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	mhl095-043	A. BUILDING: ______ B. WING ______	05/22/2026

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THREE FORKS HOME	**392 CAMP JOY ROAD** **ZIONVILLE, NC 28698**

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on May 22, 2026. The complaint was substantiated (Intake #NC00236674). Deficiencies were 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 4. The survey sample consisted of audits of 3 current clients.	V 000		
V 119	27G .0209 (D) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction. (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return	V 119		

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to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure all medications were disposed of in a manner that guarded against diversion affecting 1 of 3 audited clients (Client #1). The findings are:

Review on 5/13/26 of Client #1's record revealed:
-Date of admission: 9/4/07.
-Diagnoses: Anxiety Disorder, Moderate Intellectual Disability, Epilepsy-Controlled, Diabetes Mellitus, and Visual Impairment.
-Physicians orders:
-11/6/25, Hydrocodone 10 milligram (mg) (pain), 1 tab 3 times a day as needed, 90 pills, discontinued 1/3/26.
-12/30/25, Oxycodone 10mg (pain), 1 tab every 4 hours as needed, 180 pills, discontinued 1/3/26.
-Controlled medication count sheet:
-1/1/26, Oxycodone 10mg (pain), 1 tab every 4 hours as needed, 180 pills.
-11 doses initialed as administered from 1/1/26-1/4/26.
-169 remaining pills as of 1/4/26.

Review on 5/18/26 of Client #1's Medication Administration Record (MAR) dated 12/1/25-12/31/25 revealed:
-Hydrocodone 10 mg, 1 tab 4 times a day as

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needed, 24 doses initialed as administered.

Review on 5/18/26 of Client #1's MAR dated 1/1/26-1/31/26 revealed:
-Hydrocodone 10 mg, 1 tab 4 times a day as needed, 1dose initialed as administered.
-Oxycodone 10mg, 1 tab every 4 hours as needed, 11 doses initialed as administered.

Review on 5/19/26 of the facility's medication disposal policy dated 5/11/20 revealed:
-"All prescriptions and non-prescription medication (meds) shall be disposed of in a manner that guards against diversion or accidental ingestion...All non-controlled and controlled medications are returned to the pharmacy for disposition. The 'Return of Drugs' form is completed indicating prescription number, drug name and strength and reason for return with Intellectual Developmental Disability Ministry (IDDM) staff and pharmacy courier signatures. Documentation of any disposal will be recorded in the resident's record."

Review on 5/15/26 of the facility's internal investigation dated 1/6/26 completed by the IDDM Director/QP revealed:
-"Staff in the home (facility) whom [Former QP] supervised (Staff #2 and Staff #3) had contacted [IDDM Director/QP] to voice concerns about [Former QP] mishandling a resident's (Client #1) medication; there was also concerns that some of the controlled substance medication for that resident (Client #1) was missing as a result... [IDDM Director/QP] and [Senior Director of Human Resources (HR)] arrived at Three Forks Home (facility) around 3pm (on 1/6/26)...spoke with [Former QP]...informed her (Former QP) we (IDDM Director and Senior Director of HR) were placing her on paid administrative leave while we

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investigate the concerns...[Former QP] acknowledged there was an issue with the resident's medication but did not provide any explanation at that time."
-"Control sheet (Client #1's Oxycodone) reads 169 pills remain out of 180...MAR shows 11 doses had been given to match the number on control sheet (169 remaining)...[Staff #2] and [Staff #3] counted 107 whole pills were in the bottle (on 1/6/26)...[Former QP] stated she had dropped the bottle of Oxycodone and the pills had went into the floor and trash can there at the medication closet."
-"[Staff #2] was unable to find the remainder of the discontinued Hydrocodone tablets or the control sheet associated with that medication."
-"I (Senior Director of HR) viewed her (Former QP) actions as negligence at the least, and of a serious enough nature to possibly rise to the level of gross negligence."
-"On 1/3/26 [Former QP] stated that she had to pick up (Client #1's new prescription (Oxycodone 10mg) from [local pharmacy] and would take care of all the paperwork that needed to be filled for it. I (Staff #2) then went to the med closet to her the Hydrocodone so it could be returned to the pharmacy. However, the medication was not in the lock box in the med closet and the controlled sheet was not in the MAR (for Client #1). I then looked in the lock box outside the house (facility), and the medication was not there either. The next day, 1/4/26, [Former QP] texted me and asked if I would like to take a short break to the intense situation with [Client #1] and she would come stay with the guys (clients). I (Staff #2) left the group home (facility) for approximately 1 ½ hours. When I returned to the group home, [Former QP] told me that she was giving [Client #1] his as needed (PRN) medication (Oxycodone), and the bottle slipped out of her hand and the medication

