

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL002-032	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/12/2026
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NAME OF PROVIDER OR SUPPLIER GEORGIE'S HELPING HAND	STREET ADDRESS, CITY, STATE, ZIP CODE 490 RADIO ROAD TAYLORSVILLE, NC 28681
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V 000	<p>INITIAL COMMENTS</p> <p>An annual and follow up survey was completed on 1/12/26. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G. 1700 Residential Treatment Staff Secure for Children or Adolescents.</p> <p>This facility is licensed for 5 and has a current census of 4. The survey sample consisted of audits of 3 current clients.</p>	V 000		
V 112	<p>27G .0205 (C-D) Assessment/Treatment/Habilitation Plan</p> <p>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN</p> <p>(c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days.</p> <p>(d) The plan shall include:</p> <ol style="list-style-type: none"> (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. 	V 112	<p>When GHH GH Staff are notified or receive a Referral, from either, DSS, LME/MCO, Other Group Homes, Programs, or Hospitals, for possible placements of Clients, documents are requested for review, to include, but not limited to, PCPs, CCAs, Crisis Intervention & Discharge Plans, and the Signed Service Order Page, if available. Once documents are received, they are reviewed by GHH Administrators and Staff, at which time decisions are tentatively made regarding possible acceptance of the Clients. A Meet & Greet is requested with the referring source, to include the prospective Client for GHH Staff to speak with the individual. Following the Meet & Greet, another Team Meeting (GHH) is held, decision made, whether to accept the individual or not, referral source notified either way. If accepted a tentative admission date is scheduled. GHH Intake packet is sent to the referring source to complete and return. Other documents are requested, such as BC, SS & Medicaid Cards, Immunization/Medical Records, School Information & Records, and Signed Affidavits. Afterwards, a referral is made to the Alexander County School Placement Coordinator, which include providing documents to them as required.</p>	

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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V 112	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement treatment plans based on client needs within 30 days of admission for 3 of 3 audited clients (Clients #1, #2 and #3). The findings are:</p> <p>Review on 12/22/25 of Client #1's record revealed: -Date of Admission 8/15/25. -15 years old. -Diagnoses of Oppositional Defiant Disorder (ODD), Attention-Deficit Hyperactivity Disorder (ADHD), Autism Spectrum Disorder and Anxiety Disorder. -No treatment plan.</p> <p>Review on 12/22/25 of Client #2's record revealed: -Date of Admission 9/17/25. -14 years old. -Diagnoses of ODD and ADHD. -No treatment plan.</p> <p>Review on 12/22/25 of Client #3's record revealed: -Date of Admission 9/13/25. -14 years old. -Diagnoses of ADHD, Conduct Disorder and Disruptive Mood Dysregulation Disorder. -No treatment plan.</p>	V 112	<p>The Clients' Treatment Plans, based on their diagnoses, needs, and goals are basically identified when they are referred to us, which were and continue to be implemented during their placements at GHH GH.</p> <p>GHH absolutely did and do have Service/Treatment Plans for all Clients. Even though the Clients' Treatment Plans were not initially presented to the Surveyors upon request, they were later produced (as confirmed by Surveyor in this report) as evidence to show and prove that PCPs for all Clients had been prepared and are available.</p> <p>Surveyors did review GHH Therapist's notes for the Clients in placement, which include their diagnoses, goals, and treatment plans, all indicators that their needs were identified and being addressed from their admissions and throughout placement at GHH.</p> <p>The Clients' folders now include their Treatment Plans (from prior placements if applicable, as well as ones generated by GHH).</p>	1/28/2026

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V 112	<p>Continued From page 2</p> <p>Review on 1/6/26 of a Computer Aided Dispatch (CAD) list dated 8/1/25-1/5/26 from the local sheriff's department revealed: -Law enforcement was called to Georgie's Helping Hand Group Home for a "Missing Person" on 11/6/25 and 12/3/25. When Client #3 eloped from the facility.</p> <p>Interview on 1/5/26 with the Coordinator and Behavior Specialist from the local school where Clients #1, #2 and #3 attended revealed: -"The facility does not share their (clients') behaviors, violence tendency, triggers ...we have learned about [Client #2's] sexual comments just by him being here ...[Client #2] has made statements of wanting to kill himself ...said he had a gun or a bomb ...I don't know if this was a problem prior to him coming here ...[Client #3] ran away from the facility 2 times. If a kid (client) runs from the group home on Saturday, we need to know that on Monday ..."</p> <p>Interviews on 12/22/25, 1/5/26 and 1/8/26 with the Program Director revealed: -He was "involved" with the treatment plan meetings as they were "usually held at the facility." -Goals and interventions were "usually in their (clients') folder (record)."</p> <p>Interview on 1/6/26 with the Qualified Professional (QP) revealed: -"I believe" the therapist was responsible for development of the treatment plans. -Treatment plan "recommendations come from where they (clients) were before and what their interactions were, but that's not part of my forte. I am limited on what I can speak. I don't do that. That's not what I do ..."</p>	V 112	<p>Moving forward, GHH Administrators will assure that all Clients' Treatment Plans are not only provided and/or prepared in a timely manner, but are kept in the Clients' folders and on-site to be readily available if necessary. Clients' folders to be reviewed at least on a monthly basis by GHH Administrators, Executive Director and Director.</p> <p>GHH GH Director provided documents regarding all prospective students to Alexander County School Coordinator, which was confirmed they were in receipt of the documents during scheduled School District Team Meetings held on: 8/15/2025 (for Client #1), 9/15/2025 (for client #3) and 9/24/2025 (for Client #2), which GHH Staff attended and/or participated in. During these DTMs, pertinent information regarding the Clients/Students were discussed, documents reviewed, and privy information shared, such as the Clients' diagnoses, medications, history backgrounds, prior school information & knowledge (IEP, 504 Plan, etc.) Behaviors, Goals and Treatment Plans</p>	Jan 28, 2026

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V 112	<p>Continued From page 3</p> <p>Interview on 1/5/26 with the Director/Licensee revealed: -She would have to "pull up the computer for the other service generated plans" that were kept in another office.</p> <p>Review on 1/6/26 of an e-mail correspondence to the Division of Health Service Regulation surveyors received from the Director/Licensee and Executive Director/Licensee dated 1/6/26 revealed: -Attachments to the e-mail were the Person-Centered Plans (PCPs) (treatment plans) for Clients #1, #2 and #3. -Client #1's PCP was dated 12/28/25 and Client #3's PCP was dated 1/5/26, both after survey entrance. -Client #2's PCP was dated 9/13/25 and last updated 12/31/25.</p> <p>Interview on 1/8/26 with the Director/Licensee revealed: -The PCPs were to be completed by the QP in collaboration with the staff. "[QP] is responsible ...I did the PCPs you received (1/6/26)."</p> <p>Interviews on 1/6/26 and 1/12/26 with the Executive Director/Licensee revealed: -The Program Director, the Director/Licensee and the therapist were responsible for developing treatment plans.</p> <p>This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type B rule violation and must be corrected within 45 days.</p>	V 112	<p>Alexander County School Coordinator / Behavioral Specialist, who to my recollection, and records of participants, attended and participated in the indicated District Team Meetings. Therefore, for her to indicate to the Surveyor as noted on 1/5/2026 that the facility (referring to GHH G/H) does not share pertinent information regarding Clients #1, #2, & #3 is simply Not True!</p> <p>GHH Administrators provided SSC School Principal with Staff contact information and maintained a good rapport with her regarding the Clients/Students on a regular basis, which is expected to continue throughout the school terms and monitored by GHH Administrators; Executive Director, Director, and QP.</p> <p>The Elopement incident on 11/6/25 regarding Client #3, the School was very much aware, as it was the School's Principal who contacted GHH G/H Staff to inform that Client #3 was at the School and should be picked up, which he was.</p> <p>Client #2's Sexual, Threatening and SI comments were made in School, GHH having NO Prior Knowledge!</p>
V 118	27G .0209 (C) Medication Requirements	V 118	

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V 118	<p>Continued From page 4</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</p> <p>(c) Medication administration:</p> <p>(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.</p> <p>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.</p> <p>(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.</p> <p>(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:</p> <p>(A) client's name;</p> <p>(B) name, strength, and quantity of the drug;</p> <p>(C) instructions for administering the drug;</p> <p>(D) date and time the drug is administered; and</p> <p>(E) name or initials of person administering the drug.</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on observation, record reviews, and interviews, the facility failed to ensure prescription</p>	V 118	<p>GHH Administrators and Staff were by No Means Operating in a Serious Neglectful manner regarding the administration of the Clients medications. The Clients Medications were administered according to the records we were made privy to upon the Clients' admission, usually not with the Physician's Orders included. The Clients' legal Guardians provided the prescribed medications to us, at which time the information was recorded from the prescription bottles when the Physician Orders were not available. Medication refills were requested in a timely manner, in an effort to</p>	
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V 118	<p>Continued From page 5</p> <p>and non-prescription drugs were only administered to a client on the written order of a physician and the MARs were kept current for 3 of 3 audited clients (Clients #1, #2 and #3). The findings are:</p> <p>Cross Reference: 10A NCAC 27G.0209 Medication Requirements (V123). Based on record reviews and interviews, the facility failed to ensure drug administration errors were reported immediately to a physician or pharmacist for 3 of 3 audited clients (Clients #1, #2 and #3).</p> <p>- Review on 12/22/25 of Client #1's record revealed:</p> <ul style="list-style-type: none"> -Physician's orders dated 9/3/25 for: <ul style="list-style-type: none"> -Cetirizine Hydrochloride (HCL) (allergies) 10 milligrams (mg) 1 tablet by mouth (PO) daily. -Montelukast Sodium (asthma) 10 mg 1 tablet PO daily. -Qelbree Extended Release (ER) (ADHD) 200 mg 1 capsule PO daily. -Metformin HCL (prediabetes) 500 mg 1 tablet PO daily. -Fluoxetine HCL (depression) 10 mg 1 capsule PO every morning. -Physician's order dated 11/11/25 to discontinue Lexapro/escitalopram oxalate 10 mg. -No physician's orders for: <ul style="list-style-type: none"> -Aripiprazole (agitation) 5 mg 1 tablet PO at bedtime (HS). -Guanfacine (impulsivity/ODD) 4 mg 1 tablet PO every evening. -Oxcarbazepine (ADHD) 300 mg 1 tablet PO every evening. -Levocetirizine (allergies) 5 mg 1 tablet PO every evening. -Fluoxetine HCL 20 mg 1 capsule PO daily. 	V 118	<p>avoid any availability issues and/or lapses. Medication Management Appointments were sought and scheduled for the clients on a regular basis, which they attended. Any updates that were provided with following the Medication Management Appts. and filling the Prescriptions at the Pharmacies were noted and processed accordingly. The Pharmacies may have been made privy to the Physician's Scripts, which we were not. Therefore, it was our practice to follow through with the medications once filled by the pharmacies and noted on the prescribed medication bottles.</p>	

