	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			R
		MHL009-024	B. WING			26/2022
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
AROLII	NAS HOME CARE AG	ENCY INC	CHARDSON RO IBORO, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMEN	rs	V 000			
		w up survey was completed 2. Deficiencies were cited.				
	category: 10A NCA	sed for the following service C 27G .5600C Supervised h Developmental Disabilities.				
		sed for 5 and currently has a urvey sample consisted of clients.				
V 105	27G .0201 (A) (1-7)) Governing Body Policies	V 105			
	POLICIES (a) The governing b facility or service sh written policies for t (1) delegation of ma operation of the fac (2) criteria for admi (3) criteria for disch (4) admission asse (A) who will perform (B) time frames for (5) client record ma (A) persons authori (B) transporting rec (C) safeguard of re defacement or use (D) assurance of re authorized users at (E) assurance of co (6) screenings, whi (A) an assessment problem or need; (B) an assessment	anagement authority for the sility and services; ssion; aarge; ssments, including: n the assessment; and completing assessment. anagement, including: zed to document; cords; cords against loss, tampering, by unauthorized persons; ecord accessibility to all times; and onfidentiality of records.				

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED	
		MHL009-024	B. WING			R 10/26/2022	
IAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
		THEY INC 1468 RICI	HARDSON RO	DAD			
ARULI	NAS HOME CARE AG	BLADENE	BORO, NC 28	320			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
V 105	Continued From pa	age 1	V 105				
	 (C) the disposition, recommendations; (7) quality assurance and quality assurance and quality assurance and quality assurance and quality and approprincluding delineation of service (D) professional or a requirement that professionals and pshall be supervised that area of service (E) strategies for in (F) review of staff of determination mad treatment/habilitation (G) review of all fat were being served residential programmatic applicable standard purpose, "applicab means a level of correference to the promethods, and the context of the professional context of the p	including referrals and ce and quality improvement : d activities of a quality ality improvement committee; assurance and quality onitoring and evaluating the riateness of client care, on of client outcomes and es; clinical supervision, including staff who are not qualified provide direct client services d by a qualified professional in e; nproving client care; qualifications and a e to grant					

If continuation sheet 2 of 15

	of Health Service Re TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		MHL009-024	B. WING			
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
AROLI	NAS HOME CARE AG	ENCY INC	CHARDSON RONBORO, NC 28			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN(THE APPROPRIATE	COMPLET DATE
V 105	Continued From pa	ge 2	V 105			
	This Rule is not m	et as evidenced by: view and interviews the facility				
		id implement adoption of	y			
	standards that assu	ure operational and ormance meeting application				
	standards of practic	ce for the use of blood glucose	e			
		e CLIA (Clinical Laboratory ndments) waiver. The findings				
	are:					COMPLET
		2 of the facility records				
	revealed: -There was no CLI	A certificate for the facility.				
	-A CLIA certificate f					
	Review on 10/25/22 record revealed:	2 and 10/26/22 of client #1's				
	-66 year old male.	14				
	-Admitted on 3/22/ ² -Diagnoses of Atyp	ical psychosis, Impulse				
		Intellectual Disability, Fluid s and High Cholesterol.				
	Interview on 10/26/ -Staff checked his I					
	Interview on 10/26/ stated:	22 the Qualified Professional				
		client's blood glucose.				
		a multi-site CLIA waiver. ed multiple facilities on the				
		22 the Licensee stated:				
	-Multiple facilities w waiver.	vere included on the CLIA				
		CLIA waiver was needed for				

