Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-415	A. BUILDING: _____ B. WING _____	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF CHOY	2501 LYONS STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and complaint survey was completed on 02/04/2026. The complaint was unsubstantiated (Intake #NC00234949). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for 3 and currently has a census of 3. The survey sample consisted of audits of 2 current clients and 1 former client.	V 000	**V118 – Medication Requirements (27G .0209(c))** **Corrective Action:** Upon identification of the deficiency, the Executive Director immediately contacted the psychiatrist to obtain written discontinued orders for all medication changes. Clients MAR was reviewed and corrected to accurately reflect current active medications. Discontinued medications were removed from the MAR and medication cart. Medication Administration training was conducted with all staff on proper documentation, verification of physician orders, and the requirement that medications may only be administered with a current written physician order. **Prevention Measures:** A Medication Change Verification Form has been implemented to ensure written discontinue orders are obtained before MAR updates. No medication will be administered unless a written order is present in the client's record. Discontinued medications will be immediately removed from the MAR and secured. **Monitoring:** The AP will conduct daily MAR audits. The QP will conduct weekly medication record reviews. The Executive Director will conduct monthly medication compliance audits. **Responsible Party:** Executive Director, Qualified Professional (QP), Associate Professional (AP) **Completion Date:** Already implemented but Before April 1, 2026	
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug;	V 118		

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			V121 – Medication Review (27G .0209(f)) **Corrective Action**: The psychiatrist has been contacted to complete an immediate six-month drug regimen review for Clients. Documentation of the review will be placed in the client's record. **Prevention Measures**: A Medication Review Tracking Log has been implemented. All psychotropic medications will be reviewed every six months by a physician or pharmacist. Upcoming review dates will be tracked on a compliance calendar. **Monitoring**: The QP will review the medication tracking log monthly. The Executive Director will review compliance quarterly. **Responsible Party**: Qualified Professional (QP) – primary oversigh tExecutive Director – compliance monitoring **Completion Date**: Already implemented but Before April 1, 2026 **V366 – Incident Response Requirements (27G .0603)** **Corrective Action:** An Internal Review Team has been formally established. Written incident response policies have been updated to ensure compliance with all seven required components, including corrective measures, preventive measures, assigned responsibility, and documentation. All prior incidents cited in the survey have been reviewed, and corrective/preventive documentation has been completed. Staff training on incident response requirements was conducted. **Prevention Measures**: An Internal Review Team will be convened within 24 hours of any Level III incident. Corrective and preventive measures will	

			be documented within two weeks. A standardized Incident Review Checklist has been implemented to ensure all required elements are completed. **Monitoring:** The QP will review all incidents within 72 hours. The Executive Director will conduct monthly incident audits. **Responsible Party:** Qualified Professional (primary)Executive Director (secondary oversight; assumes responsibility if QP is involved) **Completion Date:** Already implemented but Before April 1, 2026 **V367 – Incident Reporting Requirements (27G .0604)** **Corrective Action:** All missing IRIS reports have been reviewed and submitted as applicable. The incident reporting form has been revised to include all six required reporting elements. Staff training on IRIS submission timelines (72-hour requirement) was conducted on 02/16/2026. **Prevention Measures**: The Executive Director will submit all IRIS reports within 72 hours. A 72-hour Incident Reporting Log has been implemented. A secondary staff member will verify submission. **Monitoring:** QP will verify IRIS submission within 48 hours of incident. Executive Director will conduct monthly compliance review. **Responsible Party**: Executive Director (primary IRIS submission) Qualified Professional (verification) **Completion Date:** Already implemented but Before April 1, 2026 **(Corrected)V539 – Client Privacy (27F .0102)**	

			Corrective Action: A new bedroom door was installed for Client #2 on 02/07/2026 to ensure privacy and compliance with client rights requirements. **Prevention Measures:** No bedroom door will be removed without documented treatment team approval and written safety plan. Any structural modifications will require consultation with construction professionals and compliance review **Monitoring**: Weekly environmental safety checks by AP.Monthly facility inspection by Executive Director. **Responsible Party:** Executive Director **Completion Date:February 7, 2026** **(Corrected)V736 – Facility & Grounds Maintenance (27G .0303(c))** **Corrective Action:** The inoperable vehicle was removed from the premises. Yard debris was cleared. All identified interior repairs (holes, broken drawers, tile, drywall, door repair) have been completed. Bedrooms were cleaned and reorganized. Staff and clients attended a cleanliness meeting to reinforce expectations. **Prevention Measures:** A Daily Facility Inspection Checklist has been implemented. Minor repairs will be completed within 48 hours. Major repairs will be scheduled immediately with licensed professionals. Staff will document environmental checks each shift. **Monitoring:**Direct Care Staff: Daily room inspections.AP: Weekly maintenance walkthrough.Executive Director: Monthly environmental compliance audit. **Responsible Party:** Executive Director (ultimate oversight)AP (maintenance oversight)Direct Staff (daily monitoring)	

