STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
					R	R	
		MHL053-076	B. WING	B. WING		01/18/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE			
LINNOVA	ATIONS, INC - 5023 VA	VI LEV VIEW 5023 V	ALLEY VIEW				
TINNOVA	(110N3, INC - 3023 VA	SANFO	RD, NC 27330				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODERICENCY)	JLD BE	(X5) COMPLETE DATE	
V 000	INITIAL COMMENT	rs	V 000				
	on January 18, 202 This facility is licens category: 10A NCA Living for Adults wit	w up survey was completed 2. Deficiencies were cited. sed for the following service C 27G .5600C Supervised th Developmental Disabilities. consisted of audits of 3					
	current clients.	consisted of addits of 5					
V 118	, ,	·	V 118				
	V 118 27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and						
	(D) date and time the (E) name or initials drug.						

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

TITLE (X6) DATE

STATEMEN	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.		R	
		MHL053-076	B. WING			8/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LINNOVA	ATIONS, INC - 5023 VA	ALLEY VIEW 5023 VAL	LEY VIEW			
	4110140, 1140 - 3023 VA	SANFORI	D, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	nge 1	V 118			
	checks shall be rec	corded and kept with the MAR appointment or consultation				
	This Rule is not met as evidenced by: Based on record reviews, observation and interview the facility failed to ensure the medication administration record (MAR) was current for three of three audited clients (#1, #2 and #3.) The findings are:					
	-Admission date of -Diagnoses of Schi	of Client #1's record revealed: 7/15/21. zoaffective Disorder, Bipolar ellectual Disability, Moderate.				
	Review on 1/18/22 of Client #1's physician's orders revealed: -Orders dated 9/24/21: -Divalproex Sodium 500 mg- Take 1 tablet by					
	-Ziprasidone 80 mouth twice a day.	ng and 2 tablets at bedtime. O mg- Take 2 capsules by				
	three times a day.) mg- Take 1 tablet by mouth 0 mg- Take 1 tablet by mouth				
	-	21: mg- Take 1 tablet by mouth				
	twice a dayOrders dated 11/3					
	twice a day.	5.5mg- Take 1 tablet by mouth5 mg- Take 1 tablet twice a day.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		MHL053-07	6	B. WING		R 01/18/2022	
	PROVIDER OR SUPPLIER	ALLEY VIEW	5023 VAL	DRESS, CITY, S LEY VIEW D, NC 27330	STATE, ZIP CODE		
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	-Melatonin 3 m at nightOrders dated 12/1 -Discontinue C -Clonazepam 1 three times a dayTrazadone 50 every night (in addi -Discontinue M -Melatonin 10 r every night. Observation on 1/1 medication packs r -Divalproex Somouth in the mornin Medication was ava -Ziprasidone 80 mouth twice a dayPropranolol 60 three times a day. I -Trazodone 10 at night. Medication -Benztropine 1 twice a day. Medication was ava -Clonazepam 1 three times a day. I -Trazadone 50 every night (in addi Medication was ava -Trazadone 50 every night (in addi Medication was ava -	g- Take two tables 7/21: lonazepam 0.5 m mg- Take 1 tables mg- Take 1 tables tion to Trazadone elatonin 3 mg. ng- Take 1 tablet 8/22 at 11:00 am evealed: dium 500 mg- Take dium 500 mg- Take dium 500 mg- Take mg- Take 1 tables allable. 0 mg- Take 1 tables was available. mg- Take 1 tables ation to Trazadone ailable. mg- Take 1 tables was available. of Client #1's MA rough January 20: wing dates:	g et by mouth t by mouth 100mg.) by mouth of Client #1's ke 1 tablet by at bedtime. sules by available. et by mouth vailable. et by mouth t by mouth et twice a day. et by mouth vailable. t by mouth	V 118			

