Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ MHL081-094 B. WING 06/20/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 133 KEETER ROAD **KELLYS CARE #3** MOORESBORO, NC 28114 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 000 INITIAL COMMENTS V 000 **DHSR** - Mental Health An annual survey was completed on June 20, 2018. Deficiencies were cited. JUL 23 2018 This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. Lic. & Cert. Section V 112 27G .0205 (C-D) V 112 Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE **PLAN** (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement: (2) strategies: (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement: and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDED SUPPLIER REPRESENTATIVE'S SIGNATURE

. . .

(X6) DATE

STATE FORM

899

550P

WUG111

If continuation sheet 1 of 11

Division o	f Health Service Regu	lation			NO DATE OFFICE
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		00
	MHL081-094		B. WING		06/20/2018
		OTDEET AF	DRESS, CITY, STATI	E ZIR CODE	
NAME OF PE	ROVIDER OR SUPPLIER			E, ZIF GODE	
KELLYS C	ARE #3		TER ROAD	4	
		MOORES	BORO, NC 2811		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	
IAO				DEFICIENCY)	
V 440	Osstinued From pag	- 1	V 112		
V 112	Continued From pag	e i	• ,,,,		
	This Rule is not met				
	Based on record revi				
		o ensure a client's service			
		ticipated by the provision of			
		f 3 clients (Client #3). The			
	findings are:				
	Daview on 6/10/19 o	f Client #3's record revealed:			
	Admission date: 6-23				
		Deficit Hyperactivity			
		t Explosive Disorder,			
		, Pervasive Developmental			
	Disorder, Mild-Mode				
		rder, Post-Traumatic Stress			
	Disorder				
	-12/20/17 Personal	Care Plan included:			
1	-A service goal to	maintain a neat and clean			
·	living space by clear				
		Client #3 needed staff			
1	prompting to comple	ete routine tasks.			
		with Client #3 revealed:			
	-He cleaned his bed				
		iff cleaning his bedroom move his belongings around;			
		at his bedroom looked like			
		to move out of the facility			
	next week.	To more out or the rasmy			
	noxt moon.				
	Interview on 6/19/18	3 with Staff #4 revealed:		_	
		as residential services staff;			
		the facility over one year;			
1		ded meal preparation,			
		cations to clients, house			
1		ith the clients on their goals,			
		rvision to the clients;			
	-He was knowledge	eable about the clients' service			
	goals;				
	-Client #3 had a ser	rvice goal to become as			

STATE FORM

PRINTED: 06/27/2018 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ B. WING MHL081-094 06/20/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 133 KEETER ROAD **KELLYS CARE #3** MOORESBORO, NC 28114 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Client Moved from home on 6-28-18. V 112 | Continued From page 2 V 112 independent as possible; -Client #3 was territorial about his personal space that included his bedroom: -Client #3 liked for staff to leave him alone and not tell him what to do. Interview on 6/19/18 with Staff # 6 revealed: included in the -She worked as residential services staff: -She had worked at the facility for 2 years; consumer's plan because it was -Her job duties included preparing and serving meals and snacks, giving clients their medications, house cleaning, and encouraging the clients in their personal hygiene and clearly an area grooming; -She was knowledgeable about the clients' service goals: he needed to -She worked with Client #3 on completing his hygiene activities: WORK ON. IF -She worked with Client #3 on cleaning his bedroom. he had mastered Interview on 6/20/18 with the Qualified the goal or Professional/Director of Operations revealed: -Client #3 had little motivation to clean his didn't lack in bedroom as Client #3 planned to move out of the facility the following week: that area, the goal would have been removed from the plan. Staff had prompted staff had prompted consumer numerous -Client #3 had made improvements in his bedroom by not hoarding items: -Staff were resistant to prompt Client #3 to clean his bedroom because Client #3 had a history of recording staff and making complaints against them:

-He (the Qualified Professional/Director of Operations) had to approach Client #3 in the form of a favor request to get Client #3 to clean his

of Client #3's bedroom revealed: -A foul odor in the room;

Observation on 6/19/18 between 12:06-12:30 pm

Division of Health Service Regulation (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: ___ B. WING_ 06/20/2018 MHL081-094

