

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-641</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 02/23/2026</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>C R E S T GROUP HOME #3</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>635 DASHLAND DRIVE FAYETTEVILLE, NC 28303</b>
--	---

(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	<p><b>INITIAL COMMENTS</b></p> <p>A complaint and follow up survey was completed on February 23, 2026. The complaint was unsubstantiated (intake #NC 00235711). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults With Developmental Disability.</p> <p>This facility is licensed for 5 and has a current census of 5. The survey sample consisted of audits of 2 current clients.</p>	V 000		
V 114	<p><b>27G .0207 Emergency Plans and Supplies</b></p> <p>10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES</p> <p>(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.</p> <p>(b) The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.</p> <p>(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.</p> <p>(d) Each facility shall have a first aid kit accessible for use.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure fire and disaster drills were</p>	V 114		

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

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-641</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 02/23/2026</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>C R E S T GROUP HOME #3</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>635 DASHLAND DRIVE FAYETTEVILLE, NC 28303</b>
--	---

(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 114	<p>Continued From page 1</p> <p>held at least quarterly and repeated each shift. The findings are:</p> <p>Review on 2/19/26 of the facility's records fire and disaster drills for the 4th quarter of (October 2025-December 2025) revealed: -No documentation of a fire drill held on 3rd shift or the weekend 7a-7pm shift.</p> <p>Interview on 2/19/26 client #3 stated: -She did fire and disaster drills. -They met by the mailbox for fire drills.</p> <p>Interview on 2/19/26 client #4 stated: -He had participated in fire and disaster drills at facility.</p> <p>Interview on 2/18/26 staff #1 stated: -Fire and disaster drills were done once a month on every shift.</p> <p>During interview on 2/18/26 the Residential Supervisor stated: -Fire drills and disaster drills once weekly. -He had a schedule and he would call staff to inform them to complete a drill. -The shifts were: 1st 7am-3pm, 2nd 3pm-11pm, 3rd 11am-7pm weekend-7am-7pm, 7pm-7am.</p> <p>Interview on 2/23/26 the Qualified Professional stated: -Fire and disaster drills were held on every shift quarterly.</p> <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 114		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-641</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 02/23/2026</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>C R E S T GROUP HOME #3</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>635 DASHLAND DRIVE FAYETTEVILLE, NC 28303</b>
--	---

(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 118	Continued From page 2	V 118		
V 118	<p>27G .0209 (C) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</p> <p>(c) Medication administration:</p> <p>(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.</p> <p>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.</p> <p>(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.</p> <p>(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:</p> <p>(A) client's name;</p> <p>(B) name, strength, and quantity of the drug;</p> <p>(C) instructions for administering the drug;</p> <p>(D) date and time the drug is administered; and</p> <p>(E) name or initials of person administering the drug.</p> <p>(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.</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-641</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 02/23/2026</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>C R E S T GROUP HOME #3</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>635 DASHLAND DRIVE FAYETTEVILLE, NC 28303</b>
--	---

