Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED							
		MUI 070 100	B. WING		04/0	6/0010						
NAME OF I		MHL079-109		TATE ZID CODE	04/2	6/2018						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  1216 WEST ACADEMY STREET												
ACADEMY PLACE MADISON, NC 27025												
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	VE ACTION SHOULD BE COMP ED TO THE APPROPRIATE DA							
V 000	INITIAL COMMENTS		V 000									
	An Annual and Complaint Survey was completed on April 26, 2018. The complaints were unsubstantiated (intake # NC00137973, NC00138004, NC00138107). A deficiency was cited.											
	category:											
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification		V 131									
	REGISTRY (d2) Before hiring h health care facility of health care facility of Personnel Registry	ealth care personnel into a or service, every employer at a shall access the Health Care and shall note each incident propriate business files.										
	failed to ensure that personnel into the had Care Personnel Re and that access was business file, for 3 (	et as evidenced by: and record review, the facility t before hiring health care nealth care facility, the Health gistry (HCPR) was accessed s noted in the appropriate (Staff #1, House Supervisor rofessional) of 3 staff										

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					
		MHL079-109	B. WING		04/2	6/2018				
NAME OF	PROVIDER OR SUPPLIER		STATE, ZIP CODE							
ACADEMY PLACE 1216 WEST ACADEMY STREET MADISON, NC 27025										
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE				
V 131	Continued From page 1		V 131							
	revealed: - he was hired - the HCPR was 16  Review of the Hous on 4-26-18 revealed - she was hired - the HCPR was  Review of the Quali file on 4-26-18 reve - she was hired - the HCPR was  Interview on 4-26-1 Officer (COO) reveace completed after sta staff were hired, but required training an clients. The COO a complete the HCPF staff had their crimi	s accessed for him on 12-22- se Supervisor's personnel file d: 10-25-10 s accessed for her on 11-7-11 fied Professional's personnel aled:								

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