

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-833</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/15/2018</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CARE ONE HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>926 EDISON ROAD</b> <b>RALEIGH, NC 27610</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>INITIAL COMMENTS</p> <p>A complaint survey was completed 3/15/18. The complaint (Intake # NC00135370) was substantiated. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.</p>	V 000		
V 748	<p>27G .0304(b)(2) Fire Retardant Mattresses</p> <p>10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (2) All mattresses purchased for existing or new facilities shall be fire retardant.</p> <p>This Rule is not met as evidenced by: Based on observation and interviews, the governing body failed to assure mattresses in client bedrooms were safe and in good repair. The findings are:</p> <p>Observation on 3/14/18 at approximately 3:20 PM of the client bedroom area revealed:</p> <ul style="list-style-type: none"> <li>- client #2's bed had a bed with a torn mattress with metal springs showing</li> <li>- client #6's bed had a thin and worn mattress that showed the prints of the wooden slats through the ticking</li> </ul>	V 748		

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>MHL092-833</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/15/2018</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CARE ONE HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>926 EDISON ROAD</b> <b>RALEIGH, NC 27610</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 748	<p>Continued From page 1</p> <p>During an interview on 3/14/18, client 32 reported he often had toileting accidents that contributed to the poor condition of his mattress.</p> <p>During an interview on 3/14/18, client #6 reported he could feel the wooden through his mattress which caused him not to experience comfortable sleep at night.</p> <p>During an interview on 3/15/18, the Administrator reported client #2 did have frequent toileting accidents and he also deliberately torn and hid things inside his mattress. The Administrator reported she would replace the worn mattresses.</p>	V 748		