(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 118	<p>Continued From page 3</p> <p>This Rule is not met as evidenced by: Based on record reviews, observation and interviews, the facility failed to administer medications on the written order of the physician and failed to ensure the MARs were kept current for 2 of 2 audited (#3 and #4). The findings are:</p> <p>Review on 2/19/26 of client #3's record revealed: -Date of admission: 9/19/13. -Diagnoses: Bipolar Disorder with Psychosis, Mild Intellectual Disability. No signed physician's orders for the following medications: -Austedo extended release (XR) 30 milligrams (mg) -1 tablet one a day for dyskinesia. -Zinc Gluconate 50 milligrams(mg) take 1 tablet once a day for bone support. -Acetaminophen (Tylenol) (pain relief) 1 tablet as needed for headache or fever above 101. -Betamethasone Valer (eczema) 0.1% Ointment 1 application apply a thin layer to the affected areas by topical route once daily as needed. -Deep Seas 0.65% Nose Spray 1 squirt one squirt spray in each nostril as needed for congestion. -Ger-Tusin DM (loosen phlegm and bronchial secretions) liquid MI use as directed per as needed. -Hydroxyzine HCL 25 mg 1 tablet as needed for anxiety twice a day. -Ibuprofen 800 mg 1 tablet three daily as needed for pain in left wrist. -Laxative EC (Enteric-Coated) 5 mg 1 tablet as needed for constipation do not crush meds. -Ra Antacid 500 mg chewable 1 tablet chew and swallow as needed for heart burn. -Lidocaine 5 patch 1 application apply 1 patch topical route for pain may wear up to 1 hour once a day. -Montelukast sodium 10 mg tablet once a day for</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-641</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 02/23/2026</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>C R E S T GROUP HOME #3</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>635 DASHLAND DRIVE FAYETTEVILLE, NC 28303</b>
--	---

(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 118	<p>Continued From page 4</p> <p>arthritis.</p> <p>-Mupirocin 2% ointment 1 application apply once daily to wound.</p> <p>-Hibiclens 4% liquid 1 application apply topically and wash the affected area every day let sit for 5-10 minutes then rinse once a day.</p> <p>Review on 2/19/26 of client #3's record revealed signed physician orders dated:</p> <p>(12/30/25)</p> <p>-Azelastine 0.1% 137 Mcg Spray-1 squirt place 1 spray in each nostril, twice a day for sneezing and runny nose.</p> <p>(11/19/25)</p> <p>-Cetirizine Hcl 10mg take 1 tablet at bedtime for sneezing and itching.</p> <p>(12/31/25)</p> <p>-Clonidine HCL 0.1 MG take 1 tablet by mouth three times a day for Attention Deficit Disorder (ADD)- Predominantly inattentive type.</p> <p>(9/23/25).</p> <p>-Cryselle -28 1 tablet at bedtime for hives.</p> <p>(12/31/25).</p> <p>-Duloxetine HCL Dr 60 Mg take 1 cap once a day (inhibitor antidepressant).</p> <p>(10/2/25)</p> <p>- 200mg 2. Mil Pen 1 syringe inject 1 pen (300mg) subcutaneously as directed, every 14 days.</p> <p>(3/19/25).</p> <p>-Famotidine 20mg take 1 tablet once a day. for GERD.</p> <p>(11/20/25).</p> <p>-Fluticasone Prop 50 mcg spray 1 squirt use spray in each nostril for allergic rhinitis.</p> <p>(10/29/25)</p> <p>-Gentamicin 0.1% Ointment for 1 application apply a small amount to the affected area topically 3 times daily three times a day for a bacterial infection..</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-641</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 02/23/2026</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>C R E S T GROUP HOME #3</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>635 DASHLAND DRIVE FAYETTEVILLE, NC 28303</b>
--	---