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V 119	Continued From page 4 spilled everywhere and some of it may have ended up in the trashcan. I (Staff #2) did a medication count and noted that there were 62 pills missing. On Monday morning, 1/5/26. I (Staff #2) told me coworker, [Staff #3], what had occurred over the weekend, and we did another medication count. There were 62 pills missing (Oxycodone). The two of us (Staff #2 and Staff #3) went to [Former QP] and told her what we had found (missing Oxycodone pills and rest of the Hydrocodone pills). She (Former QP) stated that, she knew and would take care of it. This morning, 1/6/26, there had been nothing done regarding the situation, so [Staff #3] and I decided we should call [IDDM Director/QP] and apprise her of the situation." -"My (Staff #3) concern is that [Former QP] may be taking these pills (Client #1's Oxycodone and Hydrocodone) for her own use, while our resident [Client #1] is declining in health." -"Investigation concludes [Former QP]: Multiple failure to follow protocols resulting in mishandling of resident's controlled substance prescription medications, failure to secure said medications, loss and improper disposal of said medications, failure to notify supervisor." -"Termination of employment (Former QP) 1/22/26 due to policy violations." Review on 5/14/26 of the Former QP's record revealed: -Date of hire: 8/25/17. -Date of termination: 1/22/26. -Medication Administration training certificate of completion signed by a Registered Nurse dated 12/9/25. Interview on 5/18/26 with the Former QP revealed: -"Didn't take any medicine (Client #1's 62 missing	V 119		

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Oxycodone and 36 missing Hydrocodone)."
-"I spilled some meds (medicine) (Client #1's Oxycodone) and didn't know how to correct it, dumped it in the toilet, swept them up and flushed them."
-"Didn't let anyone know when it happened (reporting and documenting spilling Client #1's Oxycodone on 1/4/26)."

Interview on 5/15/26 with Staff #2 revealed:
-On 1/4/26 she discovered there were 62 Oxycodone of Client #1 that were missing and informed the Former QP, "nothing was done (by Former QP about missing Oxycodone)."
-She "was concerned [Former QP] took the meds (medications)."
-"[Former QP] told her [Client #1's] meds (Oxycodone) went into the trash, were spilled and no meds were ever found."
-"There were no witnesses to spilling the medication (Client #1's Oxycodone)."

Interview on 5/15/26 with Staff #3 revealed:
-On 1/4/26 "[Former QP] said she spilled [Client #1's] Oxycodone 180 pills."
-"...62 missing (Oxycodone) and could not find them anywhere...assumed [Former QP] was trying to cover up stealing the medications."
-"Told her)Former QP) the medication error (Client #1's missing 62 Oxycodone) needed to be fixed (documented and reported) and [Former QP] said she would."
-She returned to work on 1/6/26 and "nothing had been done (about Client #1's missing 62 Oxycodone), no documentation, report, nothing."
-One 1/6/26 she "told [IDDM Director/QP], [Former QP] had taken the medication (Client #1's missing 62 Oxycodone and 36 Hydrocodone)."

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Interview on 5/20/26 with Senior Director of HR revealed:
-Received a call from the IDDM Director/QP on 1/6/26 that there were concerns at the facility about the count being off for prescribed controlled substances.
-Did an unannounced visit on 1/6/26 to the facility and informed the Former QP she is being placed on administrative leave while the internal investigation was on going about the missing 62 pills of Client #1's Oxycodone.
-"[Former QP] said meds fell on the floor around med closet, she then swept up then flushed the Oxycodone that fell on the floor."
-"She (Former QP) didn't report it (disposing of Client #1's Oxycodone) to anybody which was another concern."
-"You don't just dispose of clients controlled meds by yourself."

