JILDING: COMPLETED ING R-C 11/27/2018 CITY, STATE, ZIP CODE IN ROAD 7713 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETED R-C 11/27/2018 COMPLETED R-C 00/20 COMPLETED R-C 00/20 COM
ING 11/27/2018 CITY, STATE, ZIP CODE ON ROAD 7713 ID PROVIDER'S PLAN OF CORRECTION (XE REFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
ID PROVIDER'S PLAN OF CORRECTION (XE REFIX (EACH CORRECTIVE ACTION SHOULD BE COMPIL TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
ID     PROVIDER'S PLAN OF CORRECTION     (X5)       REFIX     (EACH CORRECTIVE ACTION SHOULD BE     COMPI       TAG     CROSS-REFERENCED TO THE APPROPRIATE     DAT       DEFICIENCY)     DEFICIENCY     DAT
ID PROVIDER'S PLAN OF CORRECTION (X5 REFIX (EACH CORRECTIVE ACTION SHOULD BE COMPI TAG CROSS-REFERENCED TO THE APPROPRIATE DAT DEFICIENCY)
TAG (EACH CORRECTIVE ACTION SHOULD BE COMPL TAG CROSS-REFERENCED TO THE APPROPRIATE DAT DEFICIENCY)
00
90
<b>c</b>

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

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-243		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NOMBER.	A. BUILDING:			
		B. WING		R-C 11/27/2018		
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
HOUSE O	F CARE, INC		KE ELTON ROAD M, NC 27713			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	O THE APPROPRIATE	COMPLETE DATE
V 290	Continued From page 1		V 290			
	developmental disabi	ilities shall be served with				
	-	every one to three clients				
	•	present for every four or				
		However, only one staff				
	need be present duri					
	specified by the emergency back-up procedures determined by the governing body.					
	(d) In facilities which serve clients whose primary					
		ce abuse dependency:				
	(1) at least one staff member who is on					
	duty shall be trained in alcohol and other drug					
	withdrawal symptoms and symptoms of					
		ions to alcohol and other				
	drug addiction; and	s of a certified substance				
	(2) the services abuse counselor sha					
	as-needed basis for e					
	This Rule is not met	as evidenced by:				
	Based on record revi	ew and interview, the facility				
	•	ents during community and				
		ting one of three audited				
	clients (#3). The findi	ngs are:				
	Review on 11/27/18 (	of Client #3's record				
	revealed:					
	-Admission date of 6/					
	-Diagnoses of Moder					
		bility, Diabetes and Chronic				
	Otitis. -Treatment plan dated 2/1/18.					
	-	he allowed in the home or				
	community.					
	Interview on 11/14/18	3 with a Neighbor revealed:				
		8 the community hosted a				
	social activity for child					

Division of Health Service Regulation STATE FORM

6899

Division of Health Service Regulation         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         MHL032-243		(X2) MULTIPLE C			E SURVEY PLETED	
		A. BUILDING:			COMPLETED	
				R-C 11/27/2018		
IAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE		
	F CARE, INC	5800 LAP	KE ELTON ROAD			
		DURHAN	I, NC 27713			
PREFIX (EACH DEFICIENC		SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
V 290	Continued From page 2		V 290			
	turn lights on to show collect candy. -The group home had -Children went to the to collect candy. -Clients' in the group candy instead of putt -Children were crying -Learned someone in in the children's bask -Felt money was an e -Parents went to the that resulted into an a	group home for Halloween home took the children's ing candy in the basket. the group home put money et rather than candy. exchange for candy. group home to talk with staff				
	-She worked at the g 2018. -Confirmed clients ini and then went outside -She was not aware of determine Halloween -Children came to the candy. -Confirmed client #3 candy. -She denied any child -A couple came to the -She had a discussion incident. -She told clients not to children. -She told client #3 he the child's candy and -She reported being of #3 grabbed a child's	of turning lights off or on to participation. e house and gave clients grabbed and took a child's d was crying. e house about the incident. n with the couple about the to accept candy from the e was not supposed to take told to return it. poutside the home when client				

E STATE FORM

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-243		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED R-C 11/27/2018								
						AME OF PROVIDER (	OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
						OUSE OF CARE,	INC		AKE ELTON ROAD M, NC 27713			
	EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE						
V 290 Continu	Continued From page 3		V 290									
-She ta piece of -The po- if they v activity -She in Intervie Profess -She w survey -She le grabbir activity -Client commu	Iked with the f candy child olice asked he were not parti and left. formed the D w on 11/27/1 sional reveale as not aware arned today s arned	of the incident until the staff #1 witnessed client #3 andy during the community ve unsupervised time in the										