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
	MHL092-581	A. BUILDING: ______ B. WING ______	R **03/19/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VARSITY CREST #2	**1503 CREST DRIVE, APT #102 RALEIGH, NC 27606**

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V 000	INITIAL COMMENTS An annual and follow up survey was completed on 3/19/26. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 2 and has a current census of 2. The survey sample consisted of audits of 2 current clients.	V 000		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician;	V 113		

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V 113	Continued From page 1 (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 2 of 2 clients (#1 and #2) records were maintained. The findings are: Review on 3/18/26 of client #1's record revealed: - Admitted: 5/12/25 - Diagnosis: Paranoid Schizophrenia - No documentation of the following: - Documentation of services provided - Copies of lab tests Review on 3/18/26 of client #2's record revealed: - Admitted: 1/11/25 - Diagnosis: Schizoaffective Disorder Bipolar type - No documentation of the following: - Documentation of services provided - Copies of lab tests	V 113		

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V 113	Continued From page 2 During interview on 3/19/26 the Assisted Director/Qualified Professional (ADQP) reported: - Staff do not attend the clients' appointments - Clients with medical appointments were given a facility's form for their physician to complete - It was the clients' responsibility to return the facility's form to staff along with any physician's summaries - The facility's nurse used to ensure the physician's medical documentation was in the clients' records but she left in February 2026 - She (ADQP) was responsible for the physician's medical documentation being in the clients' records	V 113		
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;	V 118		

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V 118	Continued From page 3	V 118		

(B) name, strength, and quantity of the drug;
(C) instructions for administering the drug;
(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 record review and interview the facility failed to administer medications on a written order of a physician and failed to keep the MAR current for 1 of 2 clients (#1). The findings are:

Review on 3/18/26 of client #1's record revealed:
- Admitted: 5/12/25
- Diagnosis: Paranoid Schizophrenia
- No physician orders for the following medications:
- Clozapine 100 milligrams 1 morning and 2 bedtime (Schizophrenia) (8am and 8pm)
- Ferrous Sulfate 325mg everyday (iron)
- Lithium Carbonate 450mg bedtime (Bipolar)
- a physician's order dated 5/9/25: Metformin 500mg 2 morning and 2 bedtime (Diabetes) (8am and 8pm)

Review on 3/18/26 of client #1's January 2026 - March 2026 revealed:
- Clozapine: 8am: no documentation staff administered medication on 3/1/26, 3/4/26, 3/13/26 - 3/15/26

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V 118	Continued From page 4 - Clozapine: 8pm: no documentation staff administered medication on 3/7/26 - 3/8/26 - Ferrous Sulfate: medication was not listed on the January and February MAR - Lithium Carbonate: no documentation staff administered medication on 3/4/26, 3/13/26 - 3/15/26 - Metformin - no documentation staff administered medication on 3/12/26 During interview on 3/19/26 the Assisted Director/Qualified Professional (ADQP) reported: - had a nurse that reviewed the clients' MARs - she (nurse) left February 2026 - she (ADQP) tried to review the clients' MARs daily, if not, at least the beginning and end of the weeks - the blank spaces on the MARs were an oversight - the nurse should have caught the missed Ferrous Sulfate on the MAR in January and February This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 367	Continued From page 5	V 367		

services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:
(1) reporting provider contact and identification information;
(2) client identification information;
(3) type of incident;
(4) description of incident;
(5) status of the effort to determine the cause of the incident; and
(6) other individuals or authorities notified or responding.
(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:
(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A

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V 367	Continued From page 6	V 367		

providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).
(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:
(1) medication errors that do not meet the definition of a level II or level III incident;
(2) restrictive interventions that do not meet the definition of a level II or level III incident;
(3) searches of a client or his living area;
(4) seizures of client property or property in the possession of a client;
(5) the total number of level II and level III incidents that occurred; and
(6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to ensure a Level II incident report was

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V 367	Continued From page 7 submitted to the Managed Care Organization/Local Management Entity within 72 hours. The findings are: Review on 3/13/26 of the Incident Response Improvement System (IRIS) revealed no level II incident reports Review on 3/19/26 of the facility's incident report book revealed: - "...2/26 (2026) - program manager (Assisted Director/Qualified Professional (ADQP) contacted local police department to report [client #1] missing...the local police department he able to leave on his own does not fit the category of missing person...the [local police department] completed wellness check by contacting the brother ...[client #1] was with brother" During interview on 3/19/26 the ADQP reported: - The brother lived in another town (approximately 25 miles from apartment) - A level II was not completed since the police did not complete a missing person report	V 367		
V 369	G.S. 122C-6 Smoking Prohibited § 122C-6 SMOKING PROHIBITED; PENALTY (a) Smoking is prohibited inside facilities licensed under this Chapter. As used in this section, "smoking" means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product. As used in this section, "inside" means a fully enclosed area. (b) The person who owns, manages, operates, or otherwise controls a facility subject to this section shall: (1) Conspicuously post signs clearly stating that smoking is prohibited inside the facility. The signs	V 369		

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V 369	Continued From page 8	V 369		

Continued From page 8

may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it.
(2) Direct any person who is smoking inside the facility to extinguish the lighted smoking product.
(3) Provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.
(c) The Department may impose an administrative penalty not to exceed two hundred dollars ($200.00) for each violation on any person who owns, manages, operates, or otherwise controls a facility licensed under this Chapter and fails to comply with subsection (b) of this section. A violation of this section constitutes a civil offense only and is not a crime.
(d) This section does not apply to State psychiatric hospitals. (2007-459, s. 3.)