(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 118	<p>Continued From page 5</p> <p>(9/25/25) -Multivitamin 1 tablet once a day for vitamin deficiencies.</p> <p>(7/31/25). -Topiramate 100mg take 1 tablet by mouth twice a day to treat seizures.</p> <p>(12/31/25)</p> <p>Review on 2/18/26 and 2/23/26 of client #3's December 2025, January 2026, February 2026 MARs revealed the following medications were not documented as administered:</p> <p>-Austedo (XR) 30 milligrams (mg) on 12/3, 12/4, 12/11, 12/13, 12/14, 12/15, 12/16, 12/17, 12/18, 12/19, 12/20, 12/22, 12/23, 12/29, 12/30, 1/1, 1/2, 2/3, 2/5, 2/6, 2/9, 2/10, 2/11, 2/12, 2/13, 2/14, 2/15, 2/16, 2/17, 2/18, 2/19.</p> <p>-Azelastine 0.1% 137 Microgram (Mcg) spray at 7am on 12/13, 12/14, 12/20 and at 7pm on 12/13, 12/14, 12/28.</p> <p>-Budesonide at 7am on 12/13, 12/14, 12/20 and for 7pm 12/5,12/13,12/14,12/28, 12/30, 2/3, 2/6 and on 2/3, 2/6, 2/19.</p> <p>-Cetirizine Hydrochloric (Hcl) 10mg for 12/11-12/14, 12/20, 12/25, 12/27, 12/28, 12/31 and for 4pm on 1/4, 1/30, 2/7.</p> <p>-Clobetasol 0.05% ointment at 7am 12/13, 12/14, 12/20 at 7pm 12/13, 12/14, 12/28, 1/5, 2/3, 2/6-19.</p> <p>-Clonidine HCL 0.1 MG at 7am 12/13, 12/14, 12/20 at 2pm 12/4, 12/13, 12/14, 12/23, 12/27, 12/28, 12/31 at 7am 1/1 12pm 1/1, 1/2, 1/3, 1/17,1/26 at 4pm 1/4/, 1/1 at 2/19.</p> <p>-Cryselle-28- 12/13,12/14,12/28,12/31,1/5, 1/7, 1/30 and for 6pm 1/3, 1/6, 1/9, 1/11, 1/19.</p> <p>-Duloxetine HCL Dr 60 Mg for 12/13, 12/14, 12/20.</p> <p>-Montelukast Sod 10mg tablet and for the time and dates at 12/13, 12/14, 12/20.</p> <p>-Multivitamin tethered at 7am 12/13, 12/14, 12/20.</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-641</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 02/23/2026</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>C R E S T GROUP HOME #3</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>635 DASHLAND DRIVE FAYETTEVILLE, NC 28303</b>
--	---

(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 118	<p>Continued From page 6</p> <ul style="list-style-type: none"> <li>-Mupirocin 2% ointment at 7am 12/13, 12/14, 12/20 and 7pm 12/13, 12/14, 12/28.</li> <li>-Topiramate 100mg at 7am on 12/13, 12/14, 12/20 at 7pm on 12/13, 12/14, 12/28.</li> <li>-Zinc Gluconate 50mg for 12/13, 12/14, 12/20.</li> </ul> <p>Observation on 2/18/26 between 12:30pm and 2:15pm of client #3's medications revealed:</p> <ul style="list-style-type: none"> <li>-Austedo XR 30 milligrams mg not available for review.</li> <li>-Hibiclens 4% liquid not available for review</li> </ul> <p>Interview on 2/19/26 client #3 stated:</p> <ul style="list-style-type: none"> <li>-Staff gave her medications except on home visits.</li> <li>-Her shampoo (Hibiclens 4%) expired and she threw it away and it had not been replaced.</li> <li>-She had not received her Austedo medications.</li> </ul> <p>Review on 2/19/26 of client #4's record revealed:</p> <ul style="list-style-type: none"> <li>-Date of admission: 8/2/91</li> <li>-Diagnoses: Severe Intellectual Disability, Hypertension, Metabolic Syndrome.</li> <li>-No signed physician orders for the following medications:</li> <li>-Ozempic 2 mg dose 8mg 3 milliliters (ml) 1 syringe sub cutaneous as directed Monday every week for diabetes.</li> <li>-Aloe Ointment 1 application as needed.</li> <li>-Artificial Tears 1.4% drops as needed.</li> <li>-Cottonelle care flush wipes 1 application as needed.</li> <li>-Diphenhydramine 25mg 1 cap as needed for allergies.</li> <li>-Guaifenesin-Codeine Syrup ml as needed for cold symptoms.</li> <li>-Hydrocortisone aloe 1% 1 capsule as needed for insect bites.</li> <li>-Kaopectate Regular lingual Vanilla 8 oz select as needed for diarrhea.</li> </ul>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-641</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 02/23/2026</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>C R E S T GROUP HOME #3</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>635 DASHLAND DRIVE FAYETTEVILLE, NC 28303</b>
--	---