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

KELLYS CARE #3 MOORESPA			ER ROAD BORO, NC 28114		
(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 112	Continued From page 3 -The carpet was heavily soiled with debris; -The bed covering was disheveled; -Clothes were piled up in a disheveled manner on a bedroom chair. 27G .0209 (D) Medication Requirements	V 112	times. He was awa that he was move home in approx a week and had little motivation to	100	
	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 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.		work on goals. It is impossible to ensu an outcome. We an outcome. We train staff on most effective ways to support clients in running goals, but at running document in achieved. To hopefully reduce this for outcomes staff will be retrained in client specifics, covering the best ways to support consumers in achieving outcomes in achieving outcomes from PCP and various methods of running		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	4	MHL081-094	B. WING		06	/20/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	, , , , , , , , , , , , , , , , , , , ,		
KELLYS	CARE #3		TER ROAD				
		MOORES	BORO, NC 28	114			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETE DATE	
	prescription medication against diversion or actindings are: Review on 6/19/18 of Admission date: 12-15 Diagnoses: Anxiety Di Intellectual Developme Pedophilia, History of Cataract in Right Eye-Physician's order date Sodium 100 milligrams needed (PRN) for consequence of Admission date: Mild-Novelopmental Disabil Disorder, Pedophilia, Ohypertension, Shunt, E-Physician's order date 150 mg, 1 tablet twice heartburn or Dyspepsis Interview on 6/19/18 with He was on medications; -Staff gave him his medication Diabetes, and Choleste His diabetic medication He could not remember -Staff gave him his medication on 19/18 with He was on 6/19/18 with He was on 6/19/18 with He was on Medication Diabetes, and Choleste His diabetic medication He could not remember -Staff gave him his medication on 19/18 with He was on 6/19/18 with	as evidenced by: ew, observation and ailed to dispose of expired in in a manner that guards ocidental ingestion. The Client 1's record revealed: 6-09 sorder, Mild-Moderate ental Disability, Syncope, Seizures, History of ed 6/13/18 for Docusate s (mg), take 1 daily as stipation. Client #2's record revealed: Moderate Intellectual ity, Antisocial Personality Derebral Palsy, Elevated Cholesterol ed 4/12/18 for Ranitidine daily as needed for a. ith Client #1 revealed: dications. th Client #2 revealed: for High Blood Pressure, erol; n was Metformin; er his other medications; dications daily.	V 119	goals.		(-30-18	
		mg and one pack of Client					

PRINTED: 06/27/2018 FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: B. WING 06/20/2018 MHL081-094 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **133 KEETER ROAD KELLYS CARE #3** MOORESBORO, NC 28114 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Staff RN will check in medications monthly at cycle fill. While checking 6-30-18 V 119 V 119 Continued From page 5 #2's Ranitidine 150 mg had expired; -He was not aware the 3 house stock medications stored in a plastic bag and found in the medication cart had expired; in medications, -He stated that the 3 house stock medications had been in the plastic bag since he started work she will check all meds in cart and remove any expired medications. 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 the bottles identified the date of issue and the expiration date; -The house stock medication was effective for 1 year from the issue date: -The small label on the bottles contained a barcode for the facility to reorder the medication. Interview on 6/20/18 with the Qualified Professional/Director of Operations revealed: -He stated he thought staff had addressed the expired medication issue. Observation on 6/19/18 at approximately 2:00 pm of Client #1's prescribed PRN medications revealed: -1 of 2 blister medication packs of Docusate Sodium 100 mg with a dispense date of 4/27/17 and an expiration date of 4/2018. Observation on 6/19/18 at approximately 2:15 pm

Division of Health Service Regulation

revealed:

expiration date of 4/2018.

of Client #2's prescribed PRN medications

Observation on 6/19/18 at 11:50 am of the facility's house stock medications revealed:

-1 of 2 blister medication packs of Ranitidine 150 mg with a dispense date of 4/27/17 and an

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL081-094			B. WING	B. WING		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
KELLYS (CARE #3	133 KEET MOORESI	ER ROAD BORO, NC 28	114		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
V 119 V 540	-A clear plastic bag the Diphenhist 25 mg, smg with a pharmacy land issue date of 5/4/15/2018; -MAPAP 500 mg, su with a pharmacy label issue date of 5/4/17 at 5/2018; -MAPAP 325 mg, su with a pharmacy label issue date of 5/4/17 at 5/2018.	at contained the following: substitute for Benadryl 25 abel on the bottle that had 7 and expiration date of bstitute for Tylenol 500 mg on the bottle that had an and expiration date of bstitute for Tylenol 325 mg on the bottle that had an	V 119			
	of personal health, hyg Such rights shall include to the: (1) opportunity for daily, or more often as (2) opportunity to 3) opportunity to barber or a beautician; (4) provision of I paper and soap for each individual personal hyg indigent client. Such of not limited to toothpast napkins, tampons, shall utensil. (b) Bathtubs or showe individual privacy shall	mane care in the provision giene and grooming care. de, but need not be limited or a shower or tub bath needed; o shave at least daily; o obtain the services of a and inens and towels, toilet ch client and other giene articles for each her articles include but are e, toothbrush, sanitary ving cream and shaving or sand toilets which ensure				

