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Division of Health Service Regulation

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		MHL081-094	B. WING		06/20/2018	
					1 00/20/2010	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE		
KELLYS C	CARE #3		TER ROAD SBORO, NC 281 [,]	14		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 000	INITIAL COMMENTS		V 000			
	2018. Deficiencies we This facility is licensed category: 10A NCAC	s completed on June 20, ere cited. d for the following service 27G .5600C Supervised Developmental Disabilities.				
V 112	PLAN (c) The plan shall be assessment, and in plegally responsible per of admission for client receive services beyon (d) The plan shall incomplete the plan shall incompose the projected date of achieved by provision projected date of achieved by a staff responsible; (a) a schedule for reannually in consultation responsible person or (b) basis for evaluation outcome achievemen (e) written consent or responsible party, or a session of the plan shall be achieved by the plan shall be achieved by the plan shall be asserted by the plan shall be	developed based on the artnership with the client or and 30 days. Indee: I that are anticipated to be a of the service and a evement; I view of the plan at least on with the client or legally both; To no or assessment of	V 112			

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL081-094	B. WING		06/20/2018
NAME OF PE	ROVIDER OR SUPPLIER	133 KEET	DRESS, CITY, STA		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 112	outcome that was and service affecting 1 of findings are: Review on 6/19/18 of Admission date: 6-23 Diagnoses: Attention Disorder, Intermittent Personality Disorder, Disorder, Mild-Modern Developmental Disorder -12/20/17 Personal C -A service goal to miliving space by cleani -A statement that C prompting to complete Interview on 6/19/18 -He cleaned his bedre-He did not want staff because staff would relt did not matter what because he planned in next week. Interview on 6/19/18 -He was employed as -He had worked at the -His job duties include administering medical	as evidenced by: ew, observation and o ensure a client's service icipated by the provision of 3 clients (Client #3). The Client #3's record revealed: -11 Deficit Hyperactivity Explosive Disorder, Pervasive Developmental ate Intellectual der, Post-Traumatic Stress are Plan included: naintain a neat and clean ng up after self; lient #3 needed staff e routine tasks. with Client #3 revealed: com occasionally; cleaning his bedroom move his belongings around; this bedroom looked like to move out of the facility with Staff #4 revealed: s residential services staff; e facility over one year; ed meal preparation, tions to clients, house	V 112	DEFICIENCY)	
	and providing supervi -He was knowledgeal goals;	n the clients on their goals, sion to the clients; ble about the clients' service ce goal to become as			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL081-094	B. WING		06/20/2018		
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE	-		
KELLYS C	CARE #3		TER ROAD				
		MOORES	BORO, NC 2811	4	Т		
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 112	Continued From page	2	V 112				
	that included his bedr -Client #3 liked for sta not tell him what to do Interview on 6/19/18 v -She worked as resid -She had worked at th -Her job duties includ meals and snacks, givenedications, house of the clients in their per grooming; -She was knowledged service goals;	ial about his personal space oom; iff to leave him alone and o. with Staff # 6 revealed: ential services staff; ne facility for 2 years; ed preparing and serving ving clients their leaning, and encouraging sonal hygiene and able about the clients' ent #3 on completing his					
	-Client #3 had little m bedroom as Client #3 facility the following w -Client #3 had made i bedroom by not hoard -Staff were resistant this bedroom because recording staff and mithem; -He (the Qualified Pro Operations) had to ap of a favor request to g bedroom.	of Operations revealed: otivation to clean his planned to move out of the reek; mprovements in his ding items; o prompt Client #3 to clean client #3 had a history of aking complaints against ofessional/Director of oproach Client #3 in the form get Client #3 to clean his					

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-A foul odor in the room;

