PRINTED: 10/11/2021 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED				
		MHL0601036	B. WING		09/29/202	21			
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE					
BARNABAS 19704 ZION AVENUE CORNELIUS, NC 28031									
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5)  COMPLET DATE					
V 000	INITIAL COMMENTS		V 000						
	An annual survey was completed on 9-29-21. Deficiencies were cited.  This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Development Disabilities.								
V 736	27G .0303(c) Facility and Grounds Maintenance  10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.		V 736						
		n and interviews, the facility n a safe, clean, attractive,							
	#1 revealed: -a wooden threshold at the entrance of the -pink and dark brown								
	-work orders had bee	f the work orders revealed: en completed by the Group 16-21, 6-21-21, and 8-19-21 old to be replaced.							
	Pictures taken on 9-2	8-21 of the shower							

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

(X6) DATE TITLE

PRINTED: 10/11/2021 FORM APPROVED

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		
		MHL0601036	B. WING		09/29/2021		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	•		
BARNAB							
(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 SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	HOULD BE COMPLETE		
V 736	threshold molding of -a wooden floor strip, and dark brown spots threshold.  Interview on 9-28-21 Manager revealed: -the threshold moldin had been cited by the their last inspection; -several work orders repair; -maintenance had loo not replaced the strip -"had asked for it (the replaced a few times; -"sanitation is saying  Interview on 9-29-21 Compliance Director -made copies of the 3 submitted; -reviewed pictures tal	Bathroom #1 revealed: painted white with pinkish s covering the entire  with the Group Home g entrance of the shower health department during had been submitted for oked at the shower but had threshold molding) to be threshold molding) to be with it is dirt and grime."  with the Corporate revealed: work orders that had been ken during survey; m corrected immediately;	V 736				

Division of Health Service Regulation

STATE FORM 6899 E81Z11 If continuation sheet 2 of 2