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						
			D WING		F						
		MHL054-093	B. WING		07/2	0/2018					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
OLD FARM HOME 1510 FARMGATE ROAD KINSTON, NC 28504											
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE					
V 000	INITIAL COMMENTS		V 000								
		w up survey was completed Deficiencies were cited.									
	category: 10A NCA	sed for the following service AC 27G .5600C, Supervised h Developmental Disabilities.									
V 736	27G .0303(c) Facilit	ty and Grounds Maintenance	V 736								
	EXTERIOR REQUI (c) Each facility and maintained in a safe	03 LOCATION AND REMENTS I its grounds shall be e, clean, attractive and orderly e kept free from offensive									
		on and interview the facility in a safe and attractive									
	revealed: - The ceiling fan light bedroom was broke three light fixture wo covering the light but - One light bulb in the #2's bedroom worked - Nails in the hall batter in the second worked - Nails in the hall batter in the second worked - Nails in the hall batter in the second worked - Nails in the hall batter in the second worked - Nails in the hall batter in the second worked worked with the second worked worked worked with the second worked w										
		B the House Manager stated albs were burned out and were									

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							
		MHL054-093	B. WING			⋜ 20/2018						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
OLD FARM HOME 1510 FARMGATE ROAD KINSTON, NC 28504												
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE						
V 738	Continued From page 1		V 738									
V 738	27G .0303(d) Pest Control		V 738									
	EXTERIOR REQUI	03 LOCATION AND REMENTS be kept free from insects and										
	This Rule is not met as evidenced by: Based on observation and interview, the Licensee failed to keep the facility free from insects. The findings are: Observation on 7/16/18 at approximately 9:30 am revealed several ants crawling on the top of the dining room table.											
	Interview on 7/16/18 they sometimes say	8 the House Manager stated w ants in the facility. The ants ter the exterminator sprayed, urned.										

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