AGENCY, INC TATEMENT OF DEFICIENCIES (CY MUST BE PRECEDED BY FULL ALSC IDENTIFYING INFORMATION) Dage 3 Personnel Requirements 0202 PERSONNEL S ucation shall be documented. ining programs shall be a minimum, shall consist of the hizational orientation;	B. WING DDRESS, CITY, S CHARDSON RC BORO, NC 28 ID PREFIX TAG V 105 V 108	TATE, ZIP CODE	R 0/26/2022
R STREET A AGENCY, INC 1468 RIG BLADEN TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) Dage 3 Personnel Requirements 0202 PERSONNEL S ucation shall be documented. ining programs shall be a minimum, shall consist of the hizational orientation;	DDRESS, CITY, S CHARDSON RO BORO, NC 28 ID PREFIX TAG	ATATE, ZIP CODE OAD 8320 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLE
AGENCY, INC 1468 RIG BLADEN TATEMENT OF DEFICIENCIES (CY MUST BE PRECEDED BY FULL RESCIDENTIFYING INFORMATION) Dage 3 Personnel Requirements 0202 PERSONNEL S ucation shall be documented. ining programs shall be a minimum, shall consist of the nizational orientation;	V 105	OAD 8320 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLE
Dersonnel Requirements O202 PERSONNEL S ucation shall be documented. ining programs shall be a minimum, shall consist of the hizational orientation;	IBORO, NC 28 ID PREFIX TAG V 105	8320 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLE
CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) page 3 Personnel Requirements 0202 PERSONNEL S ucation shall be documented. ining programs shall be a minimum, shall consist of the hizational orientation;	V 105	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLE
Personnel Requirements 0202 PERSONNEL S ucation shall be documented. ining programs shall be a minimum, shall consist of the nizational orientation;			
0202 PERSONNEL S ucation shall be documented. ining programs shall be a minimum, shall consist of the nizational orientation;	V 108		
0202 PERSONNEL S ucation shall be documented. ining programs shall be a minimum, shall consist of the nizational orientation;	V 108		
S ucation shall be documented. ining programs shall be a minimum, shall consist of the nizational orientation;			
ent rights and confidentiality as NCAC 27C, 27D, 27E, 27F and eet the mh/dd/sa needs of the d in the treatment/habilitation ectious diseases and ogens. mitted under 10a NCAC 27G ubchapter, at least one staff available in the facility at all nt is present. That staff	1		
mlich maneuver or other first aid as those provided by Red Cross art Association or their elieving airway obstruction. g body shall develop and as and procedures for identifying gating and controlling infectious	;,		
	oulmonary resuscitation and mlich maneuver or other first aid as those provided by Red Cross art Association or their elieving airway obstruction. g body shall develop and	oulmonary resuscitation and mlich maneuver or other first aid as those provided by Red Cross, art Association or their elieving airway obstruction. g body shall develop and as and procedures for identifying, gating and controlling infectious	bulmonary resuscitation and mlich maneuver or other first aid as those provided by Red Cross, art Association or their elieving airway obstruction. g body shall develop and es and procedures for identifying, gating and controlling infectious

STATEMEN	of Health Service Re TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		MHL009-024	B. WING		10/2	26/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CAROLII	NAS HOME CARE AG	FNCY INC	CHARDSON RO IBORO, NC 28			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
V 108	Continued From pa	age 4	V 108			
	Based on record re facility failed to ens #7, Qualified Profe cardiopulmonary re techniques such as	et as evidenced by: eviews and interviews the ure 3 of 3 staff (staff #1, staff ssional (QP)) were trained in esuscitation (CPR)/first aid those provided by Red Cross t Association or their ndings are:	·,			
	revealed: -Hire date 6/23/08. -No evidence staff	2 of staff #1's personnel record #1 completed an approved PR/first aid certification.	t			
	Interview on 10/26/ -He completed an i certification with the	n person CPR/first aid				
	revealed: -Hire date 9/25/18. -No evidence staff	2 of staff #2's personnel record #1 completed an approved PR/first aid certification.	t			
	year. -A portion of the tra and "some with a n	e CPR/first aid certification last ining was completed online nannequin" in person. all who lead the in person	t			
	Finding #3 Review on 10/26/22 revealed: ealth Service Regulation	2 of the QP's personnel record	1			