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V 118	<p>Continued From page 6</p> <p>Review on 12/23/25 of a dispense sheet dated 8/1/25-12/23/25 obtained by Division of Health Service Regulation (DHSR) surveyors on 12/23/25 from the local pharmacy which dispensed Client #1's medications revealed:</p> <ul style="list-style-type: none"> -Cetirizine 10 mg 1 tablet PO daily prescribed 11/5/25; Dispensed 11/5/25, 12/5/25. -Montelukast 10 mg 1 tablet PO daily prescribed 11/5/25; Dispensed 11/5/25, and 12/5/25. -Qelbree 200 mg 1 capsule PO daily prescribed 9/2/25; Dispensed 9/15/25, 10/23/25, 11/24/25, and 12/23/25. -Metformin 500 mg 1 tablet PO daily prescribed 9/2/25; Dispensed 9/4/25. -Metformin 500 mg 1 tablet PO every evening prescribed 11/5/25; Dispensed 12/16/25. -Fluoxetine 10 mg 1 capsule PO every morning prescribed 9/2/25; Dispensed 9/20/25. -Fluoxetine 20 mg 1 capsule PO daily prescribed 11/5/25; Dispensed 12/16/25. -Aripiprazole 5 mg 1 tablet PO at HS prescribed 11/5/25; Dispensed 11/5/25, and 12/5/25. -Guanfacine 4 mg 1 tablet PO at HS prescribed 11/5/25; Dispensed 11/5/25 and 12/12/25. -Oxcarbazepine 300 mg 1 tablet PO at HS prescribed 11/17/25; Dispensed 11/18/25 and 12/16/25. -Levocetirizine 5 mg 1 tablet PO every evening prescribed 10/2/25; Dispensed 10/2/25, 11/10/25, and 12/12/25. <p>Observation on 12/22/25 at 2:00 pm of Client #1's medications revealed:</p> <ul style="list-style-type: none"> -Fluoxetine HCL 20 mg 1 PO daily dispensed 12/16/25. -Cetirizine HCL 10 mg 1 PO daily dispensed 12/5/25. -Montelukast Sodium 10 mg 1 PO daily dispensed 12/5/25. -Qelbree ER 200 mg 1 PO every morning 	V 118	<p>GHH Administrators immediately reviewed all Medication Administration Records (MARs) for current Clients, once the Surveyors informed us of the concerns. Even though GHH Executive Director could explain some of the discrepancies noted on the MARs, without the proper documentation the information was problematic.</p> <p>It should be noted that it is GHH Administrator's contention that the Clients received their medications for the most part, on a regular consistent basis.</p>	
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V 118	<p>Continued From page 7</p> <p>dispensed 11/24/25.</p> <p>-Aripiprazole 5 mg 1 PO at HS dispensed 12/5/25.</p> <p>-Guanfacine HCL ER 1 PO at HS dispensed 12/12/25.</p> <p>-Oxcarbazepine 300 mg 1 PO at HS dispensed 12/16/25.</p> <p>-Metformin HCL 500 mg 1 PO every evening dispensed 12/16/25.</p> <p>-Levocetirizine 5 mg 1 PO every evening dispensed 12/12/25.</p> <p>Review on 12/22/25 at 12:30 pm-2:00 pm of Client #1's MARs dated 10/1/25-12/22/25 revealed:</p> <p>-There were no consistent specified administration time for cetirizine, montelukast, Qelbree, or Fluoxetine. The time slots on the October 2025 MARs were left blank, the November 2025 MARs listed administration times of 6:30 am and 7:00 am, and the December 2025 MARs listed administration times of 6:30 am, 7:30 am, and 8:00 am.</p> <p>-October:</p> <p>-Cetirizine was marked with an "X" 10/1/25-10/6/25 and left blank 10/7/25-11/5/25.</p> <p>-Montelukast was marked with an "X" 10/1/25-10/2/25 and left blank 10/3/25-10/31/25.</p> <p>-Aripiprazole and guanfacine were listed, but neither were documented as administered 10/1/25-10/31/25.</p> <p>-Oxcarbazepine was listed but not documented as administered 10/1/25-10/31/25.</p> <p>-Levocetirizine was marked with an "X" from 10/1/25-10/2/25 and documented as administered 10/3/25-10/31/25.</p> <p>-November:</p> <p>-Montelukast was left blank 11/1/25-11/5/25.</p> <p>-Metformin was not documented as administered 11/30/25.</p>	V 118	<p>To further address the issue as noted by Surveyors, any identified medication discrepancies or errors were promptly addressed, the prescribing practitioners were contacted. GHK licensed Registered Nurse reviewed all current Medications Orders for accuracy, transcription and proper administration.</p> <p>Staff involved received immediate re-education prior to administering further medications.</p>	12/29/2025

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V 118	<p>Continued From page 8</p> <ul style="list-style-type: none"> -Fluoxetine 20 mg was not listed and fluoxetine 10 mg continued be documented as administered 11/5/25-11/30/25. -Aripiprazole and guanfacine were listed, but neither were documented as administered from 11/1/25-11/4/25. Both were documented as administered 11/5/25-11/30/25. -Both oxcarbazepine and its brand-name formulation, Oxtellar, were listed concurrently on the MAR. Oxcarbazepine was not documented as administered 11/1/25-11/30/25 and Oxtellar was marked with an "X" from 11/1/25-11/23/25 and was initialed as administered from 11/24/25-11/30/25. -Levocetirizine was documented as administered 11/1/25-11/30/25. -December: <ul style="list-style-type: none"> -Fluoxetine 10 mg (instead of 20 mg) continued to be documented as administered 12/1/25-12/15/25. Fluoxetine 10 mg was marked with an "X" from 12/16/25-12/31/25. Fluoxetine 20 mg was documented as administered from 12/16/25-12/21/25. No administration was documented on 12/22/25. -Montelukast was marked with a circle and no staff initials on 12/5/25 and 12/22/25. On 12/6/25 montelukast was documented as administered at 6:30 am, left blank for 7:30 am and marked with a circle and no staff initials for 8:00 am. -Qelbree was not documented as administered 12/22/25. The 6:30 am and 8:00 am time slots were left blank and the 7:30 am time slot was marked with a circle and no staff initials. -Metformin was not documented as administered 12/21/25. -Aripiprazole and guanfacine were documented as administered 12/1/25-12/21/25. -Oxtellar was not listed on the MAR; only the generic medication oxcarbazepine was listed, and it was not documented as administered 	V 118	<p><i>GHH Administrators & Registered Nurse conducted an In-House audit of all MARs & Physician Orders received, to ensure medications are administered exactly as prescribed, including correct Medication, Dose, Route, Time, and Documentation. This audit applied to all residents receiving medications to ensure no other residents are at risk for similar issues.</i></p>	12/29/2025

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V 118	<p>Continued From page 9</p> <p>12/1/25-12/21/25.</p> <p>-Levocetirizine was documented as administered 12/1/25-12/19/25 and on 12/21/25. On 12/20/25 no administration was documented as the corresponding entry was left blank.</p> <p>Review on 12/22/25 of Client #2's record revealed:</p> <p>-No physician's order for any administered medications.</p> <p>Review on 12/23/25 of a dispense sheet dated 8/1/25-12/23/25 obtained by DHSR surveyors on 12/23/25 from the local pharmacy which dispensed Client #2's medications revealed:</p> <p>-Desvenlafaxine succinate ER (depression) 100 mg 1 tablet PO daily prescribed 4/13/25; Dispensed 9/29/25, 11/19/25, and 12/15/25.</p> <p>-Lurasidone (mood disorder) 60 mg 1 tablet PO every evening prescribed 6/29/25; Dispensed 9/29/25.</p> <p>-Clonidine (ADHD) ER 0.1 mg 1 tablet PO twice daily (BID) in the morning and afternoon prescribed 8/3/25; Dispensed 10/1/25, 11/10/25.</p> <p>-Clonidine 0.1 mg 1 tablet PO in the morning and 1 tablet PO in the evening prescribed 11/19/25; Dispensed 11/19/25.</p> <p>-Clonidine 0.3 mg 1 tablet PO at HS prescribed 11/19/25; Dispensed 11/19/25.</p> <p>-Trazodone (insomnia) 50 mg 1 tablet PO at HS prescribed 9/29/25; Dispensed 9/29/25.</p> <p>-Trazodone 50 mg 1 to 1 1/2 tablets PO at HS prescribed 11/19/25; Dispensed 11/19/25.</p> <p>-Qelbree ER 200 mg 1 capsule PO every morning prescribed 10/30/25; Dispensed 10/30/25.</p> <p>-Qelbree ER 200 mg 1 capsule PO daily at 1:00 pm prescribed 11/19/25; Dispensed 11/26/25.</p> <p>-Omeprazole (heartburn) 20 mg 1 capsule PO daily prescribed 11/19/25; Dispensed 11/19/25, and 12/15/25.</p>	V 118	<p><i>GHH Administrators has revised and reinforced its Medication Administration Policy to ensure compliance with NC DHSR requirements.</i></p> <p><i>All staff responsible for Medication Administration will receive re-training on proper medication administration procedures, documentation requirements, and error reporting of V118 and V123 regulations.</i></p> <p><i>Only staff who have completed Medication Administration Training and demonstrated competency will be permitted to administer medications</i></p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL002-032	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/12/2026
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NAME OF PROVIDER OR SUPPLIER
GEORGIE'S HELPING HAND