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STATEMENT	of Deficiencies OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL081-094	B. WING		06/20/2018	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
KELLYS C	ARE #3		TER ROAD			
		MOORES	BORO, NC 281	14		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 112	Continued From page	3	V 112			
	-The carpet was heav -The bed covering wa -Clothes were piled up a bedroom chair.	•				
V 119	27G .0209 (D) Medica	ation Requirements	V 119			
	guards against divers (2) Non-controlled sut of by incineration, flus system, or by transfer destruction. A record shall be maintained by Documentation shall semedication name, streate and method, the disposing of medication witnessing destruction (3) Controlled substant accordance with the N Substances Act, G.S. subsequent amendment (4) Upon discharge of remainder of his or he disposed of promptly expected that the patit to the facility and in su	al: d non-prescription sposed of in a manner that ion or accidental ingestion. ostances shall be disposed thing into septic or sewer to a local pharmacy for of the medication disposal by the program. specify the client's name, ength, quantity, disposal signature of the person on, and the person on, and the person on. horses shall be disposed of in North Carolina Controlled 90, Article 5, including any ents. f a patient or resident, the er drug supply shall be unless it is reasonably ent or resident shall return uch case, the remaining be held for more than 30				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	1 ' '	(X3) DATE SURVEY COMPLETED	
	MHL081-094	B. WING		06/	20/2018	
NAME OF PROVIDER OR SUPPLIER KELLYS CARE #3	ADDRESS, CITY, STATE ETER ROAD SBORO, NC 2811		·			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
prescription medicatic against diversion or a findings are: Review on 6/19/18 of Admission date: 12-19 Diagnoses: Anxiety D Intellectual Developm Pedophilia, History of Cataract in Right Eye -Physician's order dat Sodium 100 milligram needed (PRN) for cor Review on 6/19/18 of Admission date: Mild-Developmental Disab Disorder, Pedophilia, Hypertension, Shunt, -Physician's order dat 150 mg, 1 tablet twice heartburn or Dyspeps Interview on 6/19/18 v -He took medications -Staff gave him his medication Diabetes, and Choles -His diabetic medication -He could not rememble -Staff gave him his medication on 6/19/18 v -He was on medication -He could not rememble -Staff gave him his medication on 6/19/18 v -He was on medication -He could not rememble -Staff gave him his medication of 6/19/18 v	as evidenced by: ew, observation and failed to dispose of expired on in a manner that guards occidental ingestion. The Client 1's record revealed: 5-09 bisorder, Mild-Moderate ental Disability, Syncope, Seizures, History of ted 6/13/18 for Docusate as (mg), take 1 daily as astipation. Client #2's record revealed: Moderate Intellectual ility, Antisocial Personality Cerebral Palsy, Elevated Cholesterol ted 4/12/18 for Ranitidine te daily as needed for sia. with Client #1 revealed: the Client #2 revealed:	V 119				

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Docusate Sodium 100 mg and one pack of Client

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DIVISION	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			B. WING			
		MHL081-094	B. WING		06/20/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE		
TVAIVIL OF T	NOVIDER OR GOLT EIER		, ,	(I L, ZII OODL		
KELLYS C	ARE #3		TER ROAD			
		MOORES	BORO, NC 281	14		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION (X5)	
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO	JLD BE COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR	OPRIATE DATE	
				DEFICIENCY)		
V 119	Continued From page	5	V 119			
V 119	Continued From page	5 0	V 119			
	#2's Ranitidine 150 m	ng had expired;				
	-He was not aware th	•				
		a plastic bag and found in				
	the medication cart ha					
		house stock medications				
	-	ic bag since he started work				
	at the facility.					
	Interview on 6/19/18	with the pharmacist				
	revealed:					
	-There were 2 labels	on the house stock				
	medication bottles;					
	-The large label on th	e bottles identified the date				
	of issue and the expir					
	•	dication was effective for 1				
	year from the issue d					
	•					
	-The small label on th					
	parcode for the facility	y to reorder the medication.				
	Interview on 6/20/18 v					
		of Operations revealed:				
	-He stated he though	t staff had addressed the				
	expired medication is	sue.				
	Observation on 6/19/	18 at approximately 2:00 pm				
	of Client #1's prescrib	ped PRN medications				
	revealed:					
		tion packs of Docusate				
		a dispense date of 4/27/17				
	and an expiration date	•				
	and an expiration date	O 01 7/20 10.				
	Observation on 6/40/	19 at approximately 2:15 are				
		18 at approximately 2:15 pm				
	of Client #2's prescrib	ped PRIN medications				
	revealed:					
		tion packs of Ranitidine 150				
		ate of 4/27/17 and an				
	expiration date of 4/2	018.				
	Observation on 6/19/	18 at 11:50 am of the				

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facility's house stock medications revealed:

