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
	MHL033-137	A. BUILDING: ______ B. WING ______	R 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A CARING HAND	616 ATLANTIC AVENUE ROCKY MOUNT, NC 27801

(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, complaint and follow up survey was completed on 2/19/26. The complaints were substantiated (intake #NC00235702 & intake#NC00235730). 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 6 and has a current census of 6. The survey sample consisted of audits of 4 current clients. This survey originally closed on 1/21/26 but was reopened on 2/2/26 due to additional complaints.	V 000	RECEIVED MAR 26 2026 DHSR-MH Licensure Sect	
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include:	V 105	V105 – Governing Body Policies (Admission Assessment) Corrective Action: The facility will immediately revise its admission screening and assessment procedures to ensure all available documentation, including hospital records and guardian reports, are thoroughly reviewed prior to admission. Staff responsible for admissions will complete a standardized admission checklist to verify that all behavioral concerns and clinical needs are identified and documented. Prevention: The facility will implement an Admission Review Protocol requiring the Licensee or designee to review all clinical documentation prior to acceptance of a new admission to ensure the facility can meet the individual's needs. Monitoring: The Licensee or Qualified Professional will review all new admissions and admission documentation. Frequency: 100% of all new admissions will be reviewed for compliance. Completion Date: March 21, 2026	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Nicole Artis Owner 3/11/26

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V 105	Continued From page 1 (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105	V105 – Governing Body Policies (Admission Assessment) Corrective Action: The facility will immediately revise its admission screening and assessment procedures to ensure all available documentation, including hospital records and guardian reports, are thoroughly reviewed prior to admission. Staff responsible for admissions will complete a standardized admission checklist to verify that all behavioral concerns and clinical needs are identified and documented. Prevention: The facility will implement an Admission Review Protocol requiring the Licensee or designee to review all clinical documentation prior to acceptance of a new admission to ensure the facility can meet the individual's needs. Monitoring: The Licensee or Qualified Professional will review all new admissions and admission documentation. Frequency: 100% of all new admissions will be reviewed for compliance. Completion Date: March 21, 2026	

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V 105	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview the facility failed to assess whether or not the facility could provide services to address 1 of 4 clients (#6) needs. The findings are: Review on 2/11/26 of the facility's admission policy revealed "...The Owner/Director (Licensee) will assure...record contents are met and information is sufficient to provide services..." Review on 1/21/26 and 2/11/26 of client #6's record revealed: - Admitted 1/13/26 and discharged 1/26/26 - Diagnoses: Schizoaffective Disorder and Bipolar Disorder, Intellectual Developmental Disorder - An admission assessment from a mental health hospital dated 10/31/25 "...acute psychotic ...masturbating in public ..." - No documentation of client #6's masturbating behaviors in the facility's admission assessment During interview on 2/10/26 client #6's agency legal guardian reported: - He was not sure which staff he spoke with by phone prior to admission - He informed the staff of client #6's masturbation behaviors During interview on 2/19/26 the Licensee reported:	V 105	V105 – Governing Body Policies (Admission Assessment) Corrective Action: The facility will immediately revise its admission screening and assessment procedures to ensure all available documentation, including hospital records and guardian reports, are thoroughly reviewed prior to admission. Staff responsible for admissions will complete a standardized admission checklist to verify that all behavioral concerns and clinical needs are identified and documented. Prevention: The facility will implement an Admission Review Protocol requiring the Licensee or designee to review all clinical documentation prior to acceptance of a new admission to ensure the facility can meet the individual's needs. Monitoring: The Licensee or Qualified Professional will review all new admissions and admission documentation. Frequency: 100% of all new admissions will be reviewed for compliance. Completion Date: March 21, 2026	

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V 105	Continued From page 3 - The guardian did not make her aware of client #6's masturbation behaviors - The guardian did not document client #6's masturbation behaviors in the admission assessment paperwork completed - She overlooked masturbation in the documentation submitted from the mental health hospital for client #6 - Client #6 masturbated on 2 different occasions inside the facility near the stairway - She observed his masturbation on the facility's cameras - The female staff "did not feel comfortable" with client #6 at the facility - If she was aware masturbation was in the documentation, would have put initial strategies in place regarding his sexual behaviors	V 105		
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	V 113	V113 – Client Records Corrective Action: All client records were reviewed and updated to ensure the following documents are present: Signed emergency consent forms Admission and discharge documentation Screening and assessment documentation Missing forms have been requested from guardians and placed in the record once received. Prevention: The facility has implemented a Client Record Checklist that must be completed upon admission and reviewed monthly. Monitoring: The Licensee will conduct monthly record audits to ensure all required documentation is present. Frequency: Monthly audits of all client records. Completion Date: March 21, 2026	

