	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		SURVEY
and plan	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
mhl078-197		mhl078-197	B. WING			C 04/2024
	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE ZIP CODE		
			OR STREET			
JOHNSO	N CENTER II	RED SPI	RINGS, NC 28	377		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMENT	rs	V 000			
	on April 4, 2024. Th	take #NC00215197).				
		sed for the following service C 27G .1700 Residential cure for Children or				
		ed for 4 and currently has a irvey sample consisted of clients.				
V 108	27G .0202 (F-I) Per	rsonnel Requirements	V 108			
	(g) Employee traini	202 PERSONNEL cation shall be documented. ing programs shall be minimum, shall consist of the				
	<ol> <li>general organiz</li> <li>training on clier</li> <li>training in 10A N</li> <li>NCAC 26B;</li> </ol>	rational orientation; ht rights and confidentiality as ICAC 27C, 27D, 27E, 27F and t the mh/dd/sa needs of the				
	client as specified in plan; and (4) training in infec bloodborne pathoge	n the treatment/habilitation tious diseases and ens.				
	.5602(b) of this Sub member shall be av times when a client	itted under 10a NCAC 27G ochapter, at least one staff /ailable in the facility at all is present. That staff				
	including seizure m to provide cardiopu	ained in basic first aid anagement, currently trained Imonary resuscitation and lich maneuver or other first aid				

Division	of Health Service Re	aulation			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	mhl078-197 B.		B. WING		C 04/04/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
JOHNSO	N CENTER II		OR STREET INGS, NC 28	8377		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
V 108	Continued From pa	ge 1	V 108			
	the American Heart equivalence for relia (i) The governing b implement policies reporting, investigat	those provided by Red Cross, Association or their eving airway obstruction. ody shall develop and and procedures for identifying, ing and controlling infectious diseases of personnel and				
	facility failed to ensuin Cardiopulmonary	et as evidenced by: view and interviews, the ure staff were currently trained Resuscitation (CPR) and udited staff. The findings are:				
	revealed: -Hire date: 1/9/17. -No evidence of a c CPR/First Aid. Interview on 4/4/24					
	-She worked at the -She was full time a -She had been train Finding #2 Review on 4/4/24 or (QP)"s personnel re -Hire date: 9/30/06	facility for a couple of years. Ind worked 11:30pm -7:30pm. Ind in CPR/First Aid. If the Qualified Professional				
Division of H	ealth Service Regulation					