Division of Health Service Regulation

STATE FORM 6899 M9Q011 If continuation sheet 3 of 11

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R	
		MHL053-076	B. WING			8/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
I INNOVA	ATIONS, INC - 5023 VA	ALLEY VIEW	LEY VIEW D, NC 27330			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
V 118	Continued From pa	ige 3	V 118			
	-Divalproex So 8pm. -Ziprasidone 80 -Propranolol 60 -Clonazepam 1 -Trazodone 100 -Trazodone 50	Omg- 1/16. mg- 1/16.				
	-Melatonin 10 mg- 1/16. Review on 1/18/22 of Client #1's MAR for the month of January revealed: -Clonazepam 0.5 mg- Take 1 tablet twice a day. Appeared on the MAR and marked as being given from 1/1 through 1/15, but medication had been discontinued on 12/17/21Olanzapine 15 mg- take 1 tablet twice a day (8 am, 8 pm). Appeared on the MAR twice and marked as being given from 1/1 through 1/18Melatonin 3 mg- Take 2 tablets at night. Appeared on the MAR and marked as being given from 1/1 through 1/18, but medication had been discontinued on 12/17/21.					
	-Admission date of -Diagnoses of Autis Impulse Control an Unspecified Schizo	sm; Unspecified Disruptive, d Conduct Disorder; phrenia Spectrum and Other				
	Unspecified Schizophrenia Spectrum and Other Psychotic Disorder. Review on 1/18/22 of Client #2's physician's orders revealed: -Order dated 2/10/21: -Lithium Carbonate 300 mg- Take 3 capsules by mouth at bedtimeOrder dated: 4/12/21: -Selenium Sulfide 2.5% Top Lotion- Apply small amount to wet scalp 3 times weeklyOrder dated 10/14/21:					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
				7 t. BOILBING.			R
		MHL053-076		B. WING		l l	18/2022
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
I INNOVA	ATIONS, INC - 5023 V	ALLEY VIEW		LEY VIEW D, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCY MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 118	-Polyethylene Cinto 8 ounces of was bedtimeOrder dated 10/20 -Lamotrigine 25 tongue where it will morningOlanzapine 20 the tongue where it every dayOrder dated 11/12 -Ketoconazole affected area, lather then rinse once dai Wednesday and Fr -Potassium Ch mouth at bedtime. Observation on 1/1 medication reveale -Lithium Carbo by mouth at bedtime -Selenium Sulfismall amount to we Medication was ava -Polyethylene Cinto 8 ounces of was bedtime. Medication -Lamotrigine 25 tongue where it will morning. Medication-Olanzapine 20	Glycol 3350 17 gm- ater and drink every /21: 5 mg- Place on top dissolve, then swa mg- Place 1 table will dissolve then /21: 2% Top Shampoo- er, leave in place 5 ly (Use on Monday iday only). loride 10 meq- Tak 8/22 at 11:30 am of d: nate 300 mg- Take e. Medication was ide 2.5% Top Lotio et scalp 3 times we ailable. Glycol 3350 17 gm- ater and drink every n available. 5 mg- Place on top dissolve, then swa n available. 0 mg- Place 1 table	of the allow every of on top of swallow Apply to minutes, /, i.e 1 tablet by of Client #2's e 3 capsules available. n- Apply ekly. Mix 17 gm y day at of the allow every et on top of	V 118	DEFICIENCY)		
	-Olanzapine 20 mg- Place 1 tablet on top of the tongue where it will dissolve then swallow every day. Medication availableKetoconazole 2% Top Shampoo- Apply to affected area, lather, leave in place 5 minutes, then rinse once daily (Use on Monday, Wednesday and Friday only). Medication was availablePotassium Chloride 10 meq- Take 1 tablet by						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
			7 20.2510.	A. Bollbing.		R	
		MHL053-076	B. WING		01/1	8/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
I INNOVA	ATIONS, INC - 5023 VA	ALL FY VIFW	LEY VIEW D, NC 27330				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y 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)	.D BE	(X5) COMPLETE DATE	
V 118	Continued From pa	nge 5	V 118				
	mouth at bedtime. I	Medication was available.					
