Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVE	Υ
			A. BUILDING: _			
		MHL049-100	B. WING		08/21/20	24
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CAMELOT	Г		HESTER LAN			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE CO	DATE
V 000	INITIAL COMMENTS		V 000			
	An annual survey was 2024. Deficiencies we	s completed on August 21, ere cited.				
	category: 10A NCAC	d for the following service 27G .5600C Supervised Developmental Disabilities.				
	-	d for 3 and has a current vey sample consisted of ents.				
V 112	27G .0205 (C-D) Assessment/Treatme	nt/Habilitation Plan	V 112			
	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 beyo (d) The plan shall inc	ond 30 days.				
	achieved by provision projected date of ach (2) strategies;					
	(3) staff responsible	; view of the plan at least				
	annually in consultation responsible person of (5) basis for evaluat					
	outcome achievemen					
		a written statement by the such consent could not be				

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

(X6) DATE TITLE

Division of Health Service Regulation

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		MHL049-100	B. WING		08	3/21/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE	·	
CAMELO	-	3329 WI	NCHESTER LANE			
CAMELO	l	STATES	VILLE, NC 28625			
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 112	Continued From page	e 1	V 112			
	strategy of independe	n, record review and refailed to implement the ently refraining for urinating the toilet for 1 of 3 current				
	bedroom revealed: -A strong odor of urin	24 at 4:08pm of client #1's e vith the 4th drawer that was				
	-An admission date of -Diagnoses of Moder. Vitamin D Deficiency. Unspecified, Bipolar I Disruptive Mood Dysl Bilateral, Unspecified Other Specified Urina of Leg Perthes -Age 45 -An assessment date stature, is ambulatory limp resulting from hig age 9, is healthy and likes to be active, use gestures and moving communicate, he can as well, however his significant production.	ate Intellectual Disabilities, , Hypercholesterolemia, Disorder, Unspecified, regulation Disorder, Myopia, Asthma Uncomplicated and ary Incontinence and History d 7/8/05 noted "is short of v although he walks with a p replacement surgery at wears prescription glasses, es his facial expressions, toward or away to a communicate with words				

Division of Health Service Regulation

STATE FORM 6899 YF8Z11 If continuation sheet 2 of 9

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURV COMPLETED	
		MHL049-100	B. WING		08/21/2	024
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		3329 WII	NCHESTER LANE			
CAMELOT	Г		VILLE, NC 28625			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	DATE
V 112	Continued From page	e 2	V 112			
	three words, likes so enjoys going on com agitated when staff a not preferences, can a supervised area who during tantrum behave personal boundaries will go through states frequent portions of frespecially at night." -A treatment plan dat independently refrain other than the toilet (The facility staff failed	cializing with others and munity outings, may get sks him to do things that are escalate quickly, may leave nen upset, and is more likely vior and staff should help set between him and his peers, s where his is likely to take				
	revealed: -A Behavior Support "Inappropriate Toiletin accidents i.e. on hims shower, in clothes had of room, etc, Strategin him for reminders to his day. With age and times accidents may neutral regardless of clean his room, provi and organize in a rearemain neutral when him to clean the area independence as posattention, through tall other staff in front of soiled linens or clothi with cleaners to limit constant supervision	Plan dated 11/1/23 noted ng: Intentional toileting self, in the closet, in the amper, in the bathtub, corner les include: routinely prompt use the bathroom throughout dimedical complications, at be unintentional, remain intent, daily assist Eric to de support to sort, discard asonable manner daily, he has accidents. Prompt a or items with a much esible, refrain from negative king about his misbehavior to Eric, Assist him to laundering immediately, assist him odor as needed, provide when using agents, take advantage of				

