Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED						
			A. BOILDING.			2						
		MHL048003	B. WING			1/2025						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
HYDE COUNTY GROUP HOME 9400 PINEY WOODS ROAD												
FAIRFIELD, NC 27826												
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETE DATE							
V 000	INITIAL COMMENTS		V 000									
	An annual and follo on 5/21/25. A defici	w up survey was completed ency was cited.										
	category: 10A NCA	sed for the following service C 27G .5600C Supervised h Developmental Disability.										
		sed for 6 and has a current urvey sample consisted of clients.										
V 774	7774 27G .0304(d)(7) Minimum Furnishings		V 774									
	10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT  (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:  (7) Minimum furnishings for client bedrooms shall include a separate bed, bedding, pillow, bedside table, and storage for personal belongings for each client.											
	failed to ensure mir bedrooms that inclubedside table, and s belongings. The fine	on and interview, the facility nimum furnishings for client ided a bed, bedding, pillow, storage for personal										

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 (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED							
			A. BOILDING.		F	,						
		MHL048003	B. WING			1/2025						
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE								
HYDE COUNTY GROUP HOME 9400 PINEY WOODS ROAD FAIRFIELD, NC 27826												
(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)	(X5) COMPLETE DATE							
V 774	11:29am revealed: - An unoccupied bedside table or sto - The bedroom of the properties of the properti	client bedroom with no bed, brage for personal belongings contained the following: tube television on the floor with and a cable box sat on top rocking chair with 3 standard tacked in the chair seat.  5 the Qualified Professional of bedroom had been empty and to the discharge in July of 2024 and the facility and took the bedroom and another admission and replace the furniture once they the in date for the admitting client of the Director reported: The profession and the interest of the profession and the p	V 774									

6899

Division of Health Service Regulation STATE FORM

8QZF11 If continuation sheet 2 of 2