

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL049-059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER JAMES FARM HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 148 JAMES FARM ROAD STATESVILLE, NC 28625
--	---

(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 12, 2019. A deficiency was cited.</p> <p>This facility is licensed for the following service category:</p> <ul style="list-style-type: none"> - 10A NCAC 27G .5600C: Supervised Living for Developmentally Disabled Adults 	V 000		
V 736	<p>27G .0303(c) Facility and Grounds Maintenance</p> <p>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (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 staff failed to maintain the facility in a safe orderly manner. The findings are:</p> <p>Review on 7-9-19 of client #1 ' s facility record revealed:</p> <ul style="list-style-type: none"> - admitted 8-1-02 - 38 years old - diagnosed with: <ul style="list-style-type: none"> - Moderate Mental Retardation - Attention-Deficit Disorder - Depression - Behavior Support Plan dated 10-19-18: <ul style="list-style-type: none"> - chews on clothes, books, toothbrush, 	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: MHL049-059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER JAMES FARM HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 148 JAMES FARM ROAD STATESVILLE, NC 28625
--	---

(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	<p>Continued From page 1</p> <p>remote control</p> <ul style="list-style-type: none"> - hoards items in his room - Pica tendencies <p>Observation at approximately 3:40 pm on 7-12-19 revealed:</p> <ul style="list-style-type: none"> - 2 dishwasher cleaning pods had been laid on the window seal behind the kitchen sink - the pods were small, shiny and colorful - a plastic tub containing more cleaning pods were located under the kitchen sink - additional cleaning chemicals were observed under the kitchen sink - there was no lock on the cabinet under the kitchen sink <p>Interview on 7-12-19 with the Group Home Manager (GHM) revealed:</p> <ul style="list-style-type: none"> - she had never been told cleaning products must be kept inaccessible to clients - there had never been an incident with clients involving cleaning chemicals - acknowledged client #1 had Pica tendencies - stated the dish cleaning pods were not supposed to be out lying on the window seal - reported this facility has 24 hour awake staff to monitor clients ' safety at all times - she will contact the staff nurse and Qualified Professional (QP) about securing all cleaning chemicals <p>Interview on 7-12-19 with the QP revealed:</p> <ul style="list-style-type: none"> - she is responsible for supervising all GHMs - they have never been cited for having cleaning chemicals accessible to clients - they ' ve not locked them away, because they ' ve never had a problem or issue with the chemicals involving clients - she and the GHM will ensure the chemicals 	V 736		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL049-059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER JAMES FARM HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 148 JAMES FARM ROAD STATESVILLE, NC 28625
--	---

(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 2 are not accessible to clients	V 736		