

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL054-094	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2018
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RHEM GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 902 RHEM STREET KINSTON, NC 28501
--	---

(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	<p>INITIAL COMMENTS</p> <p>An annual survey was completed on July 20, 2018. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C, Supervised Living for Adults with Developmental Disabilities.</p>	V 000		
V 736	<p>27G .0303(c) Facility and Grounds Maintenance</p> <p>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS</p> <p>(c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.</p> <p>This Rule is not met as evidenced by: Based on observation and interview the facility was not maintained in a safe and clean manner. The findings are:</p> <p>Observation on 7/18/18 at approximately 9:15 am revealed:</p> <ul style="list-style-type: none"> - Baseboards throughout the facility were stained and dusty. - An unwrapped, cut watermelon on the bottom shelf of the refrigerator. - Heavy mildew in the grout in the walk in shower and on the bottom of the shower curtain rod in the hall bathroom. - Access to Client #1's bedroom window was blocked by boxes. - Access to Client #4's bedroom window was blocked by his bed. - An approximate 1/2 - 3/4 inch open gap between the end of the bathtub and the wall in the bathroom near the "office area." 	V 736		

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: MHL054-094	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2018
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RHEM GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 902 RHEM STREET KINSTON, NC 28501
--	---

(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 736	Continued From page 1 Interview on 7/18/18 the Qualified Professional stated Client #4 used the bathroom near the "office area." The Chief Executive Officer had made extensive renovations to the facility.	V 736		