			Completion Date: Already implemented but Before April 1, 2026	

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V 118	Continued From page 1 (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure medications were administered on the written order of a physician and failed to keep the MAR current affecting 1 of 2 Current Clients (#1). The findings are: Finding #1: Review on 01/30/2026 of Client #1's record revealed: -Admission date of 09/08/2025. -Diagnosed with Major Depression Disorder, Conduct Disorder, Post Traumatic Stress Disorder, Alcohol Abuse with Alcohol-Induced Anxiety Disorder and Cannabis Use Disorder. A physician's order dated 11/18/2025 revealed: -Clonidine HCL (Hydrochloride) .2 milligrams (mg)(Anxiety Disorder)- Take 1 tab by mouth twice daily. There were physicians' orders dated 12/16/2025 revealed: -Clonidine HCL .1 mg (Anxiety Disorder)- Take 1 tab by mouth twice daily. -Fluoxetine 10 mg (Mood Disorder)- Take 1 capsule (cap) by mouth every morning.	V 118		

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V 118	Continued From page 2 There were no discontinue orders for: -Clonidine HCL .2 mg- Take 1 tab by mouth twice daily. -Clonidine HCL .1 mg- Take 1 tab by mouth twice daily. -Fluoxetine 10 mg- Take 1 cap by mouth every morning. Reviews on 02/03/2026 and 02/04/2026 of Client #1's MARs from 11/01/2025 - 01/31/2026 revealed: -Staff documented Client #1 was administered Fluoxetine 10 mg from 11/17/2025-01/31/2026. -Staff documented Client #1 was administered Clonidine HCL .2 mg from 11/18/2025-12/15/2025. -Staff documented Client #1 was administered Clonidine HCL .1 mg from 12/15/2025-01/19/2026. Interview on 02/04/2026 with Staff #2 revealed: -The Associate Professional (AP)/ Co-Licensee (CL) was responsible for medication orders. -"I may have checked it (Client #1's Fluoxetine 10 mg) off by memory or mistake. It was discontinued." Interview on 02/04/2026 with the Qualified Professional revealed: -"It (facility staff documenting administration of Client #1's Fluoxetine after it was discontinued) was a slight oversight ..." Interview on 02/04/2026 with the AP/CL revealed: -He failed to get discharge orders for medications from the psychiatrist. -"Going forward, I will make sure I get discharge orders every time there is a med (medication) change." - Staff signed off on administering Client #1's	V 118		

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V 118	Continued From page 3 Fluoxetine after it was discharged on 1/19/2026. -"They (the facility) got a new system, and I failed to go in to discharge the medication (Fluoxetine on 01/19/2026). There will be a new training to go over the med process." Interview on 02/04/2026 with the Executive Director/CL revealed: -"It (need for discharge orders) was something that we did not realize was necessary." -"...by making sure we have (medication) discharge orders." -"We will have another class (medication administration training) to make sure everyone know how it is done."	V 118		
V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable. This Rule is not met as evidenced by: Based on record review and interviews, the	V 121		

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V 121	Continued From page 4 facility failed to obtain drug regimen reviews every six months for 1 of 1 Client (#2) who received psychotropic drugs. The findings are: Review on 01/30/2026 of Client #2's record revealed: -A physician's order dated 12/18/2025 for: -Dexmethylphenidate Hydrochloride (HCL) Extended Release (ER) 20 mg (Anti-psychotic)-Take 1 capsule by mouth once a day in the morning. -There was no documentation of a current six-month drug regimen review for Client #2. Reviews on 02/03/2026 and 02/04/2026 of Client #1's MARs from 11/01/2025 - 01/31/2026 revealed: -Staff documented Client #2 was administered Dexmethylphenidate HCL ER 20 mg from 11/01/2025-01/31/2026. Interview on 02/04/2026 with the Associate Professional/Co-Licensee (CL) revealed: -"[Client #2] had been on the med (medication; Dexmethylphenidate HCL ER) since he got here (on 09/23/2024)." -He was not aware of the six-month client drug regimen review requirement. -He confirmed that Client #2 had not received a six-month drug regimen review by a pharmacist or physician. -"... I missed the rule about the med review but going forward we will get one (six-month drug regimen)." Interview on 02/04/2026 with the Executive Director/CL revealed: -She was not aware of the six-month client drug regimen review requirement. -She confirmed that Client #1 had not received a	V 121		

