PRINTED: 06/05/2018 FORM APPROVED

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							
		MHL011-369	B. WING		06/0	5/2018						
NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
CYNTHIA'	S PLACE	45 EYE VIE CANDLER	W ROAD NC 28715									
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	(X5) COMPLETE DATE							
V 000	INITIAL COMMENTS		V 000									
	An annual survey was deficiency was cited.	s completed on 6/5/18. One										
	categories:	d for the following service O Residential Treatment for sents -Level III										
V 736	27G .0303(c) Facility	and Grounds Maintenance	V 736									
		EMENTS										
	bedroom flooring in the	ns and interviews, the Client										
	following items to be replacement: The facility's two clier the carpet had severa both rooms. These st entranceways and be greatest and spills ap time. The carpet in in both needed to have a ger	18 at 1:30 PM revealed the in need of cleaning or not bedrooms were carpeted; al dark stains throughout ains appeared in door eside beds where use was appearently occurred over client bedrooms also neral all purpose cleaning the carpeting from foot traffic.										

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

(X6) DATE TITLE

PRINTED: 06/05/2018 FORM APPROVED

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	
		MHL011-369	B. WING		06	/05/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	E, ZIP CODE			
CYNTHIA	S PLACE		VIEW ROAD ER, NC 28715				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE			
V 736	Continued From page 1		V 736				
	time. Staff had attemptimes where spills occurred	stained by client spills over oted to spot clean areas perative and planned to					

Division of Health Service Regulation

STATE FORM PGJ911 If continuation sheet 2 of 2