PRINTED: 11/01/2018 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: _								
HAL		HAL045067	B. WING		10/31/2018						
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	TE, ZIP CODE								
		600 CAROL	INA VILLAGE								
CAROLINA VILLAGE HENDERSONVILLE, NC 28792											
(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 APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE					
D 000	Initial Comments		D 000								
	The Adult Care Licensure Section and the Henderson County Department of Social Services conducted an annual survey on 10/30/18 and 10/31/18.										
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that each staff person had a criminal background check completed prior to hire for 1 of 3 sampled staff (Staff A). The findings are:		D 139								
		ersonnel record revealed: a Personal Care Assistant nentation of a criminal									
	on 10/31/18 at 8:32ar -Staff A was hired in 2 -The Director of Humal facility in 2010Each person offered to have a criminal back-At the new hire orien fingerprinted and the	an Resources started at the employment was required ckground check. tation each staff person was fingerprints were mailed to expressing (SBI) for a full									

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

TITLE (X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED						
		HAL045067	B. WING		10/3	1/2018					
NAME OF PRO	OVIDER OR SUPPLIER		RESS, CITY, STA								
CAROLINA VILLAGE HENDERSONVILLE, NC 28792											
(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 APPROPF DEFICIENCY)	BE COMPLETE						
- - - - - - - - - - - - - - - - - - -	10/31/18 at 9:20am re-Each new staff meml fingerprint mailed to the orientation. The results of the criwere kept by the Exec-The results "could be Director's office. Interview with Staff A revealed: Staff A had been emp 10/16/07. She did not know if seckground check constant in the seckground check check checker in the seckground checker in the seckground checker in the seckground checker	with the Administrator on evealed: ber was required to have a me SBI at new hire minal background check cutive Director. " in a box in the Executive on 10/31/18 at 9:40am ployed in the facility since the had a criminal mpleted upon hire. the had signed a consent for	D 139								

Division of Health Service Regulation

STATE FORM STATE FORM If continuation sheet 2 of 2