Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
			A. BOILDING		R	
		MHL059-072	B. WING		01/05/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE		
CLEARS	KY GROUP HOME		ROAD STREET			
OLLAN SI	CT GROOF HOME	MARION	I, NC 28752		1	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETE	
V 000	INITIAL COMMENTS		V 000			
	A follow up survey wa deficiency was cited.	as completed on 1/5/23. A				
		d for the following service 27G .1700 Residential re for Children or				
		d for 8 and currently has a vey sample consisted of ents.				
V 131	G.S. 131E-256 (D2) Horification	HCPR - Prior Employment	V 131			
	REGISTRY (d2) Before hiring hea health care facility or health care facility sh	alth care personnel into a service, every employer at a all access the Health Care and shall note each incident opriate business files.				
	failed to ensure the H Registry (HCPR) was of employment affecti #2). The findings are	ew and interview, the facility ealth Care Personnel accessed prior to an offer ng 1 of 3 audited staff (Staff : Staff #2's record revealed:				

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

TITLE (X6) DATE

PRINTED: 01/12/2023 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		B. WING		I	R	
	MHL059-072	B. WING		01	/05/2023	
NAME OF PROVIDER OR SUPPLIER		DDRESS, CITY, STAT	TE, ZIP CODE			
CLEAR SKY GROUP HOME		ROAD STREET , NC 28752				
PREFIX (EACH DEFICIENCY MI	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE	
V 131 Continued From page 1 -HCPR dated 6/17/22. Interview on 1/5/23 with revealed: -Staff #2 was hired befor background check proce-was submitting backgro HCPR, through DHHS (I Human Services) which one month to receive resenow used a third party or results were returned in	re he changed his ss; und checks, including Department of Health and sometimes took up to sults; company for HCPR and	V 131				

Division of Health Service Regulation

STATE FORM UNBF11 If continuation sheet 2 of 2