PRINTED: 04/25/2022 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION (X1 NAME OF PROVIDER OR SUPPLIER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING DDRESS, CITY, STATE, ZIP CODE		(X3) DATE SURVEY COMPLETED 04/22/2022	
		MHL019-068				
		STREET A			• -	· · · ·
CAROLII	NA HOUSE		HIGHWAY 751 M, NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG PREFIX TAG PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)		TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
∨ 000	INITIAL COMMENTS		V 000			
	An annual survey was completed on April 22, 2022. A deficiency was cited.					
	This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.					
	This facility is licensed for 6 beds and currently has a census of 2. The survey sample consisted of audits of 2 current clients.					
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification		V 131			
	REGISTRY (d2) Before hiring h health care facility of health care facility s Personnel Registry	EALTH CARE PERSONNEL ealth care personnel into a or service, every employer at a shall access the Health Care and shall note each incident propriate business files.	a			
	This Rule is not me	et as evidenced by:				
	Based on record re failed to access the Registry (HCPR) pr	view and interview, the facility Health Care Personnel for to employment for one of Staff #1). The findings are:				
	records revealed: -Hire date of 12/27/	of Staff #1's personnel 21. a Behavioral Health Associate				

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	of Health Service Re	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED	
		MHL019-068	B. WING		04/	22/2022
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
AROLIN	NA HOUSE		HIGHWAY 751 /I, NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y 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 COMPLET THE APPROPRIATE DATE	
V 131	Continued From page 1		V 131			
	-HCPR check for Staff #1 was completed on 4/22/22.					
	-He started working -He was not aware to be completed for -He was responsibl documentation on r employment.	that the HCPR check up had staff prior to hiring. e for completing all required new employees prior to HCPR was not assessed prior				
	ealth Service Regulation					

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