

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL054-172</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/07/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ABHS - 4123 - NORTHFORK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4123 NORTHFORK DRIVE LA GRANGE, NC 28551</b>
--	--

(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><b>INITIAL COMMENTS</b></p> <p>An annual and follow up survey was completed on March 7, 2019. 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><b>27G .0303(c) Facility and Grounds Maintenance</b></p> <p><b>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS</b></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 an attractive and orderly manner. The findings are:</p> <p>Observation on 3/7/19 at approximately 1:30 pm of the facility revealed:</p> <ul style="list-style-type: none"> <li>- One light bulb in the 4 bulb light fixture in the kitchen was not working.</li> <li>- Cabinet doors in the kitchen did not close properly.</li> <li>- Client #1's dresser was missing drawer pulls.</li> <li>- The television stand in client #3's bedroom had a broken drawer and no drawer pull.</li> <li>- 2 light bulbs in the 4 bulb light fixture in client #3's bedroom did not work.</li> <li>- The paint was peeling around the sink in the hall bathroom.</li> <li>- A green recliner in the living room with the arm broken loose and hanging away from the body of</li> </ul>	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:  <b>MHL054-172</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/07/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ABHS - 4123 - NORTHFORK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4123 NORTHFORK DRIVE</b> <b>LA GRANGE, NC 28551</b>
--	--

(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>the chair.</p> <ul style="list-style-type: none"> <li>- The upholstery on a brown sofa in the living room was worn and appeared dirty.</li> <li>- Carpet throughout the facility was soiled.</li> </ul> <p>During interview on 3/7/19 Qualified Professional/Co-Owner #1 stated the property owner/landlord was not very responsive to requests for repairs.</p> <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 736		