STATEMEN	of Health Service Re TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		SURVEY
			A. BUILDING:			_
		MHL009-024	B. WING			R 2 6/2022
	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
		ENCY INC 1468 RIC	HARDSON RC	DAD		
CARULII	NAS HOME CARE AG	BLADEN	IBORO, NC 28	320		
(X4) ID	_	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO TH	IE APPROPRIATE	DATE
				DEFICIENCY)	
V 108	Continued From pa	ige 5	V 108			
	-Hire date 11/10/04					
		P completed an approved				
	skills portion for CF	PR/first aid certification.				
	Interview on 10/26/	22 the OR stated				
		CPR/first aid certification last				
		all who lead the training.				
	, , , , , , , , , , , , , , , , , , ,	5				
		22 the Licensee stated:				
	-	eir CPR/first aid certification				
	online. -She was told staff	could complete their CPR/first				
		f they completed a skills				
	portion.					
		e skills portion with an				
	uncertified instructo	or at the office.				
V 364	G.S. 122C- 62 Add Facilities	ditional Rights in 24 Hour	V 364			
	§ 122C-62. Additio Facilities.	nal Rights in 24-Hour				
	(a) In addition to th	e rights enumerated in G.S.				
		S. 122C-61, each adult client				
		atment or habilitation in a				
	24-hour facility kee (1) Send and recei	ive sealed mail and have				
		aterial, postage, and staff				
	assistance when ne	ecessary;				
		nsult with, at his own expense				
		e facility, legal counsel, private	9			
	physicians, and privile developmental disa	abilities, or substance abuse				
	professionals of his					
	(3) Contact and co	nsult with a client advocate if				
	there is a client adv					
		d in this subsection may not be				
		cility and each adult client may ts at all reasonable times.				
	CAELOBE MESE MUT					

	IT OF DEFICIENCIES OF CORRECTION	egulation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		MHL009-024	B. WING		R 10/26/2022	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	NAS HOME CARE AG	ENCX INC 1468 RIC	HARDSON RC	DAD		
	NAS NOME CARE AG	BLADEN	BORO, NC 28	320		
(X4) ID PREFIX	_	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV		(X5) COMPLETI
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TI	HE APPROPRIATE	DATE
				DEFICIENCY	()	
V 364	Continued From pa	ge 6	V 364			
	(b) Except as prov	ided in subsections (e) and (h)				
		h adult client who is receiving				
		ation in a 24-hour facility at all				
	times keeps the rig					
		ive confidential telephone				
		nce calls shall be paid for by				
		e of making the call or made				
	collect to the receiv					
		s between the hours of 8:00 for a period of at least six				
		urs of which shall be after 6:00				
		ng shall not take precedence				
	over therapies;	······································				
		and meet under appropriate				
	•	lividuals of his own choice				
	upon the consent o					
		side the custody of the facility				
	unless:	recording a wore initiated as				
		roceedings were initiated as ent's being charged with a				
		ding a crime involving an				
	assault with a dead					
		and not guilty by reason of				
	insanity or incapabl					
		voluntarily admitted or				
		cility while under order of				
		prrectional facility of the				
		prrection of the Department of				
	Public Safety; or	ing held to determine capacity				
		it to G.S. 15A-1002;				
		expressly authorize visits				
		d by the existence of the				
		ed by this subdivision;				
		daily and have access to				
		ment for physical exercise				
	several times a wee					
		ibited by law, keep and use				
	nereonal clothing a	nd possessions, unless the				1

Division	of Health Service Re	egulation			FORM	APPROVED
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Multiple A. Building:			E SURVEY PLETED
		MHL009-024	B. WING			R 26/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
CAROLI	NAS HOME CARE AG	ENCX INC 1468 RIC	HARDSON RO	DAD		
CARULI	NAS HOME CARE AG	ENCT, INC BLADEN	BORO, NC 28	3320		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 364	Continued From pa	ge 7	V 364			
	proceed pursuant to (7) Participate in re (8) Keep and spen own money; (9) Retain a driver! prohibited by Chapt and (10)Have access to his private use. (c) In addition to th 122C-51 through G 122C-59 through G who is receiving tre 24-hour facility has proper adult superv recognition of the m individual, the mino opportunities to ena emotionally, intelled vocationally. In view and intellectual imm 24-hour facility shal structure, supervision the rights given to th The facility shall als reasonable efforts t client receives treat adult clients unless minor client dictate Each minor client w habilitation from a 2 (1) Communicate a guardian or the age custody of him; (2) Contact and co or that of his legally cost to the facility, ke	eligious worship; d a reasonable sum of his s license, unless otherwise ter 20 of the General Statutes; o individual storage space for re rights enumerated in G.S. .S. 122C-57 and G.S. .S. 122C-61, each minor client atment or habilitation in a the right to have access to rision and guidance. In ninor's status as a developing r shall be provided able him to mature physically, stually, socially, and v of the physical, emotional, naturity of the minor, the I provide appropriate on and control consistent with he minor pursuant to this Part. so, where practical, make o ensure that each minor ment apart and separate from the treatment needs of the				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED R	
			A. BUILDING.			
		MHL009-024	B. WING			26/2022
AME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
AROLI	NAS HOME CARE AG	ENCY INC	HARDSON RO BORO, NC 28			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLET DATE
V 364	Continued From pa	ige 8	V 364			
	his or his legally res (3) Contact and co there is a client adv The rights specified restricted by the fac may exercise these (d) Except as prov of this section, each treatment or habilita the right to: (1) Make and rece distance calls shall time of making the receiving party; (2) Send and recei writing materials, po when necessary; (3) Under appropri visitors between the p.m. for a period of hours of which shall visiting shall not tak therapies; (4) Receive specia training in accordance (5) Be out of doors recreation, and phy basis in accordance (6) Except as proh personal clothing an appropriate supervit held to determine c G.S. 15A-1002; (7) Participate in re (8) Have access to the safekeeping of	d in this subsection may not be cility and each minor client e rights at all reasonable times ided in subsections (e) and (h) h minor client who is receiving ation in a 24-hour facility has ive telephone calls. All long be paid for by the client at the call or made collect to the ive mail and have access to ostage, and staff assistance ate supervision, receive e hours of 8:00 a.m. and 9:00 f at least six hours daily, two Il be after 6:00 p.m.; however ce precedence over school or al education and vocational nee with federal and State law; a daily and participate in play, rsical exercise on a regular e with his needs; ibited by law, keep and use nd possessions under ision, unless the client is being capacity to proceed pursuant to eligious worship; o individual storage space for personal belongings; o and spend a reasonable sum				

