

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: mhl059-035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RECOVERY VENTURES CORPORATION	STREET ADDRESS, CITY, STATE, ZIP CODE 904 DAVISTOWN ROAD OLD FORT, NC 28762
--	---

(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 complaint survey was completed on 1/10/19. The complaint was unsubstantiated (Intake #NC00146023). A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .4300 Therapeutic Community</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 interviews, the facility was not maintained in a clean, attractive and orderly manner. The findings are:</p> <p>Observation on 1/9/19 at approximately 11:20am of the client rooms revealed: -Room #2 had mold above the bathtub in the left corner on the ceiling, approximately 2 x 8 inches. -Room #7 had mold on the ceiling above the bed in the right corner, approximately 6 inches. -Room #8 had a small hole above the bathroom sink, the area was moist around the hole.</p> <p>Interview on 1/9/19 with the Facilities Manager revealed: -He generally did a walkthrough of the facility a minimum of once each week. -The facility did not have an issue with mold. -He was not aware of the mold or the moisture</p>	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: mhl059-035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RECOVERY VENTURES CORPORATION	STREET ADDRESS, CITY, STATE, ZIP CODE 904 DAVISTOWN ROAD OLD FORT, NC 28762
--	---

(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	Continued From page 1 issue in the client areas. -He was sure there was no mold in the attic area of the building. -He would ensure the mold and moisture was resolved.	V 736		