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							
			A. BOILDING.									
MHL026-814		B. WING	B. WING		06/26/2020							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
SUMMERHILL 6350 HAWFIELD DRIVE FAYETTEVILLE, NC 28303												
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT 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									
	2020. The complain	was completed on June 26, nts were unsubstantiated 3361, NC00165560). A d.										
	category: 10A NCA	sed for the following service C 27G .5600B Supervised th Developmental Disabilities.										
V 131	G.S. 131E-256 (D2 Verification) HCPR - Prior Employment	V 131									
	REGISTRY (d2) Before hiring health care facility thealth care facility seems Personnel Registry	ealth care personnel into a personnel in										
	This Rule is not me											
	facility failed to acc	views and interviews, the ess the Health Care Personnel ior to hiring 1 of 1 former staff are findings are:										
	Professional (QP)	6/24/20 the Qualified stated: sonnel record for FS#5.										
	-He had worked at	020 Staff #1 stated: the facility for about 8-9 years. ere hired they first "shadowed"										

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

(X6) DATE TITLE

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COM	E SURVEY PLETED
A. BUILDING.	PLETED
MUL 026 944 B WING	
MUL DOC 944 B WING	
	26/2020
MITILUZ0-014 U0	26/2020
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
6350 HAWFIELD DRIVE	
SUMMERHILL FAYETTEVILLE, NC 28303	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	COMPLETE
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	DATE
DEFICIENCY)	
V 131 Continued From page 1 V 131	
in the home for a couple of hours.	
-He recalled "a couple of months ago" a "lady"	
arrived while he was on duty to "shadow."	
-He had worked the prior night shift and had to	
"stay over" that morning because his relief staff	
was late.	
-He had worked the night shift and was the only	
staff on duty until he was relieved by the (QP) and	
Staff #3.	
Interview on 6/24/2020 Staff #3 stated:	
-He typically worked the day or evening shifts.	
-He had worked with a woman not long ago who	
was in the home to "shadow."	
-During her time on site she was involved with	
clients, games and activities.	
-He showed her some of the client's books where	
they document what they were doing with the	
clients, and the "communication logs."	
-She did not look at the medication administration records.	
records.	
Interview on 6/25/2020 the QP stated:	
-FS#5 was on site during 1 shift to "shadow."	
Staff #1 was present when FS#5 arrived.	
-The QP arrived on site about 5 minutes after	
FS#5 arrived.	
-FS#5 had not been hired; therefore, they had not	
accessed the HCPR.	
-All prospective employees "shadow" in the home	
before they are hired.	
-The facility did not access the HCPR until after	
they decided to hire someone.	
Interview on 6/25/2020 the Chief Executive	
Officer (CEO) stated:	
-She suspected a disgruntled former employee	
(FS#5) was making false statements about the	
facility.	
-FS#5 had been hired for the "Operations	

Division of Health Service Regulation

STATE FORM 6899 If continuation sheet 2 of 3 B2WM11

Division of Health Service Regulation

	OT HEAITH SERVICE RE	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI TIPI	E CONSTRUCTION	(X3) DATE	SURVEY					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED						
		MHL026-814	B. WING		06/2	6/2020					
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STATE, ZIP CODE								
CUMME	6350 HAWFIFI D DRIVE										
SUMME	RHILL	FAYETTE	VILLE, NC 2	8303							
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	CTION SHOULD BE O THE APPROPRIATE						
V 131	Continued From page 2		V 131								
	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)										

Division of Health Service Regulation STATE FORM