

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL076-062	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2018
--	---	---	---

NAME OF PROVIDER OR SUPPLIER A TOUCH FROM THE HEART	STREET ADDRESS, CITY, STATE, ZIP CODE 339 RAMSEUR JULIAN ROAD RAMSEUR, NC 27316
---	---

(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 and follow-up survey was completed on October 16, 2018. A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adult with Developmental Disabilities.</p>	V 000		
V 131	<p>G.S. 131E-256 (D2) HCPR - Prior Employment Verification</p> <p>G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.</p> <p>This Rule is not met as evidenced by: Based on review of records and interview, the facility failed to access the Health Care Personnel Registry (HCPR) prior to employment for one of three staff (Staff #1). The findings are:</p> <p>Review on 10/16/18 of the facility's personnel files revealed: -Staff #1 had a hire date of 3/1/18. -Staff #1 was hired as a Paraprofessional. -No documentation of a HCPR check completed for Staff #1 prior to hire.</p> <p>Interview with the Administrator on 10/16/18 revealed: -Staff files had been used a lot lately for</p>	V 131		

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: MHL076-062	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2018
--	---	---	---

NAME OF PROVIDER OR SUPPLIER A TOUCH FROM THE HEART	STREET ADDRESS, CITY, STATE, ZIP CODE 339 RAMSEUR JULIAN ROAD RAMSEUR, NC 27316
---	---

(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 131	Continued From page 1 certifications. -Documentation may had gotten lost in the process. -She confirmed there was no documentation on file of a HCPR check completed for Staff #1 prior to hire. -A new HCPR request was made for Staff #1.	V 131		