	OF CORRECTION	IDENTIFICATION NUMBER:	The state of the s	CONSTRUCTION	COMPLE	
		MHL081-094	B. WING		06/20)/2018
NAME OF P	SUMMARY ST	133 KEE MOORES	DDRESS, CITY, STA	PROVIDER'S PLAN OF CORRECTION	"Theory	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	11990 Carrier	COMPLETE DATE
V 540	equipped for use by a impairment shall be a impairment shall be a This Rule is not met Based on record revifailed to ensure the personal hygiene arti (Client #2 and Client Review on 6/19/18 of Admission date: 3/15 Diagnoses: Mild-Mood Developmental Disat Disorder, Pedophilia, Hypertension, Shunt, Review on 6/19/18 of Admission date: 6-23 Diagnoses: Attention Disorder, Intermittent Personality Disorder, Disorder, Mild-Moder Developmental Disorder	as evidenced by: ew and interview, the facility rovision of individual cles affecting 2 of 3 clients #3). The findings are: f Client #2's record revealed: /10 lerate Intellectual bility, Antisocial Personality Cerebral Palsy, Elevated Cholesterol f Client #3's record revealed: 8-11 Deficit Hyperactivity t Explosive Disorder, Pervasive Developmental	V 540	Facility purchases all items placed on weekly shopp list. Facility provided toilet tissue, so shamper, soap, AP Spoke with facility staff ar facility staff ar with transport with transport with transport them to add a reeded hygiene	etc.	6-21-18
	for the facility in April items. Review on 6/20/18 or receipt revealed a sh	f local grocery store receipts and May 2018 revealed food f a 2018 discount store ampoo item, soap and		Supplies to weekly shopping		
	-He bought his sham razor blades, toilet ti- his personal money;	with Client #2 revealed: ipoo, deodorant, toothpaste, ssue, snacks and sodas with in type of toilet paper so he				,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL081-094		B. WING		06/	20/2018	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST	ATE, ZIP CODE		
KELLYS (CARE #3	133 KEETI MOORESE	BORO, NC 28	114		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 540	bought his own toilet particle of the received \$56.00 parsonal expenses afteo-payments were deserted. Staff #7 took him shothygiene items; He stated the facility food for the meals and wash his hands. Interview on 6/19/18 washer of the received \$66.00 paspending; He stated he bought items: soap, shampoodetergent; His one-on-one worked what he wanted and name of the stated the facility pand food. Interview on 6/19/18 washer of the togo shopping; Client #7 provided the money each month; Staff #7 provided the togo shopping; Client #3's one-on-on shopping. Interview on 6/19/18 washer of the stated the clients once a month; A staff person from the facility each month and she initially stated that own hygiene products	paper; per month to use for the his medication ducted; pping for his personal bought items that included disoap to take a bath and with Client #3 revealed: per month for personal hygiene deodorant, and clothes are took him shopping to buy eeded with his money; provided him with shelter with Staff #4 revealed: per own shampoo and with money; clients with their spending clients with transportation the worker took him with Staff #6 revealed: received spending money the company came to the distoach the clients bought their and snacks; company bought the clients	V 540			

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED	
		MHL081-094	B. WING		06/2	0/2018	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
KELLYS C	ARF #3	133 KEETE	R ROAD				
KLLLIO	ARE #3	MOORESB	ORO, NC 2811	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 APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 540	Continued From page -Client #3 did not war products bought by th own hygiene products -Client #3's one-on-or for his hygiene product -Client #3's one-on-or for his hygiene product -He had worked for th years; -His duties included n appointments for client their medical appoint checking on client me medications were at t company's office, and services staff when n -He stated the clients personal spending me each month; -He brought and prov money to the clients; -He provided the clients shopping when the client shoppi	at to use the hygiene the company and bought his s; the worker took him shopping cts. with Staff #7 revealed: the company approximately 7 making doctor's the transporting clients to ments and shopping, edications to ensure the diffilling in as residential the facility, helping in the diffilling in as residential the deeded; were provided their toney around the 10th of the diffilling money to buy their ducts, snacks and did buy Compact Discs (CDs) tos (DVDs); the sonal hygiene products uded body wash, shampoo, the accors. with the Qualified	V 540				
	-He stated he was no	ector of Operations revealed: ot aware of the rule on the					
		hygiene products for clients; s comprised personal					
		had not been cited on this					

Division of Health Service Regulation

WUG111

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2011 1000	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL081-094	B. WING		06	20/2018	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, ST	ATE, ZIP CODE		20/2010	
KELLYS (CARE #3		ER ROAD BORO, NC 28	11.4			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	COMPLETE	
V 540	Continued From page	2 10	V 540				
	Officer (CEO) reveale - A 2018 discount store shampoo item, soap a -He stated he did not the facility surveyed; -The clients needed to products they needed to the shopping list;	re receipt that identified a					