NAME OF PROVIDER OR SUPPLIER  THE LOVING HOME, INC  SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  PROVIDER'S PLAN OF CORRECTION PREFIX TAG  PREFIX TAG  PREFIX TAG  PREFIX TAG  PROVIDER'S PLAN OF CORRECTION PREFIX TAG	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` 'e			3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  THE LOVING HOME, INC  SUMMARY STATEMENT OF DEFICIENCIES PRETEX TAG  PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CARD THE CORRECTION OF THE APPROPRIATE DIET OF THE A	74101 1541			A. BUILDING:				
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PAPETEVILLE, NC 28312   PROVIDERS NAN OF CORRECTION   PROVIDERS NAN OF CORRECTION   PROVIDERS NAN OF CORRECTION   PREFIX TAG   PREFIX   PROVIDERS NAN OF CORRECTION   PREFIX TAG   PREFIX   PROVIDERS NAN OF CORRECTION   PROVIDERS NAN OF CO	NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
PRÉFIX TAG  REGULATORY OR LOS IDENTIFYING INFORMATION)  V 000  INITIAL COMMENTS  An annual and follow up survey was completed on May 10, 2023. Deficiencies were cited.  This facility is licensed for the following category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.  This facility is licensed for 3 and currently has a census of 2. The survey sample consisted of audits of 2 current clients and 1 former client.  V 114  27G .0207 Emergency Plans and Supplies  (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority.  (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.  (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterity and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies.  (d) Each facility shall have basic first aid supplies accessible for use.  This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure fire drills were held quarterly and repeated on each shift. The findings are:	THE LOV	ING HOME, INC						
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Review on 5/09/23 of the facility's fire and		Based on record re facility failed to ens quarterly and repea	views and interviews the ure fire drills were held					
Division of Health Service Regulation			of the facility's fire and					

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		MHL026-761	B. WING		05/1	0/2023
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE LOV	ING HOME, INC		EDONIA CH VILLE, NC 2	URCH ROAD 8312		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE
V 114	Continued From pa	ge 1	V 114			
	disaster drill documentation April 2022 - March 2023 revealed:  - No fire drill for the second shift during the 2nd quarter (April - June) 2022.  - No fire drills for the first or third shifts during the first quarter (January - March) 2023.  During interview on 5/09/23 client #1 stated she participated in fire drills; she went outside "by the pump house" for fire drills.  During interview on 5/09/23 client #2 stated she participated in fire drills; she went outside for fire					
	During interview on 5/09/23 staff #1/the House Manager stated:  - The facility operated with 3 shifts: first 8:30 am - 4:00 pm; second 4:00 pm - 10:00 pm; third 10:00 pm - 8:00 am.  - Drills were held monthly on each shift.  During interview on 5/10/23 the Qualified Professional/Director stated he understood the requirement for fire drills to be held quarterly and repeated on each shift.					
V 118	10A NCAC 27G .02 REQUIREMENTS (c) Medication adm (1) Prescription or r only be administere order of a person a drugs. (2) Medications sha		V 118			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY PLETED
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MHL026-761		B. WING			10/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE LO	VING HOME, INC		CEDONIA CH VILLE, NC 2	IURCH ROAD 8312		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 118	(3) Medications, incadministered only bunlicensed persons pharmacist or other privileged to prepar (4) A Medication Acall drugs administe current. Medication recorded immediate MAR is to include the (A) client's name; (B) name, strength, (C) instructions for (D) date and time the (E) name or initials drug. (5) Client requests checks shall be recorded immediate.	cluding injections, shall be by licensed persons, or by a trained by a registered nurse, regally qualified person and re and administer medications. Imministration Record (MAR) of red to each client must be kept a administered shall be ely after administration. The	V 118			
	facilty failed to ensu	et as evidenced by: views and interviews the ure medications administered he MAR immediately after cting 1 of 2 current clients (#2).				
	- 37 year old female - Diagnoses include					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			,
		MHL026-761	B. WING		F 05/1	0/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE LOV	ING HOME, INC			URCH ROAD		
040.15	CLIMMA DV CTA		VILLE, NC 2		ON	0.(5)
(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)	OULD BE COMPLETE	
V 118	Continued From pa	ge 3	V 118			
		signed 12/22/22 for divalproex nd Bi-Polar Disorder) 500 ablet twice daily.				
	Review on 5/09/23 of client #2's MARs for February - May 2023 revealed: - Transcription for divalproex sodium 500 mg 1 tablet twice daily at 7:00 am and 7:00 pm No staff documentation of administration of client #2's 7:00 pm dose of divalproex sodium 4/24/23 through 4/30/23 No documented explanation for the blanks.					
	Review on 5/09/23 of the medication count log for client #2's divalproex sodium revealed staff documented administration of the medication as ordered.					
	During interview on 5/09/23 client #2 stated: - She took her medications daily with staff assistance She never missed any of her medications.					
	During interview on 5/09/23 staff #1/the House Manager stated: - She was sure the 7:00 pm doses of client #2's divalproex sodium was administered 4/24/23 through 4/30/23 "Somebody skipped it. It was given, but not documented" on the MAR.					
	Professional/Director requirement for me	5/10/23 the Qualified or stated he understood the dication administration to be MARs immediately.				
V 131	G.S. 131E-256 (D2 Verification	) HCPR - Prior Employment	V 131			

