Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL093-060	A. BUILDING: ______ B. WING ______	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVANS RESIDENTIAL SERVICES	470 HUB QUARTER ROAD MACON, NC 27551

(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	INITIAL COMMENTS 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. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living/ Alternative Family Living. 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.	V 000	re: V 000 Referrals will continue to be presented to Mrs. Evans and screened/evaluated for appropriate placement. The home currently has a placement - providing back-up for another provider. The goal is to serve as a licensed AFL that meets the needs of the individual and benefits from the strengths and envirionment of the provider.	12/31/24

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