| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | , , | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | MHL092-833 | | B. WING | | I | R 31/2024 |
| NAME OF F | PROVIDER OR SUPPLIER | | DDRESS, CITY, S | TATE, ZIP CODE | 1 017 | 0 17 2 0 2 - |
| | | | ON ROAD | | | |
| CARE O | NE HOMES | RALEIGH | I, NC 27610 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY) | SHOULD BE | (X5) COMPLETE DATE |
| V 000 | INITIAL COMMENT | -S | V 000 | | | |
| | on July 31, 2024. D | w up survey was completed eficiencies were cited. | | | | |
| | category: 10A NCA Living for Adults wit | | | | | |
| | census of 4. The su | sed for 6 and has a current urvey sample consisted of clients. | | | | |
| V 118 | 27G .0209 (C) Med | ication Requirements | V 118 | | | |
| | audits of 3 current clients. V 118 27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and | | | | | |

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

| T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | E CONSTRUCTION | I \ / | (X3) DATE SURVEY COMPLETED | |
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| | | A. BUILDING: | A. BUILDING: | | R | |
| | MHL092-833 | B. WING | | | 31/2024 | |
| ROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, S | STATE, ZIP CODE | | | |
| NE HOMES | | | | | | |
| (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL | ID PREFIX TAG | (EACH CORRECTIVE ACTION S | HOULD BE | (X5) COMPLETE DATE | |
| (5) Client requests checks shall be rec file followed up by a with a physician. | for medication changes or orded and kept with the MAR appointment or consultation | V 118 | | | | |
| interview, the facilit was kept current af (#1). The findings at Review on 7/30/24 - Admitted 6/15/- Diagnoses of PAtaxia, Essential HyHistory of Seizure Depression, Diverti Dependence Disord Disease, Mild Intelled Disability & Psychological Psychologica | y failed to ensure the MAR fecting 1 of 3 audited clients are: of client #1's record revealed: 15 'aranoid Schizophrenia, ypertension, Hyperlipidemia, Disorder, History of culitis, Epilepsy, Alcohol der, Gastroesophageal Reflux ectual Developmental sis rder dated 2/8/24: Food Ensure) one can per day with the client #1's May, June & July ed: Light Oral Liquid Drink one can (three per day (TID)) and a snack if not eating d from May 1st-31st at 8am, ting the Ensure was | | | | | |
| | PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa (5) Client requests checks shall be rec file followed up by a with a physician. This Rule is not me Based on observati interview, the facility was kept current af (#1). The findings at Review on 7/30/24 Admitted 6/15/ Diagnoses of P Ataxia, Essential Hy History of Seizure D Depression, Diverti Dependence Disord Disease, Mild Intelle Disability & Psycho A physician's of Supplement Drink (meals (Supplement Review on 7/30/24 2024 MARs reveale Ensure Active L per day with meals drink one with each Staff #1 initialed 12pm & 5pm indica administered Staff #1 initialed | MHL092-833 PROVIDER OR SUPPLIER STREET AE 926 EDIS RALEIGH SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the MAR was kept current affecting 1 of 3 audited clients (#1). The findings are: Review on 7/30/24 of client #1's record revealed: - Admitted 6/15/15 - Diagnoses of Paranoid Schizophrenia, Ataxia, Essential Hypertension, Hyperlipidemia, History of Seizure Disorder, History of Depression, Diverticulitis, Epilepsy, Alcohol Dependence Disorder, Gastroesophageal Reflux Disease, Mild Intellectual Developmental Disability & Psychosis - A physician's order dated 2/8/24: Food Supplement Drink (Ensure) one can per day with meals (Supplement) Review on 7/30/24 of client #1's May, June & July 2024 MARs revealed: - Ensure Active Light Oral Liquid Drink one can per day with meals (three per day (TID)) and drink one with each snack if not eating - Staff #1 inititaled from May 1st-31st at 8am, 12pm & 5pm indicating the Ensure was | MHL092-833 B. WING WHOMES STREET ADDRESS, CITY, S 926 EDISON ROAD RALEIGH, NC 27610 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the MAR was kept current affecting 1 of 3 audited clients (#1). The findings are: Review on 7/30/24 of client #1's record revealed: - Admitted 6/15/15 - Diagnoses of Paranoid Schizophrenia, Ataxia, Essential Hypertension, Hyperlipidemia, History of Seizure Disorder, History of Depression, Diverticulitis, Epilepsy, Alcohol Dependence Disorder, Gastroesophageal Reflux Disease, Mild Intellectual Developmental Disability & Psychosis - A physician's order dated 2/8/24: Food Supplement Drink (Ensure) one can per day with meals (Supplement) Review on 7/30/24 of client #1's May, June & July 2024 MARs revealed: - Ensure Active Light Oral Liquid Drink one can per day with meals (three per day (TID)) and drink one with each snack if not eating - Staff #1 initialed from May 1st-31st at 8am, 12pm & 5pm indicating the Ensure was administered - Staff #1 initialed from June 1st-30th at 8am, | A BUILDING: B. WING | MHL092-833 B. WING O77. ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 926 EDISON ROAD RALEIGH, NC 27610 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION) Continued From page 1 (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the MAR was kept current affecting 1 of 3 audited clients (#1). The findings are: Review on 7/30/24 of client #1's record revealed: - Admitted 6/15/15 - Diagnoses of Peranoid Schizophrenia, Ataxia, Essential Hypertension, Hyperlipidemia, History of Seizure Disorder, History of Depression, Diverticulitis, Epilepsy, Alcohol Dependence Disorder, Gastroesophageal Reflux Disease, Mild Intellectual Developmental Disability & Psychosis - A physician's order dated 2/8/24: Food Supplement Drink (Ensure) one can per day with meals (Supplement) Review on 7/30/24 of client #1's May, June & July 2024 MARs revealed: - Ensure Active Light Oral Liquid Drink one can per day with meals (three per day (TID)) and drink one with each snack if not eating - Staff #1 initialed from May 1st-31st at 8am, 12pm & Spm indicating the Ensure was administered - Staff #1 initialed from June 1st-30th at 8am, | |

