Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE S	
ANDILAN	O CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		MHL0601078	B. WING		02/1	3/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE NOR	AND HOUSE		AND ROAD TE, NC 28212			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	completed on 2-13-20 unsubstantiated (intal Deficiencies were cite	,				
		27G .1700 Residential				
V 114	27G .0207 Emergend	y Plans and Supplies	V 114			
	AND SUPPLIES  (a) A written fire plan area-wide disaster plashall be approved by authority.  (b) The plan shall be and evacuation proceposted in the facility.  (c) Fire and disaster coshall be held at least repeated for each shi under conditions that	an shall be developed and				
	facility failed to condu	as evidenced by: and record reviews, the act fire and disaster drills on eated for each shift. The				
	Review on 2-13-20 of Drill Report Logs from	f the facility's Emergency n 2-3-19 to 2-13-20				

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

TITLE (X6) DATE

	of Health Service Regu		T		T
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
741012741	or correction.	ISENTI IONITONI NOINISEN.	A. BUILDING: _		JOHN EETEB
					R
		MHL0601078	B. WING		02/13/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	FE. ZIP CODE	
			RLAND ROAD	,:	
THE NOR	LAND HOUSE		TTE, NC 28212		
040.15	CLIMMA DV CT			PROVIDER'S PLAN OF CORRECTIO	N OVE
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(7.0)
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE DATE
				DEFICIENCY)	
V 114	Continued From page	e 1	V 114		
	revealed:	on 2 eight hour shifts from			
		on 3 eight hour shifts from 3pm-11pm (2nd shift), and			
	11pm-7am (3rd shift);				
		neld for 3rd shift during 2nd			
	quarter (April - June)				
	- No Disaster Drills w				
	- 3rd shift during	2nd quarter (April - June)			
	2019;				
	<ul> <li>1st shift during</li> </ul>	3rd quarter (July -			
	September) 2019;				
	_	4th quarter (October -			
	December) 2019;				
	•	4th quarter (October -			
	December) 2019.				
	Interview on 2-13-20	with Client #1 revealed:			
	- admitted 12-30-19;				
		re and/or Disaster Drills			
	performed since his a	idmission;			
	- "I know how to get o	out if we have an			
	emergency;"				
	- felt safe at the facilit	y.			
	Intomicus en 0.40.00	with Oliant #2 rays alad			
	- admitted 9-19-19;	with Client #2 revealed:			
		ster Drills every month;"			
	- felt safe at the facilit				
	Total data da ano radina	·			
	Interview on 2-13-20	with Client #3 revealed:			
	- admitted 12-10-19;				
		I don't remember the last			
	one but we have then	•			
	- felt safe at the facilit	y.			
		with Staff #2 revealed:			
	- works 2nd shift;	rills are performed at least 1			
	- FILE ALIU DISASIEI U	ווווס מוכ אכווטוווופט מנופמסנ ו	1		1

Division of Health Service Regulation

time a month;"

- the Program Manager oversees the schedule;

STATE FORM 897M11 If continuation sheet 2 of 12

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		MHL0601078	B. WING		02/13/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
			AND ROAD		
THE NOR	LAND HOUSE		TE, NC 28212		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 114	Continued From page	e 2	V 114		
	- "I try to get mine do month to get it over w	ne at the beginning of the vith."			
	Interview on 2-13-20 revealed:	with PM (Program Manager)			
	- drills are performed				
	- "some months there				
	Disaster drills perforn	ned on each shift."			
	Interview on 2-13-20	with QP (Qualified			
	Professional) revealed:				
	- "drills are performed	l monthly per shift;"			
	- "there are some on	all shifts."			
	Interview on 2-13-20	with the Director revealed:			
		and Disaster drills on each			
	shift, each month;"				
	- "we do one with each	ch new admission to the			
	•	are performed per shift			
	each quarter.				
V 118	27G .0209 (C) Medica	ation Requirements	V 118		
	10A NCAC 27G .0209 REQUIREMENTS				
	(c) Medication admini				
	. ,	n-prescription drugs shall to a client on the written			
	•	horized by law to prescribe			
	drugs.				
	_	be self-administered by			
	-	horized in writing by the			
	client's physician.				
		ding injections, shall be			
		licensed persons, or by			
		rained by a registered nurse, egally qualified person and			
		and administer medications.			

