Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			7t. BOILDING.				
MHL043047		B. WING 06/27/202			7/2022		
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE							
PROFES	PROFESSIONAL FAMILY CARE HOME #4 122 ORCHARD CREST CIRCLE SANFORD, NC 27330						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
V 000	INITIAL COMMEN	гѕ	V 000				
	An annual, complaint and follow up survey was completed on 6/27/22. The complaint was unsubstantiated (intake #NC00190257). Deficiencies were cited.						
	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.						
	This facility is licensed for 3 and currently has a census of 3. The survey sample consisted of audits of 3 current clients.						
V 736	27G .0303(c) Facili	ty and Grounds Maintenance	V 736				
	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.						
	failed to ensure the safe, clean and attrare:  Observation on 6/2 facility tour revealed.  Hall bathroom	ion and interview the facility home was maintained in a ractive manner. The findings 7/22 at 10:38 am during the d: oilet was loose at the base					

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

TITLE (X6) DATE Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED				
AND FLAN OF CORRECTION IDENTIFICATION NUMBER.		A. BUILDING:			,			
		MHL0430	047	B. WING		06/2	7/2022	
NAME OF PROVIDER OR SUPPLIER STREET AD				DRESS. CITY. S	STATE, ZIP CODE	·		
PROFES	PROFESSIONAL FAMILY CARE HOME #4 122 ORCHARD CREST CIRCLE SANFORD, NC 27330							
()(4) ID	CLIMMA DV CTA	TEMENT OF DEFIC		ID	PROVIDER'S PLAN OF CORRECTI	ON	()(5)	
PREFIX	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)				(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE	
TAG					CROSS-REFERENCED TO THE APPRO	PRIATE	DATE	
					DEFICIENCY)			
V 736	Continued From pa	ige 1		V 736				
	•							
	<ul><li>Hallway</li><li>hall ceiling light</li></ul>	fivture had 2 h	ulbe out					
	- furnace filter wa		ouibs out					
	- furnace filter gr		nd would not					
	latch	1140 10000 41	Hould Hot					
	- Client #3's bed	room						
	- one bulb out in	the ceiling light	t fixture					
	- ceiling light fixture was missing fixture cover							
	<ul> <li>Client #2's bedroom</li> <li>ceiling light fixture missing fixture cover</li> <li>door would not latch, missing door strike</li> </ul>							
	plate							
	- Client #1's bed	room.						
	- 3 bulbs out in fa							
	- 1 bulb out over vanity over sink							
		•						
	- Garage							
	<ul> <li>missing overhe</li> </ul>							
	<ul> <li>light switch to the garage taped over</li> <li>no electrical light in the garage, must open</li> <li>the garage door to let in light</li> <li>washer and dryer against the back wall</li> <li>plugged in</li> <li>rusted refrigerator with water leaking on the</li> </ul>							
			e, must open					
	floor							
	- Facility Exterior	-						
	<ul> <li>exterior dryer d</li> </ul>							
	<ul> <li>crawl space do</li> </ul>		ation between					
	the door and the me							
	- one car with rig	ht front passer	iger tire flat in					
	the side yard							
	- one truck behind the facility in the back yard							
	Interview on 6/22/2	2 staff #1 range	ted:					
Interview on 6/23/22 staff #1 reported: - facility repairs were reported to the								
	Residential Director							

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		(X1) PROVIDER/SUPPLI IDENTIFICATION NU		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
MHL043047		B. WING		06/:	06/27/2022			
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1 00		
PROFESSIONAL FAMILY CARE HOME #4  122 ORCHARD CREST CIRCLE								
PROFES	SIONAL FAMILY CAR	RE HOME #4	SANFORI	D, NC 27330				
(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 CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
V 736	Continued From page 2			V 736				
	(RD/QP) - the RD/QP would "take care of it"  Interview on 6/23/22 staff #2 reported: - facility repairs were reported to the RD/QP - thought the facility had a maintenance person that would do the repairs - repairs were usually done in a few days - the car had been parked beside the facility for "2 months or longer" - the car did not run - the truck had been parked behind the facility for "a month" - the truck ran and could be moved - unaware of who the vehicles belonged to  Interview on 6/27/22 the House Manager reported: - facility repairs were reported to the RD/QP - once reported, he believed the company had a maintence person that would make repairs - the car parked beside the facility was his car - did not have a key for the car - he would have to call the dealership and get a key made for the car - would move the car as soon as he had access							
	- the old refriger hauled away - the light switch over because there - the bulb had be installed once it arr - the garage bull long fluorescent bu the truck parketruck and would be	b was a special orde	ould be vas taped ight fixture uld be r 8 foot was his					

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STATE FORM 6899 HI0C11 If continuation sheet 3 of 4

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		·D.	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE COMPLETED			
		MHL043047	B. WING _		06/2	27/2022
NAME OF I	PROVIDER OR SUPPLIER	ST	REET ADDRESS, CIT	, STATE, ZIP CODE		
PROFES	SIONAL FAMILY CAR	'E H()ME #4	22 ORCHARD CRE ANFORD, NC 273			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATION	L PREFIX N) TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
V 736	would be moved fro	om the premises immed ompleted by the facility or himself if they needed		DEFICIE		

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