STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411292	A. BUILDING: _____ B. WING _____	R 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL HOUSE OF CARE III	3514 MIZELL ROAD GREENSBORO, NC 27405

(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 A limited follow up survey for the Type A2 was completed on 3/19/26. This was a limited follow up survey, only 10A NCAC 27G .5601 Scope (V289) was reviewed for compliance. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. The facility is licensed for 3 and has a current census of 2. The survey sample consisted of audits of 2 current clients (#2 and #3) and 1 Deceased client (DC #1).	V 000		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the	V 111		

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V 111	Continued From page 1 establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure an assessment was completed prior to admission for 1 of 3 audited clients (client #3). The findings are: Review on 3/18/26 of client #3's record revealed: - No documentation of an admission date - Diagnoses of Autism Spectrum Disorder (D/O) and Severe Intellectual Developmental D/O - An admission assessment completed 1/13/21 when client #3 was admitted to a sister facility - No evidence of an admission assessment to reflect when client #3 was admitted to his current facility Interview on 3/16/26 with staff #1 revealed: - Client #3 moved from a sister facility to this facility on 3/2/26 Interview on 3/19/26 with the Qualified Professional revealed: - Client #3 moved to this facility from a sister facility on 3/2/26	V 111		

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V 111	Continued From page 2 - Had not completed a new admission assessment on behalf of client #3 - She didn't think a new admission assessment had to be completed since client #3 had moved from one sister facility to another - She would complete an admission assessment on behalf of client #3	V 111		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.	V 366		

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V 366	Continued From page 3 (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose	V 366		

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V 366	Continued From page 4 catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to implement written policies governing their response to level II incidents as required. The findings are: Review on 3/18/26 of Deceased Client #1's (DC #1's) record revealed:	V 366		

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V 366	Continued From page 5 - An admission date of 12/15/24 - Diagnoses of Spastic Diplegic Cerebral Palsy; Generalized Anxiety Disorder (D/O); Major Depressive D/O, Single Episode, In Full Remission; Mild Intellectual Disabilities; Pure Hyperglyceridemia; Localized Edema; Vitamin D Deficiency, Unspecified and Essential Primary Hypertension Interview on 3/16/26 with staff #1 revealed: - On 12/15/25, she called Emergency Medical Services (EMS) personnel to the facility due to DC #1 appearing "congested and unable to easily breathe." - DC #1 was transported to the hospital on the same date where she was "sedated and placed on a breathing machine." - DC #1 remained hospitalized from 12/15/25 until she "passed during the early morning hours of Christmas Day." Review on 3/18/26 of DC #1's death certificate revealed: - DC #1 died on 12/24/25 while in the hospital - DC #1's cause of death was listed as "Klebsiella pneumonia due to (or as a consequence of) acute hypoxic respiratory failure requiring mechanical incubation due to (or as a consequence of) cerebral palsy." Review on 3/16/26 of the Incident Response Improvement System (IRIS) revealed: - No evidence that a level II incident report had been submitted to IRIS regarding DC #1's transport to the hospital by EMS on 12/15/25 and her death on 12/24/25 - No level II incident reports had been completed, thus there was no documentation to support how DC #1's health and safety needs were being attended to; a determination of the	V 366		

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V 366	Continued From page 6 cause of the incident; what corrective measures were developed and implemented to prevent similar incidents and what person(s) were assigned to be responsible for implementation of any corrective and preventative measures which are all part of a level II incident report Interview on 3/19/26 with the Chief Executive Officer/Owner revealed: - She had not submitted an IRIS report on behalf of DC #1 regarding her transport to the hospital by EMS on 12/15/25 or her death on 12/24/25 - She did not realize she had to complete an incident report regarding either of these events	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information;	V 367		

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V 367	Continued From page 7	V 367		

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

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V 367	Continued From page 8 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 interview and record review, the facility failed to report all level II incidents that occur during the provision of billable services or while the consumer is on the providers premises and or a level II death involving the client to whom the provider rendered any service within 90 days prior to the incident to the LME (Local Management Entity) responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident affecting 1 of 3 audited clients (Deceased Client #1 (DC #1)). The findings are:	V 367		

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V 367	Continued From page 9 Review on 3/18/26 of Deceased Client #1's (DC #1's) record revealed: - An admission date of 12/15/24 - Diagnoses of Spastic Diplegic Cerebral Palsy; Generalized Anxiety Disorder (D/O); Major Depressive D/O, Single Episode, In Full Remission; Mild Intellectual Disabilities; Pure Hyperglyceridemia; Localized Edema; Vitamin D Deficiency, Unspecified and Essential Primary Hypertension Interview on 3/16/26 with staff #1 revealed: - On 12/15/25, she called Emergency Medical Services (EMS) personnel to the facility due to DC #1 appearing to be "congested and unable to breathe easily." - EMS transported DC #1 to the hospital on the same date where she remained until she "passed during the early morning hours of Christmas Day." Review on 3/16/26 of the Incident Response Improvement System (IRIS) revealed: - No evidence a level II incident report had been submitted to IRIS regarding DC #1's transport to the hospital by EMS personnel on 12/15/25 or her death on 12/24/25 Review on 3/18/26 of DC #1's death certificate revealed: - DC #1 died on 12/24/25 while in the hospital - DC #1's cause of death was listed as "Klebsiella pneumonia due to (or as a consequence of) acute hypoxic respiratory failure requiring mechanical incubation due to (or as a consequence of) cerebral palsy." Interview on 3/19/26 with the Chief Executive Officer/Owner revealed:	V 367		

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V 367	Continued From page 10 - She had not submitted an IRIS report on behalf of DC #1 regarding her transport to the hospital by EMS on 12/15/25 or her death on 12/24/25 - She did not realize she had to complete an incident report regarding either of these events	V 367		