STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
MUU 000 004		B. WING		R-C <b>05/19/2022</b>		
		MHL026-884	B. WING		05/1	9/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THELO	UNIC HOME INC #4	1710 SCA	MPTON ROA	AD		
THE LOV	/ING HOME, INC #4	FAYETTE\	VILLE, NC 2	8303		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
V 000	INITIAL COMMENT	TS .	V 000			
	A complaint and follow up survey was completed on May 19, 2022. The complaint was substantiated (intake #NC00187856). Deficiencies were cited.  This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.  This facility is licensed for 4 and currently has a census of 4. The survey sample consisted of audits of 1 current client.					
V 542	27F .0105(a-c) Clie Funds	nt Rights - Client's Personal	V 542			
	10A NCAC 27F .01 FUNDS  (a) This Rule applie typically provides reclients for more than (b) Each competer above the age of 16 encouraged to main personal fund accordance to the shall include, be investment of funds (c) If funds are many employee, manage in accordance with (1) assure to and withdraw mone (2) regulate the funds in a personal (3) provide for by friends, relatives (4) provide for financial records on	es to any 24-hour facility which esidential services to individual in 30 days. It adult client and each minor is shall be assisted and intain or invest his money in a unt other than at the facility. But need not be limited to, is in interest-bearing accounts. In aged for a client by a facility ment of the funds shall occur policy and procedures that: the client the right to deposit by; he receipt and distribution of fund account; or the receipt of deposits made				

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
MHL026-884		B. WING			R-C <b>05/19/2022</b>	
THE LOVING HOME INC #4 1710 SCAN			DRESS, CITY, S MPTON ROA VILLE, NC 2		-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOTH CROSS-REFERENCED TO THE APPROPRIES OF THE APP	ULD BE	(X5) COMPLETE DATE
V 542	(5) assure the be kept separate from facility; (6) provide for personal fund accompliation services or legally responsible to admission of the (7) provide for persons depositing (8) provide the	at a client's personal funds will om any operating funds of the or the deduction from a unt payment for treatment or s when authorized by the client le person upon or subsequent	V 542			
	facility failed to (1) r of client personal fu quarterly accounting accounts, affecting findings are: Review on 5/19/22 -37 year old female -Admitted on 1/3/16	view and interviews, the manage and maintain records and sa required and provide g of clients' personal fund 1 of 1 audited client (#2). The of client #2's record revealed:				
	Review on 5/19/22 (Supplemental Sec Dispense Form" fro client #2 revealed: -January: "Balances initialed she received -February: "Balances	of the facility's "Client SSI urity Income) Allowance om January to May 2022 for s" was blank. Client #2				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING.	<del></del>	R-C	
MHL026-884		MHL026-884	B. WING		05/19/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE LOV	/ING HOME, INC #4		MPTON ROA			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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)	LD BE	(X5) COMPLETE DATE
V 542	-March: "Balances initialed she received \$3/29/22April: "Balances" w she received \$33 o -May: "Balances" w she received \$33 o -May: "Balances" w she received \$33 o -May: "Balances" w she received \$30 o -May: "Balances" w she received \$30 o -May: "Balances" w she received \$30 o -May: "Balances" w she received a stirust when experience of the second	103 brought forward" Client #2 ed \$33 on 3/9/22 and \$33 on 3/9/22 and \$33 on 4/27/22. The state of the state	V 542			
	Interview on 5/19/22 the Clinical Director stated: -Every 2 weeks the clients received \$33 from their SSI funds.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMPI	SURVEY LETED	
			A. BOILDING.		R-C		
		MHL026-884	B. WING			05/19/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
THE LOV	/ING HOME, INC #4		MPTON ROA				
(V4) ID	SHIMMADV STA	TEMENT OF DEFICIENCIES	VILLE, NC 2	PROVIDER'S PLAN OF CORRECTION		(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
V 542	Continued From pa	ge 3	V 542				
	it to the group home -The clients signed -Staff were suppose knew the clients fur -Client #2 had a ha managing her mone -He was not sure if fundsThey did not provio statements to the c -If a guardian reque client funds, they pr Allowance Dispensi -Client #2's guardia	client #2 received stimulus  de any quarterly accounting lients or guardians. ested information about the rovided the monthly "Client SSI e Form." n had requested the client rom a former staff and he					
	Interview on 5/19/22 the owner stated: -Client #2 had not received a stimulus paymentShe requested a former staff inquire about why client #2 had not received a stimulus paymentThe facility only provided financial records to guardians when requestedClient #2's guardian requested information about the stimulus payment and client #2 had not received a stimulus payment so nothing was provided.						
V 736	27G .0303(c) Facility and Grounds Maintenance  10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.		V 736				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7.4.2.1.2.4.0.1.001.4.201.0.1			A. BUILDING:	<del></del>		
MHL026-884		B. WING		R-C <b>05/19/2022</b>		
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE LO	/ING HOME, INC #4		MPTON ROA			
(X4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	COMPLETE DATE
V 736	Continued From pa	ige 4	V 736			
	was not maintained and orderly manner and orderly manner of the facing and orderly manner of the some of the facing. A window screen with the home near windown and the facing areas that were peeling. An odor of urine the areas that were peeling. An odor of urine the areas that were peeling. An odor of urine the areas that were peeling. An odor of urine the areas that were peeling. An odor of urine the areas that were peeling. An odor of urine the areas that were peeling. An odor of urine the areas that were peeling. An odor of urine the statement of the laminate of the areas that were peeling. An odor of urine the facility statement of the stat	ion and interview, the facility in a safe, clean, attractive r. The findings are:  9/22 between 9:30am - dity revealed: was leaned against the front of dows to the left. ing in the dining area had a about the size of grapefruits aroughout the group home. exterior was worn and the knob control panel. In blind slates were broken  om floor was uneven near the folight bulbs above the ere missing. In carpet had 3 large in stains. In had 2 dressers and each wers that were broken.  2 the clinical director stated: on the floor. Client #2's and a physical reason why				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE COMP		(X3) DATE COMP	E SURVEY PLETED	
		MHL026-884			R-C <b>05/19/2022</b>		
NAME OF	PROVIDER OR SUPPLIER		L	STATE, ZIP CODE	05/1	3/2022	
THE LO	/ING HOME, INC #4		MPTON RO				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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 736	•	ge 5 explore alternatives for client	V 736				

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