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V 113	Continued From page 4 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; (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 maintain 3 of 4 audited clients (#1, #2 and #6)'s records. The findings are: A. Review on 1/21/26 of client #1's record revealed: - Admitted 10/1/25 - Diagnoses of : Schizoaffective Disorder, Cannabis Use Disorder, Hypothyroidism, Obesity and Hypercholesterolemia - No signed emergency consent forms	V 113	V113 – Client Records Corrective Action: All client records were reviewed and updated to ensure the following documents are present: Signed emergency consent forms Admission and discharge documentation Screening and assessment documentation Missing forms have been requested from guardians and placed in the record once received. Prevention: The facility has implemented a Client Record Checklist that must be completed upon admission and reviewed monthly. Monitoring: The Licensee will conduct monthly record audits to ensure all required documentation is present. Frequency: Monthly audits of all client records. All direct care staff received training on the updated procedure and documentation requirements. Completion Date: March 21, 2026	

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V 113	Continued From page 5 Review on 1/21/26 of client #6's record revealed: - Admitted 1/13/26 - Diagnoses of : Schizoaffective Disorder, Intellectual Developmental Disorder and Bipolar - No signed emergency consent forms During interview on 1/21/26 the Licensee reported: - Guardians did not return the signed emergency forms back to the facility - Will ensure emergency consent forms were completed and in the record B. Review on 1/21/26 of client #2's record revealed: - Admitted 2/22/22 - Diagnoses: Schizoaffective Disorder, Mild Intellectual Developmental Disorder, Diabetes Mellitus II and Hyperlipidemia - No documentation of an admission and discharge date from the facility - No documentation of the screening and assessment During interview on 2/4/26 client #2's court ordered guardian reported: - Been client #2's guardian for a year - Client #2 moved from the Licensee's licensed facility 3/12/25 into the Licensee's multi-unit assisted housing with services (MUAHS) - Was at the MUAHS 6 or 7 months - The Licensee made him aware on 1/12/26, client #2 returned back to the licensed facility During interview on 2/11/26 the Licensee reported: - Client #2 was back and forth from the MUAHS to the license facility from September 2025 until 1/6/26	V 113	V113 – Client Records Corrective Action: All client records were reviewed and updated to ensure the following documents are present: Signed emergency consent forms Admission and discharge documentation Screening and assessment documentation Missing forms have been requested from guardians and placed in the record once received. Prevention: The facility has implemented a Client Record Checklist that must be completed upon admission and reviewed monthly. Monitoring: The Licensee will conduct monthly record audits to ensure all required documentation is present. Frequency: Monthly audits of all client records. Completion Date: March 21, 2026	

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V 113	Continued From page 6 - He officially moved back into the licensed facility on 1/7/26 - No admission and discharge summaries were completed since he was "back and forth" from the licensed facility to the MUAHS	V 113		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes. (b) The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate the facility's response to fire emergencies. (d) Each facility shall have a first aid kit accessible for use. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure fire and disaster drills were completed quarterly and repeated on each shift. The findings are: During interview on 1/21/26 the Licensee reported: - Staff shifts were 7 days on and 7 days off	V 114	V114 – Emergency Plans and Drills Corrective Action: The facility has implemented a fire and disaster drill schedule to ensure drills occur quarterly and on each shift. Prevention: A Fire and Disaster Drill Log has been created to document drills conducted on each shift. Monitoring: The Licensee or designee will review drill documentation to ensure compliance. Frequency: Quarterly with documentation review monthly. Completion Date: March 21, 2026	

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V 114	Continued From page 7 Review on 1/21/26 of the facility's fire and disaster log revealed: - Fire drills were only conducted from February 2025 - October 2025 - Fire drills were not conducted on each shift and quarterly - No documentation of disaster drills in the last year During interview on 1/20/26 client #2 reported: - Fire drills clients went to the mailbox - Tornado drills were practiced in the hallway During interview on 1/21/26 the Licensee reported: - Clients went to a pole in the yard for fire drills - Clients went in the basement for tornado drills - Will ensure fire and disaster drills were documented quarterly and on each shift	V 114	V114 – Emergency Plans and Drills Corrective Action: The facility has implemented a fire and disaster drill schedule to ensure drills occur quarterly and on each shift. Prevention: A Fire and Disaster Drill Log has been created to document drills conducted on each shift. Monitoring: The Licensee or designee will review drill documentation to ensure compliance. Frequency: Quarterly with documentation review monthly. Completion Date: March 21, 2026	
V 117	27G .0209 (B) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription	V 117	V117 – Medication Labeling Corrective Action: All medications were reviewed to ensure proper labeling is present on each medication container. Medications without proper labeling were returned to the pharmacy or replaced. Prevention: Staff will be trained not to discard medication packaging containing required labeling information. Monitoring: Medication storage and labeling will be reviewed weekly by the Licensee or designated staff. Frequency: Weekly medication checks. Completion Date: March 21, 2026	