Interview on 5/19/26 with the Vice President of HR revealed:
-The Former QP was placed on administrative leave on 1/6/26 because "[Former QP] said she spilled meds (Client #1's Oxycodone) and threw them away, she took responsibility for meds missing,."
-"[Former QP] should of counted and accounted for exact number of meds (Client #1's Oxycodone that fell on the ground), proper disposal would have been taking the meds (Client #1's Oxycodone needing to be disposed of) back to pharmacy (for disposal)."
-"Should have been documented on med log (Client #1's Oxycodone that fell on the ground needing to be disposed of), [Former QP] didn't do that.

Interview on 5/19/26 with the Senior Project Director of Properties revealed:

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-By flushing and throwing away Client #1's Oxycodone that fell on the ground and without reporting or documenting it, the Former QP "did not follow protocol."
-The Former QP should have "taken them (Client #1's Oxycodone that fell on the ground) to pharmacy and dispose of them properly and reported to pharmacy."

Interviews on 5/13/26 and 5/14/26with the IDDM Director/QP revealed:
-On 1/6/26 the Former QP said "she flushed the meds (Client #1's Oxycodone)."
-"...We let her [Former QP] go that day (placed on administrative leave), told her because of the discrepancies in the med count (Client #1's missing Oxycodone) and she needs to leave while we complete investigation."

V 132 — G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection — V 132

G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY
(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:
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.
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

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are being provided.
c. Misappropriation of the property of a healthcare facility.
d. Diversion of drugs belonging to a health care facility or to a patient or client.
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.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to report the findings of the internal investigation of an allegation of exploitation to Health Care Personnel Registry (HCPR) within 5 working days as required. The findings are:

Review on 5/13/26 of Client #1's record revealed:
-Date of admission: 9/4/07.
-Diagnoses: Anxiety Disorder, Moderate Intellectual Disability, Epilepsy-Controlled, Diabetes Mellitus, and Visual Impairment.
-Physicians orders:
-11/6/25, Hydrocodone 10 milligram (mg) (pain), 1 tab 3 times a day as needed, 90 pills, discontinued 1/3/26.
-12/30/25, Oxycodone 10mg (pain), 1 tab every 4 hours as needed, 180 pills, discontinued 1/3/26.
-Controlled medication count sheet:
-1/1/26, Oxycodone 10mg (pain), 1 tab every 4 hours as needed, 180 pills.
-11 doses initialed as administered from 1/1/26-1/4/26.

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-169 remaining pills as of 1/4/26.

Review on 5/18/26 of Client #1's Medication Administration Record (MAR) dated 12/1/25-12/31/25 revealed:
-Hydrocodone 10 mg, 1 tab 4 times a day as needed, 24 doses initialed as administered.

Review on 5/18/26 of Client #1's MAR dated 1/1/26-1/31/26 revealed:
-Hydrocodone 10 mg, 1 tab 4 times a day as needed, 1dose initialed as administered.
-Oxycodone 10mg, 1 tab every 4 hours as needed, 11 doses initialed as administered.

Review on 5/14/26 of the Former QP's record revealed:
-Date of hire: 8/25/17.
-Date of termination: 1/22/26.

Review on 5/22/26 of Incident Response Improvement System (IRIS) revealed:
-Date of incident: 1/6/26.
-Date IRIS submitted: 5/21/26.
-"Medication count did not match number of medications in bottle. [Former QP] had covered for a staff member two separate days Jan. 3 & Jan. 4 2026. When staff performed a medication count it was discovered that 55.5 Oxycodone pills were missing and 36 pills
missing of Hydrocodone."
-The allegation of exploitation on 1/6/26 against the Former QP was reported to HCPR on 5/21/26 by the IDDM Director/QP through submitting to IRIS.

