

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-926	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/01/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER PROFESSIONAL FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1016 PATRICK DRIVE FAYETTEVILLE, NC 28306
---	---

(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	<p>INITIAL COMMENTS</p> <p>An annual and a follow up survey was completed on February 1, 2024. A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p> <p>This facility is licensed for 3 and currently has a census of 3. The survey sample consisted of audits of 3 current clients.</p>	V 000		
V 736	<p>27G .0303(c) Facility and Grounds Maintenance</p> <p>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on observation and interview the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are:</p> <p>Observation on 01/31/24 at approximately 11:00am revealed:</p> <ul style="list-style-type: none"> - Water damage was underneath the dining room window. - The wall above the kitchen trash can was soiled. - The hallway bathroom had a dark substance above the tub on the ceiling. The surface around the base of the tub was stained. The bathroom had a strong odor of urine and the floor had a wet substance on the floor around the toilet. <p>Interview on 02/01/24 the Clinical Director indicated she understood the facility interior items needed for cleaning and repair.</p>	V 736		

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: MHL026-926	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/01/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER PROFESSIONAL FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1016 PATRICK DRIVE FAYETTEVILLE, NC 28306
---	---

(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 736	Continued From page 1 This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		