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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED						
			B WING		F						
		MHL092-890	B. WING		10/0	4/2022					
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE							
ARBOR HOUSE 3709 ARBOR DRIVE RALEIGH, NC 27612											
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETE DATE						
V 000	INITIAL COMMENTS		V 000								
	An annual and folloon 10/4/22. Deficie	w up survey was completed ncies were cited.									
		ed for the following service 227G .5600C Supervised nentally Disabled.									
		ed for three clients and the sisted of three current clients.									
V 752	27G .0304(b)(4) Ho	t Water Temperatures	V 752								
	EQUIPMENT (b) Safety: Each factorstructed and equensures the physical visitors. (4) In areas contexposed to hot water	04 FACILITY DESIGN AND cility shall be designed, uipped in a manner that all safety of clients, staff and of the facility where clients are er, the temperature of the tained between 100-116									
	failed to ensure the	et as evidenced by: on and interview the facility water temperature was n 100-116 Fahrenheit. The									
	-Did not realize the high in the client's b	2 the Home Manager stated: water temperature was that pathrooms.									

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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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							
					F							
MHL092-890			B. WING 10/04/			4/2022						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3709 ARBOR DRIVE												
RALEIGH, NC 27612												
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE						
V 752	causing it to be high -Client #1's family of maintain all repairsWill contact client is heather and have it Interview on 10/4/23 stated: -They had checked randomlyThinking the mostly temperature which	bathroom and that maybe ner there. bwns the facility and they the state of the stat	V 752									

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MXM611 If continuation sheet 2 of 2