Review on 5/15/26 of the facility's internal investigation dated 1/6/26 completed by the IDDM Director/QP revealed:
-"Staff in the home (facility) whom [Former QP]

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supervised (Staff #2 and Staff #3) had contacted [IDDM Director/QP] to voice concerns about [Former QP] mishandling a resident's (Client #1) medication; there was also concerns that some of the controlled substance medication for that resident (Client #1) was missing as a result... [IDDM Director/QP] and [Senior Director of Human Resources (HR)] arrived at Three Forks Home (facility) around 3pm (on 1/6/26)...spoke with [Former QP]...informed her (Former QP) we (IDDM Director and Senior Director of HR) were placing her on paid administrative leave while we investigate the concerns...[Former QP] acknowledged there was an issue with the resident's medication but did not provide any explanation at that time."
-"Control sheet (Client #1's Oxycodone) reads 169 pills remain out of 180...MAR shows 11 doses had been given to match the number on control sheet (169 remaining)...[Staff #2] and [Staff #3] counted 107 whole pills were in the bottle (on 1/6/26)...[Former QP] stated she had dropped the bottle of Oxycodone and the pills had went into the floor and trash can there at the medication closet."
-"[Staff #2] was unable to find the remainder of the discontinued Hydrocodone tablets or the control sheet associated with that medication."
-"I (Senior Director of HR) viewed her (Former QP) actions as negligence at the least, and of a serious enough nature to possibly rise to the level of gross negligence."
-"On 1/3/26 [Former QP] stated that she had to pick up (Client #1's new prescription (Oxycodone 10mg) from [local pharmacy] and would take care of all the paperwork that needed to be filled for it. I (Staff #2) then went to the med closet to her the Hydrocodone so it could be returned to the pharmacy. However, the medication was not in the lock box in the med closet and the controlled

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sheet was not in the MAR (for Client #1). I then looked in the lock box outside the house (facility), and the medication was not there either. The next day, 1/4/26, [Former QP] texted me and asked if I would like to take a short break to the intense situation with [Client #1] and she would come stay with the guys (clients). I (Staff #2) left the group home (facility) for approximately 1 ½ hours. When I returned to the group home, [Former QP] told me that she was giving [Client #1] his as needed (PRN) medication (Oxycodone), and the bottle slipped out of her hand and the medication spilled everywhere and some of it may have ended up in the trashcan. I (Staff #2) did a medication count and noted that there were 62 pills missing. On Monday morning, 1/5/26. I (Staff #2) told me coworker, [Staff #3], what had occurred over the weekend, and we did another medication count. There were 62 pills missing (Oxycodone). The two of us (Staff #2 and Staff #3) went to [Former QP] and told her what we had found (missing Oxycodone pills and rest of the Hydrocodone pills). She (Former QP) stated that, she knew and would take care of it. This morning, 1/6/26, there had been nothing done regarding the situation, so [Staff #3] and I decided we should call [IDDM Director/QP] and apprise her of the situation."

-"My (Staff #3) concern is that [Former QP] may be taking these pills (Client #1's Oxycodone and Hydrocodone) for her own use, while our resident [Client #1] is declining in health."

-"Investigation concludes [Former QP]: Multiple failure to follow protocols resulting in mishandling of resident's controlled substance prescription medications, failure to secure said medications, loss and improper disposal of said medications, failure to notify supervisor."

-"Termination of employment (Former QP) 1/22/26 due to policy violations."

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Interview on 5/15/26 with Staff #2 revealed:
-On 1/4/26 she discovered there were 62 Oxycodone of Client #1 that were missing and informed the Former QP, "nothing was done (by Former QP about missing Oxycodone)."
-She "was concerned [Former QP] took the meds (medications)."
-"[Former QP] told her [Client #1's] meds (Oxycodone) went into the trash, were spilled and no meds were ever found."
-"There were no witnesses to spilling the medication (Client #1's Oxycodone)."

Interview on 5/15/26 with Staff #3 revealed:
-On 1/4/26 "[Former QP] said she spilled [Client #1's] Oxycodone 180 pills."
-"...62 missing (Oxycodone) and could not find them anywhere...assumed [Former QP] was trying to cover up stealing the medications."
-"Told her)Former QP) the medication error (Client #1's missing 62 Oxycodone) needed to be fixed (documented and reported) and [Former QP] said she would."
-She returned to work on 1/6/26 and "nothing had been done (about Client #1's missing 62 Oxycodone), no documentation, report, nothing."
-One 1/6/26 she "told [IDDM Director/QP], [Former QP] had taken the medication (Client #1's missing 62 Oxycodone and 36 Hydrocodone)."

