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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPF IDENTIFICATION		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL063-100		B. WING		11/2	11/26/2019		
	NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  778 HOFFMAN ROAD  WEST END, NC 27376						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	ΓS		V 000			
V 736	An annual, complai completed on Nove was substantiated. Complaints were ur #NC00156830; #NC cited.  This facility is licens category: 10A NCAC 27G 190 Treatment for Child	ember 26, 2019. A (Intake #NC00156 nsubstantiated (Int C00157717) A defined for the following On Psychiatric Resorter and Adolescents  Ty and Grounds M	complaint 6639) rake riciency was rig services sidential ints.	V 736			
	10A NCAC 27G .03 EXTERIOR REQUI (c) Each facility and maintained in a safe manner and shall b odor.	REMENTS I its grounds shall e, clean, attractive	be and orderly				
	This Rule is not me Based on observati staff failed to mainta and orderly manner	ons and interviews ain the facility in a	s, the facility safe, clean				
	Observations during 26/19 revealed the 1. Wooden door en (occasionally used - cracked revealing side of the door fram - a large plywood w frame which was lo door frame on the recorner thus exposing	following: try from large confor educational pufor a jagged edge onforme. indow held in plactions and pulled awight side and botto	ference rposes) the right e by a metal ray from the				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL063-100		B. WING		11/2	26/2019	
	PROVIDER OR SUPPLIER	ENT CENTER	778 HOFF	DRESS, CITY, S FMAN ROAD ID, NC 27376	STATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCE Y MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 736	screws (installed to the bottom right cor 2. Bathrooms - faci unit-style bathroom one bath tub, four search and condition, thus forcusing that bathroom use the bathroom in currently not occup - Faucets on several and/or do not work turned on) and combard, white and grecorrosion around the Area around sinks counter top, contain on both basin and center top, contain the search tenter to the search tenter tenter tentent tenter to the search tenter tenter tenter tenter tenter tenten	hold the plywood in the lity has three separas. All contain two shainks and two toilets strong, moldy odor, throoms is not in uning clients in the uning clients in the uning clients in the uning clients.) all sinks do not have (no water flows who tained significant areen substance building base. It is basin where sinks a brown, rust-like counter top green substance, who mold between tiles are broken and/or mold between tiles are broken and/or mold between tiles and the significant are seen substance, who mold between tiles are broken and/or mold between tiles are broken and freezer has to store food contained with a green should be a staff to store food containe	frame. ate howers, inusable it usually nit area to it is handles en faucet is mounts of a -up and sits in e substance hite on the hissing the interior ubstance by as they e or screen fintainers in shelves. id d finger mmon area ed at the is in client					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
		MHL063-100	B. WING		11/2	26/2019	
	PROVIDER OR SUPPLIER	ENT CENTER 778 HOF	DDRESS, CITY, S FMAN ROAD ND, NC 2737				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 736	Continued From pa	ge 2	V 736				
	Director confirmed	11/26/19, the Executive the above observations.					
	cleanliness in the b	athrooms and kitchen were ne end of the survey.					

6899

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