Division of Health Service Regulation

STATE FORM 897M11 If continuation sheet 3 of 12

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7.1. 551EB1110		R
MHL0601078		B. WING		02/13/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STAT	TE, ZIP CODE	
THE NOR	LAND HOUSE		RLAND ROAD		
			TTE, NC 28212		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 118	Continued From page	e 3	V 118		
	all drugs administered current. Medications a recorded immediately MAR is to include the (A) client's name; (B) name, strength, a (C) instructions for ac (D) date and time the (E) name or initials of drug.  (5) Client requests for checks shall be recorded.	v after administration. The following:			
	This Rule is not met as evidenced by: Based on record reviews, interviews, and observations, the facility failed to ensure MARs were kept current and included all medication requirements effecting 2 of 3 audited clients (#2 and #3). The findings are:  Finding #1:  Review on 2-12-20 of Client #2's record revealed: - admitted on 9-19-19; - 14 years old; - diagnoses of Major Depressive Disorder, Unspecified Trauma and Stressor Related Disorder; - Physician's orders for the following medications: - Sertraline (treatment for depression) 25mg (milligram), 1 tablet daily, dated 10-30-19; - Trazadone (treatment for depression)				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7. BOILDING.		R	
		MHL0601078	B. WING		02/13/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE NOR	LAND HOUSE		LAND ROAD			
040.15	CLIMMADV CT	ATEMENT OF DEFICIENCIES	TE, NC 28212	PROVIDER'S PLAN OF CORRECTION	N 0/5	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 118	Continued From page	e 4	V 118			
	tablet, take 1 tablet tw dated 10-30-19; - no order located for be given at bedtime. Review on 2-13-20 of	e (for hyperactivity) 5mg vice daily in AM and NOON, Trazadone 100mg tablet to  Client #2's MAR dated				
	100mg tablet given da - physician order loca Trazadone 100mg tab dose as needed at be	mentation of Trazadone aily at bedtime; ted in the MAR was for olet, take 1/2 tablet (50 mg) edtime; cated for Trazadone 100mg				
	- was given daily med	medications he takes or				
	revealed: - Client #2 had an ord be given at 100mg da - could not locate the the change increasing needed at bedtime to	with PM (Program Manager)  der change for Trazadone to hily at bedtime; hysician's order showing g Trazadone from 50mg as 100mg at daily at bedtime; hurse Practitioner to get the				
	Finding #2:					
	<ul><li>admitted on 12-10-1</li><li>14 years old;</li><li>diagnoses of Disrup</li></ul>	Client #3's record revealed: 9; tive Mood Dysregulation ention Deficit Hyperactivity				

Division of Health Service Regulation

STATE FORM 897M11 If continuation sheet 5 of 12

Division c	<u>of Health Service Regu</u>	lation			
STATEMENT	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			-		'
			B. WING		R
		MHL0601078			02/13/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
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THE NORI	LAND HOUSE		TTE, NC 28212		!
(X4) ID		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	( - /
PREFIX TAG	`	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
1/ 440		_	1///10		
V 118	Continued From page	e 5	V 118		
	Disorder). Conduct D	isorder, Oppositional Defiant			
ļ		Intellectual Functioning,			
	Academic/Education	•			
		or the following medications:			
	1 -	treat depression) 50mg			
	,	t bedtime, dated 1-8-20;			
		treat ADHD) 20mg capsule,			
	take 1 capsule daily,	, .			
		eat ADHD) 0.1mg ER tablet,			
		ne, dated 12-9-19, with			
	change order dated 1				
	Clonidine 0.1mg ER t				
	Olomanio o. mig E	.o twice daily,			
	Review on 2-13-20 of	f Client #3's MARs dated			
	12/10/19 - 2/13/20 rev				
		ed 12-18-19 increasing			
	' -	g at bedtime to Clonidine			
	0.1mg twice daily;	, at beatime to other and			
		R was not changed on the			
	MAR to reflect the ord				
		0 revealed Clonidine 0.1mg			
	ER was increased to				
	- Clonidine 0.1mg ER	·			
		aily starting on 2-6-20.			
		, ,			
	Review on 2-13-20 of	f December 2019 MAR			
	revealed:				
	- Focalin to be taken	in the AM;			
	- Clonidine to be take				
		lude the following for each			
	medication:	2			
	- name, strength	, and quantity of drug;			
	- instructions for	administering the drug.			
	Review on 2-13-20 of	f January 2020 MAR			
	revealed:				
	- Focalin to be taken i	in the AM;			
	- Clonidine to be take	n in the AM and PM;			
	- Trazadone 50mg to				
		lude the following for each			

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _				
		MHL0601078	B. WING		02/1	3/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
THE NORI	LAND HOUSE		RLAND ROAD				
			TTE, NC 28212				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 118	Continued From page	e 6	V 118				
	- instructions for	, and quantity of drug; administering the drug.					
	Interview with Client #3 on 2-13-20 revealed: - takes medications daily which are given by staff; - did not know the names of any of his medications or the reasons for taking the medications.						
	Interview with PM on 2-13-20 revealed: - there was an issue with the Pharmacy not getting the December 2019 order to change the Clonidine; - it was an oversight between the Pharmacy and the facility; - there was a clarification order received from the Nurse Practitioner dated 2-5-20 to increase the Clonidine 0.1mg from 1 time daily to BID; - Client #3 started receiving the correct ordered dose of Clonidine on 2-6-20.						
V 736	10A NCAC 27G .0303 EXTERIOR REQUIRI (c) Each facility and it maintained in a safe,	EMENTS	V 736				
		n and interviews, the facility n a safe, clean, attractive					