Interview on 5/20/26 with Senior Director of HR revealed:
-The IDDM Director/QP was responsible for reporting allegations of exploitation to HCPR.
-"...Wasn't sure at the time what our (facility) obligation was with reporting (allegation of exploitation on 1/6/26 against Former QP)."
-"...At the time I thought we were compliant

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(reporting to HCPR), we (administrative staff) didn't have guidance for reporting (to HCPR)."

Interview on 5/19/26 with the Vice President of HR revealed:
-The IDDM Director/QP was responsible for reporting allegations of exploitation to HCPR.
-The allegation of exploitation on 1/6/26 against the Former QP was not reported the HCPR because the "understanding was not there that it would require an HCPR report."

Interview on 5/19/26 with the Senior Project Director of Properties revealed:
-The IDDM Director/QP was responsible for reporting allegations of exploitation to HCPR.
-Reporting the allegation of exploitation on 1/6/26 against the Former QP to HCPR would have been reported through completing the Incident Response Improvement System.
-"she (IDDM Director/QP) did work on it (reporting to HCPR), on her side it appeared to be submitted (submitting IRIS report to report to HCPR)."
-"Not sure why is wasn't submitted."
-"We (facility) don't go through this (reporting allegation of exploitation to HCPR) often so when you do you can miss steps (not reporting to HCPR correctly)."

Interviews on 5/13/26, 5/21/26 and 5/22/26 with the IDDM Director/QP revealed:
-Responsible for reporting allegations of exploitation to HCPR.
-"My first thought was that she (Fomer QP) took the meds (Client #1's Oxycodone and Hydrocodone on 1/6/26)."
-Believed completing the Department of Health and Human Services complaint intake form covered reporting to HCPR, "thought it covered

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V 132	Continued From page 14 reporting to HCPR." -Reported the Former QP on 5/21/26 to HCPR through submitting the IRIS for the allegation of exploitation against the Former QP on 1/6/26.	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 (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:	V 367		

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(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 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;

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V 367	Continued From page 16 (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 record reviews and interviews, the facility failed to report a level III incident to the Local Management Entity/Managed Care Organization (LME/MCO) within 24 hours of becoming aware of the incident. The findings are: Review on 5/14/26 of the Former QP's record revealed: -Date of hire: 8/25/17. -Date of termination: 1/22/26. Review on 5/13/26 of Client #1's record revealed: -Date of admission: 9/4/07. -Diagnoses: Anxiety Disorder, Moderate Intellectual Disability, Epilepsy-Controlled, Diabetes Mellitus, and Visual Impairment. -Physicians orders: -11/6/25, Hydrocodone 10 milligram (mg) (pain), 1 tab 3 times a day as needed, 90 pills, discontinued 1/3/26. -12/30/25, Oxycodone 10mg (pain), 1 tab every 4 hours as needed, 180 pills, discontinued 1/3/26.	V 367		

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-No documentation of level II incident reported to the LME/MCO within 72 hours of the facility becoming aware of an incident on 3/12/26 of exploitation.

Review on 5/15/26 of the facility's internal investigation dated 1/6/26 completed by the IDDM Director/QP revealed:
-"Staff in the home (facility) whom [Former QP] supervised (Staff #2 and Staff #3) had contacted [IDDM Director/QP] to voice concerns about [Former QP] mishandling a resident's (Client #1) medication; there was also concerns that some of the controlled substance medication for that resident (Client #1) was missing as a result... [IDDM Director/QP] and [Senior Director of Human Resources (HR)] arrived at Three Forks Home (facility) around 3pm (on 1/6/26)...spoke with [Former QP]...informed her (Former QP) we (IDDM Director and Senior Director of HR) were placing her on paid administrative leave while we investigate the concerns...[Former QP] acknowledged there was an issue with the resident's medication but did not provide any explanation at that time."
-"Control sheet (Client #1's Oxycodone) reads 169 pills remain out of 180...MAR shows 11 doses had been given to match the number on control sheet (169 remaining)...[Staff #2] and [Staff #3] counted 107 whole pills were in the bottle (on 1/6/26)...[Former QP] stated she had dropped the bottle of Oxycodone and the pills had went into the floor and trash can there at the medication closet."
-"[Staff #2] was unable to find the remainder of the discontinued Hydrocodone tablets or the control sheet associated with that medication."
-"I (Senior Director of HR) viewed her (Former QP) actions as negligence at the least, and of a serious enough nature to possibly rise to the level

