Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION		(X3) DATE SURVEY COMPLETED						
MHL080-169		B. WING			R <b>05/07/2024</b>							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
CABARRUS COUNTY GROUP HOME 10  160 CAMELOT ROAD SALISBURY, NC 28147												
(VA) ID	SHIMMADV STA	TEMENT OF DEFICIENCIE			PROVIDER'S PLAN OF	COPPECTION	(VE)					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE					
V 000	V 000 INITIAL COMMENTS			V 000								
		w up survey was cor deficiency was cited.										
	category: 10A NCA	sed for the following C 27G .5600C Supe h Developmental Dis	rvised									
		ed for 6 and current irvey sample consist clients.										
V 131	G.S. 131E-256 (D2 Verification	) HCPR - Prior Empl	oyment	V 131								
	G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.											
	facility failed to according Registry (HCPR) pr 2 of 3 audited staff  Review on 5/1/24 o -Date of Hire: 8/25/ -Title: Group Home	views and interviews ess the Health Care ior to the date of hire (#1 and #2). The find f staff #1's record re 17;	Personnel e affecting dings are: vealed:									

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

TITLE (X6) DATE 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						
				7. BOILDING.			R						
MHL080-169		0-169	B. WING			05/07/2024							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE													
CABARRUS COUNTY GROUP HOME 10  160 CAMELOT ROAD SALISBURY, NC 28147													
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	(X5) COMPLETE DATE							
V 131	Continued From particles Review on 5/1/24 or record revealed: -Date of Hire: 10/13 -Qualified Profession-Health Care Personal Interview on 5/1/24 Assistant (AA) revenuely assistant (AA) revenuely assistant (AB) revenuely	of the Qualified 3/08; conal; connel Registry with the Adm ealed: nd HCPR at the HCPR who completed.	: 3/4/09. inistrative ne same time;" nen new hire inistrator	V 131									

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Division of Health Service Regulation STATE FORM