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V 121	Continued From page 5 six-month drug regimen review by a pharmacist or physician. -"Moving forward, we will make sure that we have one (six-month drug regimen)."	V 121		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall	V 366		

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V 366	Continued From page 6 develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues	V 366		

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V 366	Continued From page 7 identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to implement written policies governing their response to Level I and II incidents. The findings are: Reviews on 01/30/2026 and 02/02/2026 of the facility's incident reports from 05/01/2025 - 12/29/2025 revealed: -05/06/2025; Former Client (FC) #3's defiance, verbal threats, and emotional distress incident.	V 366		

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V 366	Continued From page 8 -05/23/2026; FC #4's self-harm and Emergency Room (ER) visit incident. -07/11/2025; FC #3's verbal aggression, attempted elopement, and suicidal gestures incident. -08/16/2025; FC #3's physical altercation with a peer incident. -08/17/2026; FC #3's defiance, property destruction, and attempted elopement incident. -08/18/2026; FC #3's elopement, physical aggression, property destruction, and hospitalization incident. -11/13/2025; Client #1's defiance, verbal aggression, and emotional distress incident. -11/18/2025; Client #1's elopement, emotional distress, and ER visit incident. Reviews on 01/30/2026 and 02/02/2026 of the facility's records revealed: FC #4's incident was not evaluated for: -Developed and implemented corrective measures according to provider specified timeframes not to exceed 45 days. -Assigned persons to be responsible for implementation of the corrections and preventive measures. -Maintained documentation regarding the above subparagraphs of this Rule. There was no documentation to support that all other incidents were evaluated for: -Developed and implemented measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days. -Developed and implemented corrective measures according to provider specified timeframes not to exceed 45 days. -Assigned persons to be responsible for implementation of the corrections and preventive measures.	V 366		

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V 366	Continued From page 9 -Maintained documentation regarding the above subparagraphs of this Rule. Interview on 02/04/2026 with the Associate Professional/Co-Licensee (CL) revealed: -"We need to go back and review the rules on incidents (response requirements)." -"We are going to have a training on how to do incident reports and report in IRIS." Interview on 02/04/2026 with the Executive Director/CL revealed: -"There is no reason. We just need to reassess." -"Moving forward, we make sure they (incidents) have the 7 components."	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information;	V 367		

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V 367	Continued From page 10 (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the	V 367		

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V 367	Continued From page 11 catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to file the required incident report within 72 hours, and facility failed to submit to the Local Management Entity (LME)/Managed Care Organization (MCO) upon requests other information regarding the incident. The findings are: Reviews on 01/30/2026 and 02/02/2026 of the facility's incident reports from 05/01/2025 - 12/29/2025 revealed: -05/23/2025; Former Client (FC) #4's self-harm	V 367		

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	MHL036-415	A. BUILDING: _____ B. WING _____	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF CHOY	2501 LYONS STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	Continued From page 12 and Emergency Room (ER) visit incident. -08/18/2025; FC #3's elopement, physical aggression, property destruction, law enforcement involvement, and hospitalization incident. -11/18/2025; Client #1's elopement, emotional distress, law enforcement contact, and ER visit incident6 Reviews on 01/30/2026 and 02/02/2026 of the Incident Response Improvement System (IRIS) from 05/01/2025 - 12/29/2025 revealed: There were no IRIS reports for the following incidents: -08/18/2025; FC #3's elopement, physical aggression, property destruction, law enforcement involvement, and hospitalization incident. -11/18/2025; Client #1's elopement, emotional distress, law enforcement contact, and ER visit incident. Reviews on 01/30/2026 and 02/02/2026 an IRIS Report dated 05/28/2025 for FC #4 revealed: -The incident occurred on 05/23/2025. -The provider learned of the incident on 05/23/2025. -The report was submitted 05/28/2025. -LME/MCO Comments dated 05/28/2025: " This IRIS report has been reviewed by MCO staff. There is information missing, that needs clarification and/ or that requires further explanation. Please see below for the info that needs to be completed. Once completed, please save and resubmit this IRIS report. Please resubmit within 5 days of the date of this notification. 1. Enter Tailored Plan Client Record Number and CNDS ID." -The report was submitted 2 days after the required time frame.	V 367		