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of gross negligence."
-"On 1/3/26 [Former QP] stated that she had to pick up (Client #1's new prescription (Oxycodone 10mg) from [local pharmacy] and would take care of all the paperwork that needed to be filled for it. I (Staff #2) then went to the med closet to her the Hydrocodone so it could be returned to the pharmacy. However, the medication was not in the lock box in the med closet and the controlled sheet was not in the MAR (for Client #1). I then looked in the lock box outside the house (facility), and the medication was not there either. The next day, 1/4/26, [Former QP] texted me and asked if I would like to take a short break to the intense situation with [Client #1] and she would come stay with the guys (clients). I (Staff #2) left the group home (facility) for approximately 1 ½ hours. When I returned to the group home, [Former QP] told me that she was giving [Client #1] his as needed (PRN) medication (Oxycodone), and the bottle slipped out of her hand and the medication spilled everywhere and some of it may have ended up in the trashcan. I (Staff #2) did a medication count and noted that there were 62 pills missing. On Monday morning, 1/5/26. I (Staff #2) told me coworker, [Staff #3], what had occurred over the weekend, and we did another medication count. There were 62 pills missing (Oxycodone). The two of us (Staff #2 and Staff #3) went to [Former QP] and told her what we had found (missing Oxycodone pills and rest of the Hydrocodone pills). She (Former QP) stated that, she knew and would take care of it. This morning, 1/6/26, there had been nothing done regarding the situation, so [Staff #3] and I decided we should call [IDDM Director/QP] and apprise her of the situation."
-"My (Staff #3) concern is that [Former QP] may be taking these pills (Client #1's Oxycodone and Hydrocodone) for her own use, while our resident

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[Client #1] is declining in health."
-"Investigation concludes [Former QP]: Multiple failure to follow protocols resulting in mishandling of resident's controlled substance prescription medications, failure to secure said medications, loss and improper disposal of said medications, failure to notify supervisor."
-"Termination of employment (Former QP) 1/22/26 due to policy violations."

Review on 5/22/26 of Incident Response Improvement System (IRIS) revealed:
-Date of incident: 1/6/26.
-Date IRIS submitted: 5/21/26.
-"Medication count did not match number of medications in bottle. [Former QP] had covered for a staff member two separate days Jan. 3 & Jan. 4 2026. When staff performed a medication count it was discovered that 55.5 Oxycodone pills were missing and 36 pills
missing of Hydrocodone."
-The allegation of exploitation on 1/6/26 against the Former QP was reported to IRIS on 5/21/26 by the IDDM Director/QP.

Interview on 5/15/26 with Staff #2 revealed:
-On 1/4/26 she discovered there were 62 Oxycodone of Client #1 that were missing and informed the Former QP, "nothing was done (by Former QP about missing Oxycodone)."
-She "was concerned [Former QP] took the meds (medications)."
-"[Former QP] told her [Client #1's] meds (Oxycodone) went into the trash, were spilled and no meds were ever found."
-"There were no witnesses to spilling the medication (Client #1's Oxycodone)."

Interview on 5/15/26 with Staff #3 revealed:
-On 1/4/26 "[Former QP] said she spilled [Client

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#1's] Oxycodone 180 pills."
-"...62 missing (Oxycodone) and could not find them anywhere...assumed [Former QP] was trying to cover up stealing the medications."
-"Told her)Former QP) the medication error (Client #1's missing 62 Oxycodone) needed to be fixed (documented and reported) and [Former QP] said she would."
-She returned to work on 1/6/26 and "nothing had been done (about Client #1's missing 62 Oxycodone), no documentation, report, nothing."
-One 1/6/26 she "told [IDDM Director/QP], [Former QP] had taken the medication (Client #1's missing 62 Oxycodone and 36 Hydrocodone)."