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Division of	<u>of Health Service Regu</u>	ilation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER		ORESS, CITY, STA	TE, ZIP CODE		
THE NORI	LAND HOUSE		LAND ROAD			
		CHARLOT	TE, NC 28212			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	( - /	
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		
				DEFICIENCY)		
V 736	Continued From page	2.7	V 736			
V 730	Continued From page	<del>-</del> 1	1750			
		20 at 11:47am of the facility				
	bathroom, used by al					
		urrounding the bathtub nd peeling off the walls;				
		growing the full length of the				
		or wall, near the ceiling;				
		s full of dust with a light bulb				
	blinking continually.	Tall of dust Mar a light ball				
	,					
	Interview on 2-13-20	with Client #3 revealed:				
	- the facility was clear	n;				
		onsible for cleaning the				
	house, including the b					
		room had been there since				
	his admission in Dece	ember 2019.				
	Interview on 2 13 20	with Staff #2 revealed:				
		e cleanliness of the facility.				
	no problemo with the	o dicariiiricco or the facility.				
	Interview on 2-13-20	with the PM (Program				
	Manager) revealed:	, 5				
	- had not noticed the	mold growing on the exterior				
	wall near the ceiling a	above the shower;				
		blinking light from the				
	exhaust fan.					
	Internieux se 0.40.00	with the OD (Overlift)				
		with the QP (Qualified				
	Professional) reveale	o: y with no maintenance				
	problems noted recer					
	problems noted recei	iuy.				
	Interview on 2-13-20	with the Director revealed:				
	- was unaware of the					
		ceiling above the shower;				
	- was unaware of the	cleanliness and faulty			<b> </b>	
	lighting in the exhaus	t fan but would look into				
	getting it repaired.				<b> </b>	
			1			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE ( A. BUILDING:			E SURVEY PLETED	
			_			R
		MHL0601078	B. WING		02	2/13/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATI	E, ZIP CODE		
THE NOR	LAND HOUSE		RLAND ROAD			
	CLIMMADY CT		OTTE, NC 28212	DDOMDEDIC DI ANI OF	CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETE DATE
V 738	Continued From page	e 8	V 738			
V 738	27G .0303(d) Pest Co	ontrol	V 738			
	10A NCAC 27G .0303 EXTERIOR REQUIRI (d) Buildings shall be rodents.					
	failed to ensure buildi insects. The findings  Interview on 2-13-20 -seen "roaches in my was my fault because -"haven't seen them a in a long time;"	and observations, the facility ngs were kept free from				
	Interview on 2-13-20 - had seen roaches "a - the roaches were in living room, and kitch better;" - the exterminator had "tried to get rid of thei -"just yesterday saw of	the bathroom, bedrooms, en in the past but "it is d treated the house and				
	-seen small roaches r -"have seen roaches room;"	with Client #3 revealed: recently; in my room and the living lents had been seen in the				

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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	
		A. DOILDING		R	,		
	MHL0601078 B. WING		1	3/2020			
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
THE NORLAND HOUSE			LAND ROAD				
CHARLOT			TTE, NC 28212				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 738	Continued From page	9	V 738				
	facility.						
	-small insect resemble on the countertop in to insect was black in coinsect was alive.  Interview on 2-13-20 and not seen any but there were "water but working here but they "haven't seen any oth I've been working here."	with Staff #1 revealed: ugs or roaches lately. with the PM (Program ugs when I first started the gone;" uer bugs at the facility since e;" uts the group home monthly					
	Professional) reveale	with the QP (Qualified d: ugs or roaches recently.					
	-had done "everything home, even relocated home to get rid of the -"just had the extermi do his routine treatme	nator out again last week to					
V 750	27G .0304(b)(3) Main Water Systems	tenance of Elec., Mech., &	V 750				
	10A NCAC 27G .0304 EQUIPMENT (b) Safety: Each facil	4 FACILITY DESIGN AND ity shall be designed,					

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DIVISION	of Health Service Regu	lation			_
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
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		MHL0601078	B. WING		02/13/2020
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	IE, ZIP CODE	
THE NOR	LAND HOUSE		RLAND ROAD		
		CHARLO	OTTE, NC 28212		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 750	Continued From page	e 10	V 750		
	constructed and equi ensures the physical visitors.	pped in a manner that safety of clients, staff and nechanical and water			
	This Rule is not met Based on observation failed to ensure the fa mechanical systems operating condition.	n and interviews, the facility acility's electrical and were maintained in			
	smoke alarm beeping	edication room revealed the			
	- admission 12-30-19	with Client #1 revealed: ; "has been beeping like that			
		with Staff #2 revealed: tector beeping and was id been beeping.			
	Manager) revealed: - when first questione did not hear anything - the next time it beep the beep; - was "not sure how le - no one had looked i	with the PM (Program ed about it, he replied that he ; ped, he admitted to hearing ong it had been beeping" nto getting it repaired. with the Director revealed:			
		ke detector beeping and			

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would get it repaired.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			A. BOILDING.		R	
		MHL0601078	B. WING			3/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA			
THE NOR	LAND HOUSE		AND ROAD			
	I		TE, NC 28212			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE

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