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WCHG11 If continuation sheet 4 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` 'co			DATE SURVEY COMPLETED	
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		MHL026-761	B. WING		05/10	0/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
THE LOV	ING HOME, INC			URCH ROAD			
		FAYETTE	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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	SHOULD BE COMPLETE		
V 131	Continued From pa	ge 4	V 131				
	G.S. §131E-256 HE REGISTRY (d2) Before hiring h health care facility of health care facility of Personnel Registry	EALTH CARE PERSONNEL  ealth care personnel into a or service, every employer at a shall access the Health Care and shall note each incident propriate business files.					
	This Rule is not met as evidenced by: Based on record review and interview the facility failed to complete Health Care Personnel Registry (HCPR) check prior to hire for 1 of 3 audited staff (#2). The findings are:						
	Reviews on 5/09/23 and 5/10/23 of staff #2's personnel record revealed: - Hire date 5/29/22 No documented HCPR check completed prior to hire.						
	Professional/Direct - He was sure staff completed as requi - He could not local HCPR check He understood the checks to be comp	#2's HCPR check was red. te staff #2's pre-employment e requirement for HCPR					
V 736	27G .0303(c) Facili	ty and Grounds Maintenance	V 736				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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		MHL026-761	B. WING			0/2023
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE LOV	/ING HOME, INC	4944 MAC	EDONIA CH	URCH ROAD		
THE LOV	AING HOME, INC	FAYETTE	VILLE, NC 2	8312		
(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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 736	Continued From pa	ge 5	V 736			
	10A NCAC 27G .03 EXTERIOR REQUI (c) Each facility and maintained in a safe	03 LOCATION AND				
	This Rule is not met as evidenced by: Based on observations and interviews the facility was not maintained in a clean and attractive manner. The findings are:					
	Observations on 5/09/23 at 10:20 am revealed:  - The drawer to the right side of the stove was off the track.  - The chandelier in the dining room was missing 2 light bulbs; 1 light bulb was not working.  - The hall bathroom sink had dark rust stains at the drain and the overflow hole and white residue/corrosion on the faucet and controls; latex gloves hanging over the closed vanity door.  - Damage to the inside bottom of the wooden bathroom door.					
	<ul> <li>Paint peeling in the closet.</li> <li>Damage to the outhouth (client #1' bedroothe doorknob, an apunifinished repair arround hole.</li> <li>A drawer was missin bedroom #1; there closet; the headboar</li> </ul>	te bathtub faucet control. e hallway above the linen  tside of the door to bedroom om) included a crack below oproximate 4 inch oval shape and an approximate 1 inch  sing from the 4 drawer chest re was no covering over the and was not attached to the held against the wall by the				

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STATE FORM 6899 WCHG11 If continuation sheet 6 of 7