	November 2021 thr blanks on the follow January 2022: -Selenium Sulfii -Lamotrigine 25 -Ketoconazole -Polyethylene Cwrong place- Blank -Olanzapine- Son 1/1-1/3, 1/7, 1/10 -Lithium Carbo place. Blanks on 1/ -Potassium Chwrong place. Blank Review on 1/18/22 -Admission date of -Diagnoses of Intellow	ide- 1/7 Fri, 1/10 Mon. 5 mg- 1/1. 2% top Shampoo- 1/7, 1/10. Glycol 3350 17 gm- Signed at s on 1/1-1/3, 1/15, 1/16. igned at wrong place- Blanks 6. nate 300 mg- Signed at wrong 1-1/3, 1/7, 1/16. loride Crys 10 meq- Signed at s on 1/1-1/3, 1/7, 1/16.					
	orders revealed: -Orders dated 4/6/2						
		ng- Take 1 tablet by mouth a					
	day. -Amlodipine Besylate 10 mg- Take 1 tablet by mouth once a dayRosuvastatin Calcium 10 mg- Take 1 tablet by mouth once a dayOrder dated 6/4/21: -Metoprolol Succinate 25 mg- Take 1 tablet by mouth once a dayOrder dated 7/2/21: -Divalproex Sodium 500 mg- Take 3 tablets						
	by mouth at bedtim -Order dated 7/15/2	e.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
					R	
MHL053-076		B. WING		01/1	8/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LININOVA	TIONS INC. F022 V	5023 VAL	LEY VIEW			
IINNOVA	ATIONS, INC - 5023 VA	SANFORI	O, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	.D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 6	V 118			
V 118	-Valacyclovir 50 dayOrders dated 11/12 -Januvia 100 m once a dayMeloxicam 7.5 twice a dayOlanzapine 20 tongue twice a dayChlorpromazir mouth in the morning evening. Observation on 1/1 medication packs must a dayLisinopril 40 m day. Medication was a mouth once a dayRosuvastatin 0 by mouth once a dayRosuvastatin 0 by mouth once a dayMetoprolol Sub y mouth once a dayValacyclovir 50 day. Medication was a day.	2/21: ag- Take 1 tablet by mouth amg- Take 1 tablet by mouth amg- Take 1 tablet by mouth amg- Dissolve 1 tablet on the and 3 tablets in the 8/22 at 11:45 am of Client #3's averaged: ag- Take 1 tablet by mouth a s available. asylate 10 mg- Take 1 tablet by Medication was available. Calcium 10 mg- Take 1 tablet ay. Medication was available. Calcium 500 mg- Take 1 tablet ay. Medication was available. dium 500 mg- Take 3 tablets e. Medication was available. ong- Take 2 tablets once a s available. ong- Take 1 tablet by mouth ation was available. ang- Take 1 tablet by mouth ation was available. ang- Take 1 tablet by mouth ation was available. ang- Take 1 tablet by mouth ation was available. ang- Take 1 tablet by mouth ation was available. ang- Take 2 tablets on the Medication was available. ang- Dissolve 1 tablet on the Medication was available. ang- Take 2 tablets by ang and 3 tablets in the	V 118			
	Review on 1/18/22	of Client #3's MARs for ough January 2022 revealed				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		MHL053-0	76	B. WING			R 18/2022
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LINING	TIONO INO 5000 V		5023 VAL	LEY VIEW			
I INNOVA	ATIONS, INC - 5023 VA	ALLEY VIEW	SANFORI	D, NC 27330			
(X4) ID	-	TEMENT OF DEFICIE / MUST BE PRECEDE		ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE AC		(X5) COMPLETE
PREFIX TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO	THE APPROPRIATE	DATE
V 118	Continued From page 7			V 118			
	-December:						
	-Januvia 100 m	ıg- 12/20.					
	-Lisinopril 40 m						
		sylate 10 mg- 12	2/20.				
	-Valacyclovir 50		0/00				
	-Metoproioi Sud -Meloxicam 7.5	ccinate 25 mg- 1	2/20.				
	-Olanzapine 20 mg- 12/20Chlorpromazine 100 mg- 12/20 8am -January:						
	-Meloxicam 7.5 mg- 1/16 8pm. 1/17 8pm						
	-Olanzapine 1/						
		ne 100 mg- 1/16					
		Calcium 10 mg-					
	-Divaiproex So	dium 500 mg- 1/	төрт				
	Interview on 1/18/2	2 with Staff #4 re	evealed:				
	-She gave clients th						
	them on their MAR.		00				
	Interview on 1/18/2		Medical				
	-He was in charge		ith medical				
	records from the cli	ents.					
	-He was under the	•					
	scratch off informat						
	notice from the pha						
	physician in order to						
	MAR.	o delete a medic	audii iidiii iile				
	-He had been trying	to work with the	e pharmacist				
	in order to make the						
	-He acknowledges						
	medications from the	ne client's MAR o	or mark them				
	as "Discontinued."						
	Interview on 1/18/2	2 with the Qualif	ied				
	Professional reveal		-				
	-She was surprised		he errors in				
	the MAR. Staff had						