of Health Service Re	egulation			i orai	APPROVED
NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			СОМ	E SURVEY PLETED
	mhl078-197	B. WING		C 04/04/20	
PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
	111 TAYL0	OR STREET			
	RED SPR	INGS, NC 28	377		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETE DATE
Continued From page	ge 2	V 108			
-Both staff #2 and th CPR/First Aid. -She thought the CF filed. -She would ensure understood staff wa	ne QP had trained in PR/First Aid certifications were staff were certified and s required to be have current				
Allegations, & Prote G.S. §131E-256 HE REGISTRY (g) Health care facil Department is notifi health care personr unknown source, w any act listed in sub (which includes: a. Neglect or abus facility or a person t as defined by G.S. b. Misappropriation in a health care faci (b) of this section in care services as de hospice services as are being provided. c. Misappropriation healthcare facility. d. Diversion of dru facility or to a patier e. Fraud against a a patient or client fo providing services).	ALTH CARE PERSONNEL ities shall ensure that the ed of all allegations against hel, including injuries of hich appear to be related to division (a)(1) of this section. e of a resident in a healthcare o whom home care services 131E-136 or hospice services 131E-201 are being provided. n of the property of a resident lity, as defined in subsection cluding places where home fined by G.S. 131E-136 or defined by G.S. 131E-201 n of the property of a gs belonging to a health care at or client. health care facility or against r whom the employee is	V 132			
	PROVIDER OR SUPPLIER DN CENTER II SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pay Interview on 4/4/24 -Both staff #2 and th CPR/First Aid. -She thought the CF filed. -She would ensure understood staff wa training in CPR/Firs G.S. 131E-256(G) H Allegations, & Prote G.S. §131E-256 HE REGISTRY (g) Health care facil Department is notifi health care personr unknown source, w any act listed in sub (which includes: a. Neglect or abus facility or a person t as defined by G.S. b. Misappropriation in a health care faci (b) of this section in care services as de hospice services as are being provided. c. Misappropriation healthcare facility. d. Diversion of dru facility or to a patier e. Fraud against a a patient or client for providing services).	IDENTIFICATION NUMBER:         mhl078-197         PROVIDER OR SUPPLIER       STREET AD         DN CENTER II       111 TAYLO RED SPR         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       Continued From page 2         Interview on 4/4/24 Licensee/Owner stated: -Both staff #2 and the QP had trained in CPR/First Aid.       -She thought the CPR/First Aid certifications were filed.         -She would ensure staff were certified and understood staff was required to be have current training in CPR/First Aid.       G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection         G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-201 are being provided.         b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-201 are being provided.	NT OF DEFICIENCIES OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE A. BUILDING: B. WING B. WING B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, ST RED SPRINGS, NC 28: SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 2       V 108         Interview on 4/4/24 Licensee/Owner stated: -Both staff #2 and the QP had trained in CPR/First Aid.       V 108         She thought the CPR/First Aid certifications were filed.       V 108         -She thought the CPR/First Aid certifications were filed.       V 132         G.S. \$131E-256 (G) HCPR-Notification, Allegations, & Protection       V 132         G.S. \$131E-256 HEALTH CARE PERSONNEL REGISTRY       V 132         (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility.         d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health car	NT OF DEFICIENCIES OF CORRECTION       (X1) PROVIDERSUPPLIER/CLA DENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A BUILDING:         mhi078-197       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         N CENTER II       111 TAYLOR STREET RED SPRINGS, NC 28377         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MILE PERCENDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PROVIDERS PLAN OF CORRE (EACH ORRECTIVE ACTION SH (EACH ORRECTIVE	NT OF DEFICIENCIES OF CORRECTION       (X) PROVIDERSUPPLIERCUA IDENTIFICATION NUMBER:       (Q2) MULTIFIC CONSTRUCTION A BULDING:       (Q3) DATE         NO CONTROL       MH078-197       B. WING       (Q4)         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       (Q4)         NO CENTER II       111 TAYLOR STREET       (EACH CONRECTIVE ACTION NUMBER:       (Q4)         SUMMARY STATEMENT OF DEFICIENCIES (EACH CONRECTIVE ACTION STORE PRECEDED PYTUL RESOLUTION OR LSC IDENTIFYING INFORMATION)       ID PROVIDER'S PLAN OF CORRECTION (EACH CONRECTIVE ACTION STORE PRECEDED PYTUL RESOLUTION OR LSC IDENTIFYING INFORMATION)       ID PREFIX       (EACH CONRECTIVE ACTION STORE ACTION (EACH CONRECTIVE ACTION STORE ACTION (EACH CONRECTIVE ACTION STORE ACTION (EACH CONRECTIVE ACTION STORE ACTION (EACH CONRECTIVE ACTION ACTION DEFICIENCY)         Continued From page 2       V 108       ID PREFIX       (EACH CONRECTIVE ACTION STORE (EACH CONRECTIVE ACTION STORE CROSS-REFERENCY)         Continued From page 2       V 108       V 108       ID PREFIX       DEFICIENCY)         Continued From page 2       V 108       V 108       ID PREFIX       DEFICIENCY)         Continued From page 2       V 108       ID INTRY       V 132       ID PREFIX       DEFICIENCY)         Continued Staff was required to be have current training in CPR/First Aid.       V 132       ID PREFIX       ID PREFIX       ID PREFIX       ID PREFIX       ID PREFIX

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES (2) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:	······		
	mhl078-197		B. WING		C 04/04/2024	
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
OHNSO	N CENTER II		OR STREET RINGS, NC 28	377		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN(	THE APPROPRIATE	COMPLE DATE
V 132	Continued From pa	age 3	V 132			
	investigation is in p investigations mus	five working days of the initial				
	Based on record re facility failed to ens Registry (HCPR) w against health care unknown source an allegations were in	et as evidenced by: eviews and interviews, the sure the Health Care Personnel vas notified of all allegations e personnel including injuries of nd failed to ensure all alleged vestigated. The findings are:				
	-14 year old male. -Admitted on 8/11/2 -Diagnoses of Con	of client #1's record revealed: 23. duct Disorder, Cannabis Deficit Hyperactivity Disorder.				
	Response Improve	of North Carolina Incident ement System (IRIS)revealed: eport for client #1's allegations.				

