and the second	of Health Service Re	egulation (X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION		APPROV	
AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. DOILDING.				
		MHL001-014	B. WING		06/	17/2025	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE			
CRECTV	IEW GROUP HOME #	625 CDE	STVIEW DRIV				
CRESTV		2 BURLING	STON, NC 27	217			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE	
V 000	INITIAL COMMENT	S	V 000	6			
	An annual survey wa 2025. Deficiencies v	as completed on June 17, vere cited.					
	This facility is licens category: 10A NCAC Living for Adults with	ed for the following service C 27G .5600A Supervised Mental Illness.					
	This sector is a			RECEIV	ΈD		
	This facility is licensed for 6 and has a current census of 5. The survey sample consisted of						
	audits of 3 current cl	lients		JUN 30	2023		
	addits of 5 current ci	ients.			Suro Sact		
V 109	27G 0203 Privilegin	g/Training Professionals	V 109	DHSR-MH Licen	sule sect		
V 100	270 .0203 Filvilegin	g/ training Professionals	V 109				
	QUALIFIED PROFE ASSOCIATE PROFE (a) There shall be no qualified professional (b) Qualified profession and abilities required (c) At such time as a employment system then qualified profess professionals shall de (d) Competence shall exhibiting core skills (1) technical knowled (2) cultural awarenes (3) analytical skills; (4) decision-making; (5) interpersonal skill (6) communication s (7) clinical skills.	ESSIONALS o privileging requirements for ls or associate professionals. sionals and associate emonstrate knowledge, skills by the population served. a competency-based is established by rulemaking, sionals and associate emonstrate competence. Ill be demonstrated by including: dge; ss; ls; kills; and					
1	NCAC 27G .0104 (18	ionals as specified in 10A )(a) are deemed to have					
r	net the requirements	of the competency-based					
e	employment system i	n the State Plan for					
	IH/DD/SAS. Ith Service Regulation						

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

TITLE

PKC811

(X6) DATE

STATE FORM Carolyn E. Cartel, M.E.O.

Climical Supervisir

If continuation sheet 1 of 9

6-25-25

	NT OF DEFICIENCIES			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		MHL001-014	B. WING		06/	17/2025
				, STATE, ZIP CODE		
CRESTV	IEW GROUP HOME #	2	STVIEW DR GTON, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLE DATE
	<ul> <li>(f) The governing be develop and implen for the initiation of a plan upon hiring each (g) The associate p supervised by a qua population served for</li> </ul>	age 1 body for each facility shall nent policies and procedures an individualized supervision ch associate professional. professional shall be alified professional with the professional with the professional with the professional with the professional with the professional with the professional with the professional with the professional with the pro	V 109			
	Qualified Profession educational requirer population served. T Review on 6/17/25 of Coordinator/QP reve -Hire date of 5/20/86 -She was the Group -There was docume diploma.	eviews and interviews, the nal (QP) did not meet the ment for the MH/DD/SAS The findings are: of the Group Home ealed:		This deficiency will be addressed by documenting with the Executive Assis Office the requirements for Competer Qualified Professionals (QP) and Ass Professionals (AP). Review of current QPs and APs will b conducted for compliance with this re At the time of employment, the Execu Assistant will verify the requirements QP / AP status.	ncies of ociate e quirement. tive	7-30-2
	Review on 6/17/25 o -Admission date of 3 -Diagnoses of Schize Mellitus; Hypertensic Syndrome; Hyperlipic Chronic Back/Knee F -Person Centered PI Home Coordinator/Q "PERSON RESPON	ophrenia; Type II Diabetes on; Polycystic Ovarian demia; Hypothyroidism; Pain. an was signed by the Group				

