Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-467			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		B. WING			R 08/21/2018		
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE			
GLEN FO	OREST HOME		EN FOREST D	PRIVE			
			I, NC 27612				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 000	000 INITIAL COMMENTS		V 000				
	deficiency was cited This facility is licens	vas completed 8/21/18. A d. sed for the following service C 27G .5600C Supervised					
		h Developmental Disabilities.					
V 774 27G .0304(d)(7) Minimum Furnishings			V 774				
	EQUIPMENT (d) Indoor space reprior to October 1, square footage requireme. Unless otherwaresidential facilities 1988 shall meet the requirements: (7) Minimum furnishinclude a separate	quirements: Facilities licensed 1988 shall satisfy the minimum uirements in effect at that vise provided in these Rules, licensed after October 1, e following indoor space nings for client bedrooms shall bed, bedding, pillow, bedside for personal belongings for					
	failed to ensure one	et as evidenced by: on and interview the facility e of six (#1) clients bedroom ress for client. The findings					
	room revealed:	7/18 at 11:30 AM of client #1's ttress was deeply sunken in ped.					
	During interview on	8/17/18 client #1 stated:					

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							
			71. BOILDING.		R	,						
		MHL092-467	B. WING		08/21/2018							
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
GLEN FOREST HOME 5117 GLEN FOREST DRIVE												
RALEIGH, NC 27612												
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ORRECTIVE ACTION SHOULD BE COMPLETE PATE							
V 774	Continued From page 1		V 774									
	-Mattress has been in this shape for a whileNot told staff, "I didn't want to bother anyone."											
	stated:	8/17/18 the Home Manager										
	-Not aware client #1's mattress looked that badClient #1 did not mention issues with his mattress to anyone she is aware of.											
	stated: -Had contacted manages his funds mattress. -They do not buthe clients. -Never heard the buying replacement of the clientsIt would take upon the clients of the clients.	up to five weeks for them to or client #1 due to who they										

6899

Division of Health Service Regulation STATE FORM

761E11 If continuation sheet 2 of 2