		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL026-951		B. WING		R 02/21/2020		
NAME (	OF PROVIDER OR SUPPLI		Γ ADDRES	SS, CITY, STATE, ZIP CODE		***
		1903 E	BRIDGER	STREET		
THELO	OVING HOME, INC #6	FAYE	TTEVILL	E, NC 28303		
(X4) ID PREFI X TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFI X DEFICIENCY  TAG  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION)		OULD BE	(X5) COMPLETE DATE		
V000	INITIAL COMMENT	S	V000			
	An annual survey was 2020. Deficiencies was This facility is license	as completed on February 21, vere cited.  ed for the following service 27G. 5600A Supervised				
V121	27G .0209 (F) Medication Requirements  10A NCAC 27G .0209 MEDICATION REQURIEMENTS		V121	The Loving Home, Inc (TLH) QP or group manager, will obtain a drug regimen on each client's at least every		Implementation Date: 04/01/2020
	(f) Medication review (1) If the client received governing body or operation of the client regimen at least every shall be to be perform physician. The on-sit the client's physician the review when med (2) The findings of the	ves psychotropic drugs, the perator shall be responsible of of each client's drug ry six months. The review med by a pharmacist or the manager shall assure that is informed of the results of dical intervention is indicated. The drug regimen review shall itent record along with		six months. Group Home Mang informed in supervision that dru regimen will be received from the pharmacy at least every six most medication regimen will be revie and/or Group Home Manger and submitted to the client's primary for review of any recommendation the pharmacy.	g ne nths The ew by QP d doctor	Projected Completion Date: Ongoing
	record reviews and ir obtain a review of ea least every six month	as evidenced by: Based on interviews, the facility failed to ch client's drug regimen at its for 3 of 3 audited clients ic medications (client #2, #3,		DHSR-Menta MAR 2 3 5	2020	
	Finding #1: Review on 2/19/2020 revealed:			Lic. & Cert.	Section	
ivision of	-66 year old male adr Health Service Regulation	mitted 5/30/15.				
TATE FO		6899	XIZQ	111	If continu	ation sheet 1 of 9

Signature: W. Williams, Clinical Direct

Date: 03/19/2020

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION ILDING:		DATE SURVEY DMPLETED		
		MHL026-951	B. WIN	VG	0.	R 2/21/2020		
NAME	OF PROVIDER OR SUPPLIE	ER STREE	T ADDRES	SS, CITY, STATE, ZIP CODE				
THELO	THE LOVING HOME, INC #6							
	, and its mile, in the mo	FAYE	TTEVILL	E, NC 28303				
(X4) ID PREFI X TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI X TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE		
V121	Continued From pa	ge 3	V121					
V513	-Reviews are sent to Manager, and she fi record No one read or follorecommendations.  Interview on 2/19/20 The Clinical Directores age to the pharmage of t	r stated he had sent a macy requesting the reviews on ths.  This – Least Restrictive  1 LEAST RESTRICTIVE  provide services/supports and respectful environment.  st restrictive and most and methods; ping and engagement tives to injurious behavior to sices of activities ents served/supported; and ontrol over decisions with the ible person and staff. ictive intervention procedure behavior shall always be ons designed to insure uring and after the	V121	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		Implementation Date: 04/01/2020  Projected Completion Date: Ongoing		
		rvention as a last resort; and e intervention by people						

6899

If continuation sheet 4 of 9

(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL026-951 B. WING 02		R 2/21/2020		
NAME	OF PROVIDER OR SUPPLIE	ER STREE	T ADDRES	SS, CITY, STATE, ZIP CODE		
THEL	OVING HOME, INC #6	1903	BRIDGER	STREET		
	ovince moving free mo	FAYE	TTEVILL	E, NC 28303		
(X4) ID PREFI X TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI X TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
V736	Continued From pag Maintained in a safe manner and shall be odor.	e 6 , clean, attractive and orderly kept free from offensive	V736			
	The Rule is not met a Based on observatio was not maintained i orderly manner. The	n and interview, the facility n a safe, clean, attractive and	V736	The Loving Home, Inc (TLH) Group Home Manager will report to QP when something is broken or needs repairing in the facility. Group Home Manager will		Implementation Date: 04/01/2020  Projected
	Observations on 2/18/2020 between 11 am and 12 noon revealed:  -Broken mini blinds above the kitchen sink.  -Black and brown colored debris particle build up inside cabinet under the kitchen sink.  -Black and brown colored debris particle build up and a meat bone about 3 inches by 2 inches in size under the stove storage drawer.  -Dust and small black and brown colored debris particle build up under the sink cabinet in hall bathroom.  -Rust covered the ceiling vent in the hall bathroom.  -Client #2's window coverings were worn and sagging.  -Medicine cabinet door in back bathroom held closed with transparent tape. Door made of metal and glass; sharp edges at corners that protruded directly above the sink when opened.  Interview on 2/19/2020 the Clinical stated he had repaired the medicine cabinet door.			in the facility. Group Home Manager will ensure any debris particle build up inside cabinets or any other part of the facility will be removed and area cleaned. Dust, rust build up and window coverings will also be cleaned and repaired if needed. QP or Group Home Manager conducts an environmental check inspection at least monthly or as needed.		Completion Date: Ongoing
V738	27G .0303(d) Pest Co		V 738			
ivision of	Health Service Regulation					

Signature: June M. Williams, 35/QP Vincent M. Williams, Clinical Direct

If continuation sheet 7 of 9

	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL026-951	B. WIN	NG	0.	R 2/21/2020
NAME	OF PROVIDER OR SUPPLI	ER STREE	T ADDRES	SS, CITY, STATE, ZIP CODE		
THEL	OVING HOME DIGHT	1903 1	BRIDGER	STREET		
THEL	OVING HOME, INC #6	FAYE	TTEVILL	E, NC 28303		
(X4) ID PREFI X TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI X TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
V738	Continued From pag	je 7	V738			
	10A NCAC 27G .030 EXTERIOR REQUIF (d) Buildings shall be rodents.					
	The Rule is not me a Based on record revifacility was not kept to The finding are:	is evidenced by: iews and interviews, the free from insects and rodents.	V738	The Loving Home, Inc (TLH) QF Group Home Manager will ensu facility is free from insects and r by removing and cleaning the ar	re the odents	Implementation Date: 04/01/2020
	12 noon revealed: -Dead bugs on top at cabinets to the right of cooking pot stored in -Dead bugs in cabined-Black particles appropriate to the cooking pot stored in -Dead bugs in cabined-Black particles appropriate to the cabined bugs in	where they are identified. General Manager will contact the State Pest		ral Pest as a pest to ensure	Projected Completion Date: Ongoing	
	kitchenThey could hear the sound" inside the wal	mouse make a "knocking I, I large. He estimated the size				
	was a contract for rou -He would provide a c contract.	0 the Director stated: the General Manager there tine pest control services. copy of the pest control				
ivision of FATE FO	Health Service Regulation	6899	XIZO:	14		

Date: 03/19/2020

Signature: Um M. Williams, Clinical Direct