STREET ADDRESS, CITY, STATE, ZIP CODE
**490 RADIO ROAD
TAYLORSVILLE, NC 28681**

(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 118	<p>Continued From page 10</p> <p>-Vyvanse (ADHD) 60 mg 1 capsule PO every morning prescribed 11/19/25; Dispensed 11/21/25.</p> <p>-Vitamin D3 (supplement) 50 micrograms (mcg) 1 capsule PO daily prescribed 11/19/25; Dispensed 11/19/25 and 12/18/25.</p> <p>Observation on 12/22/25 at 2:23 p.m. of Client #2's medications revealed:</p> <p>-Vyvanse 60 mg 1 PO every morning dispensed 11/21/25.</p> <p>-Desvenlafaxine succinate 1 PO daily dispensed 12/15/25.</p> <p>-Omeprazole 20 mg 1 PO daily dispensed 12/15/25.</p> <p>-Vitamin D3 50 mcg 1 PO daily dispensed 12/18/25.</p> <p>-Clonidine 0.1 mg 1 PO in the morning and 1 PO in the evening dispensed 11/19/25.</p> <p>-Trazodone 50 mg 1-1 1/2 tablets PO at HS dispensed 11/19/25</p> <p>-The following medications were not provided:</p> <p>-Qelbree 200 mg .</p> <p>-Clonidine 0.3 mg.</p> <p>-Lurasidone HCL 60 mg.</p> <p>Review on 12/22/25 at 12:30 pm-2:00 pm of Client #2's MARs dated 10/1/25-12/22/25 revealed:</p> <p>-October:</p> <p>-Desvenlafaxine was documented as administered at 6:30 am 10/1/25-10/31/25.</p> <p>-Lurasidone was documented as administered at 5:00 pm 10/1/25-10/31/25.</p> <p>-Clonidine 0.1 mg 1 tablet in the morning and afternoon was documented as administered at 6:30 am and 1:00 pm except for 10/10/25 and 10/30/25 in which the 1:00 pm doses were left blank.</p> <p>-Clonidine 0.2 mg 1 tablet at HS was documented</p>	V 118	<p>GHH will implement a standardized double-check process for New Medication Orders and transcriptions to MARs., which will include RN</p> <p>Medication Errors will be reported, documented, and addressed according to policy, with corrective actions taken as appropriate.</p> <p>GHH Administrators will conduct Medication Administration observations & MARs audits on a regular daily basis for approximately 4 weeks, then weekly thereafter for a minimum of 3 months to ensure compliance.</p>	2/1/2026

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V 118	<p>Continued From page 11</p> <p>as administered 10/1/25-10/5/25, 10/7/25-10/8/25, and 10/10/25-10/13/25. Clonidine 0.2 mg was marked with an "X" on 10/6/25, 10/9/25, and 10/14/25-10/31/25.</p> <p>-Trazodone 1 tablet at HS was documented as administered 10/1/25-10/31/25.</p> <p>-Qelbree 200 mg 2 capsules daily at 1:00 pm was documented as administered 10/1/25-10/9/25 and 10/11/25/-10/30/25. Documentation on 10/10/25 was left blank, and entries on 10/30/25 and 10/31/25 were marked with a cross without any accompanying explanation.</p> <p>-Omeprazole was listed but left blank and not documented as administered from 10/1/25-10/31/25.</p> <p>-Vyvanse was documented as administered at 6:30 am from 10/1/25-10/9/25 and from 10/18/25-10/31/25. Entries from 10/10/25-10/17/25 were marked with an "X" without further explanation.</p> <p>-Vitamin D3 was listed with no specified administration time and was not documented as administered from 10/1/25-10/31/25.</p> <p>-Dextroamphetamine (ADHD) 5 mg was listed with instructions to take 1 tablet PO daily at 1:00 pm and was documented as administered 10/1/25-10/3/25, marked with an "X" 10/4/25-10/6/25, and left blank 10/7/25-10/31/25.</p> <p>-November:</p> <p>-Desvenlafaxine was documented as administered at 6:30 am 11/1/25-11/29/25, and at 7:00 pm 11/30/25.</p> <p>-Lurasidone was listed twice on the MAR. On one page, the administration time was blank, and no doses were documented as administered from 11/1/25-11/30/25. On another page, the administration time was listed as 8:00 pm, with doses documented as administered on 11/1/25-11/4/25 and left blank from 11/5/25-11/30/25.</p>	V 118	<p>Findings will be documented, any identified issues will be addressed immediately through re-training or disciplinary actions, if necessary.</p> <p>GHH Administrators and licensed RN will be the responsible persons for implementation and monitoring.</p>	

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V 118	<p>Continued From page 12</p> <p>-Clonidine 0.1 mg was listed twice on the MAR. On one page, instructions for 1 tablet in the morning and 1 tablet in the afternoon were documented as administered from 11/1/25-11/19/25 at 6:30 am and at an additional illegible time which appeared to read "3X5." On another page, clonidine 0.1 mg was listed with administration times of 6:30 am and 4:00 pm, with doses documented as administered from 11/20/25-11/28/25. On 11/29/25, the 6:30 am dose was documented as administered, and the 4:00 pm dose contained an entry consisting of a circled mark without initials. On 11/30/25, a dose was documented as administered at 7:00 am, and the 4:00 pm dose was left blank.</p> <p>-Clonidine 0.2 mg 1 tablet at HS was documented as administered 11/1/25-11/3/25. On 11/4/25-11/10/25, the corresponding MAR entry boxes were traced on the edges in ink without initials or documentation in the boxes. No administration was documented from 11/11/25-11/30/25, as the entries were left blank.</p> <p>-Clonidine 0.3 mg was documented as administered 11/20/25-11/30/25.</p> <p>-Trazodone 1 tablet at HS was documented as administered 11/1/25-11/19/25. Trazodone 1 to 1 1/2 tablet at HS was documented as administered 11/20/25-11/30/25 and did not specify the number of tablets administered for each dose.</p> <p>-Qelbree 200 mg 1 capsule each morning was documented as administered from 11/1/25-11/19/25 and left blank from 11/20/25-11/30/25.</p> <p>-Qelbree 200 mg 1 capsule once daily at 1:00 pm was left blank from 11/1/25-11/19/25 and documented as administered 11/20/25-11/30/25.</p> <p>-Omeprazole was listed twice on the MAR. On one page the medication time slot was left blank, and there was no documentation of administration from 11/1/25-11/30/25. On a</p>	V 118	<p>Responses to these issues previously addressed in this report.</p>	

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V 118	<p>Continued From page 13</p> <p>separate page, omeprazole was listed with instructions to take 1 capsule once daily, with two administration times specified (6:30 am and 7:00 am). Documentation indicated the medication was not administered at either time from 11/1/25-11/19/25, administered at 6:30 am on 11/20/25-11/21/25 and 11/23/25-11/29/25, and administered at 7:00 am on 11/22/25 and 11/30/25.</p> <p>-Vyvanse was listed twice on the MAR. On one page, Vyvanse was listed with a specified administration time of 6:30 am and documented as administered from 11/1/25-11/19/25. Documentation was left blank from 11/20/25-11/30/25. On a separate page, Vyvanse was listed with instructions to take 1 capsule once daily, with two administration times specified (6:30 am and 7:00 am). Documentation on this page was left blank 11/1/25-11/19/25 and documented as administered at 6:30 am 11/20/25-11/29/25 and at 7:00 am on 11/30/25. The 6:30 am entry for 11/30/25 had been initialed by staff and subsequently scribbled out with black ink, without explanation.</p> <p>-Vitamin D3 was listed twice on the MAR. On one page, Vitamin D3 was listed without a specified administration time and was marked with an "X" from 11/1/25-11/19/25. Documentation was left blank from 11/20/25-11/30/25. On a separate page, Vitamin D3 was listed with instructions to take 1 capsule once daily, with two administration times specified (6:30 am and 7:00 am). Documentation on this page indicated the medication was not administered at either time from 11/1/25-11/19/25 and was documented as administered at 6:30 am 11/20/25-11/21/25 and 11/23/25-11/29/25, and at 7:00 am 11/22/25 and 11/30/25.</p> <p>-Dextroamphetamine was not listed on the MAR.</p> <p>-December:</p>	V 118	<p><i>Responses to these issues previously addressed in this report</i></p>	

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V 118	<p>Continued From page 14</p> <p>-Desvenlafaxine was documented as administered at 6:30 am 12/1/25-12/11/25, 12/13/25-12/14/25, and 12/16/25-12/19/25. It was documented as administered at 8:00 am on 12/15/25 and 12/20/25-12/22/25. Desvenlafaxine was not documented as administered on 12/12/25.</p> <p>-Lurasidone was listed with no administration time, and doses were not documented as administered from 12/1/25-12/22/25.</p> <p>-Clonidine 0.1 mg was listed once with instructions to administer 1 tablet in the morning and 1 tablet in the evening. The administration times were listed as 6:30 am, 4:00 pm and 8:00 am. Doses were documented as administered as follows: On 12/1/25-12/4/25, 12/7/25-12/11/25, and 12/16/25 at 6:30 am and 4:00 pm. On 12/5/25 at 4:00 pm only (no am dose). On 12/6/25, 12/12/25-12/14/25, and 12/17/25-12/19/25 at 6:30 am only (no pm doses). On 12/20/25 and 12/22/25 at 8:00 am only (no pm doses). On 12/21/25 at 4:00 pm and 8:00 am. On 12/15/25 the 6:30 am slot was left blank, the 4:00 pm entry contained a circled mark without initials, and the 8:00 am dose was initialed as administered.</p> <p>-Clonidine 0.3 mg was documented as administered 12/1/25-12/19/25, left blank on 12/20/25, and marked with an "X" on 12/21/25.</p> <p>-Trazodone 1 to 1 1/2 tablet at HS was documented as administered 12/1/25-12/21/25 and did not specify the number of tablets administered for each dose.</p> <p>-Qelbree 200 mg 1 capsule once daily at 1:00 pm was documented as administered 12/1/25-12/21/25.</p> <p>-Omeprazole was listed with instructions to take 1 capsule once daily, with two administration times specified (6:30 am and 8:00 am). The medication was documented as administered at 6:30 am</p>	V 118	<p><i>Responses to these issues previously addressed in this report.</i></p>	
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V 118	<p>Continued From page 15</p> <p>from 12/1/25-12/14/25 and from 12/16/25-12/19/25 and documented as administered at 8:00 am on 12/15/25 and from 12/20/25-12/22/25.</p> <p>-Vyvanse was listed once with instructions to take 1 capsule in the morning, with two administration times specified (6:30 am and 8:00 am). Vyvanse was documented as administered at 6:30 am 12/1/25-12/11/25, 12/13/25-12/14/25, and 12/16/25-12/19/25. Documented as administered at 8:00 am on 12/15/25 and 12/20/25-12/21/25. Documentation for 12/12/25 was left blank with no record of administration.</p> <p>-Vitamin D3 was listed with instructions to take 1 capsule once daily with two specified administration times (6:30 am and 8:00 am). Vitamin D3 was documented as administered at 6:30 am 12/1/25-12/11/25, 12/13/25-12/14/25, and 12/16/25-12/19/25, and documented as administered at 8:00 am 12/15/25 and 12/20/25-12/22/25.</p> <p>-Dextroamphetamine was not listed on the MAR.</p> <p>- Review on 12/22/25 of Client #3's record revealed: -No physician's order for any administered medications.</p> <p>Review on 12/23/25 of a dispense sheet dated 8/1/25-12/23/25 obtained by DHSR surveyors on 12/23/25 from the local pharmacy which dispensed Client #3's medications revealed: -Desmopressin (bedwetting) 0.2 mg 1 tablet PO at HS prescribed 9/19/25; Dispensed 9/21/25. -Desmopressin 0.2 mg 4 tablets PO at HS prescribed 10/16/25; Dispensed 10/16/25. -Carbamazepine (seizures) 100 mg Chew and swallow 2 tablets PO at 8:00 am and 2 tablets at 8:00 pm prescribed 9/19/25; Dispensed 10/30/25. -Carbamazepine 100 mg chew and swallow 2</p>	V 118	<p><i>Responses to these Issues previously Addressed in this Report.</i></p>	