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V 367	Continued From page 13 Interview on 02/04/2026 with the Associate Professional/Co-Licensee (CL) revealed: -"[Executive Director (ED)/CL] is responsible for doing the IRIS reports." -"We were busy dealing with the incident and forgot to put it in once the incident was over." -He would ensure that facility staff were retrained on incident reporting. Interview on 02/04/2026 with the ED/CL revealed: -She overlooked submitting the IRIS reports.	V 367		
V 539	27F .0102 Client Rights - Living Environment 10A NCAC 27F .0102 LIVING ENVIRONMENT (a) Each client shall be provided: (1) an atmosphere conducive to uninterrupted sleep during scheduled sleeping hours, consistent with the types of services being provided and the type of clients being served; and (2) accessible areas for personal privacy, for at least limited periods of time, unless determined inappropriate by the treatment or habilitation team. (b) Each client shall be free to suitably decorate his room, or his portion of a multi-resident room, with respect to choice, normalization principles, and with respect for the physical structure. Any restrictions on this freedom shall be carried out in accordance with governing body policy. This Rule is not met as evidenced by: Based on observations, record review and interviews the facility failed to provide accessible	V 539		

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V 539	Continued From page 14 area for personal privacy for 1 of 1 Client (#2). The findings are: Observations on 01/30/2026 at approximately 3:02 pm of Client #2's bedroom revealed: -There was no bedroom door. Review on 01/30/2026 of Client #2's record revealed: -Admission date of 09/23/2024. -Age 8. -Diagnosed with Attention Deficit Hyperactivity Disorder, Conduct Disorder, Disruptive Mood Dysregulation Disorder, and Other specified trauma. Interview on 02/04/2026 with Client #1 revealed: -There was no door when she admitted into the facility on 09/08/2025. -"They were working on getting him a new door." Interview on 02/04/2026 with Client #2 revealed: -He did not have a bedroom door. -"I don't know (how long the door had been missing). I have not been counting." Interview on 02/04/2026 with the Associate Professional/Co-Licensee (CL) revealed: -Due to safety concerns for Client #1 the door was removed. -"Within the next 48 hours the door will be replaced." Interview on 02/04/2026 with the Executive Director/CL revealed: -"He had behavior issues and self-harming is the reason we took it (the bedroom door) off." -"We are going to replace the door and contact construction to see if there are any other safer mechanisms for the door."	V 539		

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V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observations and interviews, the facility was not maintained in a clean, attractive, and orderly manner. The findings are: Observation on 01/30/2026 at approximately 12:55 pm of the facility's grounds revealed: -A white medium sized sports utility vehicle (SUV) with two flat tires. -A pair of socks, one green bike, two white plastic buckets, one plastic water bottle and toys scattered in the yard. -A blue bike propped against the side of the house near the white SUV. Observation on 01/30/2026 at approximately 2:55 pm of the facility revealed: Living Room: -A circular hole the size of a small basketball beside an electrical outlet. Kitchen: -A extra-large square shaped unfinished dry walled repair area on the wall near the kitchen entrance. Hallway Bathroom: -A cracked tile in front of the toilet. -A cracked and fragmented tile near the toilet. -A white vanity with two broken drawers and	V 736		

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V 736	Continued From page 16 detached bottom frame. -A hole in the wall the size of a snack sized candy bar beside the window. Client #1's bedroom: -The bedroom door was covered with dark dirt like strains and would not close. -There was an unmade bed. -Bedding, clothes, shoes, clothes hangers and debris were scattered on the entire floor. -Clothing and shoes were scattered on the floor in the closet. Client #2's bedroom: -Paper and plastic debris scattered about the entire floor surface. -Toys, three paintings, and a clock were on the floor. -A white basket with clothes, a black laundry bag filled with clothes, clothing, and multiple plastic shopping bags were on the floor spanning the wall near the door frame. -A cardboard box with bedding and clothes were against the wall near the closet. -Clothes hangers, shoes, boots, and clothes were scattered on the floor of the closet. -Black shoes were on the floor near the door. -A dresser with two bent/broken cloth like drawers and one drawer with clothes hanging out. -A plastic dresser with clothes thrown on the top and four missed placed drawers. -A hole in the wall the size of a fifty cent piece. -The walls throughout the room were covered in dark dirt like stains. Interview on 02/04/2026 with the Associate Professional (AP)/Co-Licensee (CL) revealed: -"It's (the broken-down white SUV) been there (in the driveway) for a minute (a long time)." -"Just not taking care of stuff (needed repairs) as	V 736		

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V 736	Continued From page 17 soon as we see it." -Would ensure repairs to the facility were completed in the next two weeks. Interview on 02/04/2026 with the Qualified Professional revealed: -"[AP/CL] is the one responsible for doing repairs (to the facility) and the staff are responsible for making sure the (client) rooms and everything is inspection order." Interviews on 01/30/2026 and 02/04/2026 with the Executive Director/CL revealed: -The vehicle belonged to someone that lived at the facility previously. -She did not ensure the upkeep of the facility. -"Staff not going behind children to ensure completion of tasks." -Would ensure repairs to the facility were completed in the next two weeks.	V 736		