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V 117	Continued From page 8 drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner. This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure 1 of 4 audited clients (#2) medication had a packaging label. The findings are: Review on 1/21/26 of client #2's record revealed: - Admitted 2/22/22 - Diagnoses: Schizoaffective Disorder, Mild Intellectual Developmental Disorder, Diabetes Mellitus II and Hyperlipidemia - A physician's order dated 1/12/26: Ozempic 1 milligram (mg) every 7 days Observation on 1/21/26 at 1:13pm revealed: - 1 Ozempic injection pen with no medication label that consisted of: - The client's name - The prescriber's name - The current dispensing date - The name, strength, quantity, and expiration date of the prescribed drug	V 117	V117 – Medication Labeling Corrective Action: All medications were reviewed to ensure proper labeling is present on each medication container. Medications without proper labeling were returned to the pharmacy or replaced. Prevention: Staff will be trained not to discard medication packaging containing required labeling information. Monitoring: Medication storage and labeling will be reviewed weekly by the Licensee or designated staff. Frequency: Weekly medication checks. Completion Date: March 21, 2026	

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V 117	Continued From page 9 - The name, address, and phone number of the pharmacy or dispensing location During interview on 1/21/26 the Licensee reported: - She threw the box in the trash the Ozempic pen came in	V 117		
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; (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	V 118	V118 – Medication Administration / MAR Documentation Corrective Action: Medication Administration Records (MARs) were reviewed and updated. Staff were immediately retrained on proper medication administration and MAR documentation procedures. Prevention: A Medication Administration Training Program has been implemented to ensure staff understand physician orders, MAR transcription, and documentation requirements. Monitoring: The Licensee will conduct weekly medication audits to verify medications are administered as ordered and documented on the MAR. Frequency: Weekly audits. Completion Date: March 21, 2026	

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V 118	Continued From page 10 with a physician. This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to administer medications on the written order of a physician for 1 of 4 audited clients' (#2), failed to ensure 1 of 4 audited clients (#1) self administed on the written order of a physician and failed to keep MARs current for 2 of 4 audited clients (#1 and #2). The findings are: I. The following is an example of how client #2 did not receive his medication: Review on 1/21/26 of client #2's record revealed: - Admitted 2/22/22 - Diagnoses: Schizoaffective Disorder, Mild Intellectual Developmental Disorder, Diabetes Mellitus II and Hyperlipidemia - A physician's order dated 1/7/26: Metformin 500milligrams (mg) twice a day (Diabetes) Observation on 1/21/26 at 1:13pm of client #2's medications revealed: - Metformin was dispensed in a bottle Review on 1/21/26 of client #2's January 2026 MAR revealed: - Metformin was not documented on the MAR Review on 1/21/26 client #2's primary care physician summaries revealed: - Was seen on 1/6/26 and 1/12/26 for Type 2	V 118	V118 – Medication Administration / MAR Documentation Corrective Action: Medication Administration Records (MARs) were reviewed and updated. Staff were immediately retrained on proper medication administration and MAR documentation procedures. Prevention: A Medication Administration Training Program has been implemented to ensure staff understand physician orders, MAR transcription, and documentation requirements. Monitoring: The Licensee will conduct weekly medication audits to verify medications are administered as ordered and documented on the MAR. All direct care staff received training on the updated procedure and documentation requirements. Frequency: Weekly audits. Completion Date: March 21, 2026	

