PRINTED: 07/14/2022 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				
			A. BUILDING:						
		MHL080-086	B. WING		06/29/2022				
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE					
BEARD STREET 1205 BEARD STREET SALISBURY, NC 28144									
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ETE			
V 000	INITIAL COMMENTS		V 000						
	Deficiencies were cite This facility is license category: 10A NCAC	s completed on 06/29/2022. ed. d for the following service 27G .5600C Supervised Developmental Disability.							
		d for 3 and currently has a vey sample consisted of ents.							
V 131	G.S. 131E-256 (D2) I Verification	HCPR - Prior Employment	V 131						
	REGISTRY (d2) Before hiring hea health care facility or health care facility sh Personnel Registry a	ALTH CARE PERSONNEL 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 ensur Registry (HCPR) was of 3 Staff (#2). The fir Review on 06/28/202 record revealed: -Hire date of 12/16/20	view and interviews, the e the Health Care Personnel accessed prior to hire for 1 ndings are: 2 of Staff #1's personnel 200. upport Associate (DSA).							

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

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED				
		MHL080-086	B. WING		06	/29/2022				
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1205 BEARD STREET SALISBURY, NC 28144									
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE				
V 131	Continued From page Interview on 06/29/20 -Employed with Licen -Served as a DSA. Interview on 06/29/20 Professional (QP) rev -Human Resource (H responsible for HCPR Interview on 06/29/20 revealed: -Not sure why HCPR #1.	22 with Staff #1 revealed: see since 12/16/2020. 22 with the Qualified ealed: R) Coordinator was	V 131		PROPRIATE	DATE				

Division of Health Service Regulation

STATE FORM YGR711 If continuation sheet 2 of 2