

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL013-200	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/02/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MCCOY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 418 DOCKSIDE LANE NW CONCORD, NC 28027
---	--

(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 complaint survey was completed on 2/2/24. The complaint was unsubstantiated (intake #NC00211088). A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living: Alternative Family Living in a Private Residence</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 (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 observations and interviews the facility was not maintained in a safe, clean, attractive, and orderly manner. The findings are:</p> <p>Observations on 1/29/24 at approximately 5:20pm of the facility revealed: - Bedroom #1- door cracked approximately 4 inches long - Kitchen- door had a crack that was approximately 5 inches long with a hole approximately 3 centimeters wide.</p> <p>Interview on 1/29/24 with the Alternative Family Living (AFL) backup (Licensee's husband) revealed: - "It's (bedroom door) been like that for a minute"</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: MHL013-200	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/02/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MCCOY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 418 DOCKSIDE LANE NW CONCORD, NC 28027
---	--

(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 - He would have the doors repaired.	V 736		