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. BUILDING.				
MHL076-055		B. WING		02/08/2024			
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
THE OVE	THE OVERLOOK 1342 NC HWY 42 EAST ASHEBORO, NC 27205						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT 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 APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE	
V 000	INITIAL COMMENTS		V 000				
	An annual survey w 2024. A deficiency	vas completed on February 8, was cited.					
	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.						
		sed for 4 and currently has a urvey sample consisted of clients.					
V 736	27G .0303(c) Facili	ty and Grounds Maintenance	V 736				
	EXTERIOR REQU (c) Each facility and maintained in a saf	303 LOCATION AND IREMENTS d its grounds shall be e, clean, attractive and orderly be kept free from offensive					
	Based on observat	et as evidenced by: ion and interview, the facility I in a safe, clean, orderly and The findings are:					
	Observation on 2/7 Hall bathroom reve -Sink's paint/resin w	was peeling off.					
	Client #4's room re -Carpet was old/wo -There was a large	orn out. section of ed patch up work on top of the					
		/24 at about 12:15 pm of the the rooms revealed:					

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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:	IDENTIFICATION NUMBER:		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CONNECTION			A. BUILDING:		COWII ELTED	
		MHL076-055	B. WING		02/08/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE OVERLOOK			HWY 42 EAS RO, NC 2720			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 736	Continued From page 1		V 736			
	-Air Conditioning filt the wrong size. Inst	ters inside the return vent had sead of having the required so smaller filters overlapping				
	Outside of the facili -Door in the back o off. -Screen from one o placed. It was obse	f the house had paint peeling of Client #3's window was not rved to be on the ground with				
	dirty/stained and co	eding replacement. ront bay window was overed in cobwebs. There were hairs that had their paint				
	internet via google -Several websites t measuring 26x26x1	f a basic search on the revealed: hat carried air filters I. Including ACE Hardware, EBay among others.				
	manager revealed: -He understood tha	and 2/8/24 with the Facility t it was that time again of up work maintenance to the				
	-The landlord was urepairs.	usually in charge of making				
	already informed hi would await report to -Regarding Air filters the right size filters. not being made any filters to make up for filters were suppose -Regarding the unfil	s, he had a hard time finding He believed the filters were more. He had placed the two or the big one. He believed the				

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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	
		MHL076-055	B. WING		02/08/2024	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE OV	THE OVERLOOK 1342 NC HWY 42 EAST ASHEBORO, NC 27205					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 736	repairs had been m finished by the land -He acknowledged	nade, but the wall had not been	V 736			

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Division of Health Service Regulation STATE FORM

8RT811 If continuation sheet 3 of 3