

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL054-155	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/28/2018
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ABHS 4124 NORTHFORK	STREET ADDRESS, CITY, STATE, ZIP CODE 4124 NORTHFORK DRIVE LA GRANGE, NC 28551
--	--

(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>INITIAL COMMENTS</p> <p>An annual and follow up survey was completed on March 28, 2018. 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 Disabilities.</p>	V 000		
V 736	<p>27G .0303(c) Facility and Grounds Maintenance</p> <p>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain the facility in an attractive and safe manner. The findings are:</p> <p>Observation on 03/28/18 at approximately 10:00am revealed:</p> <ul style="list-style-type: none"> -The control panel on the stove was sticky to the touch and visibly soiled. -The refrigerator door handle was being held to the door with clear packing tape. -The carpet in client #4's bedroom had soiled and stained carpet and a large ripped/torn area next to the bed in the carpet. -The entrance into client #2 and client #5's bedroom the carpet appeared to be torn and pulling away from sub floor. -Several of the light fixtures throughout the facility needed light bulbs. -The light fixture in the laundry room was missing the globe. 	V 736		

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: MHL054-155	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/28/2018
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ABHS 4124 NORTHFORK	STREET ADDRESS, CITY, STATE, ZIP CODE 4124 NORTHFORK DRIVE LA GRANGE, NC 28551
--	--

(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 736	<p>Continued From page 1</p> <p>Interview on 03/28/18 the Licensee stated: - She would follow up on needed repairs at the facility with the Landlord.</p> <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 736		