PRINTED: 08/29/2019 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: MHL092-412 NAME OF PROVIDER OR SUPPLIER STREET AD			(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 08/20/2019	
		MHI 092-412				
		DDRESS, CITY, STATE, ZIP CODE				
RADLE	Y HOME EXTENSION		LIBU DRIVE H, NC 27603			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLE DATE
∨ 000	INITIAL COMMENTS		V 000			
	An annual survey was completed on 08/20/19. A deficiency was cited.					
	The facility is licensed for the following service category: 10A NCAC 27G 5600A Supervised Living for Adults with Mental Illness.					
V 736	27G .0303(c) Facility and Grounds Maintenance		V 736			
	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.		,			
	Based on observat	et as evidenced by: ion and interview, the facility I in a clean, attractive and ne findings are:				
	am revealed:	0/19 at approximately 10:10 floor had several soft spots				
	 Bedroom #2 (emp were on the floor not Hallway bathroom smelled of urine. 	oty client room) mattresses o bed frames. o 3 out of 5 clients used garette smoke in client #3 and				
	client #4's bedroom - Client #3 and #4's cigarette butts on th	bedroom had several				
		, leaning against the door				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB MHL092-412		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 08/20/2019	
		MHL092-412				
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST LIBU DRIVE H, NC 27603	TATE, ZIP CODE		
X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLET DATE
V 736	 The toilet in client overflowed and way Interview on 08/20/ The toilet sometime remember if it had Sometimes he will he knew he was noted Closet door has be remember how long Closet door has be remember how long Interview on 08/19/ She came to the feature of the clients clother cigarette smoke. Will have someoned toilet. The clients clother cigarette smoke. Will have someoned They know they at their rooms. 	 #3 and #4's bathroom had ter was on the floor. 20 Client #3 stated: nes overflowed, did not overflowed this morning. I smoke cigarettes in his room of suppose to. een broken for awhile, did not g. 19 the Licensee stated: 				

L5ZI11