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V 118	Continued From page 11 diabetes - On, 1/20/26, a telemedicine video call was conducted with client #2 and his primary physician During interview on 1/20/26 staff #1 reported: - Started at the facility on 1/15/26 - She thought the Licensee told her the Metformin was discontinued - Had not administered the Metformin from 1/15/26 - until 1/20/26 During interview on 1/21/26 the Licensee reported: - Staff #1 should have administered the Metformin to client #2 - The Metformin was not discontinued - The Metformin was prescribed in January 2026 - She forgot to transcribe the Metformin on the January 2026 MAR II. The following is an example of how the facility failed to keep clients' MARs current: A. Review on 1/20/26 and 2/11/26 of client #1's record revealed: - A physician's order dated 6/30/25: Gabapentin 100mg three times a day as needed (pain) Observation on 1/20/26 at 2:56pm of client #1's medications revealed: - The blister pack of Gabapentin was missing no pills Observation on 2/11/26 at 1:17pm of client #1's medications revealed the following: - 3 pills were missing from the blister pack of the Gabapentin	V 118	V118 – Medication Administration / MAR Documentation Corrective Action: Medication Administration Records (MARs) were reviewed and updated. Staff were immediately retrained on proper medication administration and MAR documentation procedures. Prevention: A Medication Administration Training Program has been implemented to ensure staff understand physician orders, MAR transcription, and documentation requirements. Monitoring: The Licensee will conduct weekly medication audits to verify medications are administered as ordered and documented on the MAR. Frequency: Weekly audits. Completion Date: March 21, 2026	

Division of Health Service Regulation

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	MHL033-137	A. BUILDING: ____ B. WING ____	R 02/19/2026

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V 118	Continued From page 12 Review on 2/11/26 of the January 2026 and February 2026 MAR revealed: - No documentation staff initialed the Gabapentin as administered During interview on 2/11/26 client #1 reported: - The Gabapentin was for nerve pain in his hand - Thought staff administered the Gabapentin last night but could not recall when he took the medication During interview on 2/11/26 and 2/19/26 staff #2 reported: - He administered the Gabapentin on 3 different days (no dates recalled) - Client #1 complained of pain in his hands and they were "shaky" - He "forgot" to initial the MAR on the days he administered the Gabapentin During interview on 2/11/26 and 2/19/26 the Licensee reported: - Will remind staff to sign MAR when medications were administered B. Review on 1/21/26 & 2/5/26 of client #2's January 2026 MAR revealed: - The Ozempic was not transcribed on the MAR During interview on 2/5/26 client #2 reported: - Staff #2 administered his Ozempic shots During interview on 2/5/26 staff #2 reported: - He gave client #2's Ozempic shot every 7 days - He forgot to document the Ozempic shot	V 118	V118 – Medication Administration / MAR Documentation Corrective Action: Medication Administration Records (MARs) were reviewed and updated. Staff were immediately retrained on proper medication administration and MAR documentation procedures. Prevention: A Medication Administration Training Program has been implemented to ensure staff understand physician orders, MAR transcription, and documentation requirements. Monitoring: The Licensee will conduct weekly medication audits to verify medications are administered as ordered and documented on the MAR. Frequency: Weekly audits. Completion Date: March 21, 2026	

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V 118	Continued From page 13 During interview on 1/21/26 the Licensee reported: - The pharmacy transcribed the medications on the MAR - She received January 2026 MAR in December 2025 - The Ozempic was prescribed in January 2026 - She forgot to transcribe the Ozempic on the January 2026 MAR III. The following is an example of how a client self-administered his medications without a physician's order: Review on 1/20/26 and 2/11/26 of client #1's record revealed: - Admitted 10/1/25 - Diagnoses of: Schizoaffective Disorder, Cannabis Use Disorder, Hypothyroidism, Obesity and Hypercholesterolemia - A physician's order dated 9/24/25: Symbicort 160 microgram (mcg) inhale 2 puff in morning and 2 evening (asthma) - No documentation of a self-administration order Observations on 2/11/26 of client #1's medications revealed the following: - At 1:58pm the Symbicort was in client #1's bedroom nightstand drawer Review on 2/11/26 of the January 2026 and February 2026 MAR revealed: - No documentation staff initialed the Symbicort as administered During interview on 2/11/26 client #1 reported: - Staff was aware he had the inhaler in his bedroom	V 118	V118 – Medication Administration / MAR Documentation Corrective Action: Medication Administration Records (MARs) were reviewed and updated. Staff were immediately retrained on proper medication administration and MAR documentation procedures. Prevention: A Medication Administration Training Program has been implemented to ensure staff understand physician orders, MAR transcription, and documentation requirements. Monitoring: The Licensee will conduct weekly medication audits to verify medications are administered as ordered and documented on the MAR. Frequency: Weekly audits. Completion Date: March 21, 2026	

