STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411190	A. BUILDING: _____ B. WING _____	C 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIUM KARE CORPORATION	300 BINGHAM STREET GREENSBORO, NC 27401

(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 A complaint survey was completed on 5/20/26. The complaint (intake # NC00236990) was unsubstantiated. Deficiences were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. The facility is licensed for 4 and has a current census of 0. The survey sample consisted of an audit of 1 former client.	V 000		
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		

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V 367	Continued From page 1 (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: (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:	V 367		

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V 367	Continued From page 2 (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; (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 review and interview, the facility failed to report all level II incidents to the Local Management Entity (LME) within 72 hours of learning of the incident affecting 2 of 2 Former Clients (FCs #1 and #2). The findings are: Review on 5/13/26 of the facility's "General Event Reports" (GERs) from 2/4/26-4/7/26 revealed: - On 2/4/26: While the Program Director (PD) was transporting Former Clients #1 and #2 (FCs #1 and #2) home, While inside the vehicle, FC #1 "abruptly attacked" the PD and FC #2 with FC #2 attempting to defend himself. The PD pulled over the vehicle to separate the clients and was able to resume driving after "15 min or so." FC #1 began "attacking" the PD and FC #2 again. The PD	V 367		

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V 367	Continued From page 3	V 367		

parked the vehicle, removed FC #1 from the vehicle and placed him "in a therapeutic hold until the police arrived to assist." FC #1 "bit his housemate on the chin and put scratches on his neck trying to choke him." Upon the police officers arrival, "they placed [FC #1] in handcuffs and transported him to [name of hospital] for evaluation..."

- 2/5/26: "After [FC #1] told staff (the PD) he was full. He immediately threw his food on the floor." FC #1 "walked to the living room, then back to the kitchen and flipped the table over." As staff prepared his PRN (as needed) medication and told him that he needed to clean up after himself, "he began to walk towards me (the PD), then attempted to bit, kick and grab the staff repeatedly!." The PD placed FC #1 in a "therapeutic hold" and the police were called. FC #1 was transported by Emergency Medical Services (EMS) to the hospital for evaluation
- 3/8/26: FC #1 destroyed property in his bedroom and "headbutted the walls leaving several holes!..." FC #1 attempted to break his bedroom window by "headbutting it several times." Staff #1 called the police and FC #1 agreed to taken to the hospital for evaluation
- 3/14/26: While staff #2 assisted FC #1 with cleaning his room, "...without warning, [FC #1] lunged" at staff #3 "...wrapped his fingers" in her hair and "knocked her "to the ground..." FC #1 "began hitting his head against the wall and destroying items in his bedroom." FC #1 "continued engaging in self-injurious and destructive behavior for approximately 15-20 minutes until officers (police) arrived." The police called EMS to transport FC #1 to the hospital for further evaluation
- 3/15/26: The PD discovered FC #1 putting holes in his bedroom wall (using his head) and destroying his bedroom furniture. The police and

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V 367	Continued From page 4 EMS were called and FC #1 was transported to the hospital for further evaluation - 3/31/26: As staff (the PD) were preparing FC #1's PRN medications, FC #1 began to "scream and bang his head repeatedly against the front door and living room walls..." The PD called the police and EMS for assistance. FC #1 attempted to "attack" the PD and "flipped over the kitchen table and chairs..." The PD's supervisor (the Qualified Professional (QP)) arrived at the facility as well as the police. FC #1 was transported to the hospital for evaluation. - 4/1/26: FC#1 informed th PD that he had a headache. As the PD was preparing his PRN medications, FC #1 began to "headbutt the living room walls, leaving holes." FC #1 requested the PD call 911. The PD called the police and FC #1 was transported to the hospital for evaluation - 4/7/26: While the PD was taking the trash outside, he heard banging from inside the facility. As he came back inside the facility he observed [FC #1] "repeatedly headbutting the front door and walls." FC #1 contacted the QP to inform them of FC #1's behavior. FC #1 requested the police and EMS be called as he wanted to go to the hospital. The police and EMS arrived at the facility with EMS personnel cleaning up the wound on FC #1's head. Client calmed down and prepared for dinner but became upset again, "flipped over" the kitchen table and started "crying and began to headbutt the door, walls and broke the ceiling fan. The PD called the police again. As the police spoke with FC #1, he attempted to "attack the officers." Police "restrained" FC #1 and he "put into handcuffs" and transported to the hospital for further evaluation. The PD, staff #2 and the Qualified Professional (QP) were witnesses to one or more of these incidents on 4/7/26	V 367		

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V 367	Continued From page 5 Review on 5/12/26 of the Incident Response Improvement System (IRIS) revealed: - No incident reports had been submitted to IRIS regards FC #1 between 2/4/26-4/7/26 Interviews on 5/12/26 and on 5/20/26 with the QP revealed: - The staff (the PD, staff #1 and #2) and herself had completed GERs on the dates they witnessed or were involved in FC #1's behaviors - Only GERs had been completed and no level II incident reports had been submitted to IRIS regarding the events that involved FC #1 between 2/4/26-4/7/26 to include his becoming physically aggressive towards staff and FC #2, engaging in self-injurious behaviors and staff's calls to the police Had not realized incident reports needed to be submitted to IRIS - Had printed out the incident reporting manual for her future reference to ensure she submitted incident reports to IRIS as required	V 367		