STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED C 01/25/2023	
OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: B. WING				
	MHL032-243					
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
OF CARE, INC			AD			
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
INITIAL COMMENT	rs	V 000				
25, 2023. The com	plaint was unsubstantiated					
category: 10A NCA	C 27G .5600C Supervised					
census of 3. The su	arvey sample consisted of					
27G .5602 Supervis	sed Living - Staff	V 290				
 (a) Staff-client ration numbers specified if of this Rule shall be enable staff to responeeds. (b) A minimum of compresent at all times premises, except whabilitation plan door capable of remaining without supervision as needed but not I the client continues the home or common specified periods of (c) Staff shall be profollowing client-staff child or adolescent (1) children or abuse disorders short of one staff present. How clients present. How clients present. 	bes above the minimum in Paragraphs (b), (c) and (d) e determined by the facility to ond to individualized client one staff member shall be when any adult client is on the then the client's treatment or cuments that the client is ng in the home or community . The plan shall be reviewed ess than annually to ensure to be capable of remaining in unity without supervision for f time. resent in a facility in the f ratios when more than one client is present: or adolescents with substance all be served with a minimum t for every five or fewer minor powever, only one staff need be					
	OF CORRECTION PROVIDER OR SUPPLIER DF CARE, INC SUMMARY STA (EACH DEFICIENCY REGULATORY OR L INITIAL COMMENT A complaint survey 25, 2023. The compl (intake #NC001973) This facility is licens category: 10A NCA Living for Adults wit This facility is licens category: 10A NCA Living for Adults wit This facility is licens census of 3. The su audits of 3 current of 27G .5602 Supervis 10A NCAC 27G .560 (a) Staff-client ration numbers specified of this Rule shall be enable staff to resp needs. (b) A minimum of co present at all times premises, except w habilitation plan door capable of remaining without supervision as needed but not I the client continues the home or common specified periods of (c) Staff shall be pure following client-staff child or adolescent (1) children of abuse disorders sh of one staff present. Ho present during slee	OF CORRECTION IDENTIFICATION NUMBER: MHL032-243 PROVIDER OR SUPPLIER STREET A DF CARE, INC S800 LAI DURHAM DURHAM SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS A complaint survey was completed on January 25, 2023. The complaint was unsubstantiated (intake #NC00197338). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 3 and currently has a census of 3. The survey sample consisted of audits of 3 current clients. 27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present:	OF CORRECTION IDENTIFICATION NUMBER: MHL032-243 A. BUILDING: B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST 5800 LAKE ELTON RO/ DURHAM, NC 27713 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG INITIAL COMMENTS V 000 A complaint survey was completed on January 25, 2023. The complaint was unsubstantiated (intake #NC00197338). Deficiencies were cited. V 000 This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. V 290 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimm numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. V 290 (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. C) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: C) the client continues to be capable of remaining in the home or community without supervision for specified periods of time. C) Staff shall be present in a facility	OF CORRECTION DENTIFICATION NUMBER: A. BUILDING: mHL032-243 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE DF CARE, INC S800 LAKE ELTON ROAD DURHAM, NC 27713 REQUIDEFCIENCY MUST BE PRECEDED BY FULL REGULATORY OR US 0 IDENTIFYING INFORMATION) PREFIX TAG PREFIX PREFIX (EACH DEFCIENCY MUST BE PRECEDED BY FULL REGULATORY OR US 0 IDENTIFYING INFORMATION) PREFIX TAG INITIAL COMMENTS V 000 A complaint survey was completed on January 25, 2023. The complaint was unsubstantiated (Intake #NC00197338). Deficiencies were cited. PREFIX This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. 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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-243			(X2) MULTIPLE		(X3) DATE SURVEY COMPLETED C 01/25/2023		
			A. BUILDING:				
		MHL032-243					
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE			
HOUSE	OF CARE, INC		KE ELTON RO	AD			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF			(X5)	
PREFIX TAG		CONTINUES OF THE CEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE DATE	
V 290	Continued From pa	ge 1	V 290				
	developmental disa one staff present for present and two sta more clients preser need be present du specified by the em determined by the of (d) In facilities which diagnosis is substa (1) at least on duty shall be trained withdrawal symptor secondary complicat drug addiction; and (2) the service	r adolescents with bilities shall be served with r every one to three clients aff present for every four or nt. However, only one staff iring sleeping hours if ergency back-up procedures governing body. ch serve clients whose primary nce abuse dependency: ne staff member who is on d in alcohol and other drug ns and symptoms of ations to alcohol and other d es of a certified substance nall be available on an					
	facility failed to asso unsupervised time supervision affectin clients (#1). The fin	view and interviews, the ess client's capability of having in the community without staff g one of three audited current dings are: of client #1's record revealed:					
	-Diagnoses of Seve Disability, Cerebral Osteoporosis, Hand Migraine Headache -There was no doct been assessed for	Palsy, Neurogenic Bladder, Contractures, History of and History of Sepsis. Sumentation that client #1 had					

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		Equilation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-243	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 01/25/2023	
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		01/	25/2025
			KE ELTON RO			
HOUSE	OF CARE, INC		I, NC 27713			
(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) COMPLET DATE
V 290	Continued From pa	ge 2	V 290			
	-When asked abou unsupervised, clien can go out in the co supervision. -Client #1 texted he local stores in the a the community whe facility. -Client #1 texted he -Client #1 texted he	3 with client #1 revealed: t going out into the community t #1 replied yes via text that he ommunity without staff e would normally go to several area, visit family and friends in en he was away from the e may go out twice a week. e may be out in the community enever he is away from the	•			
	-He started full time 2022. -Client #1 had beer without staff superv working at the facili -Client #1 would tel going prior to going -He confirmed the f	3 with staff #1 revealed: a the facility December 1, n going out into the community vion since he had been ty. I him when and where he is out into the community. Facility failed to assess client aving unsupervised time in the				
	revealed: -Client #1 can go or staff supervision. -Client #1 was his or going out without st facility. -No one ever broug needed to have an assessment for clie -Client #1 took local went out into the co	ent #1. Il transportation whenever he				

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA NID PLAN OF CORPECTION INFERTURE ATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION IDENTIFICATION NUM MHL032-243		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		MHL032-243	B. WING		C 01/25/2023	
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
IOUSE	OF CARE, INC		KE ELTON ROA	AD		
	-		M, NC 27713			
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V 290	Continued From pa	ige 3	V 290			
	unsupervised by sta weekend. -Client #1 goes out family and friends. at some of the stor -She confirmed the	but in the community aff for about 5-6 hours on the in the community to visit Client #1 also goes shopping				

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