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
	MHL075-025	A. BUILDING: ______ B. WING ______	R 11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIGHTHOUSE	**85 MIMOSA INN LANE TRYON, NC 28782**

(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 follow up survey was completed on November 13, 2025. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 5 and has a current census of 3. The survey sample consisted of audits of 3 current clients and 1 deceased client.	V 000		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified	V 367	RECEIVED DEC 18 2025 DHSR-MH Licensure Sect	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE (X6) DATE 12/5/25

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V 367	Continued From page 1 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 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	V 367		

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V 367	Continued From page 2 definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to notify the LME/MCO (Local Management Entity/Managed Care Organization) of all level II/level III incidents within 72 hours as required. The findings are: Review on 11/12/25 and 11/13/25 of the North Carolina Incident Response Improvement System (IRIS) revealed: -No level II/level III incidents reported for this facility. Review on 11/13/25 of Deceased Client (DC #4)'s record revealed: -Date of Admission: 1/1/12. -Diagnoses: Intellectual Developmental Disability, Moderate; Psychotic Disorder (D/O); Seizure	V 367	Iris and other reports were completed November 17, 2025. His legal guardian, Haywood Cares and his closest relative were all notified at the time of the incident. His legal guardian of Haywood Cares, was directly involved with his care during his hospital admission. Provider will endeavor to ensure all deadlines are met for future incidents. Carolyn Good BSW	

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V 367	Continued From page 3 D/O; Traumatic Brain Injury (TBI) Unspecified; Hypertension; and Diverticulitis. -Date of death: 8/29/25. Review on 11/13/25 of the facility's internal incident reports revealed: -8/24/25, 11:50 PM, "Client (DC #4) was taken to [local emergency room (ER)] on 8/24/25 and admitted to another local hospital on 8/25/25 ... [DC #4] had a seizure and was taken by ambulance to the hospital and was admitted." Interview on 11/12/25 with the Lead Staff revealed: -DC #4 passed away in August 2025. -He was transported by EMS from the facility to the hospital and later died in the intensive care unit. -The Qualified Professional (QP) or office staff would have completed the IRIS report. Interview on 11/13/25 with a Lead Staff from a sister facility revealed: -The Executive Director (ED) and QP were out of the office currently. -ED reported to her via text message that the facility completed an incident report when DC #4 had a seizure at the facility which led to his hospitalization. -DC #4 later passed away at a hospital. -Due to DC #4 not passing away at the facility, was not aware that an IRIS report had to be completed. -The ED would ensure that the IRIS report was completed as soon as possible.	V 367		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL075-025 Y1	A. Building B. Wing Y2	11/13/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIGHTHOUSE	85 MIMOSA INN LANE TRYON, NC 28782

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0118 Reg. # 27G .0209 (C) LSC	Correction Completed 11/13/2025	ID Prefix V0736 Reg. # 27G .0303(c) LSC	Correction Completed 11/13/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR [illegible signature]	DATE 11/13/25
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
11/26/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

JOSH STEIN • Governor
DEVDUTTA SANGVAI • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

November 24, 2025

Ms. Julie Grigg, Executive Director
Synergy in Action, Inc.
2976 Peniel Rd
Tryon, NC 28782

Re: Annual and Follow Up Survey completed November 13, 2025
The Lighthouse, 85 Mimosa Inn Lane, Tryon, NC 28782
MHL # 075-025
E-mail Address: j.grigg@siainc.org

Dear Ms. Grigg:

Thank you for the cooperation and courtesy extended during the annual and follow up survey completed November 13, 2025.

As a result of the follow up survey, it was determined that all of the deficiencies are now in compliance, which is reflected in the enclosed Revisit Report. An additional deficiency was cited during the survey.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- A standard level deficiency.

Time Frames for Compliance

- A standard level deficiency be ***corrected*** within 60 days from the exit of the survey, which is 1/12/26.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Ms. Eileen Moreno at 336-247-0107.

Sincerely,

Anne E Nelson

Anne Nelson
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: QM@partnersbhm.org
dhhs@vayahealth.com
Mr. Joshua Kennedy, Director Polk County DSS
Michael Blake, Administrative Supervisor