PRINTED: 11/29/2018 FORM APPROVED

Division c	of Health Service Regu	lation			FORWAPPROVED						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED						
		MHL034-172	B. WING		11/28/2018						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
COMMUNITY ASSISTED RESIDENTIAL ENVIRONMEN  2530 MERRIMONT DRIVE WINSTON-SALEM, NC 27107											
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON SHOULD BE COMPLETE BE APPROPRIATE DATE						
V 000	INITIAL COMMENTS		V 000								
	An annual survey was A deficiency was cited	s completed on 11/28/2018. d.									
	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.										
V 738	27G .0303(d) Pest Control		V 738								
	10A NCAC 27G .0303 EXTERIOR REQUIRI (d) Buildings shall be rodents.										
	facility was not mainta findings are:  Observation at approx 11/27/2018 revealed: - The County Sanitation doors to the lower call - Mouse droppings we Review on 11/28/2018 Residential Care Faci Sanitation Inspector range - A total of 6 demerits Control" due for "effect other vermin" and "breeding areas."	n, review and interviews, the sained free of rodents. The eximately 3:30 Pm on on Inspector opened the binets in the kitchen; ere present in the cabinets.  B of the "Inspection of lity" report by the County									

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

TITLE (X6) DATE

PRINTED: 11/29/2018 FORM APPROVED

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL034-172		B. WING		11/28	/2018	
	ROVIDER OR SUPPLIER	TIAL ENVIRONMEN	2530 MERR	RESS, CITY, STA IMONT DRIVE SALEM, NC 2	Ē			
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	E ACTION SHOULD BE COMPLETE TO THE APPROPRIATE DATE		
V 738	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		V 738					

Division of Health Service Regulation

STATE FORM 6899 MQ7T11 If continuation sheet 2 of 2