PRINTED: 01/17/2025 FORM APPROVED

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				R		
MHL081-091		B. WING		01/08/2025		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KELLY'S	CARE #8		PER'S GAP			
KLLLI O	OAKL #0	RUTHERI	FORDTON, N	C 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	-S	V 000			
	An annual and follo on 1/8/25. A deficie	w up survey was completed ency was cited.				
	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.					
		sed for 9 and currently has a urvey sample consisted of an ients.				
V 369	G.S. 122C-6 Smoki	ng Prohibited	V 369			
	(a) Smoking is prohunder this Chapter. "smoking" means the lighted cigar, cigare smoking product. A means a fully enclo (b) The person who otherwise controls a shall: (1) Conspicuously passociated in the symbol, which considered in the symbol, which considered in the symbol, which considered in the symbol is prohibited as a red circle with a red (2) Direct any personal facility to extinguish (3) Provide written in admittance that small facility and obtain the or the individual's red receipt of the notice.	owns, manages, operates, or a facility subject to this section ost signs clearly stating that ed inside the facility. The signs ernational "No Smoking" sists of a pictorial burning cigarette enclosed in ed bar across it. On who is smoking inside the the lighted smoking product. Inotice to individuals upon oking is prohibited inside the esignature of the individual epresentative acknowledging et.				
		t may impose an Ity not to exceed two hundred r each violation on any person				

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

TITLE (X6) DATE Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) DATE SURVEY COMPLETED	
					F	₹	
MHL081-091		MHL081-091	B. WING		01/08/2025		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
KELLY'S	CARE #8		PER'S GAP ORDTON, N				
(X4) ID	SUMMARY STA		ID ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)	
PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	COMPLETE DATE		
V 369	Continued From page 1		V 369				
	who owns, manage controls a facility lic fails to comply with A violation of this se offense only and is	es, operates, or otherwise sensed under this Chapter and subsection (b) of this section. Section constitutes a civil not a crime.					
	This Rule is not met as evidenced by: Based on observation and interviews the facility failed to prohibit smoking within the facility. The findings are:						
	during facility walk to Client #3 was lying bedroom he shared bedroom was an approximate with a half full can of too smaller approximate with a heavy layer of were 7 vape cartrid stated, "[Client #6] sopens the window small tin box." Staff revealing 4 burnt cities. Both Client #1 and beds in their shared	Client #2 were lying in their d bedroom. In this bedroom tray with tobacco and products					
	-When asked if he	with Client #1 revealed: smoked in his bedroom he supposed to (smoke in					

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Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NOMBER.	A. BUILDING:		COMPLETED	
					F	۱ ا
MHL081-091		B. WING			8/2025	
			1			0.2020
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KELLY'S	CARE #8	1366 COC	PER'S GAP	ROAD		
INEEE! O	OAILE #0	RUTHER	FORDTON, N	IC 28139		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
TAG	REGULATORT OR L	SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	TIAIE	DAIL
				,		
V 369	Continued From pa	ge 2	V 369			
	-Δsked again if he s	smoked in the bedroom, he				
		answer that question."				
	-"We just got it (tob					
	- vvc just got it (tob	accor back.				
	Interview on 1/8/25	with Client #2 revealed:				
	-"Not smoking in be					
		e outside (to smoke) but it's				
	been too cold."	,				
	-Staff #1 would ask every hour or 2 if "we wanted					
	to smoke." -"Got caught cause [Client #3] ratted on us." Interview on 1/8/25 with Client #3 revealed: -"I don't smoke, I dip."					
	-It did not bother him that Client #6 smoked in					
	their bedroom.					
	It	with Otaff #4 manual ale				
		with Staff #1 revealed:				
		essyits everywhere and				
	these guys don't keep their rooms clean."					
	-"Put all tobacco products in the locked pantry overnight."					
	-"They have to ask me to access to their tobacco					
	to smoke"					
	-"No smoking after 8pm."					
	3					
	Interview on 1/8/25	with the Residential				
	Supervisor revealed					
		Client #2] were always having				
	issues with smoking					
		staff. The previous staff				
		ans about locking up				
		tobacco upstairs with her				
	overnight. Staff #1	was new out there.				
	Interview 1/0/05	with the Qualified				
	Interview on 1/8/25 Professional/Direct					
	-"Has been an ongoing issue at this house (with					
	clients smoking)."	nd putting stronger rules in				
	- will be creating at	na patting stronger rules in				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL081-091		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
		B. WING			R 01/08/2025		
	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S OPER'S GAP RFORDTON, N				
(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 T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 369	Continued From parplace."	ge 3	V 369				

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