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V 118	<p>Continued From page 16</p> <p>tablets PO BID prescribed 9/22/25 and 12/12/25; Dispensed 9/22/25 and 12/15/25.</p> <p>-Concerta (ADHD) 27 mg 2 tablet PO in the morning (Do Not Exceed 1 per 24 hours) prescribed 9/22/25; Dispensed 9/22/25.</p> <p>-Concerta 36 mg 1 tablet PO in the morning (Do Not Exceed 1 per 24 hours) prescribed 10/16/25; Dispensed 10/16/25 and 12/2/25.</p> <p>-Melatonin (insomnia) 3 mg Dissolve 1-2 tablets PO at HS prescribed 9/22/25; Dispensed 9/22/25.</p> <p>Observation on 12/22/25 at 2:49 p.m. of Client #3's medications revealed:</p> <p>-Desmopressin 0.2 mg 4 tablets PO at HS dispensed 10/16/25.</p> <p>-Methylphenidate ER 36 mg 1 PO in the morning dispensed 12/2/25.</p> <p>-Fluticasone 27.5 mcg nasal spray 1 ml spray into each nostril daily dispensed 3/28/25.</p> <p>-The following medications were not provided:</p> <p>-Carbamazepine 100 mg.</p> <p>-Melatonin 3 mg.</p> <p>-Docusate Sodium 50 mg.</p> <p>Review on 12/22/25 at 12:30 pm-2:00 pm of Client #3's MARs dated 10/1/25-12/22/25 revealed:</p> <p>-Fluticasone nasal spray (allergy symptoms) 27.5 mcg was listed on the October 2025, November 2025, and December 2025 MARs with instructions to take 1 milliliter (ml) of nasal spray daily and was not documented as administered from 10/1/25-12/22/25.</p> <p>-Docusate sodium (constipation) 50 mg was listed on the October 2025 and November 2025 MARs with instructions to take 1 capsule PO BID at 8:00 am and 8:00 pm and was not documented as administered for either dose from 10/1/25-11/30/25.</p> <p>-Carbamazepine had written instructions on the</p>	V 118	<p><i>Responses to these Issues Previously Addressed in this Report.</i></p>	

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V 118	<p>Continued From page 17</p> <p>October 2025, November 2025 and December 2025 MARs to take 2 tablets "twice daily (8am, 8pm)" but had specified administration times for 8:00 am, 6:30 am, and 8:00 pm.</p> <p>October:</p> <ul style="list-style-type: none"> -Carbamazepine was left blank for the 8:00 am dose from 10/1/25-10/31/25. Carbamazepine was documented as administered at 6:30 am and 8:00 pm on 10/1/25-10/8/25, 10/10/25-10/11/25, and 10/13/25-10/27/25. On 10/9/25, the 6:30 am dose was documented as administered, and the 8:00 pm dose was left blank. On 10/12/25 and 10/31/25, the 6:30 am dose was documented as administered, and the 8:00 pm dose was marked with an "X." From 10/28/25-10/30/25, both the 6:30 am and 8:00 pm doses were marked with an "X." -Desmopressin 0.2 mg 1 tablet (instead 4 tablets as instructed on the label) at HS was documented as administered from 10/1/25-10/31/25. -Concerta 27 mg was documented administered 10/1/25-10/19/25 and marked with an "X" from 10/20/25-10/31/25. -Concerta (methylphenidate) 36 mg with instructions was blacked out with ink from 10/1/25-10/19/25 and documented as administered at 6:30 am 10/20/25-10/31/25. -Melatonin 1-2 tablets at HS was documented as administered 10/1/25-10/31/25 but the number of tablets administered were not specified. <p>November:</p> <ul style="list-style-type: none"> -Carbamazepine was documented as administered at 8:00 am and 8:00 pm on 11/1/25-11/2/25 and 11/16/25. It was documented at 6:30 am and 8:00 pm from 11/3/25-11/7/25, 11/10/25-11/14/25, 11/17/25-11/21/25, and 11/24/25-11/25/25. On 11/8/25 and 11/9/25, the 8:00 am and 8:00 pm doses were documented as administered, and the 6:30 am doses were marked with circles over what appeared to be 	V 118	<p><i>Responses to these Issues previously Addressed in this Report.</i></p>	

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V 118	<p>Continued From page 18</p> <p>whited-out initials. On 11/15/25, the 8:00 am and 8:00 pm doses were documented as administered, and the 6:30 am doses were left blank, and the 8:00 pm doses were marked with an "X." On 11/27/25, the 8:00 am dose was documented as administered, and the 6:30 am and 8:00 pm doses were left blank. On 11/28/25, the 8:00 pm dose was documented as administered, and the 6:30 am and 8:00 am doses were left blank.</p> <p>-Desmopressin 0.2 mg 1 tablet (instead 4 tablets as instructed on the label) at HS was documented as administered from 11/1/25-11/30/25.</p> <p>-Concerta (methylphenidate) 36 mg with instructions "DO NOT EXCEED 1 PER 24 HOURS" was blacked out with ink from 10/1/25-10/19/25, documented as administered at 6:30 am 11/1/25-11/15/25, at 8:00 am 11/16/25 (22 ½ hours from previous dose), and at 6:30 am 11/17/25-11/22/25, then marked with an "X" from 11/23/25-11/30/25.</p> <p>-Melatonin 1-2 tablets at HS was documented as administered 11/1/25-11/26 and 11/28/25 but the number of tablets administered were not specified. Melatonin was marked with an "X" on 11/29/25-11/30/25 and was left blank on 11/27/25.</p> <p>December:</p> <p>-Carbamazepine doses were documented as follows: On 12/1/25, an "R" was documented at 8:00 am, the 6:30 am dose was left blank, and the 8:00 pm dose was documented as administered. On 12/2/25, the 6:30 am dose was documented as administered, and the 8:00 am and 8:00 pm doses were left blank. On 12/3/25, the 6:30 am and 8:00 am doses were left blank, and the 8:00 pm dose was marked with an "R" and initials without further explanation. On 12/4/25, the 8:00 am dose was left blank, and the 6:30 am and 8:00 pm doses were marked with an "R" and initials. On 12/5/25, the 8:00 am and 8:00</p>	V 118	<p><i>Responses to these Issues Previously Addressed in this Report.</i></p>	

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NAME OF PROVIDER OR SUPPLIER GEORGIE'S HELPING HAND	STREET ADDRESS, CITY, STATE, ZIP CODE 490 RADIO ROAD TAYLORSVILLE, NC 28681
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V 118	<p>Continued From page 19</p> <p>pm doses were documented as administered, and the 6:30 am dose contained scribbled-out initials. On 12/6/25, the 6:30 am and 8:00 am doses were marked with an "X," and the 8:00 pm dose was left blank. On 12/7/25, the 8:00 am and 8:00 pm doses were left blank, and the 6:30 am dose was marked with an "R" and initials. Carbamazepine was documented as administered at 6:30 am and 8:00 pm on 12/8/25, 12/10/25, and 12/11/25. On 12/9/25, the 6:30 am and 8:00 pm doses were documented as administered, and the 8:00 am dose was marked with an "R" and initials. On 12/12/25, the 6:30 am dose was documented as administered, the 8:00 am dose was left blank, and the 8:00 pm dose was marked with a "?." From 12/13/25 through 12/16/25, on 12/18/25 through 12/19/25, and on 12/21/25, doses were documented as administered at 8:00 am and 8:00 pm. On 12/17/25, the 6:30 am and 8:00 pm doses were documented as administered. On 12/20/25, all doses were left blank. On 12/22/25, the 8:00 am dose was documented as administered. Desmopressin 0.2 mg 1 tablet (instead 4 tablets as instructed on the label) at HS was documented as administered from 12/1/25-12/19/25 and 12/21/25. Administration was not documented for 12/20/25 as the entry was left blank. -Methylphenidate 36 mg was listed with specified administration times of 6:30 am and 8:00 am. Methylphenidate was left blank on 12/1/25-12/2/25 and 12/20/25. It was documented as administered at 6:30 am on 12/3/25-12/4/25, 12/6/25-12/8/25, 12/11/25-12/12/25, and 12/16/25-12/17/25. It was documented as administered at 8:00 am on 12/5/25, 12/9/25-12/10/25, 12/13/25-12/15/25, 12/18/25-12/19/25, and 12/21/25-12/22/25. -Melatonin 1-2 tablets at HS was left blank 12/1/25-12/22/25.</p>	V 118	<p><i>Responses to these Issues Previously Addressed in this Report.</i></p>	

