

Division of Health Service Regulation

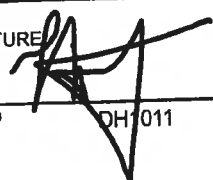
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-955</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>02/19/2026</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>VICTORY HEALTHCARE SERVICES 2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1421 PJ FARMS LANE</b> <b>RALEIGH, NC 27603</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>An annual and follow-up survey was completed 2/19/26. A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.</p> <p>This facility is licensed for 6 and has a current census of 4. The survey sample consisted of audits of 3 current clients.</p>	V 000	<p style="text-align: center;"><b>RECEIVED</b> <b>APR 1 0 2026</b> <b>DHSR-MH Licensure Sect</b></p>	
V 736	<p><b>27G .0303(c) Facility and Grounds Maintenance</b></p> <p><b>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS</b> (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility was not maintained in a safe, attractive and orderly manner. The findings are:</p> <p>Observation on 2/18/26 at approximately 12:30pm revealed:</p> <ul style="list-style-type: none"> <li>- Client #2's bathroom had a long blue stain under the faucet in the bath tub and rust completely covering one of the vents that didn't work and would not turn on</li> <li>- Client #2 had several trash bags of clothes in the closet</li> <li>- Hallway bathroom's vent had dust throughout it</li> <li>- A crack in the paint on the wall from the ceiling down the side of the wall in the bathroom</li> <li>- Client #4's room had multiple brown stains on</li> </ul>	V 736		<p>The facility administrator has removed the van with no tags. Facility will only have vehicles with tags on the grounds.</p> <p>Facility administrator will remove and replace rusted vent. Facility staff will clean dust off vent from hallway bathroom. Facility administrator will work with landlord to get vent to operate.</p> <p>Facility administrator has removed prior client's clothing to return to family.</p> <p>Facility will contact property landlord to have painting, wall repair, and stain removal from faucet, bathroom wall and ceiling, behind client 4's door and wall, and hallway wall. Facility administrator will continue to contact landlord or employ maintenance for repairs.</p>

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE **QP**

(X6) DATE  
**3/5/2026**

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-955</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>02/19/2026</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>VICTORY HEALTHCARE SERVICES 2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1421 PJ FARMS LANE</b> <b>RALEIGH, NC 27603</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 736	<p>Continued From page 1</p> <p>the back of the door and on the wall beside the door</p> <ul style="list-style-type: none"> <li>- Hallway wall had brown stains in the middle of the wall from one end to the other end</li> <li>- Cover on the hallway wall was leaning forward and not fully attached to the wall</li> <li>- Gray minivan in the driveway with no tags and stains all over it</li> </ul> <p>Interview on 2/18/26 Client #4 reported:</p> <ul style="list-style-type: none"> <li>- the stains on her door were there when she moved it</li> <li>- she didn't think the stains would come off</li> <li>- she hadn't tried to get the stains off but thought it was paint and wouldn't come off</li> </ul> <p>Interview on 2/19/26 the Administrator reported:</p> <ul style="list-style-type: none"> <li>- the trash bags in client #2's bedroom closet were from a former client that moved out back in September 2025</li> <li>- the former client's family never came to get her belongings but he would try and call them again</li> <li>- he did minor repairs around the facility</li> <li>- the landlord was responsible for major repairs</li> <li>- he was responsible for making sure the facility was clean</li> <li>- staff #1 checked the bathrooms and was responsible for helping the client's clean the bathrooms</li> <li>- if the bathroom was not cleaned correctly, staff#1 was responsible for having the client's clean them again</li> <li>- the van lift caught on fire one day when he tried to start the van</li> <li>- he just recently took the tags off because he was not going to use the van anymore but couldn't recall when he took the tags off</li> <li>- someone was coming to pick up the van</li> </ul>	V 736		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-955</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>02/19/2026</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>VICTORY HEALTHCARE SERVICES 2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1421 PJ FARMS LANE</b> <b>RALEIGH, NC 27603</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 736	Continued From page 2  This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		