

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-083	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/23/2024
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NAME OF PROVIDER OR SUPPLIER CAMERON DRIVE FAMILY CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 2608 CAMERON DRIVE SANFORD, NC 27332
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(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
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V 736	<p>Continued From page 1</p> <p>-Medicine closet - There was a hole punched in on the door about the size of a fist.</p> <p>-Bathroom - Blinds in window were missing 3 sections</p> <p>Interview on 5/23/24 with the Director of Quality Management revealed:</p> <p>-He was not aware of the holes on the walls.</p> <p>-Client #3 had a history of property destruction.</p> <p>-Client #3 would be receiving a new Psychological evaluation.</p> <p>-Facility would be requesting for a 1:1 and perhaps a higher level of care for Client #3.</p>	V 736		
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