Division of Health Service STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		A. BOILDING.			<u> </u>
	mhl078-197	B. WING		C 04/04/2024	
NAME OF PROVIDER OR SUPPL	IER STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
IOHNSON CENTER II		LOR STREET RINGS, NC 28	377		
(X4) ID SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX (EACH DEFICI	ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLET DATE
V 132 Continued From	n page 4	V 132			
Licensee/Owne accused staff, v indication or do learned of alleg -No evidence of the HCPR During interview -He had lived at -He told the Ow allegations again Interview on 4/4 stated: -Client #1 had r against the staff -She learned of	the allegation being reported to on 4/4/24 client #1 stated: the facility for 8 months. ner/Administrator about his nst staff #1 on 3/14/24. /24 the Owner/Administrator ot mentioned any allegations				
-She was inform #1 by client #1 of department of S -She normally of but it slipped he	n internal investigation and				
V 318 13O .0102 HCF	R - 24 Hour Reporting	V 318			
The reporting b Department of a personnel as de including injurie done within 24 l	.0102 INVESTIGATING AND EALTH CARE PERSONNEL y health care facilities to the all allegations against health care fined in G.S. 131E-256 (a)(1), s of unknown source, shall be hours of the health care facility re of the allegation. The results o				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	mhl078-197		B. WING		C 04/04/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
JOHNSO	N CENTER II		OR STREET	377		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (	CORRECTION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
V 318	Continued From pa	ge 5	V 318			
		lity's investigation shall be partment in accordance with				
	failed to report all a personnel within 24 facility becoming a findings are:	et as evidenced by: view and interview, the facility llegations against health care hours of the health care ware of the allegation. The f the Licensee/Owner's				
	personnel record re -Hire date: 5/13/10.	evealed:				
	-14 year old male. -Admitted on 8/11/2 -Diagnoses of Cond	f client #1's record revealed: 3. duct Disorder, Cannabis Deficit Hyperactivity Disorder.				
	dated 3/25/24 revea -An allegation of ab against staff #1. In Licensee/Owner. S accused staff, withe	f a facility investigation report aled: use reported by client #1 vestigator identified as Statement obtained from the ess staff and 3 clients. No nentation of when facility				
ision of H	learned of allegation					

If continuation sheet 6 of 11

Division	of Health Service Re	egulation			FORM	APPROVED
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
	mhl078-197		B. WING		C 04/04/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
JOHNSC	ON CENTER II		OR STREET RINGS, NC 283	377		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETE DATE
V 318	Continued From pa	ge 6	V 318			
	the HCPR within 24 the allegation	hours of becoming aware of				
	Response Improver	f the North Carolina Incident ment System (IRIS) revealed: IRIS report submitted for y client #1.				
	-He had lived at the	4/4/24 client #1 stated: facility for 8 months. /Administrator about his staff #1 on 3/14/24.				
	stated: -Client #1 had not n against the staff to l	allegations from the				
	-She was responsible allegations to the H Registry. -She learned of clies #1 on 3/25/24. -It slipped her mind #1 made against state -She understood allegations and states	legations of abuse should be vithin 24 hours of becoming				
V 500	27D .0101(a-e) Clie	ent Rights - Policy on Rights	V 500			
	RESTRICTIONS AI (a) The governing	01 POLICY ON RIGHTS ND INTERVENTIONS body shall develop policy that thentation of G.S. 122C-59, G.S. 122C-66.				