Division of Health Service Regulation

STATE FORM 6899 YF8Z11 If continuation sheet 3 of 9

Division of Health Service Regulation

	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		MHL049-100	B. WING		08/21/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE	
CAMELO	-	3329 WING	CHESTER LAN	E	
CANILLO		STATESVI	LLE, NC 28625	5	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
V 112	Continued From page	e 3	V 112		
	and moving and limit activity to prompt the	interrupting of a preferred bathroom, if able. Attempt to niture that are durable and			
	-Was unable to make	with client #2 revealed: any statements related to ne in his bedroom and why as missing.			
	-"It has gotten worse -"[Client #1] urinated that is why his drawe	ealed: had a strong odor of urine over the last few weeks." in his dresser drawer and			
	-"The goals and strate	with staff #1 revealed: egies were are using are not eed on his floor last week dresser drawers."			
	-Client #1's room sma -Reminded client #1 t -"We work together to do it to keep his indep water with [a cleaner' cleaner's name] to ma even pull out his dres and do his laundry da room first and then I g				
		ent #1's psychiatrist again d, the psychiatrist suggested			

Division of Health Service Regulation

STATE FORM YF8Z11 If continuation sheet 4 of 9

Division of Health Service Regulation

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		MHL049-100	B. WING		08/21/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
	_	3329 WIN	CHESTER LANI	Ē	
CAMELOT	Ī	STATESV	LLE, NC 28625	5	
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
V 112	Continued From page	e 4	V 112		
	nocitivo roinforcomon	nt. If [client #1] did not urinate			
		e would be rewarded"			
	Interview on 8/21/24	with the Qualified			
	Professional revealed	d:			
	-"[Client #1]'s treatme	ent plan was written by the			
	care coordinator and				
		ve a mini team meeting to			
	· · · · · · · · · · · · · · · · · · ·	, and we plan to meet with use it is a behavior and not			
	medically related"	decit is a beliavior and not			
	•	ent #1]'s urinating (in other			
		ilet) has gotten worse"			
		ystem and staff are to check			
		itesthe staff are also to			
		amperwe are trying to nues to see what will help			
	•	er mattress covers in the			
		aff is documenting when they			
		.staff is supposed to assist			
		ng daily and practicing good			
	hygiene"				
V 114	27G .0207 Emergeno	cy Plans and Supplies	V 114		
	10A NCAC 27G .020 AND SUPPLIES	7 EMERGENCY PLANS			
		develop a written fire plan			
		nd shall make a copy of			
	these plans available				
		ncy services agencies upon			
		nall include evacuation			
	procedures and route				
		e made available to all staff edures and routes shall be			
	posted in the	Guires and Toutes Shall De			
	facility.				
		drills in a 24-hour facility			
		quarterly and shall be			

Division of Health Service Regulation

STATE FORM 6899 YF8Z11 If continuation sheet 5 of 9

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
		MHL049-100	B. WING		08/2	1/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CAMELOT	-		HESTER LANI .LE, NC 28625			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 114	simulate the facility's emergencies. (d) Each facility shall accessible for use. This Rule is not met Based on record revie facility failed to conductorie per quarter per series. Review of the facility's August 2023 to July 2-Fire Drills: 7/9/24 at 34/10/24 3:00pm, 3/6/21/11/24 2:26pm, 12/16:25pm, 10/10/23 8:28/10/23 6:45pm -No documentation of June 2024Disaster Drills: 7/10/34/10/24 8:16am, 3/5/21/9/24 8:15am, 12/10	ted under conditions that response to fire have a first aid kit as evidenced by: ews and interviews, the let fire and disaster drills shift. The findings are: s fire and disaster drills from 2024 revealed: 2:00pm, 5/7/24 5:45pm, 2:4 2:05am, 2/7/24 7:00pm, 2/23 2:02am, 11/8/23 0am, 9/3/23 12:00 am, f a fire drill conducted in 24 8:12am, 5/5/24 12:35pm, 24 8:15pm, 2/7/24 7:35pm,	V 114	DEFICIENCY)		
	June 2024	f a disaster drill conducted in				
	-"I have only done a	ten fire and disaster drills				

