Division of Health Service Regulation

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			B WING			R
		MHL026-299	B. WING		04/	25/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
STANBER	RY PLACE		BERRY PLAC			
			ILLE, NC 283			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IS CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETE DATE	
V 000	INITIAL COMMENTS		V 000			
·	An annual and follow on April 25, 2024. A d	up survey was completed eficiency was cited.				
	This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.					
	The survey sample cocurrent clients and 1 for					
V 736	27G .0303(c) Facility 8	and Grounds Maintenance	V 736			5/25/2024
	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. This Rule is not met as evidenced by: Based on observation and interview, the facility was not maintained in a safe, clean, attractive, manner. The findings are: Observation on 04/25/24 at approximately 11:30am of the facility revealed: -The kitchen table was a black card table and the center of the table was broken and sinking in.			By 5/25/2024 all deficiencies cited of corrected. The kitchen table/chairs kitchen linoleum will be replaced. To sheet-rock will be painted, and all ligwill have working bulbs. Any blinds missing slats will be repaired or report The bedroom doors will be cleaned maintain a safe, clean, and attractive The group home manager will conditioned weekly inspection of the facility to it areas or items in the home that need replacement/repair.	and the he ght fixtur that are laced. to e facility uct a lentify	es
	-The Linoleum in the k -The wall to the right o patched sheetrock are paintedThe hall bathroom ligh of 3 that was not worki	itchen had tears. f the hallway had a large a that had not been nt fixture had one bulb out		RECEIVED		
	broken slatClient #1's bedroom d			MAY 0 8 2024		
	During interview on 04			DHSR-MH Licensure Sect		

Division of Health Service Regulation

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

STATE FORM

D OP Supervisor

PRINTED: 04/30/2024 FORM APPROVED

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED						
			A. BUILDING	:	СОМ							
		MHL026-299	B. WING		04	R 1/25/2024						
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
STANBERRY PLACE 1909 STANBERRY PLACE												
FAYETTEVILLE, NC 28301												
PREFIX TAG	(EACH DEFICIENCY	ATEMENT 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 DEFICIENCE	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE						
V 736	House Manager revea -He would replace the -He had contacted the paint the area in the h	aled: table after the survey. maintenance person to allway. sutes a re-cited deficiency	V 736	DEFICIENC	2Y)							

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STATE FORM