Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE SURVEY COMPLETED	
			A. BUILDING.	VI			
		FCL060135	B. WING		08/2	4/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
UNLIMITED POSSIBILITIES # 5 13931 THOMPSON ROAD MINT HILL, NC 28227							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
C 000	Initial Comments		C 000				
	Survey on August 2 11:30 AM at the ab records indicate the November 25, 2014 six non-ambulatory evacuate and responsible assistance of the following: the 2 Homes 10A NCAC Carolina State Build Small Non-ambulated At the time of our vision of the solution of the following: the 2 Homes 10A NCAC Carolina State Build Small Non-ambulated At the time of our vision of the solution of the	n Section conducted a Biennial 24, 2016 from 10:15 AM to ove referenced facility. DHSR is home was first licensed on 4 as a Family Care Home for a Residents (unable to ond without any physical or during a fire or other d on this information we are to maintain compliance with 2005 Rules for Family Care 13G, and the 2012 North ding Code - Section 425.4 - tory Care Facilities.					
C 148	SECTION .0300 - 10A NCAC 13G .03 AND EXITS (e) All entrances/e obstructions or impinstant use in case This Rule is not man 1. Observations rescreened porch was screen door to the Either remove the exit. Verify with the any exit signs. Pro	Exits-Free of Obstructions THE BUILDING B12 OUTSIDE ENTRANCE Exits shall be free of all rediments to allow for full of fire or other emergency. The exit as evidenced by: The exercise was nailed shut. The exterior was nailed shut. The exit sign indicating from this are exit sign indicating this is an exit local officials prior to removal vide documentation of the of photos, receipts or work	C 148				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE SURVEY COMPLETED	
		FCL060135	B. WING		08/2	4/2016	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
UNLIMITED POSSIBILITIES # 5 13931 THOMPSON ROAD MINT HILL, NC 28227							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG			(X5) COMPLETE DATE	
C 148	Continued From page 1 orders.		C 148				
C 174	, -		C 174				
C 918	` ,	claration of Resident's Rights I have the following rights:	C 918				

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6899 HHAO21 If continuation sheet 2 of 3

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
		FCL060135	B. WING		08/2	24/2016
	PROVIDER OR SUPPLIER	13931 TH	DRESS, CITY, S OMPSON RO _, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
C 918	To associate an without restriction v	nd communicate privately and with people and groups of his on his or her own or their	C 918			
	Observations re for one of the Resid documentation from Resident's guardian	et as evidenced by: vealed a monitor in the kitchen dent rooms. Provide in the Resident or the in that they are allowing the ides the Resident's right to tion.				

Division of Health Service Regulation STATE FORM