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V 118	Continued From page 14 - Sometimes he used the Symbicort in the morning and then sometimes at night - He does not need the Symbicort daily - Used the Symbicort when he took long walks or if he went for a run During interview on 2/11/26 and 2/19/26 the Licensee reported: - Aware client #1 had the Symbicort in his bedroom - Will follow up with the physician for a self administration order and change the order to as needed for the Symbicort "Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician" This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118	V118 – Medication Administration / MAR Documentation Corrective Action: Medication Administration Records (MARs) were reviewed and updated. Staff were immediately retrained on proper medication administration and MAR documentation procedures. Prevention: A Medication Administration Training Program has been implemented to ensure staff understand physician orders, MAR transcription, and documentation requirements. Monitoring: The Licensee will conduct weekly medication audits to verify medications are administered as ordered and documented on the MAR. Frequency: Weekly audits. Completion Date: March 21, 2026	
V 120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician	V 120	V120 – Medication Storage Corrective Action: A locked container has been placed in the refrigerator to store medications that require refrigeration. Prevention: Staff were trained on medication storage requirements including locked storage and separation of medications. Monitoring: Medication storage will be checked weekly. Frequency: Weekly monitoring. Completion Date: March 21, 2026	

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V 120	Continued From page 15 for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to store 1 of 4 audited clients (#2) medication was stored in a separate locked container in the refrigerator. The findings are: Review on 1/21/26 of client #2's record revealed: - Admitted 2/22/22 - Diagnoses: Schizoaffective Disorder, Mild Intellectual Developmental Disorder, Diabetes Mellitus II and Hyperlipidemia - A physician's order dated 1/12/26: Ozempic 1 milligrams every 7 days (Diabetes) Observation on 2/19/26 at 10:18am revealed: - Client #2's unopened box of Ozempic in the facility's refrigerator door During interview on 2/19/26 the Licensee reported: - Will get a locked container to store the Ozempic in the refrigerator	V 120	V120 – Medication Storage Corrective Action: A locked container has been placed in the refrigerator to store medications that require refrigeration. Prevention: Staff were trained on medication storage requirements including locked storage and separation of medications. Monitoring: Medication storage will be checked weekly. All direct care staff received training on the updated procedure and documentation requirements. Frequency: Weekly monitoring. Completion Date: March 21, 2026 V291 – Coordination with Qualified Professionals Corrective Action: The facility implemented a communication protocol to ensure guardians and treatment providers are notified immediately when a client is hospitalized or experiences a significant event. Prevention: A Guardian Notification Log will be maintained to document all communication with guardians and providers. Monitoring: The Licensee will review communication documentation. Frequency: Monthly. Completion Date: March 21, 2026	
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than	V 291		

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V 291	Continued From page 16 six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record review and interview the facility failed to coordinate with other qualified professionals were responsible for the treatment/habilitation or case management for 1 of 4 audited clients (#5). The findings are: Review on 2/11/26 of client #5's record revealed:	V 291	V291 – Coordination with Qualified Professionals Corrective Action: The facility implemented a communication protocol to ensure guardians and treatment providers are notified immediately when a client is hospitalized or experiences a significant event. Prevention: A Guardian Notification Log will be maintained to document all communication with guardians and providers. Monitoring: The Licensee will review communication documentation. Frequency: Monthly. Completion Date: March 21, 2026	

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V 291	Continued From page 17 - Admitted 1/9/26 and discharged 2/6/26 - Diagnoses: Personality Disorder, Seizure Disorder and Schizoaffective Disorder During interview on 2/5/26 client #5's Department of Social Services (DSS) guardian reported: - Client #5 was admitted to the hospital on 1/22/26 - A hospital representative informed her client #5 had been hospitalized - She had not received a call from the Licensee since client #5 was admitted - She attempted to reach the Licensee on 1/22/26 but was unable to reach her During interview on 2/10/26 and 2/11/26 the Licensee reported: - On 2/10/26, thought the Office Administrator (OA) notified client #5's DSS guardian of client #5's hospitalization - On 2/11/26, she spoke with the OA who informed her she did not notify client #5's guardian of client #5's hospitalization	V 291	V291 – Coordination with Qualified Professionals Corrective Action: The facility implemented a communication protocol to ensure guardians and treatment providers are notified immediately when a client is hospitalized or experiences a significant event. Prevention: A Guardian Notification Log will be maintained to document all communication with guardians and providers. Monitoring: The Licensee will review communication documentation. Frequency: Monthly. Completion Date: March 21, 2026	
V 513	27E .0101 Client Rights - Least Restrictive Alternative 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (a) Each facility shall provide services/supports that promote a safe and respectful environment. These include: (1) using the least restrictive and most appropriate settings and methods; (2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the clients served/supported; and	V 513	V513 – Client Rights / Least Restrictive Environment Corrective Action: The facility reviewed kitchen access policies to ensure residents maintain appropriate access to food and beverages while maintaining safety. Prevention: Staff were trained on client rights and maintaining a respectful and least restrictive environment. Monitoring: The Licensee will monitor compliance with client rights policies. All direct care staff received training on the updated procedure and documentation requirements. Frequency: Monthly review. Completion Date: March 21, 2026	