Division of Health Service Regulation

STATE FORM 6899 YF8Z11 If continuation sheet 6 of 9

Division of Health Service Regulation

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUR	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETE	ED
		MHL049-100	B. WING		08/21/2	2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
CAMELOT	<u>-</u>	3329 WING	CHESTER LAN	E		
CAMELOT		STATESVI	LLE, NC 28625	5		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
V 114	Continued From page	e 6	V 114			
	Interview on 8/21/24 and -When it came to condrills at the facility, states or I don't know how the facility of the facility of the facility, states or I don't know how the facility of the f	with staff #2 revealed: ducting fire and disaster aff #2 stated " I just started, he staff usually does it. We r or five times. I have been nown what to do" with the GHM revealed: ter) are done month and We run them on each shift. the Vocational Instructor. No s. I will monitor the new de documentation for a fire the month of June 2024. with the Qualified realed: ter) are conducted every ow"				
V 736	27G .0303(c) Facility	and Grounds Maintenance	V 736			
		EMENTS				
	maintained in an attra					
	Observations on 8/20	/24 from 4:01pm to 4:33pm				

Division of Health Service Regulation

STATE FORM 6899 YF8Z11 If continuation sheet 7 of 9

Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SI COMPLE	
		MHL049-100	B. WING		08/2	1/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CAMELO	г		WINCHESTER LANE ESVILLE, NC 28625			
(Y4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	COMPLETE DATE
V 736	Continued From page	e 7	V 736			
	of the facility and its gardenesses of the facility and its gardenesses of the the lower frame. The kitchen counters was in need of repair. The refrigerator's bladetached from the frather air return filter aarche main den area's damaged. Client #1's bedroom. Client #1's 5 drawer drawer. One of client #3's fol missing on the left sid against the wall.	grounds revealed: facility had dirt build up on s had deep scratches and ack sealant was loose and ame. and grill had dust buildup. switch plate cover was had a strong odor of urine. dresser was missing the 4th ding closet doors was de and was propped up				
	-An admission date o -Diagnoses of Moders Vitamin D Deficiency, Unspecified, Bipolar I Disruptive Mood Dysi Bilateral, Unspecified Other Specified Urina of Leg Perthes -Age 45 -A treatment plan date independently refrain other than the toilet (I) Interview on 8/21/24 -"Some times it (the majority of the time. I or go into his drawers say he does it every of weeks, it seems to ha	ate Intellectual Disabilities, , Hypercholesterolemia, Disorder, Unspecified, regulation Disorder, Myopia, Asthma Uncomplicated and ary Incontinence and History ed 12/31/23 "will from urinating in places pottles, shoes, etc.)" with staff #1 revealed: e facility) smells like pee, the Client #1] pees on the floor, is and pees in thereI would other dayFor the past the 2				

Division of Health Service Regulation

STATE FORM 6899 YF8Z11 If continuation sheet 8 of 9

Division of Health Service Regulation

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		SURVEY PLETED
		MHL049-100	B. WING		08	/21/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE		
CAMELO	г		CHESTER LANE ILLE, NC 28625			
(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	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 736	facility)just the urine roomwhen I am the smell nice. " -"I heard they were go They are scratched use Interview on 8/21/24 Manager revealed: -"[Client #2] did state 'his room smells' reference 'The staff go into [client map and then they mused [a name of a cleen cleaner] and encourabathroom" -"The counters (count (scratched) for a little landlord about it. He statem this yeartowar (2023) was when I not on the side of the door I will put a work order closet door." Interview on 8/21/24 Professional revealed Client #1 urinated in "[Client #1] has ment room does not smell gassist him with cleanimentioned it (urine of few times. I have spoabout practicing good daily." -"I am thinking becaut that the landlord isn't	e smell in [client #1]'s re, I try to make the facility bing to replace the counters. p" with the Group Home to me in a meeting one day, rring to [client #1]'s room" ent #1]'s bedroom, let him op behind himwe have aner], [another name of a ge him to go to the ters) have been that way bit. I have talked to the said he would purchase ds the end of last year ticed itthe fridge (sealant or) just came loose recently. in for it and for [client #3]'s with the Qualified bithis dresser drawer. Itioned once or twice that his good. Staff is supposed to	V 736			

Division of Health Service Regulation

STATE FORM YF8Z11 If continuation sheet 9 of 9