

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL093-060</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/11/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>EVANS RESIDENTIAL SERVICES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>470 HUB QUARTER ROAD MACON, NC 27551</b>
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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
V 000	<p><b>INITIAL COMMENTS</b></p> <p>An annual survey was attempted on 7/11/24. The NC state director representing the Licensee stated there are no clients being served. The last client served was over a year ago.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living/ Alternative Family Living.</p> <p>Interview on 7/11/24 with the NC state director revealed: -The last client moved out a year and half ago. -Had trouble trying find clients for the facility due to its location.</p>	V 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_