Division of Health Service Regulation

STATE FORM RSCE11 If continuation sheet 2 of 10

| AND BLAN OF CORRECTION \ \ \ \ IDENTIFICATION NUMBER: \ \ \ \ \ \ | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
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| | | | | R | | |
| | | MHL092-833 | B. WING | | 07/3 | 1/2024 |
| NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| CARE O | NE HOMES | 926 EDISC RALEIGH | ON ROAD , NC 27610 | | | |
| (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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| V 118 | Continued From pa | nge 2 | V 118 | | | |
| | 12pm & 5pm & 8ar Ensure was admini | d from July 1st -30th at 8am, n on July 31st indicating the istered 9am on 7/30/24 revealed: | | | | |
| | - No Ensure in the | ne facility | | | | |
| | - Was supposed meals, but he hadn - "Been a long til - Couldn't recall Interviews on 7/30/ - Client #1 didn't - Client #1 drank #1 ran out of his Er - He initialed the administered the E - Initialing client administered the E - Was trained to administered the cl - He made a mis out of Ensure two whis Ensure on Mon - Told the Regist | me" since he had an Ensure the last time he had an Ensure 24 & 7/31/24 staff #1 reported: have any Ensure in the facility Ensure everyday, but Client asure two weeks ago MARs indicating that he nsure to client #1 #1's MARs indicating he nsure was "my mistake" sign the MAR after he ients' medications stake by saying client #1 ran eveeks ago; client #1 ran out of day (7/29/24) ered Nurse (RN)/Qualified Licensee that client #1 was out | | | | |
| | - The RN/QP/Lic | y (7/30/24) censee purchased client #1's it them to the facility today | | | | |
| | reported: - Was unaware of the was unaware s | 4 the RN/QP/Licensee client #1 had ran out of Ensure staff #1 signed client #1's administered client #1 his | | | | |

Division of Health Service Regulation

STATE FORM RSCE11 If continuation sheet 3 of 10

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
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| MUI 002 922 | | B. WING | | R 07/31/2024 | | |
| | | MHL092-833 | B. WINO | | 07/3 | 31/2024 |
| NAME OF | PROVIDER OR SUPPLIER | | , , | STATE, ZIP CODE | | |
| CARE O | NE HOMES | 926 EDIS RALEIGH | ON ROAD , NC 27610 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETE DATE |
| V 118 | Continued From pa | ge 3 | V 118 | | | |
| | · | sign the clients MARs after | | | | |
| V 291 | 27G .5603 Supervis | sed Living - Operations | V 291 | | | |
| | six clients when the developmental disa on June 15, 2001, at than six clients at the provide services at licensed capacity. (b) Service Coording maintained between qualified profession treatment/habilitation (c) Participation of Responsible Person provided the opport relationship with he means as visits to the facility. Reports annually to the parelegally responsible Reports may be in conference and shaprogress toward med (d) Program Activitiant activity opportunitien needs and the treat Activities shall be dinclusion. Choices or legal system is in | OPERATIONS cility shall serve no more than a clients have mental illness or bilities. Any facility licensed and providing services to more nat time, may continue to no more than the facility's nation. Coordination shall be a the facility operator and the als who are responsible for on or case management. The Family or Legally and the facility and visits outside a shall be submitted at least and of a minor resident, or the person of an adult resident. Writing or take the form of a all focus on the client's a teeting individual goals. The seed on her/his choices, ment/habilitation plan. The seigned to foster community may be limited when the court and primary concern. | | | | |

