PRINTED: 09/01/2022 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: _ | | | | | | | | |
| | | MHL011-433 | B. WING | | 08/31/2022 | | | | | | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | | | | | | | |
| STEWART HOME 35 EILEEN WAY LEICESTER, NC 28748 | | | | | | | | | | | |
| (X4) ID | SUMMARY ST | PROVIDER'S PLAN OF CORRECTION | N | (X5) | | | | | | | |
| PREFIX TAG | • | Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | | COMPLETE DATE | | | | | |
| V 000 | INITIAL COMMENTS | | V 000 | | | | | | | | |
| | An annual survey was Deficiencies were cite | s completed on 8-31-22. ed. | | | | | | | | | |
| | This facility is licensed for the following service category: 10A NCAC 5600F Supervised Living for Alternative Family Living. | | | | | | | | | | |
| | _ | d for 3 and currently has a ey sample consisted of ents. | | | | | | | | | |
| V 131 | G.S. 131E-256 (D2) H Verification | HCPR - Prior Employment | V 131 | | | | | | | | |
| | REGISTRY (d2) Before hiring hea health care facility or health care facility sha | LTH 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 acces Registry (HCPR) prio affecting 1 of 2 audite Professional). The fin | ews and interviews, the s the Health Care Personnel r to an offer of employment d staff (Qualified dings are: the Qualified Professional's | | | | | | | | | |

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

TITLE (X6) DATE

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Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | | | |
|--|--|---|--|--|-------------|----------------------------|--|--|--|
| MHL011-433 | | | B. WING | B. WING | | | | | |
| NAME OF PROVIDER OR SUPPLIER STEWART HOME MHL011-433 B. WING B. WIN | | | | | | | | | |
| (X4) ID PREFIX TAG | 4) ID SUMMARY STATEMENT OF DEFICIENCIES REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5) COMPLETE DATE | | | |
| V 131 | -HCPR accessed on 6 Interview on 8-31-22 revealed: -Aware the start date the HCPRThere are two people checks, one for new higher checks. Interview on 8-31-22 revealed: -Aware the QP had be survey at a sister faciling- | with the Office Assistant for the QP doesn't match who complete HCPR hires and one for yearly with the CEO revealed: een cited before during a lity. le in Human Resources that liks, one for new hires and | V 131 | | | | | | |

Division of Health Service Regulation

STATE FORM 6899 CIH111 If continuation sheet 2 of 2