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Division of Health Service Regulation

COMPLETED	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COM		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	OF DEFICIENCIES OF CORRECTION						
08/11/2021	B. WING			MHL001-195								
CODE	TATE, ZIP C	RESS, CITY, ST	STREET ADD	ROVIDER OR SUPPLIER	NAME OF P							
		TT STREET	413 EVERE									
VISION II BURLINGTON, NC 27215												
PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE		ID PREFIX TAG	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	(EACH DEFICIENCY	(X4) ID PREFIX TAG							
		V 000		INITIAL COMMENTS	V 000							
			I for the following service: OA Supervised Living for	2021. A deficiency wa								
		V 107		27G .0202 (A-E) Pers	V 107							
			have a written job ector and each staff position minimum level of education, perience and other position; duties and responsibilities of the staff member and the the staff member's file. ensure that the director, any other person who does to clients on behalf of syears of age; ad, write, understand and inimum level of education, perience, skills and other position; and tantiated findings of abuse or North Carolina Health Care	which: (1) specifies the competency, work expected and inflications for the properties of the position; (3) is signed by supervisor; and (4) is retained in the provides care or servithe facilities shall be each staff member or provides care or servithe facility: (1) is at least 18 (2) is able to reast 18 (3) meets the macompetency, work expected and incompetency, work expected and incompetency, work expected and incompetency, work expected and incompetency. (4) has no substanced and incompeted and incomp								
			ensure that the director, any other person who ices to clients on behalf of syears of age; ad, write, understand and inimum level of education, perience, skills and other position; and tantiated findings of abuse or North Carolina Health Care	(4) is retained in (b) All facilities shall each staff member or provides care or servithe facility: (1) is at least 18 (2) is able to reafollow directions; (3) meets the mompetency, work expended in the properties of the pro								

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

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE S COMPLI						
	MHL001-195			B. WING							
NAME OF P	ROVIDER OR SUPPLIER	413 EVE	DDRESS, CITY, STAT	E, ZIP CODE							
BURLINGTON, NC 27215											
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD B								
V 107	which the applicant is (d) Staff of a facility of currently licensed, regaccordance with appl services provided. (e) A file shall be main employed indicating to other qualifications for verification of licensus certification.	elationship to the job for applying. or a service shall be gistered or certified in icable state laws for the intained for each individual he training, experience and r the position, including re, registration or	V 107								
	failed to assure one of complete personnel relations of the complete personnel relations of the complete personnel relation of the complete personnel relations of the complete p	ew and interview, the facility of one audited staff (#1) had ecords. The findings are: staff #1's personnel record of a state nor national check. 11/21 the Licensee reported: e a state or national criminal									

Division of Health Service Regulation

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