PRINTED: 04/03/2024 FORM APPROVED

Division of Health Service Regulation

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Annual September 1997	PLE CONSTRUCTION  G:		E SURVEY IPLETED
	MHL032-613		B. WING		04/	R 03/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY	STATE, ZIP CODE	1 04/	03/2024
HOUSE	OF CARE, INC	DURHAN	BALL DRIV I, NC 27712			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	S	V 000			
	on April 3, 2024. De This facility is licens category: 10A NCAC Living for Adults with The facility is license	w up survey was completed ficiencies were cited.  ed for the following service C 27G .5600C Supervised in Developmental Disability.  ed for 6 and currently has a rivey sample consisted of lients.				
	PLAN (c) The plan shall be assessment, and in plegally responsible pof admission for clier receive services beyond the plan shall in (1) client outcome(sachieved by provision projected date of ach (2) strategies; (3) staff responsible (4) a schedule for reannually in consultating responsible person of (5) basis for evaluation of the possible party, or responsible party.	ASSESSMENT AND LITATION OR SERVICE  developed based on the partnership with the client or erson or both, within 30 days at the service and a s	V 112	RECEIVED APR 1 5 2024  DHSR-MH Licensure Sect		

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

TITLE Director

V 000  INITIAL COMMENTS  An annual and follow up survey was completed on April 3, 2024. Deficiencies were cited.  This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.  The facility is licensed for 6 and currently has a census of 4. The survey sample consisted of audits of 4 current clients.  V 112  27G .0205 (C-D)  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		PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		120 20 000000	PLE CONSTRUCTION G:		(X3) DATE SURVEY COMPLETED	
HOUSE OF CARE, INC  1118 KIMBALL DRIVE DURHAM, NC 27712  (A4) ID PREFIX FIGAH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 000  INITIAL COMMENTS  An annual and follow up survey was completed on April 3, 2024. Deficiencies were cited.  This facility is licensed for 6 and currently has a census of 4. The survey sample consisted of audits of 4 current clients.  V 112  27G. 0.205 (C-D) 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			MHL032-613	B. WING _		1		
CAJ ID   SUMMARY STATEMENT OF DEFICIENCIES   CACH DEFICIENCY   CEACH DEFICIENCY   SUMMARY STATEMENT OF DEFICIENCIES   CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   TAG   CROSS-REFERENCED TO THE APPROPRIATE   COMPILED AT TAG      V 000	NAME OF F	PROVIDER OR SUPPLIER			· · · · · · · · · · · · · · · · · · ·			
SUMMARY STATEMENT OF DEFICIENCIES   CIRCHED   PREFIX   CIRCH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   D PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SCHOOLD BE CROSS-REFERENCED TO THE APPROPRIATE   DATE OF THE PROPERTY	HOUSE	OF CARE, INC						
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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		on April 3, 2024. De This facility is license category: 10A NCAC Living for Adults with The facility is license census of 4. The sur	ed for the following service 27G .5600C Supervised Developmental Disability.  ed for 6 and currently has a rivey sample consisted of					
(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.		Assessment/Treatment 10A NCAC 27G .020 TREATMENT/HABIL PLAN  (c) The plan shall be assessment, and in plegally responsible per of admission for client receive services beyond in the plan shall industry and the plan shall industry as staff responsible; as staff responsible; as staff responsible; as schedule for responsible person of the plan shall industry as the plan shall be provided by provided the plan shall industry as the plan shall be provided by the plan shall be provided by the plan shall be plan	ASSESSMENT AND LITATION OR SERVICE  developed based on the partnership with the client or erson or both, within 30 days of the service and a dievement;  view of the plan at least on with the client or legally r both; on or assessment of at; and r agreement by the client or a written statement by the	V 112	See page 2.			

