

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL089-003</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/08/2026</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>TYRRELL COUNTY GROUP HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>601 NORTH LIGHT STREET COLUMBIA, NC 27925</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 complaint survey was completed on May 8, 2026. The complaint was unsubstantiated (intake #NC00236532). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p> <p>This facility is licensed for 6 and has a current census of 3. The survey sample consisted of audits of 3 current clients, 1 former client and 1 deceased client.</p>	V 000		
V 132	<p>G.S. 131E-256(G) HCPR-Notification, Allegations, &amp; Protection</p> <p>G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY</p> <p>(g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes:</p> <ol style="list-style-type: none"> <li>a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.</li> <li>b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.</li> <li>c. Misappropriation of the property of a healthcare facility.</li> <li>d. Diversion of drugs belonging to a health care facility or to a patient or client.</li> </ol>	V 132		

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>MHL089-003</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/08/2026</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>TYRRELL COUNTY GROUP HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>601 NORTH LIGHT STREET COLUMBIA, NC 27925</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 132	<p>Continued From page 1</p> <p>e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the Health Care Personnel Registry (HCPR) was notified of all allegations against healthcare personnel and report results of the investigation to HCPR within 5 business days. The findings are:</p> <p>Review on 05/08/26 of facility records from February 2026 through May 2028 revealed no documentation the HCPR had been notified of an allegation by former client (FC) #4 against staff #1.</p> <p>Review on 05/08/26 of FC #4's record revealed: - Admission date of 05/27/14. - Diagnoses of Mild Intellectual Developmental Disability, Pervasive Developmental Disability, Diabetes Type II, Hypertension and Schizophrenia. - Discharge date of 04/25/26.</p> <p>Review on 05/08/26 of staff #1's record revealed: - Date of hire: 11/05/12. - Training in population served on 11/06/12.</p> <p>Review on 05/08/26 of a handwritten incident report completed by the Director revealed: - On 03/12/26 FC #4 called her mother and made</p>	V 132		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL089-003</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/08/2026</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>TYRRELL COUNTY GROUP HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>601 NORTH LIGHT STREET COLUMBIA, NC 27925</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 132	Continued From page 2  an allegation staff #1 had slapped her. - No documentation the facility had notified the HCPR of FC #1's allegation. - No documentation the facility sent  Interview on 05/08/26 the Director stated: - The HCPR was not notified of FC #4's allegation of abuse against staff #1. - He was aware the HCPR needed to be notified of all allegations of abuse and investigation results sent within 5 business days.	V 132		
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; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL089-003</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/08/2026</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>TYRRELL COUNTY GROUP HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>601 NORTH LIGHT STREET COLUMBIA, NC 27925</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 367	<p>Continued From page 3</p> <p>(6) other individuals or authorities notified or responding.</p> <p>(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:</p> <p>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or</p> <p>(2) the provider obtains information required on the incident form that was previously unavailable.</p> <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <p>(1) hospital records including confidential information;</p> <p>(2) reports by other authorities; and</p> <p>(3) the provider's response to the incident.</p> <p>(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).</p> <p>(e) Category A and B providers shall send a report quarterly to the LME responsible for the 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:</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL089-003</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/08/2026</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>TYRRELL COUNTY GROUP HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>601 NORTH LIGHT STREET COLUMBIA, NC 27925</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 367	<p>Continued From page 4</p> <p>(1) medication errors that do not meet the definition of a level II or level III incident;</p> <p>(2) restrictive interventions that do not meet the definition of a level II or level III incident;</p> <p>(3) searches of a client or his living area;</p> <p>(4) seizures of client property or property in the possession of a client;</p> <p>(5) the total number of level II and level III incidents that occurred; and</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to notify the Local Management Entity/Managed Care Organization (LME/MCO) of a level II incident as required. The findings are:</p> <p>Review on 05/08/26 of the North Carolina Incident Response Improvement System (IRIS) revealed no Level III incident report had been submitted for FC #4's allegation against staff #1 on 03/12/26.