PRINTED: 12/20/2021 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED				
			A. BUILDING: _						
		MHL0601329	B. WING		R 12/15/2021				
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STAT	E, ZIP CODE					
NELSON HOME 10619 RIVER HOLLOW COURT CHARLOTTE, NC 28214									
240.15	CLIMMADV CT		·	PROVIDER'S PLAN OF CORRECTION	V 045				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(XEACH CORRECTION OF CORRECTION (XECOMP) (EACH CORRECTIVE ACTION SHOULD BE COMP) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					
V 000	INITIAL COMMENTS		V 000						
	An annual and follow- on 12/15/2021. A def	-up survey was completed riciency was cited.							
	The facility is licensed for the follow service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living.								
	The survey sample co current clients.	onsisted of audits of 2							
V 131	G.S. 131E-256 (D2) H Verification	HCPR - Prior Employment	V 131						
	REGISTRY (d2) Before hiring hea health care facility or health care facility sha	alth care personnel into a service, every employer at a all access the Health Care and shall note each incident opriate business files.							
	facility failed to ensure	ews and interviews, the e the Health Care Personnel accessed prior to hire for 1							
	Review on 12/14/202 Professional's (QP) p -Hire date of 08/26/20 -Job title of QP and C -HCPR accessed on	ersonnel record revealed: 019. linical Director.							

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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					R					
		MHL0601329	B. WING		12/15/2021					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE										
NELSON HOME 10619 RIVER HOLLOW COURT CHARLOTTE, NC 28214										
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	DN (X5)					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE					
V 131	Continued From page	: 1	V 131							
	-Started with the ager -Served as QP and C -Formal job duties; suresidential direct care Interview on 12/14/20 Resource Director rev -Responsible for com to the hire of a new er -Change in leadership -Believed the HCPR of the required timefram documentation to sup -"My process is to run which includes Crimin Offender, and Medica records, the Criminal fraud checks were co HCPR check would h too"Will continue to comp	linical Director. upervise all QPs and staff on her caseload. 21 with the Human vealed: pleting HCPR checks prior mployee. o when the QP onboarded. check was completed within e but could not locate the								

Division of Health Service Regulation

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