AND PLAN OF CORRECTION  MHL026-761  MHL026-761  MHL026-761  MHL026-761  MHL026-761  MHL026-761  MHL026-761  MHL026-761  MHL026-761  STREET ADDRESS, CITY, STATE, ZIP CODE  4944 MACEDONIA CHURCH ROAD FAVETTEULLE, NC 28312  PREFIX TAG  PREFIX TAG  V 736  Continued From page 6  mattress and box spring, - The ceiling fan in bedroom #1 was dusty and the light fixture had no globe There were no coverings over the closets in bedroom #2 The walk in shower for bedroom #3 had rust stains on the tile walks; the toilet tank cover was too large and did not fit securely; white residue/corrosion on the sink fixture; no covering on the light fixture on the back porch Walls and painted surfaces throughout the facility were scuffed and scratched.  During interview on 5/09/23 staff #1/the House Manager stated the facility had been cited for damage to the door to bedroom #1.  During interview on 5/10/23 the Qualified Professional/Director stated maintenance staff were at the facility making repairs and removing the washing machine from the back porch.  This deficiency has been cited 3 times since the original cite on 10/14/20 and must be corrected within 30 days.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MUI TIPI	E CONSTRUCTION	(X3) DATE	SURVEY	
MHL026-761    MHL026-761   STREET ADDRESS, CITY, STATE, ZIP CODE   STREET ADDRESS, CITY, STATE, ZIP CODE   STATE LOVING HOME, INC   SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX   CACH DEFICIENCY MUST BE PRECEDED BY FULL   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX   TAG   PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE   DATE							
MAME OF PROVIDER OR SUPPLIER THE LOVING HOME, INC  STREET ADDRESS, CITY, STATE, ZIP CODE 4944 MACEDONIA CHURCH ROAD FAYETTEVILLE, NC 28312  (X4) ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 736  Continued From page 6 mattress and box spring.  - The ceiling fan in bedroom #1 was dusty and the light fixture had no globe.  - There was no globe over the light fixture in bedroom #2 (clent #2's bedroom).  - The walk in shower for bedroom #3 had rust stains on the tile walls; the toilet tank cover was too large and did not fit securely; white residue/corrosion on the sink fixture; no covering on the light fixture above the bathroom sink.  - A disconnected washing machine was stored on the back porch.  - Walls and painted surfaces throughout the facility were souffed and scratched.  During interview on 5/09/23 staff #1/the House Manager stated the facility had been cited for damage to the door to bedroom #1.  During interview on 5/10/23 the Qualified Professional/Director stated maintenance staff were at the facility making repairs and removing the washing machine from the back porch.  This deficiency has been cited 3 times since the original cite on 10/14/20 and must be corrected				7 ti BOILBIITO.		_	
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THE LOVING HOME, INC  ### MACEDONIA CHURCH ROAD FAYETTEVILLE, NC 28312    CALIFORNIA   SUMMARY STATEMENT OF DEFICIENCIES (LEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE      V 736						03/1	0/2023
THE LOVING HOME, INC  FAYETTEVILLE, NC 28312    (A4)   D   PROVIDER'S PLAN OF CORRECTION   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)    V 736	NAME OF F	PROVIDER OR SUPPLIER					
SUMMARY STATEMENT OF DEFICIENCIES   PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)    V 736	THE LOV	ING HOME, INC					
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		mattress and box syarane ceiling fan in be the light fixture had a composition of the light fixture had a composition of the light in shower stains on the tile was too large and did not residue/corrosion of the light fixture a composition of the light fixture and the back porch.  During interview on Manager stated the damage to the door During interview on Professional/Director were at the facility in the washing machin.  This deficiency has original cite on 10/1	pring. bedroom #1 was dusty and no globe. verings over the closets in #2's bedroom). be over the light fixture in er for bedroom #3 had rust alls; the toilet tank cover was of fit securely; white n the sink fixture; no covering above the bathroom sink. ashing machine was stored on surfaces throughout the and scratched.  5/09/23 staff #1/the House facilty had been cited for to bedroom #1.  5/10/23 the Qualified or stated maintenance staff making repairs and removing he from the back porch.				

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