Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED						
,	o. com.zom.		A. BUILDING:								
		MHL001-220	B. WING		02/0	6/2020					
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE										
GREEN VALLEY HAVEN 2528 ANDERSON ROAD BURLINGTON, NC 27217											
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETE DATE						
V 000	INITIAL COMMENTS		V 000								
	2020. Deficiencies										
	This facility is licensed for the following service category: 10A NCAC 27G. 5600A Supervised Living for Adults with Mental Illness										
V 736	27G .0303(c) Facili	ty and Grounds Maintenance	V 736								
	EXTERIOR REQUI (c) Each facility and maintained in a safe	803 LOCATION AND REMENTS If its grounds shall be e, clean, attractive and orderly e kept free from offensive									
	failed to ensure fac	et as evidenced by: on and interview, the facility ility grounds were maintained I attractive manner. The									
	bedroom located ne	/20 at about 12:05 p.m. of the ext to the living area revealed: ad entrance door was									
		/20 at about 12:10 p.m. of the front of staff office revealed: door was loose/off.									
	hall bathroom revea	ildew around the edges									

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

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMF	(X3) DATE SURVEY COMPLETED					
		MHL001-220	B. WING		02/0	06/2020					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2528 ANDERSON ROAD BURLINGTON, NC 27217											
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE					
V 736	Interview on 2/6/20 revealed: -She was unaware -She was unaware bathroomAgency was resporeplacing items as to painting inside the function of the statement	with the Director/Owner of door frame being loose. of mold/mildew in the nsible for maintaining and they brake down as well as nome. facility failed to ensure facility tained in a safe, clean,	V 736								

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