharmacist for missed or delayed medications, documentation on Level I incident reports, and follow-up actions. **Completed 1/21/2026** **Ongoing Monitoring by CD, PD, SPD QI**	1-21-26

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V 123	Continued From page 6 prescribed Farxiga 10 mg 1 tab (tablet) by mouth) PO every day in the morning on 8/19/25 - Level I incident reports reviewed by the Center Director on 9/4/25 which documented client #2 was not administered his dose of Farxiga 10 mg (used to treat Type II diabetes) on those days due to the medication not being onsite as client #2 was awaiting an authorization for a refill from his provider - No documentation to reflect any staff contacted a pharmacist or a physician on behalf of client #2 regarding this missed medication Review on of client #6's record revealed: - An admission date of 7/14/25 - A diagnosis of Cocaine Use, D/O, Severe - A physician's order most recently dated 11/25/25 for Propanfenone ER (Extended Release) 225 mg (used to treat irregular heartbeat) 1 tab PO every 12 hours - Level I incident report reviewed by the Center Director on 9/4/25 which documented client #6 was not administered her morning dose of Propanfenone ER (Extended Release) 225 mg on 9/1/25 due to no refills being available - No documentation to reflect any staff contacted a pharmacist or a physician on behalf of client #6 regarding this medication error Review on of client #7's record revealed: - An admission date of 9/11/25 - Diagnoses of Opioid Use D/O, Severe; Amphetamine Type Substance Use D/O, Severe; Generalized Anxiety D/O Severe; Post Traumatic Stress D/O, Severe and Major Depressive D/O, Non Psychotic, Recurrent, Severe - A physician's order most recently dated 10/1/25 for Gabapentin 600 mg (used to treat nerve pain or an anticonvulsant) 1 tab PO four times a day	V 123		

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V 123	Continued From page 7 - A level I incident report reviewed by the Center Director on 10/8/25 which documented client #7 was not administered his morning dose of Gabapentin 600 mg - No documentation to reflect any staff contacted pharmacist or a physician on behalf of client #7 regarding this medication error Review on 12/19/25 of Former Client #8's (FC #8) record revealed: - An admission date of 7/14/25 - A diagnosis of Cocaine Use D/O, Severe - A discharge date of 9/18/25 - A physician's order dated 9/9/25 for Eliquis 5 mg 1 tab PO twice a day (8 am and 8 pm) - A level I incident report reviewed by the Center Director on 9/15/25 which documented FC #8 was not administered her 8 pm dose of Eliquis 5 mg (blood thinner) on 9/11/25 because a request for a refill had not been submitted prior to FC #8 running out of the medication - No documentation to reflect any staff contacted a pharmacist or a physician on behalf of FC #8 regarding this medication error Review on 12/19/25 of Former Client #9's record revealed - An admission date of 10/7/25 - A diagnosis of Cocaine Use D/O, Severe - A discharge date of 11/7/25 - A level I incident report reviewed by the Center Director on 10/8/25 which documented FC #9 was not administered her 8 pm dose of Prazosin HCL (Hydrochloride) 2 mg (used to treat hypertension) on 10/7/25 due to the medication not being onsite as client #9 was awaiting an authorization for a refill from her provider - A level I incident report reviewed by the Center Director on 10/8/25 which documented FC #9 was not administered her 8 pm dose of Abilify	V 123		

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V 123	Continued From page 8 5 mg (used to balance dopamine/serotonin levels in brain) on 10/7/25 due to the medication needing prior authorization from pharmacy. - No documentation to reflect any staff contacted a pharmacist or a physician on behalf of FC #9 regarding this medication error Interviews on 12/31/25 with the Center Director; Enhanced Operations Senior Program Manager and the Quality Improvement Manager revealed: - Acknowledgement that a pharmacist or physician should have been contacted when a client missed a medication and the results of this contact noted on the level I incident report - There had been some challenges associated with medications due to recent staffing issues and the facility changing from a short term placement to a more long term option for care - Were working on ways to ensure client medications were always onsite for administration	V 123		
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;	V 366		

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V 366	Continued From page 9 (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 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	V 366		