6899

Division of Health Service Regulation STATE FORM

RSCE11 If continuation sheet 4 of 10

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE A. BUILDING: | CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|--|--|-----------------------------------|--------------------------|
| | | MHL092-833 | B. WING | | | R 31/2024 |
| | PROVIDER OR SUPPLIER | 926 EDIS | ODRESS, CITY, ST ON ROAD I, NC 27610 | TATE, ZIP CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| V 291 | This Rule is not me Review on 7/30/24 - Admitted 6/15// - Diagnoses of P Ataxia, Essential Hy History of Seizure D Depression, Diverti Dependence Disord disease, Mild Intelle & Psychosis - A physician's of Supplement Drink of (Supplement) Review on 7/30/24 2024 MARs reveale - Ensure Active L per day with meals drink one with each 12pm & 5pm indicated administered - Staff #1 initialed 12pm & 5pm indicated administered - Staff #1 initialed 12pm & 5pm & 8an Ensure was administered - Staff #1 initialed 12pm & 5pm & 8an Ensure was administered - Staff #1 initialed 12pm & 5pm & 8an Ensure was administered - Staff #1 initialed 12pm & 5pm & 8an Ensure was adminicated 12pm & 5pm & 8an | et as evidenced by: of client #1's record revealed: 15 laranoid Schizophrenia, ypertension, Hyperlipidemia, Disorder, History of culitis, Epilepsy, Alcohol der, Gastroesophageal reflux ectual Developmental Disability order dated 2/8/24: Food one can per day with meals of client #1's May, June & July ed: light Oral Liquid Drink one can (three per day (TID)) and a snack if not eating d from May 1st-31st at 8am, ting the Ensure was of from June 1st-30th at 8am, ting the Ensure was ed from July 1st -30th at 8am, on on July 31st indicating the stered Oam on 7/30/24 revealed: he facility 24 client #1 reported: to drink Ensure with his | | | | |

Division of Health Service Regulation

STATE FORM RSCE11 If continuation sheet 5 of 10

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--|--|---|-----------------------|---|-------------------------------|--------------------------|
| | | A. BOILDING. | | R | | |
| | | MHL092-833 | B. WING | | | 1/2024 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| CARE O | NE HOMES | 926 EDISC RALEIGH | ON ROAD , NC 27610 | | | |
| (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 APPROI DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| V 291 | - Client #1 drunk #1 ran out of Ensur - The Registered Professional (QP)/L purchasing client # - Made a mistake Ensure two weeks a Ensure on Monday - Told the RN/QF out of Ensure yeste - The RN/QP/Lic Ensure and brough (7/31/24) Interview on 7/31/24 reported: - Was unaware of Staff #1 was succlient #1 had 7 Ensure - She could've section #1 more Ensure - Staff #1 "forget - Staff #1 called that client #1's drunt (7/30/24) | have any Ensure in the facility Ensure everyday, but Client e two weeks ago Nurse (RN)/Qualified cicensee was responsible for l's Ensure e by saying client #1 ran out of ago; client #1 ran out of his (7/29/24) P/Licensee that client #1 was erday (7/30/24) ensee purchased client #1's t them to the facility today 4 the RN/QP/Licensee client #1 had ran out of Ensure pposed to notify her when ure left so she could purchase ent staff #1 money to purchase are s a lot" her yesterday (7/30/24) and k his last Ensure that morning client #1's Ensure and took it | V 291 | | | |
| V 513 | 27E .0101 Client Ri Alternative | ghts - Least Restrictive | V 513 | | | |
| | that promote a safe These include: | 01 LEAST RESTRICTIVE all provide services/supports and respectful environment. | | | | |

Division of Health Service Regulation

STATE FORM RSCE11 If continuation sheet 6 of 10

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | | (Y2) MI II TIDI | E CONSTRUCTION | (X3) DATE | SLIBVEV |
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| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | . , | | COMPLETED | | |
| | | | A. BUILDING. | | R | |
| MHL092-833 | | B. WING | | | 1/2024 | |
| | | MITICU92-833 | | | 07/3 | 1/2024 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| CARE O | NE HOMES | 926 EDIS0 | _ | | | |
| | | RALEIGH | , NC 27610 | | | , |
| (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 CROSS-REFERENCED TO THE APPROPERTION OF THE APPROPERTIES OF THE A | D BE | (X5) COMPLETE DATE |
| V 513 | Continued From pa | ge 6 | V 513 | | | |
| | skills that are altern self or others; (3) providing meaningful to the client/legally residue (4) sharing of the client/legally residue (b) The use of a reprocedure designed always be accompainsure dignity and reintervention. These (1) using the and | coping and engagement atives to injurious behavior to choices of activities lients served/supported; and control over decisions with sponsible person and staff. strictive intervention to reduce a behavior shall anied by actions designed to espect during and after the | | | | |
| | failed to use the lead appropriate method Observations at 9:2 9:36am and 10:30a - Staff #1 used k | on and interview, the facility st restrictive and most l. The findings are: 6am on 7/30/24 and at m on 7/31/24 revealed: eys to unlock the kitchen door of the living room area | | | | |
| | - The kitchen doo clients couldn't go in Interview on 7/30/24 | or was locked after meals so the kitchen and take food 4 client #2 reported: e kitchen door locked after | | | | |