(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 118	<p>Continued From page 7</p> <ul style="list-style-type: none"> <li>-Phillip Milk of Magnesia regular 4oz ml as needed for constipation.</li> <li>-Prep Ease alcohol pads 1 application as need for prep.</li> <li>-There work relief foam 7.1 oz 1 application as needed for muscle spasms.</li> <li>-Triple antibiotic ointment as needed.</li> </ul> <p>Review on 2/19/26 of client #4's FL2 dated 9/16/25 revealed:</p> <ul style="list-style-type: none"> <li>-Dextroamp-Amphetamin 20mg 1 tablet twice a day for attention deficit disorder.</li> <li>-Carbamazepine 200mg1 tablet twice a day for bipolar disorder.</li> <li>-Quetiapine ER (extended relief) 300mg 1 tablet twice a day for schizophrenia.</li> <li>-Fish Oil 1000 mg cap 1 cap twice a day for fatty acids.</li> <li>-Fenofibrate 160 mg 1 tablet one a day for the removal of triglycerides.</li> <li>-Tegretol 200mg 1 twice a day for seizures.</li> <li>-Divalproex Sodium 50mg 1 tablet a day for seizure prevention.</li> </ul> <p>Review on 2/19/26 and 2/23/26 of client #4's December 2025, January 2026, February 2026 MARs revealed the following dates with no staff initials to indicate the medication had been administered:</p> <ul style="list-style-type: none"> <li>-Carbamazepine 200 mg at 7am on 12/6, 12/7, 12/13, 12/14, 12/20, 2/15 and at 7pm on 12/6, 12/13, 12/14, 12/28, 1/3, 1/24, 2/12, 2/14 at 4pm, on 1/10, 1/17, 1/18.</li> <li>-Dextroamphetamine Amphetamine 20 mg take 1 tablet by mouth twice a day every day and at 12/6, 12/7, 12/13, 12/14, 12/20 and at 2pm 12/7 12/13, 12/14, 12/28, 1/10, 1/18, 1/19, 1/26, 7am 1/4, 1/10, 1/17, 1/18, 1/15 at 2pm 1/15th and at 7a or at 2pm on 2/4, 2/10, 2/17, 2/18.</li> <li>-Fenofibrate 160 mg- take 1 tablet by mouth one</li> </ul>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-641</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 02/23/2026</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>C R E S T GROUP HOME #3</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>635 DASHLAND DRIVE FAYETTEVILLE, NC 28303</b>
--	---

(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 118	<p>Continued From page 8</p> <p>a day every day at 12/6, 12/7, 12/13, 12/14, 12/20 and at 1/4, 1/10, 1/11, 1/17, 1/18.</p> <p>-Lorazepam 1 mg-take 1 tablet by mouth once day on 12/6, 12/7, 12/13, 12/14, 12/20 at 1/4, 1/10, 1/17, 1/18 2 pm 1/3, 1/24, 2/15.</p> <p>-Fish Oil 1 Gm-take 1 cap by mouth twice a day at 7am 12/6, 12/7, 12/13, 12/14, 12/20 and at 7pm 12/6, 12/13, 12/14, 12/28 and at 7am 1/4, 1/10, 1/1, 1/18 and 7pm 1/3 and 1/24, 2/12, 2/14 and 2/19.</p> <p>-Omeprazole dr 20mg - take 1 cap by mouth do not crush once a day every day 12/6, 12/7, 12/13, 12/14, 12/20 and at 7am 1/4, 1/10, 1/17, 1/18, 2/15.</p> <p>-Quetiapine ER 300mg - take 1 tablet by mouth twice a day every day at 7a 12-6, 12/7, 12/13, 12/14, 12/20 and 7pm 12/6, 12/13, 12/14, 12/28, 2/3, 2/12, 2/14, 2/19, 2/15.</p> <p>Interview on 2/23/26 client #4 stated: -He gets his medications every day and on time.</p> <p>Interview on 2/18/26 staff #1 stated: -Clients #3 and #4 may have been on home visits or at appointments with the missing staff signatures on the MARs. -There was an insurance issue with client #3's Austedo medication. -Client #3 could not was unable to get her medication. Her co-pay was 1400 and it used to be free. -Client #3 had her upcoming appointment on 2/25/26 at 9:00 am. -She administered client #4's Ozempic. -There were no medication issues or refusals.</p> <p>Interview on 2/23/26 the Qualified Professional stated: -There was an issue with client #3's insurance and the co-pays was 1400 with getting the</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-641</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 02/23/2026</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>C R E S T GROUP HOME #3</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>635 DASHLAND DRIVE FAYETTEVILLE, NC 28303</b>
--	---