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V 366	Continued From page 10 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 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 11 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement written policies governing their response to level II incidents as required. The findings are: Review on 12/29/25 and on 12/30/25 of client #5's record revealed: - An admission date of 5/16/25 - Diagnoses of Alcohol Use Disorder (D/O), Severe; Cocaine Use D/O, Severe; Major Depressive D/O, Single Episode, Moderate; Generalized Anxiety D/O and Hypertension - Client left the facility on 9/15/25 to go to a medical center for "hypertension." - No time was listed as to when client #5 left the facility; however, it was documented she returned to the facility from the medical center at 2:30 pm on the same date Interview on 12/19/25 with client #5 revealed: - Per agency protocol, she was taken a local medical center due to her blood pressure being "160 over something." - Cannot recall the exact date but believed it was in October 2025 - Felt "ok" other than "maybe some swelling" around the rings on her fingers - Believed her blood pressure had increased due to her not receiving her blood pressure medication for at least two days while at the facility - A medical professional administered her normal dose of Lisinopril 40 mg and she later	V 366		

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V 366	Continued From page 12 returned to the facility on the same day Review on 12/30/25 of the Incident Response Improvement System (IRIS) revealed: - No level II incident report had been submitted to IRIS regarding client #5 having been transported to a medical center where she received treatment (administered medication) to treat her hypertension Interviews on 12/31/25 with the Center Director and the Quality Improvement Manager revealed: - Client #5 had been transported to a medical center on 9/15/25, per agency protocol due to her blood pressure being elevated - No level II incident report had been completed, thus there was no documentation to support how client (#5's) health and safety needs were being attended to; a determination of the cause of the incident; what corrective measures were developed and implemented to prevent similar incidents and what person(s) were assigned to be responsible for implementation of any corrective and preventative measures which were all part of a level II incident report	V 366	All residential, nursing, and supervisory staff were re-educated on Level II incident requirements, including: Any offsite medical transport or treatment meeting Level II criteria must be reported in IRIS. Required documentation includes incident description, health and safety actions, cause determination, corrective measures, and assignment of responsible staff. **Completed 1/21/2026** **Ongoing Monitoring by CD, RD QI Review**	1-21-26
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	V 367		

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V 367	Continued From page 13 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 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	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411015	A. BUILDING: _____ B. WING _____	12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 367	Continued From page 14 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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report a level II incidents to the Local Management Entity (LME) responsible for the catchment area where services were provided within 72 hours of becoming aware of the incident affecting 1 of 7 audited clients (client #5). The findings are:	V 367		

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V 367	Continued From page 15 Review on 12/29/25 and on 12/30/25 of client #5's record revealed: - An admission date of 5/16/25 - Diagnoses of Alcohol Use Disorder (D/O), Severe; Cocaine Use D/O, Severe; Major Depressive D/O, Single Episode, Moderate; Generalized Anxiety D/O and Hypertension - Client left the facility on 9/15/25 to go to a medical center for "hypertension." - No time was listed as to when client #5 left the facility; however, it was documented she returned to the facility from the medical center at 2:30 pm on the same date Interview on 12/19/25 with client #5 revealed: - Per agency protocol, she was taken a local medical center due to her blood pressure being "160 over something." - Cannot recall the exact date but believed it was in October 2025 - Felt "ok" other than "maybe some swelling" around the rings on her fingers - Believed her blood pressure had increased due to her not receiving her blood pressure medication for at least two days while at the facility - A medical professional administered her normal dose of Lisinopril 40 mg and she later returned to the facility on the same day Review on 12/30/25 of the Incident Response Improvement System (IRIS) revealed: - No level II incident report had been submitted to IRIS regarding client #5 having been transported to a medical center where she received treatment (administered medication) to treat her hypertension -	V 367	All residential, nursing, and supervisory staff were re-educated on the requirement that **any Level II incident, including offsite medical transport or treatment, must be reported to the LME within 72 hours**. Training included documentation requirements in IRIS, verification of provider notification, and assignment of responsible staff. **Completed 1/22/2026** **Ongoing monitoring by CD, RD and QI Review**	1-22-26

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V 367	Continued From page 16 Interviews on 12/31/25 with the Center Director and the Quality Improvement Manager revealed: - Client #5 had been transported to a medical center on 9/15/25, per agency protocol due to her blood pressure being elevated - No level II incident report had been completed regarding client #5 being transported to a medical center and receiving treatment for an elevated blood pressure	V 367		