Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
		MHL043-014	B. WING		04/12/2018					
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE						
RAWLS ROAD GROUP HOME 190 RAWLS ROAD ANGIER, NC 27501										
(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					
V 000	INITIAL COMMENTS		V 000							
	2018. Deficiencies w This facility is licensed category: 10A NCAC	s completed on April 12, ere cited. d for the following service 27G. 5600C Supervised Developmental Disabilities.								
V 131	1 G.S. 131E-256 (D2) HCPR - Prior Employment Verification		V 131							
	REGISTRY (d2) Before hiring hea health care facility or health care facility sha	LTH CARE PERSONNEL  Alth care personnel into a service, every employer at a sell access the Health Care and shall note each incident opriate business files.								
	failed to access the H Registry (HCPR) prior	ew and interview, the facility								
	Review on 4/12/18 of records revealed: -Hire date of 3/6/17Job title: Direct Supp -HCPR check for Staf 5/12/17.									
	-She was hired on 3/6	with Staff #1 revealed: 5/17. tion training prior to starting.								

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

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED					
		MHL043-014	B. WING		04/	12/2018					
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  190 RAWLS ROAD  ANGIER, NC 27501											
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE					
V 131	-She started working weeks after completing Interview on 4/12/18 Assistant revealed: -Agency procedure weemployees being hire -She was responsible new employees prior	at the home about two ng orientation training.  with th Administrative  as to pull HCPR prior to ad.  was checking HCPR on to employment. CPR was not assessed	V 131								

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STATE FORM 5899 YDKL11 If continuation sheet 2 of 2