

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL033-058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/05/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WAY FARER COURT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>145 WAY FARER COURT ROCKY MOUNT, NC 27801</b>
--	---

(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)	(X5) COMPLETE DATE
V 000	<p><b>INITIAL COMMENTS</b></p> <p>An annual and follow up survey was completed on 9/5/24. A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.</p> <p>This facility is licensed for 5 and currently has a census of 3. The survey sample consisted of audits of 3 current clients.</p>	V 000		
V 774	<p><b>27G .0304(d)(7) Minimum Furnishings</b></p> <p><b>10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT</b></p> <p>(d) Indoor space requirements: Facilities licensed prior to October 1, 1988 shall satisfy the minimum square footage requirements in effect at that time. Unless otherwise provided in these Rules, residential facilities licensed after October 1, 1988 shall meet the following indoor space requirements:</p> <p>(7) Minimum furnishings for client bedrooms shall include a separate bed, bedding, pillow, bedside table, and storage for personal belongings for each client.</p> <p>This Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure clients' bedrooms had minimum furnishings. The findings are:</p> <p>Observation on 9/4/24 at 1:05pm of the facility revealed: - 2 empty bedrooms without the following:</p>	V 774		

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:  <b>MHL033-058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/05/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WAY FARER COURT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>145 WAY FARER COURT</b> <b>ROCKY MOUNT, NC 27801</b>
--	---

(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)	(X5) COMPLETE DATE
V 774	<p>Continued From page 1</p> <ul style="list-style-type: none"> <li>- a separate bed, bedding, pillow, bedside table and storage for personal belongings</li> </ul> <p>During interview on 9/4/24 &amp; 9/5/24 the Facility's Director reported</p> <ul style="list-style-type: none"> <li>- one client moved out a week ago and the other client 5 months ago</li> <li>- the furniture belonged to the clients</li> <li>- on 7/5/24, the Facility Director said furniture was ordered today (7/5/24) for both bedrooms</li> </ul>	V 774		