STATE FORM

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TITLE

If continuation sheet 1 of 9

(X6) DATE

	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G:		E SURVEY
		MHL032-613	B. WING			R
	PROVIDER OR SUPPLIER  OF CARE, INC	STREET AD	DRESS, CITY BALL DRIV , NC 27712		04	/03/2024
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DRE	(X5) COMPLETE DATE
V 112	Continued From pag	ge 1	V 112			
	interviews, the facilitimplement strategies four clients (#2). The Observation on 4/2/2 revealed: -Kitchen area-The borefrigerator had a wir attached to a hard plemagnet on the side of	on, record review and y failed to develop and is to meet the needs of one of e findings are:  14 at approximately 10:15 AM of the e going through the handle eastic black square with a		The Director and/or QP of Hou Care, Inc. will instruct the staff remove the lock attached to the refrigerator.  House of Care, Inc. iwll include restriction of locking the refrige in the Care Plan for Client #1  House of Care, Inc. shall discuss locking of the refrigerator in the Client Rights Committee meeting This to enable every client to as	to e the rator ss the ir	4/12/2024 6-4-2024 6-4-2024
	-The Associate Profethe refrigerator with a Reviews on 4/2/24 arrecord revealed: -Admission date of 6/-Diagnoses of Autism Disability, Bipolar I Difeatures, Hypertensio Kyphosis, Cleft Palate-Person Centered Plastrategies to address Interview with staff #1-The refrigerator was clients go to bed.	nd 4/3/24 of client #2's  15/15.  Moderate Intellectual sorder with psychotic n, Nocturnal Enuresis, e and Cerebral Palsy. In dated 6/1/23 had no stealing food.  on 4/3/24 revealed: normally locked when locked because client #2		the subject.		

ENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY
N OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
	i.			
	MHL032-613	B. WING		R 04/03/2024
PROVIDER OR SUPPLIER	STREET AT	DRESS CITY	STATE ZID CODE	07/03/2024
OF CARE, INC				
SUMMARY STA	TEMENT OF DEFICIENCIES			
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE COMPLETE
Continued From page	ge 2	V 112		
Professional/Superv-The refrigerator wa would take food and -Staff normally locke eveningsStaff had been lock monthsHe confirmed client address stealing foo Interview on 4/3/24 v Professional reveale-She was out of the cand returned in Nove-She was aware clien-She didn't know staff refrigeratorShe confirmed clien address stealing food	risor revealed: s locked because client #2 I hide in her room. ed the refrigerator in the ing the refrigerator for a few #2 had no strategies to d. with the Director/Qualified d: country for several months ember 2023. Int #2 would steal food. Iff were locking the t #2 had no strategies to d.			
10A NCAC 27G .020 REQUIREMENTS (e) Medication Storag (1) All medication sha (A) in a securely lock well-lighted, ventilated and 86 degrees Fahr (B) in a refrigerator, if degrees and 46 degrees refrigerator is used for shall be kept in a sep or container; (C) separately for each (D) separately for extended	9 MEDICATION  ge: all be stored: ed cabinet in a clean, d room between 59 degrees enheit; f required, between 36 ees Fahrenheit. If the or food items, medications arate, locked compartment ch client; ernal and internal use:	V 120	See page 4.	
	Continued From page Interview on 4/2/24 professional/Superv-The refrigerator wa would take food and -Staff normally locked eveningsStaff had been lock monthsHe confirmed client address stealing food Interview on 4/3/24 professional revealershe was out of the confirmed in Nove-She was aware cliently and returned in Nove-She was aware cliently and returned cliently and refrigeratorShe confirmed cliently address stealing food 27G .0209 (E) Medication Storage (1) All medication shad (A) in a securely lock well-lighted, ventilater and 86 degrees Fahr (B) in a refrigerator, it degrees and 46 degrees fahr (B) in a refrigerator is used for shall be kept in a sepor container; (C) separately for each (D) separately for external services and separately for external separately for external services and separately for external services and separately for external separat	MHL032-613  PROVIDER OR SUPPLIER  OF CARE, INC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 2  Interview on 4/2/24 with the Associate Professional/Supervisor revealed:  -The refrigerator was locked because client #2 would take food and hide in her room.  -Staff normally locked the refrigerator in the evenings.  -Staff had been locking the refrigerator for a few months.  -He confirmed client #2 had no strategies to address stealing food.  Interview on 4/3/24 with the Director/Qualified Professional revealed:  -She was out of the country for several months and returned in November 2023.  -She was aware client #2 would steal foodShe didn't know staff were locking the refrigeratorShe confirmed client #2 had no strategies to address stealing food.  27G .0209 (E) Medication Requirements  10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician	PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, 1118 KIMBALL DRIVIDURHAM, NC 27712  SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 2  Interview on 4/2/24 with the Associate Professional/Supervisor revealed: -The refrigerator was locked because client #2 would take food and hide in her roomStaff normally locked the refrigerator for a few monthsHe confirmed client #2 had no strategies to address stealing food.  Interview on 4/3/24 with the Director/Qualified Professional revealed: -She was out of the country for several months and returned in November 2023She was aware client #2 would steal foodShe didn't know staff were locking the refrigeratorShe confirmed client #2 had no strategies to address stealing food.  27G .0209 (E) Medication Requirements  V 120  10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician	PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  118 KIMBALL DRIVE DURHAM, NC 27712  SUMMARY STATEMENT OF DEFICIENCIES (ACAH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 2  Interview on 4/2/24 with the Associate Professional/Supervisor revealed: -The refrigerator was locked because client #2 would take food and hide in her roomStaff normally locked the refrigerator in the eveningsStaff had been locking the refrigerator for a few monthsHe confirmed client #2 had no strategies to address stealing food.  Interview on 4/3/24 with the Director/Qualified Professional revealed: -She was aware client #2 would steal foodShe didn't know staff were locking the refrigeratorShe confirmed client #2 had no strategies to address stealing food.  27G .0209 (E) Medication Requirements  V 120  See page 4.  See page 4.