(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 118	<p>Continued From page 9</p> <p>Austedo.</p> <ul style="list-style-type: none"> <li>-The facility never thought of getting client #3 the generic for Austedo.</li> <li>-He was not aware that client #3's (Hibiclens 4%) had expired.</li> <li>-The staff had been trained to indicate on the MAR if any of the clients go on home visits.</li> <li>-A Therapeutic leave code should be used. There should never be a blank on the MAR.</li> <li>-Scripts are to be obtained by first shift staff and the Residential supervisor puts them in the computer.</li> <li>-He would see if client #3's Austedo could be discontinued or if there were a generic med.</li> </ul> <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 118		
V 120	<p>27G .0209 (E) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</p> <p>(e) Medication Storage:</p> <ul style="list-style-type: none"> <li>(1) All medication shall be stored: <ul style="list-style-type: none"> <li>(A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit;</li> <li>(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;</li> <li>(C) separately for each client;</li> <li>(D) separately for external and internal use;</li> <li>(E) in a secure manner if approved by a physician for a client to self-medicate.</li> </ul> </li> <li>(2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled</li> </ul>	V 120		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-641</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 02/23/2026</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>C R E S T GROUP HOME #3</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>635 DASHLAND DRIVE FAYETTEVILLE, NC 28303</b>
--	---

(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 120	<p>Continued From page 10</p> <p>Substances Act, G.S. 90, Article 5, including any subsequent amendments.</p> <p>This Rule is not met as evidenced by: Based on observation and interviews the facility failed to ensure all medications were kept separately for 2 of 2 audited clients (#3, and #4). The findings are:</p> <p>Review on 2/19/26 of client 3's record revealed: -Date of admission: 9/19/13. -Diagnoses: Bipolar Disorder with Psychosis, Mild Intellectual Disability.</p> <p>Review on 2/19/26 of client #4's record revealed: -Date of admission: 8/2/91. -Diagnoses: Severe Intellectual Disability, Hypertension, Metabolic Syndrome.</p> <p>Observation on 2/19/26 at approximately between 11:00-11:45am of the facility refrigerator revealed: -The refrigerator contained a box that had 2 boxes of client #4's Ozempic 2 milligram (mg) along with 1 box of client #2's Dupixent 300mg syringe.</p> <p>Interview on 2/19/26 client #3 stated: -Her medication was stored in the refrigerator.</p> <p>Interview on 2/19/26 client #4 stated: -He was unaware of where his medication was stored.</p> <p>Interview on 2/18/26 staff #1 stated: -The medications were stored in the refrigerator in a box together.</p>	V 120		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-641</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 02/23/2026</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>C R E S T GROUP HOME #3</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>635 DASHLAND DRIVE FAYETTEVILLE, NC 28303</b>
--	---

(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 120	<p>Continued From page 11</p> <p>Interview on 2/23/26 the Qualified Professional stated: -He would ensure the medications were in separate lock boxes in the refrigerator.</p> <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 120		