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,	CONSTRUCTION		
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		MHL009-024	B. WING		R 10/26/2022	
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
		1468 RIC	HARDSON RO	DAD		
ARULII	AS HOME CARE AG	BLADEN	BORO, NC 28	3320		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
V 364	Continued From pa	age 9	V 364			
	prohibited by Chap (e) No right enume of this section may by the qualified pro- formulation of the or plan. A written state client's record that for the restriction. The reasonable and relishabilitation needs. period not to excees each restriction shat qualified profession at which time the re- Each evaluation of documented in the rights may be rener statement entered the client's record the renewal of the restriction of ri- by the client shall, the be notified of the re- it. In the case of a re- adult client, the leg be notified of each or renewal of a ress reason for it. Notifici individual or legally documented in write	's license, unless otherwise ter 20 of the General Statutes. erated in subsections (b) or (d) be limited or restricted except fessional responsible for the client's treatment or habilitation ement shall be placed in the indicates the detailed reason The restriction shall be ated to the client's treatment of A restriction is effective for a ed 30 days. An evaluation of all be conducted by the nal at least every seven days, estriction may be removed. a restriction shall be client's record. Restrictions on wed only by a written by the qualified professional in that states the reason for the riction. In the case of an adult been adjudicated incompetent f an initial restriction or renewal ghts, an individual designated upon the consent of the client, estriction and of the reason for minor client or an incompetent ally responsible person shall instance of an initial restriction triction of rights and of the cation of the designated of responsible person shall be ting in the client's record.	r ,			
	ealth Service Regulation					

Division	of Health Service Re	egulation			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		MHL009-024	B. WING			R 26/2022
NAME OF I	PROVIDER OR SUPPLIER		T ADDRESS, CITY,	STATE ZIP CODE	1 100	
-		1468 1				
CARULI	NAS HOME CARE AG	BLAD	ENBORO, NC	28320		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
V 364	Continued From pa	ge 10	V 364			
	failed to ensure clie storage space for p	ion and interview, the facility ents had access to individua private use affecting 2 of 5 nts #4 and #5). The finding	I			
	10/25/22 revealed: -1 closet in the bed -1 bar inside the clo hanging clothes. -No clothing of either to be stored in the of -The closet was be include, but not limit -Out of service -Generator -Holiday decora	ing used for facility storage ted to, the following: chest freezer ations ontinent supplies				
		22 client #5 stated: at one would hang in a close ng in his closet "yesterday."	ət.			
	stated: -The generator had storage to the facili anticipation of a sto -The generator had		in			
	-She was not aware closet for facility sto -The generator had storage.	22 the Licensee stated: e the staff were using the prage. I been returned to offsite				
Division of H STATE FOR	ealth Service Regulation M		6899	E77K11	If continuati	on sheet 11 of 15