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V 513	Continued From page 18 (4) sharing of control over decisions with the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include: (1) using the intervention as a last resort; and (2) employing the intervention by people trained in its use. This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to promote a safe and respectful environment for 6 of 6 clients (#1 - #6). The findings are: Review on 1/21/26 of client #1's record revealed: - admitted 10/1/25 - diagnoses of : Schizoaffective Disorder, Cannabis Use Disorder, Hypothyroidism, Obesity and Hypercholesterolemia Review on 1/21/26 of client #2's record revealed: - Admitted 2/22/22 - Diagnoses: Schizoaffective Disorder, Mild Intellectual Developmental Disorder, Diabetes Mellitus II and Hyperlipidemia Review on 2/11/26 of client #5's record revealed: - Admitted 1/9/26 and discharged 2/6/26 - Diagnoses: Personality Disorder, Seizure Disorder and Schizoaffective Disorder Review on 1/21/26 of client #6's record revealed:	V 513	V513 – Client Rights / Least Restrictive Environment Corrective Action: The facility reviewed kitchen access policies to ensure residents maintain appropriate access to food and beverages while maintaining safety. Prevention: Staff were trained on client rights and maintaining a respectful and least restrictive environment. Monitoring: The Licensee will monitor compliance with client rights policies. Frequency: Monthly review. Completion Date: March 21, 2026	

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V 513	Continued From page 19 - Admitted 1/13/26 - Diagnoses of: Schizoaffective Disorder, Intellectual Developmental Disorder and Bipolar Observation on 1/20/26 at 11:47am of the facility revealed: - The kitchen door was locked and staff #1 used her fingerprint to unlock the kitchen door During interview on 1/20/26 client #1 reported: - The kitchen was locked - Will asked staff to get him drinks out kitchen During interview on 1/20/26 client #2 reported: - "Staff controls the kitchen" - He was "ok with it" - Staff brought what he needed from the kitchen like food and drinks During interview on 1/20/26 staff #1 reported: - Clients "mess up food." - Will pour drinks and leave the cups half full, open food and do not eat it - The Licensee requested the kitchen be locked During interview on 1/21/26 the Licensee reported: - Clients do not have access to the kitchen - Clients had stolen food like chips and yogurt - Staff prepared the meals for clients	V 513	V513 – Client Rights / Least Restrictive Environment Corrective Action: The facility reviewed kitchen access policies to ensure residents maintain appropriate access to food and beverages while maintaining safety. Prevention: Staff were trained on client rights and maintaining a respectful and least restrictive environment. Monitoring: The Licensee will monitor compliance with client rights policies. Frequency: Monthly review. Completion Date: March 21, 2026	
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	V 736		

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V 736 — Continued From page 20

odor.

This Rule is not met as evidenced by:
Based on observation and interview the facility was not maintained in a safe and orderly manner. The findings are:

Observations on 1/20/26 at 11:47am revealed the following:
- Client #1 and client #6's bedroom had a space heater plugged in but not turned on
- Client #2's bedroom had a space heater plugged in but was not turned on
- Client #3's bedroom had a space heater plugged in but it was not turned on
- Client 4's bedroom had a space heater and it was turned on, it was in the middle of an open floor
- Client #5's bedroom had an unplugged space heater

Observation on 1/21/26 at 1:47pm revealed the following:
- The Licensee instructed staff #1 to remove all the space heaters from the bedrooms

During interview on 1/21/26 the Licensee reported:
- The HVAC system was repaired last week
- She forgot to remove all space heaters from the clients' bedrooms

This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.

V 752 — 27G .0304(b)(4) Hot Water Temperatures

10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT

Provider's Plan of Correction (V 736, V 752):

V736 – Facility Maintenance

Corrective Action:
All space heaters were removed from client bedrooms immediately.

Prevention:
Staff were educated regarding environmental safety hazards and prohibited equipment.

Monitoring:
Weekly environmental safety inspections will be conducted.

Frequency:
Weekly.

Completion Date:
March 21, 2026

V752 – Hot Water Temperatures (A2 Violation)

Corrective Action:
Water temperature adjustments were initiated immediately. Maintenance was contacted to install temperature-control devices to ensure water temperatures remain between 100-116° F.

