PRINTED: 02/28/2022 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 | | | | | |
|--|---|---|----------------------------|---|-------------------------------|------------------------|--|--|--|--|
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER. | A. BUILDING: _ | | COMPLETED | | | | | |
| | | MHL026-884 | B. WING | | R 02/23/202 | :2 | | | | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | | | | | | |
| THE LOVING HOME, INC #4 1710 SCAMPTON ROAD | | | | | | | | | | |
| FAYETTEVILLE, NC 28303 | | | | | | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE CON | (X5) IPLETE DATE | | | | |
| V 000 | INITIAL COMMENTS | | V 000 | | | | | | | |
| | completed on Februa | and follow up survey was ry 23, 2022. The complaint (Intake #NC00184340). A | | | | | | | | |
| | category: 10A NCAC | d for the following service 27G .5600C Supervised Developmental Disabilities. | | | | | | | | |
| | The survey sample cocurrent clients. | onsisted of audits of 3 | | | | | | | | |
| V 736 | 27G .0303(c) Facility | and Grounds Maintenance | V 736 | | | | | | | |
| | | EMENTS | | | | | | | | |
| | was not maintained in and orderly manner. Observation on 02/23 10:00am revealed: -In the kitchen the stothe paint was discolor-Client #3's bedroom the carpet was soiled -Client #1's blind slate the bedroom. | n and interview, the facility n a safe, clean, attractive The findings are: 3/22 at approximately ove's exterior was worn and red and chipping off. had a strong urine odor and | | | | | | | | |

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

TITLE (X6) DATE

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | | | | | |
|---|--|----------------------|--|----------------------------------|--------------------------|--|--|--|--|--|
| | | 5 44414 | | | R | | | | | |
| | MHL026-884 | B. WING | | 02 | /23/2022 | | | | | |
| NAME OF PROVIDER OR SUPPLIER | | ADDRESS, CITY, STATE | , ZIP CODE | | | | | | | |
| THE LOVING HOME, INC #4 FAYETTEVILLE, NC 28303 | | | | | | | | | | |
| PREFIX (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE | | | | | |
| sagging in the area of -Client #1's bedroom s -Client #2's blind slate the bedroom. During interview on 02 Professional and the L -A contract was alread bathroom due to the w -The blinds in the facil -Client #3 intentionally and they had replaced and she continues to w -They would look at of | e bathtub. The floor was the damage. smelled of urine. It is were broken and bent in 2/23/22 the Qualified Licensee revealed: It is water damage. It is would be replaced. It is pees in her bed at night it is several mattresses for her | V 736 | | | | | | | | |

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STATE FORM SIAC11 If continuation sheet 2 of 2