Interview on 5/20/26 with Senior Director of HR revealed:
-The IDDM Director/QP was responsible for completing IRIS to report level III incidents to the LME/MCO within 24 hours of becoming aware.
-"Knew IRIS had to be filed (for allegation of exploitation on 1/6/26 for Former QP), thought IRIS was being done 1/13/26.
-"...Wasn't sure at the time what our (facility) obligation was with reporting (allegation of exploitation on 1/6/26 against Former QP)."
-"...At the time I thought we were compliant (completing IRIS), we (administrative staff) didn't have guidance for reporting (completing IRIS)."

Interview on 5/19/26 with the Vice President of HR revealed:
-The IDDM Director/QP was responsible for completing IRIS to report level III incidents to the LME/MCO within 24 hours of becoming aware.
-The allegation of exploitation on 1/6/26 against the Former QP was not reported to the LME/MCO within 72 hours of becoming aware because the "understanding was not there that it would require

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V 367	Continued From page 21 an IRIS report." Interview on 5/19/26 with the Senior Project Director of Properties revealed: -The IDDM Director/QP was responsible for completing IRIS to report level III incidents to the LME/MCO within 24 hours of becoming aware. -"she (IDDM Director/QP) did work on it (IRIS), on her side it appeared to be submitted (submitting IRIS report)." -"Not sure why it wasn't submitted (IRIS)." -"We (facility) don't go through this (completing IRIS) often so when you do you can miss steps (not reporting to HCPR correctly)." Interviews on 5/13/26, 5/21/26 and 5/22/26 with the IDDM Director/QP revealed: -Responsible for completing IRIS to report level III incidents to the LME/MCO within 24 hours of becoming aware. -"My first thought was that she (Fomer QP) took the meds (Client #1's Oxycodone and Hydrocodone on 1/6/26)." -"I did not do one for 1/6/26 (complete IRIS for allegation of exploitation on Former QP until 5/21/26)." -Completed IRIS on 5/21/26 to report the allegation of exploitation against the Former QP on 1/6/26.	V 367		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that:	V 500		

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V 500	Continued From page 22 (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated	V 500		

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competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E);
(2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and
(3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure all allegations of suspected exploitation were reported to the local Department of Social Services (DSS) affecting 1 of 3 audited clients (Clients #1). The findings are:

Review on 5/14/26 of the Former QP's record revealed:
-Date of hire: 8/25/17.
-Date of termination: 1/22/26.

Review on 5/13/26 of Client #1's record revealed:
-Date of admission: 9/4/07.
-Diagnoses: Anxiety Disorder, Moderate Intellectual Disability, Epilepsy-Controlled, Diabetes Mellitus, and Visual Impairment.
-Physicians orders:
-11/6/25, Hydrocodone 10 milligram (mg) (pain), 1 tab 3 times a day as needed, 90 pills, discontinued 1/3/26.
-12/30/25, Oxycodone 10mg (pain), 1 tab every 4 hours as needed, 180 pills, discontinued 1/3/26.