Prevention:
A Water Temperature Monitoring Log has been implemented requiring staff to check and document temperatures daily until repairs are completed.

Monitoring:
The Licensee or designee will review water temperature logs.

Frequency:
Daily until verified compliant, then weekly.

Completion Date:
March 14, 2026

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V 752	Continued From page 21 (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (4) In areas of the facility where clients are exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit. This Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure hot water temperatures were maintained between 100 - 116 degrees Fahrenheit. The findings are: Observation on 1/20/26 at 11:47am revealed the following: - The kitchen sink's water temperature was 140 degrees Fahrenheit - Clients' bathroom sink and shower was 120 degrees Fahrenheit During interview on 1/20/26 client #1 reported: - The water temperature was "just right" in the bathroom During interview on 1/20/26 client #2 reported: - He knew how to adjust the water temperatures in the bathroom During interview on 1/20/26 staff #1 reported: - The sink water was "hot but I like dishwater being hot" - She was not informed to check the water temperatures During interview on 2/5/26 staff #2 reported: - He checked the water temperatures "sometimes" but did not document the water	V 752	V752 – Hot Water Temperatures (A2 Violation) Corrective Action: Water temperature adjustments were initiated immediately. Maintenance was contacted to install temperature-control devices to ensure water temperatures remain between 100-116° F. Prevention: Effective immediately, staff began monitoring and documenting water temperatures daily to ensure compliance with the required range of 100–116°F." A Water Temperature Monitoring Log has been implemented requiring staff to check and document temperatures daily until repairs are completed. Monitoring: The Licensee or designee will review water temperature logs. Frequency: Daily until verified compliant, then weekly. Completion Date: March 14, 2026	

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V 752	Continued From page 22 temperatures - Did not recall the dates he checked the water temperatures but it was around 90 degrees Fahrenheit - "I like hot water ...did not think it needed to be turned down" During interview on 1/21/26 the Licensee reported: - The water temperatures were operated by a gas water heater - The water temperatures could not be adjusted on the gas water heater - Was in the process of pricing an electric water heater - She had not requested staff to check the water temperatures - She had not checked the facility's water temperatures - They "just didn't" check the water temperatures Review on 1/21/26 of the facility's Plan of Protection dated 1/21/26 written by the Licensee revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Effective immediately, the facility has taken steps to ensure that the physical environment and all equipment meet safety standards in accordance with 10A NCAC 27G .0304. Any identified hazards, unsafe conditions, or non-compliant equipment have been removed from use and secured. Residents have been relocated away from affected areas as needed to prevent risk of injury. Staff are providing increased supervision and monitoring to ensure all consumers remain safe while corrective actions are implemented. Describe your plans to make sure the above	V 752	V752 – Hot Water Temperatures (A2 Violation) Corrective Action: Water temperature adjustments were initiated immediately. Maintenance was contacted to install temperature-control devices to ensure water temperatures remain between 100-116°F. Prevention: A Water Temperature Monitoring Log has been implemented requiring staff to check and document temperatures daily until repairs are completed. Monitoring: The Licensee or designee will review water temperature logs. Frequency: Daily until verified compliant, then weekly. Completion Date: March 14, 2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL033-137	A. BUILDING: ______ B. WING ______	R 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A CARING HAND	616 ATLANTIC AVENUE ROCKY MOUNT, NC 27801

(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 752	Continued From page 23 happens. The facility will conduct an immediate environmental and safety inspection of all living areas, common areas, and equipment to identify and correct any deficiencies. Maintenance and/or qualified vendors will be engaged to complete necessary repairs or replacements. A checklist will be used to document completion and compliance. Staff will be re-educated on routine safety checks and reporting procedures. Ongoing monitoring will be conducted by management to ensure continued compliance, with documentation maintained in facility records." Review on 1/21/26 of the facility's addendum Plan of Protection dated 1/21/26 written by the Licensee revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? ...Staff will actively monitor water temperatures before resident use and providing supervision and assistance as needed to prevent any risk of burns or injury. Maintenance has been notified and corrective actions are in progress to adjust all water outlets to comply with State requirements. Documentation of monitoring and corrective measures will be maintained until full compliance is verified. Both staff and [Licensee] will ensure the corrective measures are completed. Describe your plans to make sure the above happens. The facility will conduct an immediate environmental and safety inspection of all living areas, common areas and equipment to identify and correct any deficiencies." This deficiency constitutes a re-cited deficiency. Clients were admitted to the facility with diagnoses of Schizoaffective Disorder, Intellectual	V 752	V752 – Hot Water Temperatures (A2 Violation) Corrective Action: Water temperature adjustments were initiated immediately. Maintenance was contacted to install temperature-control devices to ensure water temperatures remain between 100-116°F. Prevention: A Water Temperature Monitoring Log has been implemented requiring staff to check and document temperatures daily until repairs are completed. Monitoring: The Licensee or designee will review water temperature logs. Frequency: Daily until verified compliant, then weekly. Completion Date: March 14, 2026	