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V 118	<p>Continued From page 20</p> <p>Interviews on 12/22/25, 1/5/26 and 1/8/26 with the Program Director revealed: - "I don't have medication certification. I'm not trained in that. Am I in trouble?" - He initialed and circled his initials on the MAR to indicate the medication was administered. - "We (staff) are taught to not use white out on the MAR."</p> <p>Interviews on 12/23/25 and 1/8/26 with the Director/Licensee revealed: - The Program Director did have medication administration training by a Registered Nurse (RN), "I don't know why he would say that (he didn't have training)." - On 12/22/25 the Program Director "didn't give you all of the (clients') medications. The rest is kept in a different cabinet drawer." - The Executive Director/Licensee transcribed the new MARs each month, reviewed them at the end of the month and was responsible for obtaining the physician's orders.</p> <p>Interview on 1/6/26 with the Executive Director/Licensee revealed: - He listed all the medications on the MARs for each client every month. - He and the facility RN reviewed the MARs for accuracy at the end of each month. - "I didn't know if you circle it (the box on the MAR) it means they didn't receive their medications and I didn't know that just a circle did that. There's nothing down there (bottom of MAR) telling what an "O" is and what an "R" is. I found out when you (DHSR surveyors) came here and then the (facility) nurse came and said I shouldn't circle it. It was an unknowledgeable mistake." - "I should have let you (DHSR surveyors) in the office (on 12/22/25). Some of the medications</p>	V 118	<p>Upon GHH Director speaking with Program Director on 12/22/25 regarding statement made to surveyor on same date, it is my understanding from the Program Director that he misunderstood the question, thought he was being asked did he have Administration Training (meaning some type of supervision training) and not did he have Medication Administration Training (the administering of medications). Program Director acknowledged and confirmed that he indeed did have Medication Administration Training at GHH which was provided by Registered Nurse on 8/13/2025, as well as recently under went an Emergency Medication Administration & MARs Documentation Trainings on 12/29/25 provided at GHH by RN.</p>	
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V 118	<p>Continued From page 21</p> <p>were on the right-hand side and you have to go on the left hand side to get those medications and when he (the Program Director) brought it out he forgot to take the boxes out and that's rare but they (clients) get their medications." -An 'X' on the MAR meant the client did not receive the medication, " ...that means they didn't get it ...It's a careless mistake, nothing behind it ...but you can't do that." -The physician's orders were sent directly to the pharmacy. "We don't touch it (physician's orders) ...We don't have copies (of physician's orders) in the facility." -He picked up the medications from the pharmacy.</p> <p>Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician.</p> <p>Review on 12/23/25 of the Plan of Protection dated 12/23/25 written by the Director/Licensee revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? GHH (Georgie's Helping Hand) Administrative Staff will immediately review all Physicians' Medication Orders for all consumers (clients) in our care, as well as contact the prescribing physicians to request a listing and review of the medication profiles for each of the consumers; to assure we have the most current and accurate listings of the consumers prescribed medications. GHH Administrators will have a Staff Meeting on this date to review the MARS document for omissions; missing documentation to be addressed with late entries noted. Medication administration to be temporarily restricted to Staff with verified medication</p>	V 118	<p>GHH Administrators had a Staff Meeting, at which time employees who are authorized to administer medications to the Clients were made aware again where each Client's medications are kept in the Office (in their individual labeled locked boxes, and in the locked file cabinet for the overflow medications).</p> <p>GHH Staff have recently participated in an Emergency Training to address the proper documentation on the Medication Administration Record (MAR) sheets, which have been revised to include a Key and Legend identifying what and how the record should be marked.</p> <p>Additionally, the back of the MARs sheet now have specified spaces for Narratives to be made to explain the noted information</p>	<p>12/23/2025</p> <p>12/29/2025</p>
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V 118	<p>Continued From page 22</p> <p>management competency until corrective training is completed.</p> <p>GHH Administrator have contacted our Registered Nurse Medication Management Trainer today, 12/23/2025, who will avail herself to conduct a Mandatory Medication Management Training, her earliest available date being Monday, 12/29/2025 or an immediate date thereafter.</p> <p>Describe your plans to make sure the above happens.</p> <p>Discrepancies identified are to be acknowledged and corrected immediately for future references. Updated, verified medication lists to be placed in the consumers' records and medication administration area. GHH Staff will undergo immediate training today on how to properly fill out the MARS document, as well as the required follow-up documents necessary to be submitted in the event that medications are not administered as expected, which would include consumer refusals, out of the GH (group home), and any other situations that may apply.</p> <p>Daily review audits of the MARS documents to be conducted by GHH Administrators; Executive Director (Licensee) and Director (Licensee)."</p> <p>This deficiency constitutes a re-cited deficiency.</p> <p>The facility served clients with diagnoses that included but were not limited to Oppositional Defiant Disorder, Attention-Deficit Hyperactivity Disorder, Autism Spectrum Disorder, Anxiety Disorder, Conduct Disorder, and Disruptive Mood Dysregulation Disorder. Client #1 had at least 5 missing physician's orders. Client #2 and Client #3 had no documented physician's orders for any medications administered. For Client #1, at least 94 medication doses were documented as administered without a corresponding physician's</p>	V 118	<p>Such as; Clients refusals, being off site/absent (HV etc.), Medications N = Not Available (Out of Stock/ pharmacy issue), L = late administration, E = Error (Must complete an Incident Report</p> <p>Other Information noted Date, Time, Initials, Medication, Reason, Result, Initials & Staff Signature, as well as the Client's Name, Month/Year Days with listing of the Client's Medications = Name, Dosage, Frequency & Indication.</p> <p>GHH Administrators to monitor MARS daily</p> <p>GHH Administrators reviewed the prescribed Medications for each Client, comparing the Dr.'s Medication Orders & Pharmacy scripts and prescriptions as indicated on the Medication Bottles, that were in GHH possession.</p>	12/29/2025

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V 118	Continued From page 23 order and at least 72 physician-ordered doses of medication lacked documentation of administration. For Client #2, at least 1,200 medication doses were documented as administered without a corresponding physician's order and at least 210 doses were marked with an "X," circles without initials, altered entries, or blank fields were present on Client #2's MARs. These doses included psychotropics, stimulants, and supplement medications. For Client #3, at least 980 medication doses were documented as administered without a corresponding physician's order and at least 265 medication doses were marked with an "X," "R," "?," crossed-out entry, or left blank. The facility did not maintain documentation to indicate a physician or pharmacist had been notified of medication errors. Across all three clients, the facility documented at least 2,274 medication doses administered without physician orders and at least 547 missed or undocumented doses from 10/1/25 through 12/22/25. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 118	Most recent Prescribing Physician's Orders and Listings for all Clients were requested and made a part of the Clients' MARs, which were updated accordingly. Any discrepancies are discussed with GHH RN, as well as referred back to the Physician and Medication Management Office related to the Client. GHH Administrators, in consultation with RN, to monitor and check Dr's Orders, Medications and the documentation of the MARs sheets on a regular basis, preferably daily, but minimally weekly.	2/1/2026
V 123	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.	V 123		

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V 123	<p>Continued From page 24</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure drug administration errors were reported immediately to a physician or pharmacist for 3 of 3 audited clients (Clients #1, #2 and #3). The findings are:</p> <p>Review on 12/23/25 and 1/5/26 of facility records between 10/1/25 and 1/5/26 requested from the Director/Licensee and the Executive Director/Licensee revealed: -No documentation that medication errors had been reported to a physician or pharmacist.</p> <p>Review on 12/22/25 of Client #1's record revealed: -Date of Admission 8/15/25. -15 years old. -Diagnoses of Oppositional Defiant Disorder (ODD), Attention-Deficit Hyperactivity Disorder (ADHD), Autism Spectrum Disorder and Anxiety Disorder.</p> <p>Review on 12/22/25 at 12:30 pm-2:00 pm of Client #1's MARs dated 10/1/25-12/22/25 revealed the following medications had dates that were documented with an "X", left blank, or circled: -Cetirizine HCL (allergies) 10 mg - between 10/1/25 and 11/5/25 - 35 doses. -Montelukast Sodium (asthma) 10 mg - between 10/1/25 and 12/22/25 - 54 doses. -Qelbree ER (ADHD) 200 mg - 12/22/25 - 1 dose. -Metformin HCL (prediabetes) 500 mg - on 11/30/25 and 12/21/25 - 2 doses. -Fluoxetine HCL (depression) 10 mg - between</p>	V 123	<p><i>Medication Administration issues addressed in this report. (V118) See Pages 21-24</i></p>	
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V 123	<p>Continued From page 25</p> <p>12/16/25 - 12/31/25 - 16 doses. -Aripiprazole (agitation) 5 mg - between 10/1/25 - 10/31/25 - 31 doses. -Guanfacine (impulsivity/ODD) 4 mg - between 10/1/25 - 10/31/25 - 31 doses. -Oxcarbazepine (ADHD) 300 mg - between 10/1/25 - 12/22/25 - 83 doses. -Levocetirizine (allergies) 5 mg - on 10/1/25, 10/2/25 and 12/20/25 - 3 doses. -Fluoxetine HCL 20 mg - on 11/6/25 and between 11/30/25 and 12/22/25 - 26 doses.</p> <p>Review on 12/22/25 of Client #2's record revealed: -Date of Admission 9/17/25. -14 years old. -Diagnoses of ODD and ADHD.</p> <p>Review on 12/22/25 at 12:30 pm-2:00 pm of Client #2's MARs dated 10/1/25-12/22/25 revealed the following medications had dates that were documented with an "X", left blank, outlined or circled: -Desvenlafaxine succinate ER (depression) 100 mg - 12/12/25 - 1 dose. -Lurasidone (mood disorder) 60 mg - between 11/5/25 - 11/30/25, and 12/1/25 - 12/22/25 - 47 doses. -Clonidine (ADHD) 0.1 mg - 1 tablet in the am and 1 tablet in the pm - 11/29/25, and 12/15/25 am and pm - 3 doses. -Clonidine 0.2 mg -1 tablet at HS - 10/6/25, 10/9/25, between 10/14/25 - 10/31/25, 11/4/25 - 11/30/25, 12/20/25 and 12/21/25 - 49 doses. -Clonidine 0.3 mg 1 tablet at HS - 12/20/25 and 12/21/25 - 2 doses. -Qelbree ER 200 mg 1 capsule in am - between 11/20/25 - 11/30/25 - 10 doses. -Qelbree ER 200 mg 1 capsule at 1:00 pm - between 11/1/25 - 11/19/25 - 19 doses.</p>	V 123	<p><i>Medication Administration issues addressed in this report (V118) See Pages 21-24</i></p>	