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THREE FORKS HOME	**392 CAMP JOY ROAD ZIONVILLE, NC 28698**

(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 500	Continued From page 24 Review on 5/15/26 of the facility's internal investigation dated 1/6/26 completed by the IDDM Director/QP revealed: -"Staff in the home (facility) whom [Former QP] supervised (Staff #2 and Staff #3) had contacted [IDDM Director/QP] to voice concerns about [Former QP] mishandling a resident's (Client #1) medication; there was also concerns that some of the controlled substance medication for that resident (Client #1) was missing as a result... [IDDM Director/QP] and [Senior Director of Human Resources (HR)] arrived at Three Forks Home (facility) around 3pm (on 1/6/26)...spoke with [Former QP]...informed her (Former QP) we (IDDM Director and Senior Director of HR) were placing her on paid administrative leave while we investigate the concerns...[Former QP] acknowledged there was an issue with the resident's medication but did not provide any explanation at that time." -"Control sheet (Client #1's Oxycodone) reads 169 pills remain out of 180...MAR shows 11 doses had been given to match the number on control sheet (169 remaining)...[Staff #2] and [Staff #3] counted 107 whole pills were in the bottle (on 1/6/26)...[Former QP] stated she had dropped the bottle of Oxycodone and the pills had went into the floor and trash can there at the medication closet." -"[Staff #2] was unable to find the remainder of the discontinued Hydrocodone tablets or the control sheet associated with that medication." -"I (Senior Director of HR) viewed her (Former QP) actions as negligence at the least, and of a serious enough nature to possibly rise to the level of gross negligence." -"On 1/3/26 [Former QP] stated that she had to pick up (Client #1's new prescription (Oxycodone 10mg) from [local pharmacy] and would take care	V 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mhl095-043	A. BUILDING: ______ B. WING ______	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE FORKS HOME	**392 CAMP JOY ROAD ZIONVILLE, NC 28698**

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V 500	Continued From page 25 of all the paperwork that needed to be filled for it. I (Staff #2) then went to the med closet to her the Hydrocodone so it could be returned to the pharmacy. However, the medication was not in the lock box in the med closet and the controlled sheet was not in the MAR (for Client #1). I then looked in the lock box outside the house (facility), and the medication was not there either. The next day, 1/4/26, [Former QP] texted me and asked if I would like to take a short break to the intense situation with [Client #1] and she would come stay with the guys (clients). I (Staff #2) left the group home (facility) for approximately 1 ½ hours. When I returned to the group home, [Former QP] told me that she was giving [Client #1] his as needed (PRN) medication (Oxycodone), and the bottle slipped out of her hand and the medication spilled everywhere and some of it may have ended up in the trashcan. I (Staff #2) did a medication count and noted that there were 62 pills missing. On Monday morning, 1/5/26. I (Staff #2) told me coworker, [Staff #3], what had occurred over the weekend, and we did another medication count. There were 62 pills missing (Oxycodone). The two of us (Staff #2 and Staff #3) went to [Former QP] and told her what we had found (missing Oxycodone pills and rest of the Hydrocodone pills). She (Former QP) stated that, she knew and would take care of it. This morning, 1/6/26, there had been nothing done regarding the situation, so [Staff #3] and I decided we should call [IDDM Director/QP] and apprise her of the situation." -"My (Staff #3) concern is that [Former QP] may be taking these pills (Client #1's Oxycodone and Hydrocodone) for her own use, while our resident [Client #1] is declining in health." -"Investigation concludes [Former QP]: Multiple failure to follow protocols resulting in mishandling of resident's controlled substance prescription	V 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mhl095-043	A. BUILDING: ______ B. WING ______	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE FORKS HOME	392 CAMP JOY ROAD ZIONVILLE, NC 28698

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V 500	Continued From page 26	V 500		

medications, failure to secure said medications, loss and improper disposal of said medications, failure to notify supervisor."
-"Termination of employment (Former QP) 1/22/26 due to policy violations."
-No documentation of allegation of suspected exploitation were reported to the local DSS.

Interview on 5/20/26 with Senior Director of HR revealed:
-The IDDM Director/QP was responsible for reporting allegations of exploitation to DSS.
-"...Wasn't sure at the time what our (facility) obligation was with reporting (allegation of exploitation on 1/6/26 against Former QP)."
-"...At the time I thought we were compliant (reporting to DSS), we (administrative staff) didn't have guidance for reporting (to DSS)."

Interview on 5/19/26 with the Senior Project Director of Properties revealed:
-The IDDM Director/QP was responsible for reporting allegations of exploitation to DSS.
-"We (facility) don't go through this (reporting allegation of exploitation to DSS) often so when you do you can miss steps (not reporting to DSS)."

Interviews on 5/18/26 with the Senior IDDM Director revealed:
-"Contacted them (DSS) on March 12, 2026, informed DSS of [Former QP] allegation of exploitation from 1/6/26."