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
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A CARING HAND	616 ATLANTIC AVENUE ROCKY MOUNT, NC 27801

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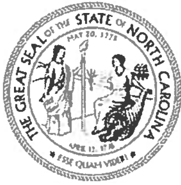
V 752	Continued From page 24 Developmental Disorder and Bipolar Disorder. On 1/20/26, the facility's hot water temperatures measured 140 degrees Fahrenheit at the kitchen sink and the clients' bathroom sink and shower was 120 degrees Fahrenheit. This deficiency constitutes a Type A2 rule violation for substantial risk of serious harm and must be corrected within 23 days.	V 752	V752 – Hot Water Temperatures (A2 Violation) Corrective Action: Water temperature adjustments were initiated immediately. Maintenance was contacted to install temperature-control devices to ensure water temperatures remain between 100-116°F. Prevention: A Water Temperature Monitoring Log has been implemented requiring staff to check and document temperatures daily until repairs are completed. Monitoring: The Licensee or designee will review water temperature logs. Frequency: Daily until verified compliant, then weekly. Completion Date: March 14, 2026	



NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

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

March 11, 2026

Nicole Artis, Director
ACH Residential Care Facilities, Inc
8378 Six Forks Road, Suite 202
Raleigh, NC 27615

Re: Annual, follow up and Complaint Survey completed February 19, 2026
A Caring Hand, 616 Atlantic Avenue, Rocky Mount, NC 27801
MHL #033-137
E-mail Address: info@achresidential.com
Intake #NC00235702 and #NC00235730

Dear Ms. Artis:

Thank you for the cooperation and courtesy extended during the Annual, follow up and Complaint Survey completed February 19, 2026. The complaints were substantiated.

As a result of the follow up survey, it was determined that a deficiency is in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were 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

- Type A2 rule violation is cited for 10A NCAC 27G .0304 Facility Design and Equipment (V752).
- Re-cited standard level deficiencies.
- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- Type A2 violations must be ***corrected*** within 23 days from the exit date of the survey, which is March 14, 2026. Pursuant to North Carolina General Statute § 122C-24.1, failure to correct the enclosed Type A2 violation by the 23rd day from the date of the survey may result in the assessment of an administrative penalty of $500.00 (Five Hundred) against ACH Residential Care Facilities, Inc. for each day the deficiency remains out of compliance.
- Re-cited standard level deficiencies must be ***corrected*** within 30 days from the exit of the survey, which is March 21, 2026.
- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is April 20, 2026.

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 Shawn Page at (910) 990 -3708.

Sincerely,

Rhonda Smith
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: networkEngagement@trilliumnc.org, CEO, Trillium Health Resources LME/MCO
Fonda Gonzales, Director of Quality Management, Trillium Health Resources LME/MCO
Betty Battle, Director, Edgecombe DSS
Michael J. Blake, Administrative Supervisor

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL033-137 (Y1)	A. Building B. Wing (Y2)	2/19/2026 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
A CARING HAND	616 ATLANTIC AVENUE ROCKY MOUNT, NC 27801

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 V0121 Reg. # 27G .0209 (F) LSC	Correction Completed 02/19/2026	ID Prefix Reg. # LSC	Correction Completed	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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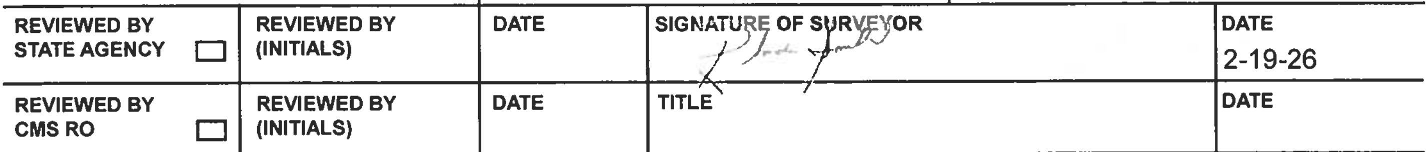

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE 2-19-26
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 10/1/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: YCXV12