PRINTED: 08/06/2021 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED							
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.	A. BUILDING:		COMPLI	TIED						
MHL020-082		B. WING		08/04/2021								
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
THE RIVER HOUSE 284 SMOKEFORD ROAD												
MURPHY, NC 28906												
(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 SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE						
V 000	INITIAL COMMENTS		V 000									
	on August 4, 2021. TI	aint survey was completed he complaint was ke #00178970). A deficiency										
	category: 10A NCAC	d for the following service 27G .5600C: Supervised Developmental Disabilities.										
V 736	27G .0303(c) Facility	and Grounds Maintenance	V 736									
		EMENTS										
		n and interview, the facility y grounds were maintained										
	of the home revealed -The base of the hand broken board in the n approximately 12 inch -The underside of the porch had been repla appeared to have wa	dicap accessible ramp had a niddle of the ramp nes by 4 inches in size. To overhang eave of the front ced with newer plywood but ter damage.										
	Observation on 8/2/2 PM revealed:	1 between 3:15 PM and 4:45										

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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					
MHL020-082			B. WING	B. WING							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
THE RIVER HOUSE 284 SMOKEFORD ROAD MURPHY, NC 28906											
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE					
V 736	-In bathroom #2, blace above the shower on -In bedroom #4, an or one outlet that was actelevisionOn the back porch to nest attached to the lither of the room one outlet that was actelevisionOn the back porch to nest attached to the lither of the room o	k-like substance on the wall two walls. utlet cover was missing on ctively being used for a  the right, an active hornet ght fixture on the ceiling. Ind handicap accessible ailing pickets were loose or of the railing.  11:40 am with the Director velopmental Disabilities ed: In home where the clients  consible for repairs and will ves, hire a handyman, or the landlord to fix any issues. I are some issues with the could be in better condition. I the form the clients of the clients. I would take but	V 736								

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STATE FORM UURR11 If continuation sheet 2 of 2