This Rule is not met as evidenced by:
Based on observation and interview the facility failed to ensure smoking was prohibited from inside the facility for 2 of 2 clients (#1 and #2).
The findings are:

Review on 3/18/26 of client #1's record revealed:
- Admitted: 5/12/25
- Diagnosis: Paranoid Schizophrenia

Review on 3/18/26 of client #2's record revealed:
- Admitted: 1/11/25
- Diagnosis: Schizoaffective Disorder Bipolar type

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V 369	Continued From page 9	V 369		

Observation on 3/13/26 at 1:24pm and 3:13pm of the apartment revealed:
- The apartment smelled of smoke
- Client #1 was the only client present
- Client #1 had a vape pen in his window sill and a pack of cigarettes on his dresser
- Staff #1 asked client #1 if he knew where the designated smoking area was and he nodded "yes"
- at 3:13pm a no smoking sign was posted inside the apartment near the entrance

During interview on 3/13/26 client #1 reported:
- He had vaped in the apartment throughout the day
- Aware he was not supposed to vape inside the apartment
- It was cold today and he did not want to go outside to vape
- During the winter months he went to the designated smoke area to vape
- Staff encouraged him not to vape inside the apartment
- He smoked one other time inside the apartment but do not recall when it was

During interview on 3/13/26 client #2 reported:
- Had smoked inside the apartment one time a month ago
- it was snow on the ground and he did not want to go outside to smoke
- Staff encouraged them to smoke at designated area
- his roommate (client #2) vaped once a week in the living room

During interview on 3/13/26 staff #1 reported:
- the apartment smelled like smoke when he entered

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V 369	Continued From page 10 - this was the first time he smelled smoke inside the apartment During interview on 3/13/26 staff #2 reported: - he did his rounds to each apartment this morning and did not smell smoke - had not smelled smoke inside the apartment during previous visits to the apartment During interview on 3/13/26 the Assistant Director/Qualified Professional reported: - was not aware client #1 vaped and client #2 smoked in the apartments - both signed agreements upon admission not to smoke in the apartment	V 369		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated.	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-581	A. BUILDING: ______ B. WING ______	R 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 537	Continued From page 11	V 537		

(c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions.
(d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
(e) Formal refresher training must be completed by each service provider periodically (minimum annually).
(f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.
(g) Acceptable training programs shall include, but are not limited to, presentation of:
(1) refresher information on alternatives to the use of restrictive interventions;
(2) guidelines on when to intervene (understanding imminent danger to self and others);
(3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention);
(4) strategies for the safe implementation of restrictive interventions;
(5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention;
(6) prohibited procedures;
(7) debriefing strategies, including their importance and purpose; and

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V 537	Continued From page 12	V 537		

(8) documentation methods/procedures.
(h) Service providers shall maintain documentation of initial and refresher training for at least three years.
(1) Documentation shall include:
(A) who participated in the training and the outcomes (pass/fail);
(B) when and where they attended; and
(C) instructor's name.
(2) The Division of MH/DD/SAS may review/request this documentation at any time.
(i) Instructor Qualification and Training Requirements:
(1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.
(2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out.
(3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.
(4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
(5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule.
(6) Acceptable instructor training programs shall include, but not be limited to, presentation of:
(A) understanding the adult learner;
(B) methods for teaching content of the

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V 537	Continued From page 13 course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers.	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-581	A. BUILDING: ______ B. WING ______	R 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VARSITY CREST #2	**1503 CREST DRIVE, APT #102 RALEIGH, NC 27606**

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V 537	Continued From page 14	V 537		

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to ensure 2 of 8 audited staff (#1 and the Assisted Director/Qualified Professional (ADQP) were trained in physical restraints. The findings are:

Review on 3/19/26 of staff #1's record revealed:
- Date of Hire (DOH): 7/14/23
- A restrictive intervention certificate dated 6/11/25: North Carolina Intervention+ Prevention and Defensive

Review on 3/19/26 of the ADQP's record revealed:
- DOH: 7/24/23
- A restrictive intervention certificate dated 6/11/25: North Carolina Intervention+ Prevention and Defensive

During interview on 3/19/26 staff #1 reported:
- The restrictive intervention training was completed online
- The online training consisted of videos to watch

During interview on 3/19/26 the ADQP reported:
- The restrictive intervention training was completed online
- The training informed staff how to deescalate or redirect clients behaviors

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-581	A. BUILDING: ______ B. WING ______	R 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VARSITY CREST #2	**1503 CREST DRIVE, APT #102** **RALEIGH, NC 27606**

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V 736	Continued From page 15	V 736		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview the facility was not maintained in a clean, attractive and orderly manner. The findings are: Observation on 3/13/26 at 1:24pm of the facility revealed: - Oodles of noodles covered the sink drain - Used piles of tissue balled up in a corner of the bathroom floor - inside of the toilet bowl had a circular brown stain During interview on 3/18/26 client #1 reported: - tried to drain his noodles this morning and they spilled in the sink During interview on 3/19/26 the Assisted Director/Qualified Professional reported: - Staff encouraged the clients to clean their apartments - Staff "cannot make them (clients) clean their apartment"	V 736		