PRINTED: 03/03/2025 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
AND FLAN OF CORRECTION			A. BUILDING:		COMIT EL TED		
		MHL0601195	B. WING		02/28/2025		
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
CARMEL	FOREST DRIVE		IEL FOREST [FE, NC 28205	PRIVE			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETE DATE	
V 000	INITIAL COMMENTS		V 000				
	An annual survey was completed on 2-28-25. Deficiencies were cited.						
	This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.						
	-	d for 6 and currently has a vey sample consisted of 3					
V 736	27G .0303(c) Facility	and Grounds Maintenance	V 736				
		EMENTS					
		n and interviews the facility ed in a clean, attractive and					
	revealed:	25, 2-27-25, and 2-28-25 beeping in the back hallway.					
	revealed: -Shower bathroo broken, dark substan	25 at approximately 3:45 pm m: stopper in the left sink ce in the corner of the the toilet worn, dark area					
	along the outside of the along the outside of the along approximately 2 inches	he door. way ceiling cracked. r is worn in an area					

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

TITLE (X6) DATE Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		MHL0601195	B. WING		02	/28/2025	
NAME OF PROVID	DER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
CARMEL FORE	EST DRIVE		RMEL FOREST DR OTTE, NC 28205	IVE			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	E ACTION SHOULD BE COMPLETE D TO THE APPROPRIATE DATE		
fau bes by sub mu soft the Intervention of the	side the toilet, crathe tub. -Outside dining ostance along the -Chair in the livilitiple areas were a in the living roo leather has chipperview on 2-25-25 -The smoke deflong." -His chore this whrooms. erview on 2-25-25 -The smoke deflek alsoHer chore was erview on 2-25-25 -The smoke deflek alsoHer chore was erview on 2-25-25 -The smoke deflet long." -She did have continued and dust erview on 2-28-25 -Both she and to companyThey would market along.	bubbling paint along the wall cked paint with a small hole room door has dark edge on the outside. ng room worn and had the leather had chipped off, m has multiple areas were	V 736				
		nimum Furnishings 04 FACILITY DESIGN AND	V 774				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL0601195	B. WING		02/28/2025		
		3711 CAR	DRESS, CITY, STATE, ZIP CODE MEL FOREST DRIVE				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 774	PROVIDER OR SUPPLIER STREET ADDR 3711 CARMI CHARLOTTI SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		V 774				

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