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		MHL032-613	B. WING _		04	R /03/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CODE	1 04	103/2024
HOUSE	OF CARE, INC	1118 KIMI	BALL DRIV	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICE)	DRF	(X5) COMPLETE DATE
V 120	for a client to self-m (2) Each facility that controlled substance registered under the	edicate. maintains stocks of es shall be currently North Carolina Controlled 5. 90, Article 5, including any	V 120			
	medications were ke compartment or conficients (#1). The find Observation on 4/2/2 revealed: -There was a bottle of (milligrams) mg/5 mill Disorder) medication #1The medication was -The dispense date of -There were various is stored with the Gabal Review on 4/2/24 of of -Admission date of 7/2-Diagnoses of Moderal Irritable Bowel Syndro ArthritisPhysician's order date 250 mg/5 ml Solution.	in, record review and y failed to ensure refrigerated pt in a separate, locked tainer affecting one of four dings are:  4 at approximately 10:15 AM of Gabapentin 250 diliters (ml) Solution (Seizure in the refrigerator for client not in a locked box. In the bottle was 3/21/24. If so ditems in the refrigerator pentin for client #1.  Slient #1's record revealed: 1/14. Intellectual Disability, ome, Seizure Disorder and sted 2/21/24 for Gabapentin take 15 ml at bedtime.		QP/Director of House of Care, Ir shall purchase a locked box for medicationthat needs to be refrigive. No medicatons shall be stored ir refrigerator without a locked box	gerated	4-11-2024
doing of Han		or revealed: Gabapentin for client #1				

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	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY
		——————————————————————————————————————	A. BUILDIN	G:	COM	PLETED
		MHL032-613	B. WING_			R <b>03/2024</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY	, STATE, ZIP CODE		11
HOUSE	OF CARE, INC		BALL DRIV			
			I, NC 2771	2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBF	(X5) COMPLETE DATE
V 120	Continued From page	ge 4	V 120			
V 512	refrigerator about a refrigerated medicat locked compartment Interview on 4/3/24 v Professional reveale -She didn't know the in the refrigerator an -She acknowledged refrigerated medicati locked compartment	ng the Gabapentin in the month or two ago. he facility failed to ensure ions were kept in a separate, tor container.  with the Director/Qualified d: medication for client #1 was d not in a locked box. the facility failed to ensure ions were kept in a separate, or container.				
	that promote a safe at These include:  (1) using the leappropriate settings at (2) promoting of skills that are alternative self or others;  (3) providing chameaningful to the clie (4) sharing of country the client/legally responsible. The use of a restrict procedure designed to always be accompanially insure dignity and responsible.	I provide services/supports and respectful environment.  ast restrictive and most and methods; coping and engagement cives to injurious behavior to noices of activities and ontrol over decisions with possible person and staff. rictive intervention or reduce a behavior shall ed by actions designed to pect during and after the	V 513	See page 3 and 4.		

