

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-248	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/27/2018
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NAME OF PROVIDER OR SUPPLIER EVANS-WALSTON HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 808 HAWKS VIEW COURT FUQUAY VARINA, NC 27526
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(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 Survey was completed 09/27/18. A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G 5600F Supervised Living/Alternative Family Living</p>	V 000		
V 736	<p>27G .0303(c) Facility and Grounds Maintenance</p> <p>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS</p> <p>(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 was not maintained in a clean and orderly manner. The findings are:</p> <p>Observation and tour on 09/27/18 between 3:30P-5:30P revealed: -Banister leading to the upstairs loose -Carpet on banister steps worn and torn causing possible trip hazard</p> <p>Interview on 09/27/18, the Licensee reported: -She was aware of issues with the banister and carpet -Estimates for repairs had been completed.... had not secured a date for repairs to be completed</p>	V 736		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____