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DIVISION	n nealth Service Regu	ialion				
STATEMENT	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
		MHL081-094	B. WING		06/2	20/2018
NAME OF D		STDEET AL	DDRESS, CITY, STA	ATE ZID CODE		
NAIVIE OF P	ROVIDER OR SUPPLIER		, ,	KIE, ZIP CODE		
KELLYS C	ARE #3		TER ROAD			
		MOORES	BORO, NC 281	14		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	٧	(X5)
PRÉFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
V 119	Continued From page	2.6	V 119			
• 110	Continued From page	. 0	' ' ' '			
	-A clear plastic bag th	at contained the following:				
	-Diphenhist 25 mg,	substitute for Benadryl 25				
		abel on the bottle that had				
		7 and expiration date of				
	5/2018;	. and expiration date of				
		ubstitute for Tylenol 500 mg				
	•	I on the bottle that had an				
	issue date of 5/4/17 a					
		ind expiration date of				
	5/2018;	abotitute for Talenel 205 and				
	_	ubstitute for Tylenol 325 mg				
		I on the bottle that had an				
	issue date of 5/4/17 a	ind expiration date of				
	5/2018.					
V 540	27F 0103 Client Righ	nts - Health, Hygiene And	V 540			
	Grooming	no ricani, riygicho ma				
	Orooming					
	10A NCAC 27F .0103	B HEALTH, HYGIENE				
	AND GROOMING	HEALITI, ITT GILINE				
		h = ==================================				
		be assured the right to				
		umane care in the provision				
		giene and grooming care.				
	-	ide, but need not be limited				
	to the:					
		for a shower or tub bath				
	daily, or more often a	s needed;				
	(2) opportunity	to shave at least daily;				
	(3) opportunity	to obtain the services of a				
	barber or a beauticiar	n; and				
		linens and towels, toilet				
	paper and soap for ea					
	· · ·	giene articles for each				
		other articles include but are				
		ste, toothbrush, sanitary				
		aving cream and shaving				
	utensil.	roug and toilate which are sur-				
	. ,	ers and toilets which ensure				
	individual privacy sha					
	(c) Adequate toilets,	lavatory and bath facilities				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL081-094	B. WING		06/20/2018	3
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
KELLYS C	ARE #3	133 KEETE	ER ROAD SORO, NC 281 ^o	14		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE OF CORRECTION SHOULD DEFICIENCY)	BE COMP	(5) PLETE ATE
V 540	Continued From page equipped for use by a impairment shall be a	client with a mobility	V 540			
	failed to ensure the p	ew and interview, the facility rovision of individual cles affecting 2 of 3 clients				
	Review on 6/19/18 of Client #2's record revealed: Admission date: 3/15/10 Diagnoses: Mild-Moderate Intellectual Developmental Disability, Antisocial Personality Disorder, Pedophilia, Cerebral Palsy, Hypertension, Shunt, Elevated Cholesterol					
	Admission date: 6-23 Diagnoses: Attention Disorder, Intermittent Personality Disorder, Disorder, Mild-Moder	Deficit Hyperactivity Explosive Disorder, Pervasive Developmental				
		local grocery store receipts and May 2018 revealed food				
		a 2018 discount store ampoo item, soap and				
	-He bought his shamp razor blades, toilet tis his personal money;	with Client #2 revealed: boo, deodorant, toothpaste, sue, snacks and sodas with in type of toilet paper so he				

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Division of	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		MHL081-094	B. WING		06/20/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE		
KELLYS C	ARE #3		TER ROAD BBORO, NC 2811	14		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLI	ETE
V 540	hygiene items; -He stated the facility food for the meals and wash his hands. Interview on 6/19/18 v.—He received \$66.00 p. spending; -He stated he bought items: soap, shampood detergent; -His one-on-one work what he wanted and r.—He stated the facility and food. Interview on 6/19/18 v.—The clients bought the deodorant with their c.—Staff # 7 provided the money each month; -Staff #7 provided the to go shopping; -Client #3's one-on-or shopping. Interview on 6/19/18 v.—She stated the clients once a month; -A staff person from the facility each month are	paper; per month to use for fter his medication educted; opping for his personal bought items that included d soap to take a bath and with Client #3 revealed: per month for personal all his personal hygiene o, deodorant, and clothes ker took him shopping to buy needed with his money; provided him with shelter with Staff #4 revealed: neir own shampoo and own money; e clients with their spending e clients with transportation ne worker took him with Staff #6 revealed: se received spending money the company came to the and took the clients shopping; nat the clients bought their	V 540	BEHOLINGT)		
		s and snacks; company bought the clients				

their shampoo and deodorant;

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
			B WING	B. WING	
		MHL081-094	D. WING		06/20/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
KELLYS C	ARE #3		ER ROAD		
			BORO, NC 281		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 540	Continued From page	9	V 540		
V 540	-Client #3 did not war products bought by the own hygiene products -Client #3's one-on-or for his hygiene products -He had worked for the years; -His duties included in appointments for client their medical appoint checking on client medications were at the company's office, and services staff when nother the brought and proving money to the clients; -He provided the clients; -He provided the clients personal spending meach month; -He stated the clients; -He provided the clients; -He provided the clients shopping when the clients used their spersonal hygiene products.	nt to use the hygiene ne company and bought his s; ne worker took him shopping cts. with Staff #7 revealed: ne company approximately 7 making doctor's nts, transporting clients to ments and shopping, edications to ensure the he facility, helping in the d filling in as residential eeded; were provided their oney around the 10th of ided the personal spending nts with transportation to go ients had their spending ending money to buy their ducts, snacks and	V 540		
	sometimes they would and Digital Video Disc	d buy Compact Discs (CDs)			
	-He stated that the pe	ersonal hygiene products			
	bought by clients inclushaving cream and ra	uded body wash, shampoo,			
	Interview on 6/20/18 v Professional and Dire -He stated he was no provision of personal -He asked what items hygiene;	with the Qualified ector of Operations revealed: t aware of the rule on the hygiene products for clients;			

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rule in the past.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED	
		MHL081-094	B. WING		06	/20/2018
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE		
KELLYS C	ARE #3		TER ROAD SBORO, NC 28114	.		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 540	Interview on 6/20/18 Officer (CEO) reveale - A 2018 discount sto shampoo item, soap -He stated he did not the facility surveyed; -The clients needed to products they needed to the shopping list;	e 10 with the Chief Executive	V 540			DATE

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