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				
		MIII 000 004	B. WING		F				
		MHL026-884	D. WING		02/2	1/2020			
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE					
THE LOVING HOME, INC #4 1710 SCAMPTON ROAD FAYETTEVILLE, NC 28303									
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE			
V 000	INITIAL COMMENTS		V 000						
	on February 21, 202	w up survey was completed 20. A deficiency was cited.							
	category: 10A NCA	C 27G .5600C Supervised h Developmental Disabilities.							
V 752	27G .0304(b)(4) Ho	t Water Temperatures	V 752						
	EQUIPMENT (b) Safety: Each factorstructed and equensures the physical visitors. (4) In areas contexposed to hot water	cility shall be designed, uipped in a manner that all safety of clients, staff and of the facility where clients are er, the temperature of the tained between 100-116							
	degrees Fahrenheit This Rule is not me Based on observati failed to maintain th	i.							
	and 1:00 pm reveal -The water tempera measured 120 degr -The water tempera measured 120 degr -The water tempera measured 120 degr -The water tempera sink measured 118	ature at the kitchen sink rees Fahrenheit. Ature at the hall bathroom sink rees Fahrenheit. Ature at the hall bathroom tub rees Fahrenheit. Ature in client #1's bathroom degrees Fahrenheit. Ature in client #1's bathroom							

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

MHL026-884 NAME OF PROVIDER OR SUPPLIER THE LOVING HOME, INC #4 STREET ADDRESS, CITY, STATE, ZIP CODE 1710 SCAMPTON ROAD FAYETTEVILLE, NC 28303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED								
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Division of Health Service Regulation STATE FORM