		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R 05/17/2023	
		MHL081-111				
IAME OF PF	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
PEACE IN	THE CITY HOUSE OF LO	OVE	NDALE STREET LE, NC 28160			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLET
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO 1 DEFICIENC		DATE
V 000	INITIAL COMMENTS		V 000			
	An annual and follow up survey was completed on May 17, 2023. Deficencies were cited.					
	The facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment Facilities for Children or Adolescents.					
	This facility is licensed for 4 and has a current census of 4. The survey sample consisted of audits of 3 current clients.					
V 108	27G .0202 (F-I) Perso	onnel Requirements	V 108			
	 (g) Employee training provided and, at a mi following: (1) general organiza (2) training on client delineated in 10A NC 10A NCAC 26B; (3) training to meet the client as specified in the plan; and (4) training in infection bloodborne pathogen (h) Except as permitter. 5602(b) of this Subclimember shall be availatimes when a client is member shall be training including seizure mar to provide cardiopulm trained in the Heimlic techniques such as the the American Heart A 	tion shall be documented. g programs shall be nimum, shall consist of the tional orientation; rights and confidentiality as AC 27C, 27D, 27E, 27F and the mh/dd/sa needs of the the treatment/habilitation bus diseases and s. ed under 10a NCAC 27G hapter, at least one staff ilable in the facility at all present. That staff hed in basic first aid hagement, currently trained ionary resuscitation and h maneuver or other first aid hose provided by Red Cross,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		MHL081-111	B. WING		05	R 5/ 17/2023
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
EACE IN	THE CITY HOUSE OF L	OVE 795 SPIN	NDALE STREET			
		SPINDA	LE, NC 28160			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLE ⁻ DATE
V 108	Continued From page 1		V 108			
	(i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients.					
	facility failed to ensur House Manager (HM Professional (QP) we	ews and interviews, the e 3 of 3 audited staff (#1,), and the Qualified				
	revealed: -Hire date 11/27/ -First Aid/CPR ca -First Aid/CPR re	f staff #1's personnel record /18. ertification expired on 1/4/23. ecertification was completed al CPR Foundation website				
	revealed: -Hire date 7/23/2 -First Aid/CPR re	f the HM's personnel record 2014. ecertification was completed al CPR Foundation website				
	revealed: -Hire date 4/1/20 -First Aid/CPR re	f the QP's personnel record 014. ecertification was completed al CPR Foundation website				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL081-111	B. WING	05	R 05/17/2023	
AME OF PF	ROVIDER OR SUPPLIER	STREETA	ADDRESS, CITY, STATE	, ZIP CODE		
EACE IN	THE CITY HOUSE OF L	OVE 795 SPII	NDALE STREET			
		SPINDA	LE, NC 28160			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 108	Continued From page	2	V 108			
	-Chest compress practiced in the online External Defibrillator through the National -"it (CPR training Interview on 5/17/23 -Chest compress practiced in the online online through the Native website. -"no it (CPR training Interview on 5/16/23 -"one staff working Interview on 5/17/23 Officer revealed: -Responsible for staff	CPR Foundation website. ng) was online only" with HM revealed: sions were not physically e First Aid/CPR/AED training ational CPR Foundation aining) was online" with the QP revealed: on each shift" with the Chief Executive				
V 736	10A NCAC 27G .030 EXTERIOR REQUIR (c) Each facility and i maintained in a safe,	EMENTS	V 736			
	This Rule is not met	as evidenced by:				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED R 05/17/2023	
MHL081-111		BERTH IO, HON HOMBER.				
		B. WING				
IAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
	THE CITY HOUSE OF	1 OVE 795 SPI	NDALE STREET			
		SPINDA	LE, NC 28160			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
V 736	Continued From pa	ge 3	V 736			
		on and interview the facility in a safe, clean, attractive . The findings are:				
	Observation on 5/16/23 at 2:00 pm of the facility's staff office revealed: -The smoke detector was beeping.					
	Observation on 5/16/23 at 2:20 pm of the shared bathroom of Client #2 and Client #3 revealed: -Brown/black substance on the wall next to the tub.					
	-The floor in front of the tub was soft and sunk in when stepped on. -About 24 inches of deteriorated sheetrock next to the tub.					
	on the floor in front -Caulk was mis	of sheetrock were observed on the tub. ssing around the tub basin. as missing above the mirror				
	revealed:	3 with Client #2 and #3 had always had brown/black all next to the tub,				
	deteriorated sheetro the tub basin.	ock and missing caulk around				
		ed: vas responsible for the facility's				
	fix the damage to th -The facility wa	a sked him several times to be sheetrock in the bathroom. s cited by the Department of ulation Construction for the				
	deteriorated sheetro bathroom on 3/7/23	ock next to the tub in the				

STATE FORM

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ ND PLAN OF CORRECTION IDENTIFICATION NUMB		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED R	
		MHL081-111	B. WING	·····	05	5/17/2023
ME OF PF	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE		
EACE IN	THE CITY HOUSE OF I	_OVE				
			LE, NC 28160			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 736	Continued From pag	je 4	V 736			
	Officer revealed:	with the Chief Executive bathroom damage, "I'll take				
	This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.					