	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DA	TE SURVEY
AND PLAI	NOF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G:		MPLETED
		MHL032-613	B. WING _		04	R / <b>/03/2024</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY	, STATE, ZIP CODE	1 04	10012024
HOUSE	OF CARE INC		BALL DRIV			
HOUSE	OF CARE, INC		NC 27712			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	2N	
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR LS	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DRE	(X5) COMPLETE DATE
V 513	Continued From page	70 F	V 540	DEFICIENCY)		
* 010	р-,	ge 5	V 513			
	and	0.00				
	(2) employing trained in its use.	the intervention by people				
	trained in its use.					
	This Rule is not me	t as evidenced by:				
	failed to provide sen	on and interviews, the facility				
	restrictive and most	appropriate methods				
	affecting four of four	clients (#1, #2, #3 and #4).				
	The findings are:	(" ', " =, " o and " ').				
	01					
	Observation on 4/2/2 revealed:	24 at approximately 10:15 AM				
	-Kitchen area-The bo	ottom portion of the				
	refrigerator had a wir	re going through the handle				
	attached to a hard pl	astic black square with a				
	magnet on the side of	of the refrigerator.				
		e on the front portion of the		Soo page 2 and 4		
	refrigerator door.			See page 3 and 4.		
	the refrigerator with a	essional/Supervisor unlocked				
	me remgerator with a	a Ney.				
	Interview on 4/3/24 w	vith client #1 revealed:				
	-The refrigerator was					
	-She was told "it was	locked for their safety."				
	Intention with staff #	1 on 4/2/24 several at	li li			
	Interview with staff #	normally locked when				
	clients go to bed.	normally locked when				
		locked because client #2				
	would take food and l	hide it in her room.				
	-When she returned t	to the facility in October				
	2023 staff were lockir	ng the refrigerator.				
	Intension on 4/0/04	ith the Associate				
	Interview on 4/2/24 w Professional/Supervis					
	alth Service Pegulation	sor revealed.				

	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE		_
			A. BUILDIN	G:	COMP	PLETED	
		MHL032-613	B. WING _			R 0 <b>3/2024</b>	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY	, STATE, ZIP CODE			
HOUSE	OF CARE, INC		BALL DRIV				
	SUBMASS 2	The state of the s	I, NC 2771	2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT 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	(X5) COMPLETE DATE	
V 513	Continued From pag	ge 6	V 513				_
	-The refrigerator wa would take food and -Staff normally locked eveningsStaff had been lock monthsClient #2's mother be refrigeratorWhenever the refrigedon't have a key and -He didn't realize the the refrigerator.  Interview on 4/3/24 where the refrigerator in the refrigerator in the condition of the condition of the condition of the condition of the condition in the refrigerator.	s locked because client #2 I hide in her room. Indicated the refrigerator in the sing the refrigerator for a few brought that lock for the greator was locked the clients I can't get into it. In y were not allowed to lock with the Director/Qualified discountry for several months ember 2023.	V 736				
	10A NCAC 27G .030 EXTERIOR REQUIR (c) Each facility and it maintained in a safe, manner and shall be odor.  This Rule is not met Based on observatior was not maintained ir orderly manner and k The findings are:  Observation on 4/2/24 revealed: -Den area-Triangle sh	3 LOCATION AND EMENTS ts grounds shall be clean, attractive and orderly kept free from offensive	V 736	House of Care, Inc. will continue to submitt service requests for repair to the walls in the dining area and throughtout the home.  House of Care, Inc. will also purch new window coverings for the living room and other rooms as needed.  House of Care Inc. will submit inforthe property owner of the peeling on the hand rails leading to the frodoor.	nase 6	On-going 6-4-2024 6-4-2024	