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V 123	<p>Continued From page 26</p> <ul style="list-style-type: none"> -Qelbree ER 200 mg 2 capsules at 1:00 pm - 10/10/25, 10/30/25, 10/31/25 - 3 doses. -Vyvanse (ADHD) 60 mg - between 10/10/25 - 10/17/25, 11/1/25 - 11/19/25, 12/12/25 - 27 doses. -Vitamin D3 (supplement) 50 micrograms - between 10/1/25 - 10/31/25, 11/1/25 - 11/19/25 - 50 doses. -Dextroamphetamine (ADHD) 5 mg - between 10/4/25 - 10/31/25 - 28 doses. <p>Review on 12/22/25 of Client #3's record revealed:</p> <ul style="list-style-type: none"> -Date of Admission 9/13/25. -14 years old. -Diagnoses of ADHD, Conduct Disorder and Disruptive Mood Dysregulation Disorder. <p>Review on 12/22/25 at 12:30 pm-2:00 pm of Client #3's MARs dated 10/1/25-12/22/25 revealed the following medications had dates that were documented with an "X", "R", left blank, or circled:</p> <ul style="list-style-type: none"> -Desmopressin (bedwetting) 0.2 mg - 12/20/25 - 1 dose. -Carbamazepine (seizures) 100 mg - am - 10/28/25 - 10/30/25, 11/28/25, 12/1/25, 12/3/25, 12/4/25, 12/6/25, 12/7/25, 12/20/25 for a total of 9 doses; pm - 10/9/25, 10/12/25, 10/28/25 - 10/31/25, 11/15/25, 11/27/25, 12/2/25, 12/3/25, 12/4/25, 12/6/25, 12/7/25, 12/12/25, 12/20/25 - a total of 15 doses. -Concerta (ADHD) 36 mg - between 10/1/25 - 10/19/25, 11/23/25 - 11/30/25 - 27 doses. -Melatonin (insomnia) 3 mg - 11/27/25, 11/29/25, 11/30/25, between 12/1/25 - 12/22/25 - 25 doses. -Fluticasone nasal spray (allergy symptoms) 27.5 mcg - between 10/1/25 - 12/22/25 - 83 doses. -Docusate sodium (constipation) 50 mg - am and pm - between 10/1/25 - 11/30/25 - 122 doses. 	V 123	<p><i>Medication Administration issued addressed in this report (V118) See pages 21-24.</i></p>	

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V 123	<p>Continued From page 27</p> <p>Interviews on 12/22/25, 1/5/26 and 1/8/26 with the Program Director revealed: -His duties included administration of medications to the clients. -If a client refused their medications "we are to indicate it on the back of the MAR but we were doing an 'X' or just leaving it blank."</p> <p>Interview on 1/6/26 with the Qualified Professional revealed: -"I just do (administer) the medications. [Executive Director/Licensee] is over it (MARs) and talks over it with the nurse ...again that is not my forte." -Reported medication errors to the Executive Director/Licensee, "it's verbal and written. It's written on the MARs on the opposite side there's a place if there is an error that occurs, we put it on the back ..."</p> <p>Interview on 1/6/26 with the Executive Director/Licensee revealed: -An 'X' on the MAR meant the client did not receive the medication. "If there's blanks, I want to find out why there's blanks and I look back and see who was on shift and ask why there's blanks on the medication and there's a big discussion. You might have a sheet (MAR) but they aren't getting that medication anymore. I need to get behind that and make sure I am getting letters (physician's orders) stating that medication has been discontinued." -If there's an error that has been made "I will contact the (client's physician's) office, the (client's physician's) nurse and let her know and she will get in touch with the doctor (client's physician) and get back to me." -"No," there was no medication errors made in the past 3 months (October, November and December 2025).</p>	V 123	<p>Medication Administration issues addressed in this report (V118) See Pages 21-24.</p>	

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NAME OF PROVIDER OR SUPPLIER GEORGIE'S HELPING HAND	STREET ADDRESS, CITY, STATE, ZIP CODE 490 RADIO ROAD TAYLORSVILLE, NC 28681
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(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 123	Continued From page 28 This deficiency is cross-referenced into 10A NCAC 27G.0209 Medication Requirements (V118) for a Type A1 rule violation and must be corrected within 23 days.	V 123		
V 293	27G .1701 Residential Tx. Child/Adol - Scope 10A NCAC 27G .1701 SCOPE (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility. (b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to a community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting. (e) Services shall be designed to: (1) include individualized supervision and structure of daily living; (2) minimize the occurrence of behaviors related to functional deficits; (3) ensure safety and deescalate out of	V 293	GHH Administrators fully affirm, and in Good Faith, to demonstrate the facility's readiness and ability to maintain an ongoing commitment to continuous compliance through regular internal monitoring, staffing patterns & training, & quality assurance activities to meet or excel in all mandated standards. Additionally, including but not limited to, licensing requirements, health & safety regulations, supervision, staffing ratios, Service/Treatment Plans, Medication Administration & Management, Incident Response and Reporting, as	

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V 293	<p>Continued From page 29</p> <p>control behaviors including frequent crisis management with or without physical restraint;</p> <p>(4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and</p> <p>(5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting.</p> <p>(f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care.</p> <p>This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to operate within the scope of their license to include individualized supervision and structure of daily living, ensure safety, assist in the acquisition of adaptive functioning, and support in gaining skills needed to step-down to a less intensive treatment setting and failed to ensure an individual who was not a client did not maintain their primary residence at the facility. The findings are:</p> <p>Cross Reference: 10A NCAC 27G.0205 Assessment and Treatment/Habilitation or Service Plan (V112): Based on record reviews and interviews, the facility failed to develop and implement treatment plans based on client needs</p>	V 293	<p>Well as provide clinical and behavioral support services appropriate to the population served. The cooperation with NC's HSR inspections, reviews, and corrective actions as required, will enhance GHH's compliance. It is GHH Administrator's contention that all clients who have been and are currently residing in the Group Home, were provided with quality care, treatment and services, which is expected to continue.</p>	
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V 293	<p>Continued From page 30</p> <p>within 30 days of admission for 3 of 3 audited clients (Clients #1, #2 and #3).</p> <p>Cross Reference: 10A NCAC 27G.1702 Requirements of Qualified Professionals (V294): Based on record reviews and interviews, the Qualified Professional (QP) failed to perform clinical and administrative responsibilities at a minimum to include the supervision of the Associate Professional (AP), oversight of emergencies, provision of direct psychoeducational services, participation and coordination of treatment plans, and provision of case management functions.</p> <p>Cross Reference: 10A NCAC 27G.1703 Requirements for Associate Professionals (V295): Based on record reviews and interviews, the facility failed to employ a full-time Associate Professional (AP) who ensured management of the daily operations of the facility, supervision of paraprofessionals, and participation in service planning meetings.</p> <p>Cross Reference: 10A NCAC 27G.1704 Minimum Staffing Requirements (V296): Based on observation, record reviews and interviews, the facility failed to ensure the required minimum number of 2 direct care staff for 1 to 4 clients were present.</p> <p>Review on 12/30/25 of the Program Director's record revealed: -Date of Hire: 7/6/21. -North Carolina (NC) driver's license listed the facility address as his residence.</p> <p>Interviews on 12/22/25 and 1/5/26 with Client #1 revealed: -The Program Director "sleeps (at the facility) on</p>	V 293	<p>This deficiency was addressed in this report (V294). Please See Pages 35-36.</p> <p>This deficiency was addressed in this report (V295). Please See Pages 39-40.</p> <p>This deficiency was addressed in this report (V296). Please See Pages 41-42.</p> <p>This deficiency was addressed in the Plan of Protection submitted on regarding GHH Program Director's domicile</p>	<p>1/15/2026</p> <p>1/15/2026</p> <p>12/23/2025</p> <p>1/9/2026</p>

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V 293	Continued From page 31 the couch." Interview on 12/30/25 with Client #4 revealed: -"[Program Director] stays here (facility) pretty much." Interviews on 12/22/25, 1/5/26 and 1/8/26 with the Program Director revealed: -"I work all shifts. I am here (facility) pretty much around the clock. I am in and out but here every shift. I don't live here. I have another home. I just use this address on my license. My address is in (another state). I am a traveler ...I have no home in North Carolina. I don't need sleep ...just kind of rest ...I sleep in the office, there's a recliner ...When we work, 1 (staff) is allowed to sleep ...1 (staff) awake and 1 asleep." Review on 1/9/26 of the Plan of Protection dated 1/9/26 written by the Director/Licensee revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? (V293) GHH (Georgie's Helping Hand) current Program Director does spend a great amount of time at the Group Home, fulfilling his duties, as well as filling in as needed when there's a shortage of staff. However, the facility is not his place of domicile. (V294) GHH Administrative Staff will meet with current QP immediately, at least by 01/10/2026, to review, explain and reiterate the duties and responsibilities of the QP position for which he was hired for. (V295) GHH Administrative Staff will identify and/or hire an Associate Professional, as required, to fulfill their duties in this position, which would include their participation and input with the Residents' Service (treatment) Plans and Staff Meetings, as well as addressing the daily operation of the facility, and the supervision of	V 293	Not being at GHH GH facility. See Statement to the left on this page (V293) and on page 33 of this report (V293)	2/25/2026 2/25/2026 1/15/2026 1/15/2026

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V 293	<p>Continued From page 32</p> <p>Direct Support Staff.</p> <p>(V296) GHH Administrators will ensure that at least the Minimum Staff Ratio is satisfied on all shifts going forward by scheduling Staff to work and provide coverage for the shifts accordingly.</p> <p>(V112) GHH do have Treatment Plans for all current Residents. Even though all were not initially presented to the Surveyors upon request, they were later produced as evidence that these documents had been prepared and are available. Describe your plans to make sure the above happens.</p> <p>(V293) Program Director does have a separate residency in the State of North Carolina, which has been confirmed by GHH Administrators. Program Director will obtain a new ID (identification), confirming his current NC residence.</p> <p>(V294) GHH Administrators will get the necessary feedback from the QP, after having a meeting with him to assure that he has a full understanding and is still willing and capable of performing the duties and responsibilities of the QP Position. We will have the QP sign a new job description form to review his roles and responsibilities. QP will be place on a Performance Improvement Plan as well.</p> <p>(V295) GHH Administrators will offer an internal hire for the AP position. In the event it cannot be filled internally, we will post the position and seek an external hire.</p> <p>V296) GHH Administrators will maintain a log which will identify and indicate the staff member's time in and time out for the clinical day, thereby maintaining at least two staff members at the facility at all times.</p> <p>(V112) GHH Administrators will make sure that all the Residents' (clients') Treatment Plans are kept in their folders, or at least on-site to be readily available if necessary."</p>	V 293		<p>2/25/2026</p> <p>2/25/2026</p> <p>2/25/2026</p> <p>1/12/2026</p> <p>1/15/2026</p> <p>2/25/2026</p> <p>2/25/2026</p>

