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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
AND PLAN OF CORRECTION		IDENTIFICATION NOWIBER.	A. BUILDING:		GOIVII LETED					
		MHL0411211	B. WING		02/29/2024					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE										
MCCRARY HOME 721 PARAMOUNT STREET HIGH POINT, NC 27260										
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					
V 000	INITIAL COMMENTS		V 000							
	An annual survey was Deficiency was cited.	s completed on 2/29/24. A								
	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.									
	-	d for 4 and currently has a reconstruction of ents.								
V 736	27G .0303(c) Facility	and Grounds Maintenance	V 736							
		EMENTS								
		n and interview the facility n a clean and attractive								
	revealed: -One outside lawn ch table for clients.	cility on 2/27/24 at 12:15pm air placed at the kitchen he mini blinds in Client #1's								
	black residue at the b residue along the side -Hallway bathroom ha	nower/tub had 1.5 feet of ottom and 6 inches of black e of the tub wall. ad two ½ dollar size peeling rn ceiling by the ventilation								
	-	window had 4 broken slats								

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

TITLE (X6) DATE

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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	
MHL0411211		B. WING		02/29/2024		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
MCCRAR	Y HOME		MOUNT STREE NT, NC 27260	ET .		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) (X5) COMPLETE DATE		
V 736	SUMMARY STATEMENT OF DEFICIENCIES ((EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		V 736			

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