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		MHL053-076		B. WING			R 18/2022
						1 017	IOIZOZZ
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
I INNOVA	ATIONS, INC - 5023 VA	ALI FY VIFW		LEY VIEW), NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FI SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
V 118	Continued From page 8			V 118			
	about medication as recordsShe believed that of forgotten to log in the was out at the house-She acknowledged reviewed MAR prior specifically, the Clie have reviewed the I making sure the MA-She acknowledged MAR current for the	dministration and keep on 1/16, staff may had be initials because the le. If that staff should have to starting to record; and Medical Coordinate MAR as he is in charge ARs are correct. If that staff did not main a clients.	power e more or should e of ntained				
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				
	failed to ensure facin a clean, safe and findings are: Observation on 1/18 bedroom revealed:	et as evidenced by: on and interview, the f ility grounds were mai attractive manner. Th 8/22 at 12:40 pm of Cl making it very difficul	ntained ne lient #1's				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
MHL053-076		B. WING		I	R 01/18/2022		
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
IINNOVA	ATIONS, INC - 5023 VA	ALLEY VIEW		LEY VIEW D, NC 27330			
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 736	Continued From pa	ge 9		V 736			
	-One of the glass pa	anels was lose and c	pened.				
	Observation on 1/18/22 at 12:43 pm of Client #2's bedroom revealed: -Window was stuck making it very difficult to open.						
V 752	open. Interview on 1/18/22 with the Qualified Professional revealed: -Agency was responsible for doing maintenance for the homeShe could not understand why the windows were so hard to open because she had seen them opened a couple of weeks agoShe believed the recent snow and ice may had warped the wood from the windows which made them hard to openShe would contact the landlord in order to make windows open more easilyShe confirmed the facility failed to ensure facility grounds were maintained in a safe, clean, attractive and orderly manner. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.			V 752			
V 132	and must be corrected within 30 days. 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.			V 132			

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
				A. BUILDING.			R	
		MHL053-076		B. WING			18/2022	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
I INNOV	ATIONS, INC - 5023 VA	ALLEY VIEW		LEY VIEW D, NC 27330				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 752	Continued From pa	ge 10		V 752				
	failed to maintain the 100-116 degrees Fall Observation of the 12:34 pm and 12:50. The kitchen sink with degrees Fahrenheir-Bathroom's sink with degrees Fahrenheir-Bathroom's sink with degrees Fahrenheir-Bathroom's sink with degrees Fahrenheir-She was surprised was high again becaused adjusted the water-She was unaware needed to be adjusted to be adjusted to be adjusted to be adjusted so it would temperature thems-She would contact again in order to have adjusted so it would temperature range Fahrenheit.	on and interview the se water temperature ahrenheit. The finding facility on 1/18/22 bet 0 pm revealed: rater temperature was t. 2 with the Qualified ed: to see that the tempause the landlord had temperature last year that the water tempered ted. let to adjust the water elves. maintenance staff or ove the water temperature of 100-116 degrees facility failed to main between 100-116 degrees stitutes a re-cited definding and results.	between gs are: tween s 124 s 120 erature d r. rature still r landlord ature ed water stain the grees					

6899

Division of Health Service Regulation STATE FORM