C

STATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		MHL009-024	B. WING			R 26/2022	
	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
		1468 RIC	HARDSON RO				
CAROLI	NAS HOME CARE AG	ENCY INC	BORO, NC 28				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE	
V 736	27G .0303(c) Facili	ty and Grounds Maintenance	V 736				
		303 LOCATION AND					
	EXTERIOR REQU						
		d its grounds shall be					
	maintained in a saf	e, clean, attractive and orderly					
		e kept free from offensive					
	odor.						
	This Rule is not me						
		ion and interview, the facility I in a safe, clean, attractive,					
	and orderly manner						
	Observation on 10/	25/22 between 11:55 am and					
	12:30 pm revealed:	:					
	-Hall bathroom:						
	shift underfoot.	squeaking sound and would					
		were covered with dust					
	particles.	were covered with dust					
		est in upper left corner of the					
	window.						
		90% of the ceiling was					
		discoloration with 3 small ly 2 inches in diameter, of					
		ng away from the surface.					
		ee-standing toilet paper holder					
	covered in rust cold						
		m door facing surface.					
		on the door frame for the					
	lock/latch mechanis Bedroom of clients						
		carpet stains at the foot of the					
		dow, extending approximately					
		om one side of the foot board					

Division of Health Service Re STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED R 10/26/2022	
		MHL009-024				
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CAROLII	NAS HOME CARE AG		HARDSON RO BORO, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	TION SHOULD BE COMPL THE APPROPRIATE DATE	
V 736	Continued From page 12		V 736			
	difficult to open and handle or knob to o -Client #5's dre not close. Left mid knob to open/close -Carpet frayed the kitchen into the This deficiency has	esser: 1 drawer off track and d close. 1 drawer had no open/close drawer. esser: Left top drawer would dle drawer had no handle or and worn on the steps from				
V 752	27G .0304(b)(4) Ho	ot Water Temperatures	V 752			
	EQUIPMENT (b) Safety: Each fa constructed and eq ensures the physic visitors. (4) In areas of exposed to hot wat	304 FACILITY DESIGN AND acility shall be designed, juipped in a manner that al safety of clients, staff and of the facility where clients are er, the temperature of the itained between 100-116 t.				
	Based on observat water temperatures 100-116 degrees F	et as evidenced by: ion and interview, the facility s were not maintained betweer ahrenheit in areas where ed to hot water. The findings				
	12:30 pm revealed	perature at the kitchen sink				

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.	A. BUILDING: B. WING					
		MHL009-024				R 10/26/2022		
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	DDRESS, CITY, STATE, ZIP CODE				
	NAS HOME CARE AG		HARDSON RO					
		BLADEN	IBORO, NC 28					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE		
V 752	Continued From page 13		V 752					
	 The hot water terr sink was 126 degree. The hot water terr in the hall bathroom. The hot water terr in client 2's room was in client 2's room was inclient 2's room and help hit temperature. He had "turned do thermostat on 10/26/. The hot water heat temperature setting a sett	 apperature at the hall bathroom sees Fahrenheit. apperature at the bathtub fauced in was 130 degrees Fahrenheit. as 126 degrees Fahrenheit. 22 client #3 stated: and will burn the hI out of indently adjust the water lid not burn her. 22 Staff #7 stated: client #1 in and out of the madjust the water wn" the hot water heater 5/22. ter thermostat had 3 printed gs and they were 90, 125, and water heater gauge to en the 90 and 125, trying to around 105 degrees. thermometer to measure the after he adjusted the hot water where between 115 and 120 e adjustment. of any procedure for staff to ecord hot water temperatures. 						
	water heater had be	een adjusted on 10/26/22 and ure had been confirmed to be						
	This deficiency con	stitutes a re-cited deficiency						

AND PLAN OF CORRECTION IDENTIFICATION I		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	CLIA (X2) MULTIPLE CONSTRUCTION ER: A. BUILDING: B. WING		COMF	SURVEY PLETED
		MHL009-024			R 10/26/2022	
AME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	TATE, ZIP CODE		
AROLIN	NAS HOME CARE AG	SENCY INC.	CHARDSON RO NBORO, NC 28			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLE THE APPROPRIATE DATE	
V 752	Continued From page 14		V 752			
	and must be corrected within 30 days.					