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 | o. oo.uo | | A. BUILDING: | | | | |
| | | MHL084-078 | B. WING | | | २ 21/2022 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | | |
| WAVERLY GROUP HOME 2215 WAVERLY STREET ALBEMARLE, NC 28001 | | | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETE DATE | |
| V 000 | INITIAL COMMENTS | | V 000 | | | | |
| V 726 | on June 21, 2022. I This facility is licens category: 10A NCA Living for Adults wit This facility is licens census of 5. The su audits of 3 current of | sed for 6 and currently has a urvey sample consisted of clients. | V 736 | | | | |
| V 730 | 10A NCAC 27G .03 EXTERIOR REQUI (c) Each facility and maintained in a safe manner and shall b odor. | I its grounds shall be e, clean, attractive and orderly e kept free from offensive | V 736 | | | | |
| | failed to ensure facting a clean, safe and findings are: Observation on 6/2 | on and interview, the facility illty grounds were maintained I attractive manner. The | | | | | |
| | between sink and soff at certain partsThere was mold/m walls and floor. | evealed: covering corner of the wall hower was lose and coming ildew inside the shower on the | | | | | |

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 | |
|---|--|--|---|-----------------------------------|-------------------------------|--|
| | | A. BOILDING. | | | R | |
| | MHL084-078 | B. WING | | | 21/2022 | |
| NAME OF PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | | |
| WAVERLY GROUP HOME 2215 WAVERLY STREET ALBEMARLE, NC 28001 | | | | | | |
| PREFIX (EACH DEFICIENCY | EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | ΓΙΟΝ SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE | |
| Observation on 6/20 Client #4's room reverance -There was a sticky front of the window. Observation on 6/20 Client #5's room reverance -The floor was dirtyWalls were dirtyWalls were dirtyThere was a pile of tobacco on top of the noted on survey back. Observation on 6/20 Client #1's room reverance -Three strips from the broken. Observation on 6/20 Outside area revealedThe grass was tall. Interview on 6/21/22 Coordinator revealedHouse belonged to and Urban Development of the houseShe was last at the she was aware of revealed to the houseShe was aware of revealed to the houseShe was not aware. | vealed: Idew on the bottom of the tub. I/22 at about 2:18 pm of ealed: substance on the floor, in I/22 at about 2:20 pm of ealed: cigarette butts and lose et dresser. This was also k on 2/26/20. I/22 at about 2:23 pm of ealed: In ewindow blinds were I/22 at about 2:28 pm of the ed: with the Program d: the Department of Housing ment (HUD.) Tole for doing maintenance to house last month. Tubber strip on the corner of floom coming off as well as the room needing to be replaced. Of Client #5's room being in with the cigarette butts | V 736 | | | | |

Division of Health Service Regulation

STATE FORM 6899 7O4011 If continuation sheet 2 of 3

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING: | | (X3) DATE COMP | (3) DATE SURVEY COMPLETED | |
|--|-----------------------|--|---|---|-------------------|------------------------------|--|
| | | | 7. BOILDING. | | F | ₹ | |
| | | MHL084-078 | B. WING | | | 1/2022 | |
| NAME OF F | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | | |
| WAVERLY GROUP HOME 2215 WAVERLY STREET ALBEMARLE, NC 28001 | | | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETE DATE | |
| V 736 | Continued From page 2 | | V 736 | | | | |
| | and attractive man | ner. | | | | | |
| | | stitutes a re-cited deficiency | | | | | |
| | | | | | | | |
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6899

Division of Health Service Regulation STATE FORM

7O4011 If continuation sheet 3 of 3