PRINTED: 06/12/2019 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED				
			A. BUILDING:						
MHL039-057		MHL039-057	B. WING		04/26/2019				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE									
MELROSE HOME 107 W TALLY HO ROAD STEM, NC 27581									
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE				
V 000	INITIAL COMMENTS		V 000						
	An annual and complaint survey was completed 4/26/19. The complaint, (Intake #NC00150395) was substantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.								
V 742	42 27G .0304(a) Privacy		V 742						
	10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (a) Privacy: Facilities shall be designed and constructed in a manner that will provide clients privacy while bathing, dressing or using toilet facilities.								
	This Rule is not met as evidenced by: Based on observation and interview, the governing body failed to assure one of three clients (#3) had privacy in his bedroom. The findings are:								
	of client #3's room rev door between his bed Further observation re jammed into the wall	19 at approximately 3:18 PM vealed an adjoining pocket room and the living room. evealed the pocket door was and could not be retrieved, petween client #3's bedroom							
	client #3 slammed the March 2019 and they	n 4/25/19, staff #4 reported e pocket door into the wall in had not been able to get it orted arrangements were e door repaired.							

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		MIII 020 057	B. WING		0.4/0.0/0.40			
		MHL039-057	D. WING		04/26/2019			
NAME OF PE	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE				
MELROSE HOME 107 W TALLY HO ROAD STEM, NC 27581								
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE		
V 774	Continued From page 1		V 774					
V 774	27G .0304(d)(7) Minimum Furnishings		V 774					
	10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (d) Indoor space requirements: Facilities licensed prior to October 1, 1988 shall satisfy the minimum square footage requirements in effect at that time. Unless otherwise provided in these Rules, residential facilities licensed after October 1, 1988 shall meet the following indoor space requirements: (7) Minimum furnishings for client bedrooms shall include a separate bed, bedding, pillow, bedside table, and storage for personal belongings for each client. This Rule is not met as evidenced by: Based on observation and interviews, the governing body failed to assure a designated client bedroom had minimum furnishings. The findings are:							
		19 at 3:20 PM of a vacant led no bed, mattress or the room.						
	the furnishings for the that resided in the roc another client was ex	pected to move in in a few facility and his bedroom						

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