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V 293	<p>Continued From page 33</p> <p>Clients served by the facility were adolescents who had mental health diagnoses including but not limited to Oppositional Defiant Disorder, Attention-Deficit Hyperactivity Disorder, Autism Spectrum Disorder, Anxiety Disorder, Conduct Disorder and Disruptive Mood Dysregulation Disorder. The facility did not ensure the Program Director did not maintain their primary residence at the facility. The Program Director routinely stayed overnight and used the facility address as his residence. Client #1, Client #2 and Client #3 did not have individualized treatment plans within 30 days of admission and treatment strategies were not documented or implemented based on assessed client needs. The Qualified Professional did not fulfill required clinical and administrative responsibilities, including supervision of staff, participation in treatment planning, coordination of services, emergency oversight, and case management. The facility did not employ an Associate Professional responsible for daily operations, supervision of paraprofessionals, and participation in service planning meetings. The facility did not maintain required minimum staffing ratios, as fewer than two direct care staff were present which limited supervision and support.</p> <p>This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients and must be corrected within 45 days.</p>	V 293	<ul style="list-style-type: none"> • See statement on pages 32-33 (V293) • See statement regarding Client Treatment Plans pages 1-4 (V112) • See statement regarding Op. pages 35-36 (V294) • See statement regarding AP, pages 39-40 (V295) • See statement regarding Minimum Staff Ratio pages 41-42 (V296) 	
V 294	<p>27G .1702 Residential Tx. Child/Adol -Req. for Q P</p> <p>10A NCAC 27G .1702 REQUIREMENTS OF QUALIFIED PROFESSIONALS</p>	V 294		

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V 294	<p>Continued From page 34</p> <p>(a) Each facility shall utilize at least one direct care staff who meets the requirements of a qualified professional as set forth in 10A NCAC 27G .0104(18). In addition, this qualified professional shall have two years of direct client care experience.</p> <p>(b) For each facility of five or less beds:</p> <p>(1) the qualified professional specified in Paragraph (a) of this Rule shall perform clinical and administrative responsibilities a minimum of 10 hours each week; and</p> <p>(2) 70% of the time shall occur when children or adolescents are awake and present in the facility.</p> <p>(c) For each facility of six or more beds:</p> <p>(1) the qualified professional specified in Paragraph (a) of this Rule shall perform clinical and administrative responsibilities a minimum of 32 hours each week; and</p> <p>(2) 70% of the time shall occur when children or adolescents are awake and present in the facility.</p> <p>(d) The governing body responsible for each facility shall develop and implement written policies that specify the clinical and administrative responsibilities of its qualified professional(s). At a minimum these policies shall include:</p> <p>(1) supervision of its associate professional(s) as set forth in Rule .1703 of this Section;</p> <p>(2) oversight of emergencies;</p> <p>(3) provision of direct psychoeducational services to children or adolescents;</p> <p>(4) participation in treatment planning meetings;</p> <p>(5) coordination of each child or adolescent's treatment plan; and</p> <p>(6) provision of basic case management functions.</p>	V 294	<p>GHH Administrators initially met with our then QP on 1/10/2026 to address the deficiency as it related to him and performing his duties and responsibilities for this position. The job description was reviewed, explained, and reiterated for which he had been hired to perform. The then QP indicated he fully understood what was expected from him while performing the duties of the QP, signed a new job description form, and was placed on a performance Improvement Plan. However, after further review and consultation amongst Administrators and Professional Staff at GHH, an administrative decision was made for the QP position to be offered internally to a different employee, which was accepted.</p>	1/10/2026
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V 294	<p>Continued From page 36</p> <p>Review on 12/22/25 of Client #1's record revealed: -Date of Admission 8/15/25. -15 years old. -Diagnoses of Oppositional Defiant Disorder (ODD), Attention-Deficit Hyperactivity Disorder (ADHD), Autism Spectrum Disorder and Anxiety Disorder. -No treatment plan.</p> <p>Review on 12/22/25 of Client #2's record revealed: -Date of Admission 9/17/25. -14 years old. -Diagnoses of ODD and ADHD. -No treatment plan.</p> <p>Review on 12/22/25 of Client #3's record revealed: -Date of Admission 9/13/25. -14 years old. -Diagnoses of ADHD, Conduct Disorder and Disruptive Mood Dysregulation Disorder. -No treatment plan.</p> <p>Review on 12/22/25 and 1/5/26 of facility records revealed: -No documentation that the QP provided supervision to an Associate Professional (AP), oversight of emergencies, psychoeducational services, case management functions, or participation and coordination of treatment plans.</p> <p>Review on 1/6/26 of a Computer Aided Dispatch (CAD) list dated 8/1/25-1/5/26 from the local sheriff's department revealed: -Law enforcement was called to Georgie's Helping Hand Group Home for a "Missing Person" on 11/6/25 and 12/3/25. When Client #3 eloped from the facility.</p>	V 294	<p>The issue of Treatment Plans for the Clients was previously addressed in this report. Please See Pages 1-4 (included with VII2 deficiency)</p> <p>Newly assigned Staff member will perform the QP duties & responsibilities, which will include all things pertaining to the Clients' Treatment Plans, as well as the supervision of the newly internally assigned AP, and other mandated duties as required Administrators to monitor QP's performance initially at least weekly</p>	<p>2/23/2026</p> <p>1/15/2026</p>

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V 294	<p>Continued From page 37</p> <p>Interview on 1/5/26 with the Coordinator and Behavior Specialist from the local school where Clients #1, #2 and #3 attended revealed: -"The facility does not share their (clients') behaviors, violence tendency, triggers ...we have learned about [Client #2's] sexual comments just by him being here ...[Client #2] has made statements of wanting to kill himself ...said he had a gun or a bomb ...I don't know if this was a problem prior to him coming here ...[Client #3] ran away from the facility 2 times. If a kid (client) runs from the group home on Saturday, we need to know that on Monday ..."</p> <p>Interview on 1/6/26 with the QP revealed: -Unable to identify who was designated as the AP for the facility. -Regarding interventions and follow up to incidents involving Client #3's elopements from the facility on 11/6/25 and 12/23/25, "I wouldn't call it an incident, but it's part of [Client #3's] diagnosis that he runs away at times, but it wasn't on my shift so I can't speak so much about it because I wasn't there and I don't speak on things that I didn't witness ..." -Treatment plan "recommendations come from where they (clients) were before and what their interactions were, but that's not part of my forte. I am limited on what I can speak. I don't do that. That's not what I do ..." -Coordination with educational services "That's not my job. I stay in my lane ..."</p> <p>Interview on 1/6/26 with the Executive Director/Licensee revealed: -The QP was "still learning" his responsibilities.</p> <p>Interviews on 1/12/26 with the Director/Licensee and the Executive Director/Licensee revealed:</p>	V 294	<p><i>This issue regarding the School Staff, as it relate to the Clients and GHH Staff, was addressed in this report (to include V112 deficiency). Please Pages 3-4 of this report.</i></p> <p><i>The issue involving the QP is addressed in this report. Please See Pages 35-37.</i></p>

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V 294	Continued From page 38 -The QP had been in his role for "about 2 years." This deficiency constitutes a re-cited deficiency. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type B rule violation and must be corrected within 45 days.	V 294	<i>This issue regarding GHH then QP has been addressed in this report See pages 35-36.</i>	<i>1/15/2026</i>
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. This Rule is not met as evidenced by: Based on record reviews and interviews, the	V 295	<i>As indicated on the Plan of Protection dated it was the contention that GHH Administrators would offer and possibly internally hire an employee for the Associate Professional (AP) position. An internal employee agreed and accepted the Associate Professional (AP) position effective as of This designated employee has signed the job description form, which is now enclosed in his file.</i>	<i>4/9/2026, 4/15/2026</i>

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V 294	Continued From page 35 This Rule is not met as evidenced by: Based on record reviews and interviews, the Qualified Professional (QP) failed to perform clinical and administrative responsibilities at a minimum to include the supervision of the Associate Professional (AP), oversight of emergencies, provision of direct psychoeducational services, participation and coordination of treatment plans, and provision of case management functions. The findings are: Review on 12/30/25 of the QP's record revealed: -Date of Hire: 11/19/21. -A job description signed by the QP on 9/29, but lacked a legible year of signature: " ...Duties: ...Develops, supervises and updates a client plan of care to include type of services needed, frequency of services needed, days services are needed, and time of day services are needed ...Completes and records assessment, client's plan of care for physician's, or other sources' approval, including physicians orders plan for treatment ...return upon completion all documents to facility premises ...Completes supervision standards, including Evaluations of all clients to include at a minimum: Any and all changes to be noted in clients current plan of care ...Document any safety concerns regarding client's current condition related to mental, physical, emotional, or living conditions. Document any suggestions in resolving the concern ...Delegates tasks and supervises Staff ..."	V 294	Consequently, effective as of 1/15/2026 GHH will have a different designated QP who is qualified, willing, and able to perform the indicated duties of the QP position. This QP signed the job description form, which is now enclosed in his file. GHH Administrators are confident that this newly assigned QP will be able to appropriately fulfill the duties & responsibilities of the position, but will be monitored initially on at least a weekly basis by Administrators to confirm the position is being performed appropriately. 1/15/2026	1/15/2026