</p> <p>Review on 05/08/26 of FC #4's record revealed:</p> <ul style="list-style-type: none"> <li>- Admission date of 05/27/14.</li> <li>- Diagnoses of Mild Intellectual Developmental Disability, Pervasive Developmental Disability, Diabetes Type II, Hypertension and Schizophrenia.</li> </ul>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL089-003</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/08/2026</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>TYRRELL COUNTY GROUP HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>601 NORTH LIGHT STREET COLUMBIA, NC 27925</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 367	Continued From page 5  - Discharge date of 04/25/26.  Review on 05/08/26 of a handwritten incident report completed by the Director revealed: - On 03/12/26 FC #4 called her mother and made an allegation staff #1 had slapped her.  Interview on 05/08/26 the Director stated: - He had not submitted a Level III incident report to the LME/MCO as required. - He would ensure reports were submitted as required.	V 367		
V 542	27F .0105(a-c) Client Rights - Client's Personal Funds  10A NCAC 27F .0105 CLIENT'S PERSONAL FUNDS (a) This Rule applies to any 24-hour facility which typically provides residential services to individual clients for more than 30 days. (b) Each competent adult client and each minor above the age of 16 shall be assisted and encouraged to maintain or invest his money in a personal fund account other than at the facility. This shall include, but need not be limited to, investment of funds in interest-bearing accounts. (c) If funds are managed for a client by a facility employee, management of the funds shall occur in accordance with policy and procedures that: (1) assure to the client the right to deposit and withdraw money; (2) regulate the receipt and distribution of funds in a personal fund account; (3) provide for the receipt of deposits made by friends, relatives or others; (4) provide for the keeping of adequate financial records on all transactions affecting funds on deposit in personal fund account;	V 542		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL089-003</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/08/2026</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>TYRRELL COUNTY GROUP HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>601 NORTH LIGHT STREET COLUMBIA, NC 27925</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 542	<p>Continued From page 6</p> <p>(5) assure that a client's personal funds will be kept separate from any operating funds of the facility;</p> <p>(6) provide for the deduction from a personal fund account payment for treatment or habilitation services when authorized by the client or legally responsible person upon or subsequent to admission of the client;</p> <p>(7) provide for the issuance of receipts to persons depositing or withdrawing funds; and</p> <p>(8) provide the client with a quarterly accounting of his personal fund account.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide quarterly accounting of personal funds for 1 of 1 former clients (FC) (#4) The findings are:</p> <p>Review on 05/08/26 of FC #4's record revealed: - Admission date of 05/27/14. - Diagnoses of Mild Intellectual Developmental Disability, Pervasive Developmental Disability, Diabetes Type II, Hypertension and Schizophrenia. - Client's legal guardian was her mother. - Discharge date of 04/25/26.</p> <p>Review on 05/08/26 of facility records of FC #4's financial statements from July 2025 thru May 2025 revealed: - No documentation the guardian was provided a quarterly accounting of FC #4's personal funds.</p> <p>Interview on 05/07/26 FC #4's Guardian stated: - FC #4 had lived at the facility for several years</p>	V 542		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL089-003</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/08/2026</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>TYRRELL COUNTY GROUP HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>601 NORTH LIGHT STREET COLUMBIA, NC 27925</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 542	<p>Continued From page 7</p> <p>before she moved to another group home.</p> <ul style="list-style-type: none"> <li>- There were issues with FC #4's funds.</li> <li>- She never received a quarterly statement from the facility.</li> </ul> <p>Interview on 05/08/26 the Financial Manager stated:</p> <ul style="list-style-type: none"> <li>- She had not sent a quarterly financial statement to FC #4's guardian.</li> <li>- She would send statements if the guardian requested.</li> <li>- FC #4's guardian never requested a quarterly statement.</li> <li>- FC #4 reviewed the funds monthly.</li> </ul> <p>Interview on 05/08/26 the Director stated he understood quarterly statements had to be provided to the client/guardian.</p>	V 542		