6899

Division of Health Service Regulation STATE FORM

RSCE11 If continuation sheet 7 of 10

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|---|---|---|-----------------------|--|-------|--------------------------|
| | | A. BOILDING. | | R | | |
| | | MHL092-833 | B. WING | | 1 | 1/2024 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| CARE O | NE HOMES | 926 EDISC RALEIGH | ON ROAD , NC 27610 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| V 513 | Interview on 7/30/2 The kitchen doclients couldn't go i Interview on 7/31/2 He "always keet to a former client at of the kitchen The Registered Professional (QP)/L kitchen door locked He kept the kitcyear (2023), but constarted Wanted to keel access to knives in like the way need anything I'll gi Interview on 7/31/24 reported: Was unaware to locked Saw the kitchen and told staff #1 to locked Couldn't recall the kitchen door un like in like way need anything I'll gipter in locked Saw the kitchen and told staff #1 to like kitchen door un like in like | 4 client #4 reported: or was locked after meals so in the kitchen and eat food 4 staff #1 reported: ep it (kitchen door) locked" due and client #4 stealing food out 8 Nurse (RN)/Qualified cicensee told him to keep the chen door locked since last uldn't recall exactly when he of the clients from having the kitchen it's going nowif they (clients) we it to them" 8 the RN/QP/Licensee the kitchen door was kept and door locked during a visit leave the door unlocked when she told staff #1 to keep | V 513 | | | |
| V 736 | 10A NCAC 27G .03 EXTERIOR REQUI (c) Each facility and | ty and Grounds Maintenance 303 LOCATION AND IREMENTS It its grounds shall be e, clean, attractive and orderly | V 736 | | | |
| | | e kept free from offensive | | | | |

Division of Health Service Regulation

STATE FORM RSCE11 If continuation sheet 8 of 10

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ′ | CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--|---|--|-------------------------|---|-------------------------------|--------------------------|
| | | MHL092-833 | B. WING | | | R 31/2024 |
| NAME OF | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| CARE O | NE HOMES | | SON ROAD H, NC 27610 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETE DATE |
| V 736 | odor. This Rule is not me Based on observation at 9:39 following: Client #1's room: - 2 out of 3 lights Spare bedroom: - brown spots sp closet door - water stains on - small circular h bedroom door - air vent in the lower was rusted and dus Upstairs bathroom: - 2 out of 3 lights - paint peeling up the wall - vent in the lower coming apart Upstairs hallway: - beeping smoke Downstairs bathrood - toilet paper hole Interview on 7/30/2- - was responsible - the Registered | et as evidenced by: on and interview, the facility in a clean & attractive gs are: Dam on 7/30/24 revealed the ulbs were not working lashed on the front of the the wall inside the closet ole in the wall behind the ower wall under the window sty ulbs were not working nder the light plate cover on er wall very rusty, dirty and detector m: der broken and missing 4 staff #1 reported: e for cleaning the facility Nurse (RN)/Qualified cicensee was responsible for | V 736 | | | |

Division of Health Service Regulation

STATE FORM RSCE11 If continuation sheet 9 of 10

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---|---|-------------------------------|--------------------------|
| | | | A. BUILDING: | | | , |
| | | MHL092-833 | B. WING | | | ⋜ 31/2024 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| CARE O | NE HOMES | 926 EDISC RALEIGH | ON ROAD , NC 27610 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETE DATE |
| V 736 | - was unaware the he would change the battery in the srice things in the facility could - the stains in the former client Interview on 7/30/24 reported: - was responsible the facility - she repaired so cited in the previous Regulation survey - staff #1 was restacility - was "very particulative facility - planned to repassore bedroom - there was a stofacility and she was replaced the blown | ne light bulbs weren't working ge the blown light bulbs and moke detector ensee asked if he could repair and he repaired the things he espare bedroom were from a 4 the RN/QP/Licensee e for overseeing the repairs in ome of the issues that were so Division of Health Service esponsible for cleaning the cular" with the cleanliness of air and paint the walls in the espace of light bulbs in the shocked that staff #1 hadn't light bulbs estitutes a re-cited deficiency | V 736 | | | |

Division of Health Service Regulation STATE FORM

RSCE11 If continuation sheet 10 of 10