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V 295	<p>Continued From page 39</p> <p>facility failed to employ a full-time Associate Professional (AP) who ensured management of the daily operations of the facility, supervision of paraprofessionals, and participation in service planning meetings. The findings are:</p> <p>Review on 12/22/25 of the facility's Client and Staff Census completed by the Program Director on 12/22/25 revealed: -An AP was not identified.</p> <p>Interview on 1/5/26 with the Program Director revealed: -He was not familiar with the term "AP" and sought clarification. -He could not confirm that an AP worked for the facility.</p> <p>Interview on 1/6/26 with the Qualified Professional revealed: -He was unable to identify who was designated as the AP for the facility.</p> <p>Interview on 12/23/25 with the Director/Licensee revealed: -An AP for the facility had not been hired yet.</p> <p>Interview on 1/6/26 with the Executive Director/Licensee revealed: -The facility did not have an AP.</p> <p>Interviews on 1/12/26 with the Director/Licensee and the Executive Director/Licensee revealed: -There had not been an AP for the facility since August 2025.</p> <p>This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type B rule violation and must be corrected within 45 days.</p>	V 295	<p>GHH Administrators are satisfied with the newly designated AP's ability to fulfill the duties of this position which will include, but not limited to, his participation and input with Clients' Service/Treatment Plans, Staff Members, as well as address the daily operation of the facility and the supervision of Direct Support Staff. GHH Administrators will initially monitor, on at least a weekly basis, the AP's performance to confirm the duties and responsibilities of the position are being performed.</p>	2/25/2026

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V 296	Continued From page 40	V 296		
V 296	<p>27G .1704 Residential Tx. Child/Adol - Min. Staffing</p> <p>10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS</p> <p>(a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times.</p> <p>(b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows:</p> <p>(1) two direct care staff shall be present for one, two, three or four children or adolescents;</p> <p>(2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and</p> <p>(3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents.</p> <p>(c) The minimum number of direct care staff during child or adolescent sleep hours is as follows:</p> <p>(1) two direct care staff shall be present and one shall be awake for one through four children or adolescents;</p> <p>(2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and</p> <p>(3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents.</p> <p>(d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan.</p>	V 296	<p><i>GHH Administrators will assure that at least the Minimum Staff Ratio is satisfied, as had been, excusing the 12/22/2025 date, and going forward by being cognizant of Staff work and shift schedules for coverage to be provided accordingly, specifically, at least 2 Staff members present when 1-4 Clients are in the Group Home. GHH Administrators to maintain and check on a regular basis, a log which will identify and indicate the Staff members' time in and time out for the clinical day, thereby being in compliance with the required Staff to Client Ratio</i></p>	2/25/2026

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V 296	<p>Continued From page 41</p> <p>(e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan.</p> <p>This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to ensure the required minimum number of 2 direct care staff for 1 to 4 clients were present. The findings are:</p> <p>Review on 1/6/26 of the facility staff schedule sheets from 8/1/25 through 12/31/25 revealed: -The Director/Licensee and the Executive Director/Licensee were scheduled to work 12/22/25 from 7:00 am - 3:00 pm.</p> <p>Observation on 12/22/25 at 11:55 am revealed: -Clients' #1, #2 and #3 were in the living room playing video games. -The Program Manager was present and worked alone with the 3 clients. -At 12:58 pm Staff #1 arrived at the facility and asked clients' if they wanted a snack.</p> <p>Interviews on 12/22/25 and 1/5/26 with Client #1 revealed: -There were "always 2 staff" present on all 3 shifts. -"Today (12/22/25) was the first day (1 staff on shift) ..."</p>	V 296	<p>On the date of 12/22/2025, the staff that were initially scheduled to work the 7 AM - 3pm shift had to be adjusted to include the proper coverage, which resulted in an approximate 1 hour time lapse for two staff members to be in the GH with the clients. Prior to this date, and now subsequent dates, 2 staff members were and will be present accordingly</p>	2/25/26

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V 296	<p>Continued From page 42</p> <p>Attempted interviews on 12/22/25, 12/30/25 and 1/5/26 with Clients #2 and #3 were unsuccessful as both clients refused to be interviewed.</p> <p>Interview on 12/22/25 with Staff #1 revealed: -Worked the second shift, 3:00 pm - 11:00 pm. -"I wasn't at the facility earlier (upon arrival) because I ran to the store ..."</p> <p>Interviews on 12/22/25, 1/5/26 and 1/8/26 with the Program Director revealed: -The Executive Director/Licensee made the staff schedule. -"No set person (scheduled for a shift). I rotate with everybody. I work all shifts. I am here pretty much around the clock. I am in and out but here every shift." -"We always schedule 2 staff to be present with the boys (clients)."</p> <p>Interview on 1/6/26 with the Qualified Professional revealed: -Worked "mostly" the 3:00 pm - 11:00 pm shift and the weekends: "There is no set time slots." -"The house (facility) has to be covered by 2 staff members, and [Executive Director/Licensee] does the best that he can to make sure there is always 2 people (staff) there ...If staff are not available, then I've got to fill it, but there's no void of staff at any given moment."</p> <p>Interviews on 1/6/26 and 1/12/26 with the Executive Director/Licensee revealed: -"I have a schedule sheet and it's indicated on my schedule sheet ...I am here almost 24/7 and make sure the staff are here ...and if staff don't come in, I have to fill in for them ..." -"I was at the store when you (Division of Health Service Regulation surveyors) all came</p>	V 296		

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V 296	Continued From page 43 (12/22/25)." This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type B rule violation and must be corrected within 45 days.	V 296		
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	V 366	The two incidents cited occurred on 11/6/2025 & 12/3/2025, whereby Client #3 Eloped from the Group Home, in both instances the Client either returned on his own or was brought back to the by Staff members. The Staff members working at the times of these incidents did document the incidents as Level I In-House events. Client #3's Legal Guardians/ Parents were notified of Client's Elopements during a CFT Meeting/Group Home Visit, calls to and from Client's Parents/Legal Guardians and LME Care Manager.	

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V 366	<p>Continued From page 44</p> <p>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> <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</p>	V 366	<p><i>GHM Staff addressed the Elopement incidents of the Client by meeting with GHM Administrators and discussing the circumstances which may have led up to the Client's Elopements, as well as informing the legal Guardian and meeting with the Client in an effort to prevent a re-occurrence.</i></p>	
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V 366	<p>Continued From page 45</p> <p>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> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement policies regarding documentation of Level II incidents. The findings are:</p> <p>Review on 12/22/25 of Client #3's record revealed: -Date of Admission 9/13/25. -14 years old.</p>	V 366	<p>GPH Administrators have met with staff to re-iterate the importance of not only verbally reporting, but promptly preparing written documentation as well, to include a Risk Analysis indicating corrective measures to be utilized to possibly prevent similar occurrences of incidents.</p>	

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V 366	<p>Continued From page 47</p> <p>Interview on 1/6/26 with the Executive Director/Licensee revealed: -The Director/Licensee was responsible to review incidents and determine any actions needed. -"I may glimpse them..."</p> <p>Interview on 1/8/26 with the Director/Licensee revealed: -The staff who were on shift during an incident were "responsible for filling out incident reports and it comes to [Executive Director/Licensee]." -She and the Executive Director/Licensee determined what actions were needed when an incident was received. -She was unaware of notifications needed when an incident occurred.</p> <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 366		
V 367	<p>27G .0604 Incident Reporting Requirements</p> <p>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</p>	V 367	<p><i>As previously indicated, it was GHM Administrators contention that the 2 Elopement Incidents regarding Client #3 were level I Incidents which would not require IRLS Reporting</i></p>	

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V 367	<p>Continued From page 48</p> <p>means. The report shall include the following information:</p> <ol style="list-style-type: none"> (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. <p>(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:</p> <ol style="list-style-type: none"> (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. <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <ol style="list-style-type: none"> (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. <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</p>	V 367		

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V 367	<p>Continued From page 49</p> <p>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:</p> <ol style="list-style-type: none"> (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. <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report all level II incidents 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 72 hours of</p>	V 367	<p><i>GHH Administrators did not submit IRIS reports regarding the 2 Incidents of Client's Elopements (on 11/6/2025 & 12/3/2025) which did include minimal Police Contact. The Incidents were assessed and determined to be level I events. The Police involvement was for assistance only and did not involve arrest, charges, injury, use of force, or any outcome that meets the criteria for level II Incidents.</i></p>

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V 367	<p>Continued From page 50</p> <p>becoming aware of the incident. The findings are:</p> <p>Review on 12/22/25 of Client #3's record revealed: -Date of Admission 9/13/25. -14 years old. -Diagnoses of Attention Deficit Hyperactivity Disorder, Conduct Disorder and Disruptive Mood Dysregulation Disorder.</p> <p>Review on 12/22/25 and 1/5/26 of the IRIS from 10/1/25 - 1/5/26 revealed: -No incidents were reported.</p> <p>Review on 1/5/26 of facility incident reports from 10/1/25 - 1/5/26 revealed: -11/6/25 at 6:00 p.m. and 12/3/25 at 6:40 p.m. - Client #3 ran away from the facility and law enforcement was called.</p> <p>Attempted interviews on 12/22/25, 12/30/25 and 1/5/26 with Client #3 were unsuccessful as the client refused to be interviewed.</p> <p>Interview on 1/5/26 with the Program Director revealed: -Completed incident reports and "primarily it's been with [Client #3]." -After he completed the report he gave it to the Executive Director/Licensee. -The Executive Director/Licensee "reviews internal incident reports and determines the levels (of incidents)."</p> <p>Interview on 1/6/26 with the Executive Director/Licensee revealed: -The Director/Licensee was responsible to review incidents and determine any actions needed. -"I may glimpse them..."</p>	V 367	<p>Based on this assessment and determination, IRIS Reporting was not generated.</p> <p>During the course of GHH's Survey/Audit, Surveyors stated again that anytime there's police involvement, even minimal episodes of contact and/or participation, an IRIS Report should be generated, submitted and followed up accordingly.</p> <p>The Client's legal Guardians and HME/MCO should be notified as well.</p>	
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V 367	<p>Continued From page 51</p> <p>Interview on 1/8/26 with the Director/Licensee revealed:</p> <ul style="list-style-type: none"> -The staff who were on shift during an incident were "responsible for filling out incident reports and it comes to [Executive Director/Licensee]." -She and the Executive Director/Licensee determined if incidents should be entered into IRIS. -She was not aware contacts to law enforcement needed to be entered into IRIS. <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 367	<p>Since GHH Administrators have received verifying documentation from Surveyors' and advised regarding reporting incidents whereby there's police involvement, moving forward, any similar incidents will be handled accordingly, reports generated and submitted to IAIS in a timely manner, which all current staff have been made aware of as well, as of</p>	1/15/2026
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