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
	MHL078-312	A. BUILDING: ______ B. WING ______	R 03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBESON #3	504 S ELM STREET MAXTON, NC 28364

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and follow up survey was completed on March 20, 2026. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 6 and has a current census of 6. The survey sample consisted of audits of 3 current clients.	V 000		
V 752	27G .0304(b)(4) Hot Water Temperatures 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (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 interviews, the facility failed to maintain water temperatures between 100-116 degrees Fahrenheit where clients had access to hot water. The findings are: Observation on 3/19/26 between 11:10am - 11:40am during a tour of the facility revealed: -The hot water at the kitchen sink was 128 degrees Fahrenheit. Attempted interview on 3/19/26 client #6 was difficult to understand.	V 752	V 752 The facility will record all hot water temperatures on the water temperature log. If for three days, the temperature has exceeded it will be reported to the maintenance coordinator. Maintenance Coordinator will follow up with the proper protocol.	

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Executive Director (X6) DATE 4/6/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBESON #3	504 S ELM STREET MAXTON, NC 28364

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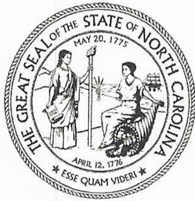
V 752	Continued From page 1 Attempted interview on 3/20/26 client #4 responded yes to most questions. Interview on 3/20/26 client #5 stated: -She helped wash the dishes last night. -Staff prepared the water for her to wash the dishes. Interview on 3/19/26 staff #5 stated: -Hot water temperatures were checked daily on 3rd shift. -There was a water temperature log maintained for all water temperature checks. -The clients did not use the kitchen sink. Interview on 3/20/26 the Qualified Professional stated: -The water temperatures were checked daily at the facility. -The water heater was recently serviced due to the water temperatures fluctuating from too hot to too cold. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 752		



NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

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

March 27, 2026

Tammie Hollingsworth, Regional Administrator
RHA Health Services NC, LLC
2003 Godwin Ave., Ste A1
Lumberton, NC 28358

Re: Annual and Follow Up Survey completed March 20, 2026
Robeson #3, 504 South Elm Street, Maxton, NC 28364
MHL # 078-312
E-mail Address: tammie.hollingsworth@rhanet.org

Dear Ms. Hollingsworth:

Thank you for the cooperation and courtesy extended during the annual and follow up survey completed March 20, 2026.

As a result of the follow up survey, it was determined that some of the deficiencies are now 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

- Re-cited standard level deficiencies.

Time Frames for Compliance

- Re-cited standard level deficiency must be ***corrected*** within 30 days from the exit of the survey, which is April 19, 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 Gloria Locklear, Team Leader at 910-214-0350.

Sincerely,

Tareva Jones, MSW
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: DHSR@Alliancebhc.org
networkEngagement@trilliumnc.org, CEO, Trillium Health Resources LME/MCO
Fonda Gonzales, Director of Quality Management, Trillium Health Resources LME/MCO
Velvet Nixon, Director, Robeson County DSS
Michael Blake, Administrative Supervisor

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL078-312 (Y1)	A. Building B. Wing (Y2)	3/20/2026 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBESON #3	504 S ELM STREET MAXTON, NC 28364

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 V0120 Reg. # 27G .0209 (E) LSC	Correction Completed 03/20/2026	ID Prefix V0366 Reg. # 27G .0603 LSC	Correction Completed 03/20/2026	ID Prefix V0367 Reg. # 27G .0604 LSC	Correction Completed 03/20/2026
ID Prefix V0736 Reg. # 27G .0303(c) LSC	Correction Completed 03/20/2026	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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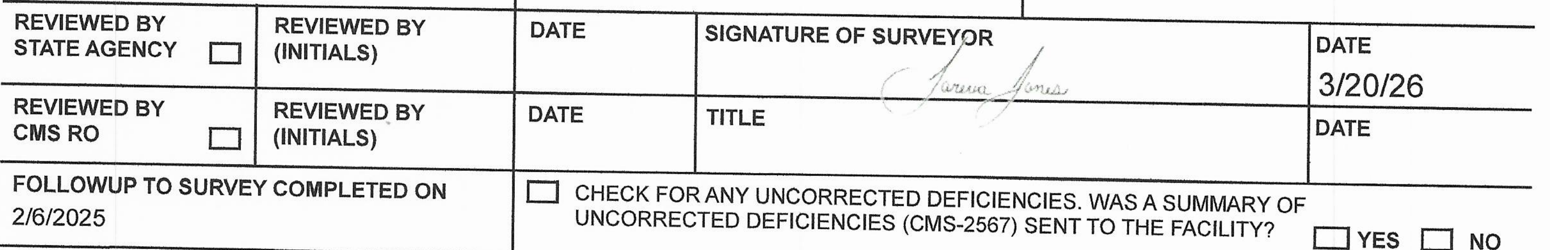

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE 3/20/26
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 2/6/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO