Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
, , , , , , , , , , , , , , , , , , , ,				A. BUILDING.				
	MHL063-055		B. WING	B. WING		09/08/2021		
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
CRYSTAL LAKE CASAWORKS AND MATERNA 285 CAMP EASTER ROAD LAKEVIEW, NC 28350								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
V 000	INITIAL COMMEN	гѕ		V 000				
	An annual survey was completed on September 8, 2021. A deficiency was cited.  This facility is licensed for the following services: 10A NCAC 27G 3700 Day Treatment for Substance Abuse; 10A NCAC 27G 4100 Therapeutic Homes for							
	Individuals With Su Children; 10A NCAC 27G 44 Intensive Outpatien	bstance Disorders And Th 100 Substance Abuse It Program and 00 Substance Abuse						
V 736	10A NCAC 27G .03 EXTERIOR REQUI (c) Each facility and maintained in a saf	ty and Grounds Maintena 303 LOCATION AND IREMENTS d its grounds shall be e, clean, attractive and ord e kept free from offensive	derly	V 736				
	failed to ensure factin a clean, safe and findings are:  Observation on 9/8 1A revealed: -Closet doors from	ion and interview, the facility grounds were maintain attractive manner. The //21 at 11:30 am of Apartm hallway closet were not	ned					
		nallway closet were not dinside the closet leaning						

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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 (X		(X1) PROVIDER/SUPPLI IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL063-055		B. WING		09/	08/2021	
	PROVIDER OR SUPPLIER	S AND MATERNA	285 CAM	DRESS, CITY, S PEASTER R W, NC 28356				
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE COMPLETE HE APPROPRIATE DATE			
V 736	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		V 736					
		e on time in the pas						

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STATE FORM 6899 G90Q11 If continuation sheet 2 of 3

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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		
		MHL063-055	B. WING		09/0	8/2021
NAME OF PROVIDER OR SUPPLIER  CRYSTAL LAKE CASAWORKS AND MATERNA  CRYSTAL LAKE CASAWORKS AND MATERNA  LAKEVIEW, NC 28350						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETE DATE	
V 736	-She confirmed the	facility failed to ensure facility tained in a safe, clean,	V 736			

6899

Division of Health Service Regulation STATE FORM