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 SURVEY COMPLETED				
					F	2			
MHL092-866		B. WING		02/12/2020					
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
HEAVENLY PLACE, LLC 8600 NEUSE HUNTER DRIVE RALEIGH, NC 27616									
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)								
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE			
V 000	INITIAL COMMENTS		V 000						
	An Annual and Follo 02/12/20. A deficien	ow Up Survey was completed acy was cited.							
	category: 10A NCA	sed for the following service C 27G .5600C Supervised h Developmental Disabilities.							
V 736	27G .0303(c) Facilit	ty and Grounds Maintenance	V 736						
	EXTERIOR REQUI (c) Each facility and maintained in a safe	03 LOCATION AND REMENTS I its grounds shall be e, clean, attractive and orderly e kept free from offensive							
	governing body faile	on and interview, the ed to assure the facility and tained in a safe and attractive							
	revealed:     - First room: cluconnecting walls     - Hallways: thick ceiling peeling     - Master bathrovent, water stain novent, water stain noventher broken     -Fourth Bedroom	10/20 12:45 PM - 1:00 PM attered, sheetrock not flush k dust noted near air vent, om: ceiling peeling near the ted n: door damaged, light switch m: hole in the door om: ceiling peeling							

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

TITLE (X6) DATE Division of Health Service Regulation

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING:	(X3) DATE SURVEY COMPLETED						
	R						
MHL092-866 B. WING	02/12/2020						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
HEAVENLY PLACE, LLC 8600 NEUSE HUNTER DRIVE RALEIGH, NC 27616							
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)							
V 736 Continued From page 1  During interview on 02/10/20, staff #1 reported:							

Division of Health Service Regulation STATE FORM