Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE SURVEY COMPLETED	
			A. BUILDING:				
		MHL084-085	5 B. WING		06/08/2022		
NAME OF PROVIDER OR SUPPLIER STREET ADDRE				STATE, ZIP CODE			
LORETT	A'S PLACE		IY STREET RLE, NC 280	001			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
V 000	INITIAL COMMENTS		V 000				
	on June 8, 2022. TI	ke #NC00188613). A					
	category: 10A NCA	sed for the following service C 27G .1900 Psychiatric ent Facility for Children and					
		sed for 12 beds and currently The survey sample consisted nt clients.					
V 736	27G .0303(c) Facility and Grounds Maintenance		V 736				
	EXTERIOR REQUI (c) Each facility and maintained in a saf	803 LOCATION AND IREMENTS If its grounds shall be e, clean, attractive and orderly e kept free from offensive					
	failed to ensure fac	et as evidenced by: ion and interview, the facility ility grounds were maintained I attractive manner. The					
	Second Floor:						
	#2 revealed:	/22 at about 2:50 pm of Room					

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

TITLE (X6) DATE 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	
		MHL084-085	B. WING		06/0	8/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LORETT	A'S PLACE		Y STREET	•••		
	01 II 41 41 F) / 0 TA		RLE, NC 280			
(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 APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 736	Continued From page 1		V 736			
	Bathroom between -Ceiling needed to I unfinishedExtractor was miss  Observation on 6/8, #3 revealed: -Significant number -Extractor inside the coverThere was a hole of switch inside the bathroom on 6/8, #4 revealed: -Paint was peeled of bathroomBathroom door was	/22 at about 2:55 pm of Room of scratches on the wall. be bathroom was missing its on the wall above the right othroom. //22 at about 2:58 pm of Room of from wall next to the				
	Observation on 6/8/ #5 revealed:	/22 at about 3:01 pm of Room				
	#6 revealed:	/22 at about 3:05 pm of Room eled off from wall underneath				
	Observation on 6/8	/22 at about 3:08 pm of the				

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Common Area revealed:

STATE FORM 98I111 If continuation sheet 2 of 3

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL084-085	B. WING		06/0	8/2022	
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
LORETT	LORETTA'S PLACE 109 PENNY STREET ALBEMARLE, NC 28001						
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TIVE ACTION SHOULD BE COMPL CED TO THE APPROPRIATE DAT		
V 736	-There were unpair the walls.  Interview on 6/8/22 revealed: -Agency was respo maintenanceShe was aware that need to be patched residents would chit punch/brake the water -She confirmed the grounds were main attractive and order	with the Clinical Director nsible for doing its at the facility was always in up and maintained as p paint off from walls or alls. facility failed to ensure facility tained in a safe, clean, ly manner.  nstitutes a re-cited deficiency	V 736				

6899

Division of Health Service Regulation STATE FORM