PRINTED: 08/31/2020 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED							
			A. BOILDING.		R						
		090-145	B. WING		08/26/2020						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
UNION DIVERSIFIED INDUSTRIES 2815 WALKUP AVENUE											
MONROE, NC 28110											
(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 APPROF DEFICIENCY)	D BE COMPLETE						
V 000	INITIAL COMMENTS		V 000								
	on 8-26-20. The com (intake #NC 0016783. This facility is licensed category: 10A NCAC	ocational Programs for									
V 131	G.S. 131E-256 (D2) F Verification	HCPR - Prior Employment	V 131								
	REGISTRY (d2) Before hiring hea health care facility or health care facility sha	LTH CARE PERSONNEL alth care personnel into a service, every employer at a sell access the Health Care and shall note each incident opriate business files.									
	facility failed to ensure Registry (HCPR) was affecting 2 of 3 staff (stindings are:	and record reviews, the te the Health Care Personnel accessed prior to hire Staff #1 and Staff #3). The Staff #1's record revealed:									
	-Hire date was 4/16/2 -Employed as Direct 9 -HCPR check comple	Support Professional;									
	Review on 8/20/20 of	Staff #3's record revealed:									

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

(X6) DATE TITLE

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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				
		090-145	B. WING		 	R / 26/2020				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE										
UNION DIVERSIFIED INDUSTRIES 2815 WALKUP AVENUE MONROE, NC 28110										
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE				
V 131	-Hire date was 6/18/1 -Employed as Direct solution of the complete of the complete of the complete of the complete of the company; -Was not aware that the company of the company; -Was not aware that the company of the company; -Was not aware that the company of the company; -Was not aware that the company of the company; -Was not aware that the company of the company; -Was not aware that the company of the c	8; Support Professional / sted on 6/20/18. with the Director revealed: g manager for Staff #1; was no longer with the he HCPR checks for Staff incomplete at the start of	V 131							

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STATE FORM 6899 K4B311 If continuation sheet 2 of 2