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10-26-21

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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. BOILDING.	·	F	₹			
		MHL074-111	B. WING			6/2021			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE									
PORT HEALTH SERVICES - GREENVILLE RES GREENVILLE, NC 27834									
(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) COMPLETE DATE			
V 000	INITIAL COMMENTS		V 000						
	on October 6, 2021 This facility is licens	w up survey was completed Deficiencies were cited. Sed for the following service							
	category: 10A NCAC 27G .5600D Supervised Living for Minors with Substance Abuse Dependency								
V 736	V 736 27G .0303(c) Facility and Grounds Maintenance		V 736						
	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.								
	was not maintained. The findings are: Observations on 10 pm revealed:	et as evidenced by: ons and interview the facility in an clean and safe manner. 0/06/21 at approximately 2:00 shower light fixture room #1's		Debris in shower has been removille has been repaired	ved and				
		room #1's bathroom was racket with sharp edges		Shelf brackets have been remove	ed				
	- An air duct access #2.	s hole with no cover in room		Access cover has been ordered a be replaced when it arrives	and will				
	on one side.			New mattresses have been ordered	ed				
	was loose with a ga	ixture in room #5's bathroom up approximately 1/2 to 3/4		Fixture repaired					
Division of Health Service Regulation ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DAT						(X6) DATE			

Paville STATE FORM J2BG11 If continuation sheet 1 of 3

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
, , , , , , , , , , , , , , , , , , , ,			A. BUILDING:		R	
		MHL074-111	B. WING		10/06/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PORT HEALTH SERVICES - GREENVILLE RES						
GREENVILLE, NC 2/834						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
V 736	Continued From page 1		V 736			
	inch wide between the fixture trim and the ceiling Extensive black staining and an old glue trap under the kitchen sink The stove vent was missing the filter and cover; the light bulb was exposed Rusty areas inside the microwave The finish on the kitchen drawers was worn and sticky to touch. During interview on 10/06/21 the Case Manager/Qualified Professional stated: - The County owned building was older New mattresses were ordered recently A contracted exterminator sprayed the facility on a regularly scheduled basis She would make sure a request for the light fixture in room #5's bathroom to be repaired was submitted. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days. 2752 27G .0304(b)(4) Hot Water Temperatures 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (4) In areas of the facility where clients are exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit.			Stains have been cleaned. Trap	removed	
				Stove vent filter and cover have be	een replaced	
				Microwave will be replaced by No	vember 5	
				The building is owned by Pitt Cou have requested new cabinets 2 years.	-	
				have requested new cabinets 2 year County has assured us that cabiner replaced this fiscal year		
V 752			V 752			
		et as evidenced by: ons and interview the facility rater temperatures between				

Division of Health Service Regulation

STATE FORM 6899 J2BG11 If continuation sheet 2 of 3

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
7 IND 1 L7 IIV	OF CONTRECTION	BENTI TO KNOW NOWBER.	A. BUILDING:				
		MHL074-111	B. WING		R 10/06/2021		
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
PORT HE	PORT HEALTH SERVICES - GREENVILLE RES GREENVILLE, NC 27834						
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE		
V 752	Continued From page 2		V 752				
V 752	100 and 116 degreclients are exposed are: Observations on 10 2:00 pm and 2:15 pc. The sink in room temperature of 140 - The sink in room temperature of 136 - The sink in room temperature of 138 - The sink in room temperature of 138 - The sink in room temperature of 134 - The sink in room temperat	es Fahrenheit in areas where d to hot water. The findings 0/06/21 between approximately om revealed: #1's bathroom had a hot water degrees. #2's bathroom had a hot water degrees. #5's bathroom had a hot water degrees. #7's bathroom had a hot water degrees. #7's bathroom had a hot water degrees. #10's bathroom had a hot water degrees.		The water temperature has beer and the temperature is within rar will check temperature regularly the proper functionality of the walf temperatures continue to vary ask the County to repair or replawater heater.	nge. We to ensure ater heater. we will		
	temperatures adjus						
		estitutes a re-cited deficiency cted within 30 days.					

Division of Health Service Regulation STATE FORM