	of Health Service Re		1		1	
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
	mhl078-197		B. WING		C 04/04/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
JOHNSC	ON CENTER II		OR STREET RINGS, NC 283	377		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 500	Continued From pa	ge 7	V 500			
	implement policy to (1) all instance abuse, neglect or ex- reported to the Cour- Services as specifie G.S. 7A, Article 44; (2) procedure instituted in accorda practice when a me- present serious risk Particular attention neuroleptic medicat (c) In addition to th 10A NCAC 27E .01 each facility shall de that identifies: (1) any restric prohibited from use (2) in a 24-ho under which staff at the rights of a client (d) If the governing restrictive interventi the restrictions of cl 122C-62(b) and (d) identify: (1) the permit allowed restrictions (2) the indivice the client; and (3) the due pr involuntary client wh restrictive interventi (e) If restrictive interventi (f) If ne facility, th develop and implementing the client, the facility interventing within the facility, the facility interventing the velop and implementing the velop and implementing the velop and the ve	ees of alleged or suspected xploitation of clients are nty Department of Social ed in G.S. 108A, Article 6 or and es and safeguards are ance with sound medical edication that is known to a to the client is prescribed. shall be given to the use of tions. ose procedures prohibited in 02(1), the governing body of evelop and implement policy ctive intervention that is within the facility; and bur facility, the circumstances re prohibited from restricting t. body allows the use of ons or if, in a 24-hour facility, lient rights specified in G.S. are allowed, the policy shall tted restrictive interventions or ; dual responsible for informing rocess procedures for an no refuses the use of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	СОМ	E SURVEY PLETED
	mhl078-197	B. WING	· · · · · · · · · · · · · · · · · · ·	04/	04/2024
NAME OF PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
IOHNSON CENTER II		LOR STREET RINGS, NC 28	377		
PRÉFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y 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 THE APPROPRIATE	(X5) COMPLET DATE
has been trained ar competence to use provide written auth restrictive interventi renewed for up to a accordance with the NCAC 27E .0104(e (2) the design responsible for revi interventions; and (3) the establ appeal for the resol	hation of an individual, who not who has demonstrated restrictive interventions, to norization for the use of ions when the original order is a total of 24 hours in total in 10A	V 500			
facility failed to repor Services in the court provided all allegati health care personn Review on 4/4/24 o dated 3/25/24 revea -An allegation of ab against staff #1. Im Licensee/Owner. S accused staff, withe indication or docum learned of allegation Review on 4/4/24 o	views and interviews the ort to the Department of Socia nty where services are ons of resident abuse by nel. The findings are: f a facility investigation report aled: use reported by client #1 vestigator identified as Statement obtained from the ess staff and 3 clients. No inentation of when facility				
Review on 4/4/24 o -14 year old male. -Admitted on 8/11/2	f client #1's record revealed: 23.				

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED
	mhl078-197		B. WING		C 04/04/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
JOHNSO	N CENTER II		OR STREET INGS, NC 28	377		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 THE APPROPRIATE	(X5) COMPLE <sup>-</sup> DATE
V 500	Continued From pa	ge 9	V 500			
		duct Disorder, Cannabis Deficit Hyperactivity Disorder.				
	-He had lived at the -He told the Owner	4/4/24 client #1 stated: a facility for 8 months. Administrator about his staff #1 on 3/14/24.				
	stated: -Client #1 had not r against the staff to	allegations from the				
	Interview on 4/4/24 -She was responsit allegations to the lo Services. -She initiated an inv -She learned of the Services came to the about the allegation -She did not file a for social services age -It slipped her mind #1 made against st -She understood al	Licensee/Owner stated: ble for submitting reports of ocal department of Social vestigation. allegation when Social he facility on March 25, 2024 h. formal report with the local ncy about the investigation. to report the allegation client aff #1. legations of abuse should be within 24 hours of becoming				
V 736	10A NCAC 27G .03 EXTERIOR REQU (c) Each facility and maintained in a saf	ty and Grounds Maintenance 803 LOCATION AND IREMENTS d its grounds shall be e, clean, attractive and orderly e kept free from offensive	V 736			

STATEMENT OF DEFICIENCIES ( AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		mhl078-197	B. WING			C 04/04/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
OHNSC	ON CENTER II		LOR STREET RINGS, NC 283	377			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
V 736	Continued From pa	ge 10	V 736				
	was not maintained and orderly manner Observation of the approximately 3:05 - Client #2's bedroo side of the armoire; window; an approxi beside the window bottom drawer of th 6 drawer dresser w left drawer. - Client #3's bedroo behind the bedroon softball; paper and throughout the floo - Client #1 had a go bedroom door. Interview on 4/4/24 - Client #2 and clier wall in client #3's be	ion and interview, the facility I in a safe, clean, attractive r. The findings are: facility on 4/4/24 at pm revealed: om had debris scattered on the pm had debris scattered on the sthere was torn curtain at the mately 3 inch hole in the wall above the nightstand; the ne nightstand had no knob; the as missing a knob on the top om had a hole in the wall n door about the size of a puzzle pieces scattered or off ball sized hole behind his the Licensee/Owner stated: nt #3 caused the hole in the edroom. She understood the d to maintain a safe, clean,					