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	O(a) DAT	E 01101 (E)	
AND PLAI	N OF CORRECTION	IDENTIFICATION NUMBER:		G:	COM	E SURVEY	
			A. BUILDIN	3	001	III LL I LD	
		MIII 000 040	D MINO			R	
		MHL032-613	B. WING _		04/	/03/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CCDE			
HOUSE	OF CARE, INC	1118 KIM	BALL DRIV	E			
HOUSE	OF CARE, INC		, NC 27712				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION			_
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL)	DRF	(X5) COMPLETE	
TAG	REGULATURY OR ES	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF	RIATE	DATE	
				DEFICIENCY)			
V 736	Continued From page	ge 7	V 736				
	was approximately 2	2 inches long and 3 inches					
	wide. A hole in wall	was about the size of a plum.					
	One set of blinds ha	d one slat missing. All 3 sets					
	of blinds had a build	up of dust. Curtains were					
	stained and had a te	ear approximately 4 inches					
	long. Table had a cra	ack approximately 2 inches					
	long and 2 inches w	ide, another crack in table					1
		inches wide and 6 inches					1
	long.	:					1
	paint.	ing up to steps had peeling					1
		n-Walls had crayon markings,		See page 7			1
	approximately 40 pir	sized holes, grease stains. 7		See page 7			١
	blind slats were brok	ten on the ends					İ
	-Client #1's bedroom	n-Strong musty odor. The					١
	walls had approxima	tely 200 pin sized holes and					1
	black/brown scruff m	narks. Bedroom door had					1
	scruff marks and dirt						١
	-Bathroom in client #	1's bedroom-Walls had					ł
	pencil markings, brow	wn stains and peeling paint.					1
	-Client #6's bedroom	-Strong urine smell. Walls					ı
	nad crayon markings	s, pencil markings, peeling					ı
	sized holes. The had	nd approximately 60 pin room door had black and					ı
	brown stains Smalle	r window had a build up of					l
	dust.	window had a build up of					ı
	-Hallway-Walls brown	n stains, black stains and					ı
	scuff marks.	,		House of Core Inc. to otaff will a			l
	-Client #3's bedroom-	-Strong body odor smell.		House of Care, Inc.'s staff will as the Member in deep cleaning Cli	SSIST	6-15-2024	1
	Walls had scuff mark	s and grease stains. The		#3's bedroom.	ent		l
	dresser had 2 handle	s missing. The bedroom		T C DOGIOGITI.			
	door had an orange s	stain, brownish stains and		House of Care, Inc. will also hav	e		
	peeling paint.			have the carpets deep cleaned f	or		
	-upstairs bathroom-T	he soap and toothbrush		all carpeted areas in the home		6-4-2024	
	moider nad a build up	dust. The mirror had black					
	markings.						
	Interview on 4/2/24 w	ith the Associate					
	Professional/Supervis						
	-Client #1 was respon	sible for some of the					
		ionale for dolline of the					į.

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: A. BUILDING: B. WING \_\_\_ MHL032-613 04/03/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

HOUSE OF CARE, INC

1118 KIMBALL DRIVE

HOUSE	DE CARE, INC.	M, NC 27712		
(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 736	Continued From page 8 property damage to the facilityThe landlord was aware of some the	V 736	House of Care, Inc. has contacted the Landlord for the reapirs of the listed items indicated.	On-going
	maintenance issues with the facility.  -The landlord repaired some of those maintenance issues.  -"They would make repairs to the facility and they have to fix it again."		If the Landlord refused to comply with fixing the home, House of Care, Inc. will contact a contractor to fix the areas tht are siptulated in this citation.	On-going
	<ul> <li>-He confirmed the facility was not maintained in a safe, clean, attractive, orderly manner and kept free from offensive odor.</li> </ul>		The Staff of House of Care, Inc. shall conduct daily cleaining, dusting, and keeping all areas clean.	On-going
			The Director/QP will make unannounced visists to inspect the home.	On-going
ion of Hon				

Division of Health Service Regulation

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