STATEMENT OF DEFICIENCIES       (M1) PROVIDERSUPPLIERCUA DESTINCTION NUMBER       (M2) MULTIPLE CONSTRUCTION A BUILDING       (M2) OTE SURVEY COMPLETED         MAE OF PROVIDER OR SUPPLIER       STREETADRESS OTTY STATE_ZP CODE       06/17/2025         CRESTVIEW GROUP HOME #2       STREETADRESS OTTY STATE_ZP CODE       06/07/2025         CRESTVIEW GROUP HOME #2       STREETADRESS OTTY STATE_ZP CODE       06/07/2025         CRESTVIEW GROUP HOME #2       STREETADRESS OTTY STATE_ZP CODE       06/07/2025         V109       SUMMARY STATEMENT OF DEFICIENCES       PREVIDENCES       PREVIDENCES OT TRANSFORMANDE       06/08/2025         V109       Continued From page 2       V109       PREVIDENCES TO TRANSFORMANDE       06/08/2025         V109       Continued From page 2       V109       V109       Continued From page 2       V109         V109       Continued From page 2       V109       PREVIDENCES       CONSACTES OT VERVIDENCE       06/08/2025         -Group Home Coordinator had the initials "QP"       placed after her signature.       V109       PREVIDENTIAL CORRECTIVE ACTION SHOULD BE       06/08/2025         -Person Centered Plan was signed by the Group Home       Coordinator had the initials "QP"       Placed after her signature.       Interview on 6/17/25 with the Group Home       StreetAddet her signature.       Interview on 6/17/25 with the Group Home       StreetAddet her signature.	Division	of Health Service Re	egulation				APPROVEL
NUME OF CORRECTION       DEATTIFICATION NUMBER       A. BUILDING       COMPLETED         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZP CODE       06/17//2025         CRESTVIEW GROUP HOME #2       BURLINGTON, NC 27217       06/17//2025         OVER THE PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZP CODE       06/17//2025         OVER THE OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZP CODE       06/17//2025         OVER THE OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZP CODE       CRESTVIEW ORLS       CONTINUES THE OF OF CHECKTON, NO. 27217         OVER THE OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZP CODE       CRESTVIEW ORLS       CONTINUES TO THE ADDRESS OF THE OP CHECKTON, CRESTPLEW DRIVE, CROSS-REFERENCE TO THE ADDLE DECOMPONENT       CONTINUES TO THE ADDRESS OF CONTINUES TO THE ADDLE OF THE ADDRESS, CITY, STATE, ZP CODE         V109       Continued From page 2       V 109       VI09       CRESTVIEW ORLS       CONTINUES TO THE ADDRESS, CITY, STATE, ZP CODE         V109       Continued From page 2       V 109       VI09       CRESTVIEW ORLS       CONTINUES TO THE ADDRESS, CITY, STATE, ZP CODE         V109       Continued From page 2       V 109       VI09       CRESTVIEW ORLS       CONTINUES TO THE ADDRESS, CITY, STATE, ZP CODE         V109       Continued From page 2       V 109       VI09       CRESTVIEW ORLSCIDENTITY INFORMATION, THE ADDRESS, CITY, ST				(X2) MULTI	PLE CONSTRUCTION		
MARE OF PROVIDER OR SUPPLIE     STREET ADDRESS, CITY, STATE, ZIP CODE       CRESTVIEW GROUP HOME #2     BURLINGTON, NC 27217       Data     SUMMARY STREMENT OF DEFICIENCES       Data     Providers P AM OF CORRECTION RESULATORY OR LSC IDENTIFYING INFORMATION)     PLEPA PLEPA       V109     Continued From page 2     V 109       Continued From page 2     V 109       deprive     Street Continued From page 2       V 109     Continued From page 2     V 109       deprive     Deprive       signature indicates agreement with the services/supports to be provided."     -Oroup Home Coordinator had the initials "QP" placed after her signature.       Review on 6/17/25 of Client #2's record revealed: Admission date of 4/1/20.     -Dispose of Schizophrenia; Obesity; Sinus tachycardia (secondary to Clozapine); Chronic Constration; Hypertriglyceridemia; Metornhagia; Vitamin Deficiency, High Blood Pressure; Overactive Bladder; Seasonal Allergies.       -Person Centered Plan was signed by the Group Home Coordinator/QP revealed.       -She had worked for the agency for over 30 years.       -She had worked for the agency for over 30 years.       -She had worked for the agency for over 30 years.       -She had worked for the ducation she completed was high schoo	AND PLAN	I OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G:		
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PRETX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATION CLISC IDENTIFYING INFORMATION)       PRETX TAG       (EACH CORRECTVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       Continued From page 2       V 109         V 109       Continued From page 2       V 109       V 109         Me OP/LP for the development of this PCP. The signature indicates agreement with the services/supports to be provided."       V 109       V 109         Review on 6/17/25 of Client #2's record revealed: -Admission date of 4/1/20.       -Diagnoses of Schizophrenia; Obesity; Sinus tachycardia (Secondary to Clozapine); Chronic Constipation; Hypertriglyceridemia; Metrornhagia; Vitamin Deficiency; High Blood Pressure; Overative Bladder: Seasonal Allergies. -Person Centered Plan was signed by the Group Horme Coordinator/QP under Section 2.       "PERSON RESPONSIBLE FOR THE PCP: The following signature confirms the responsibility of the QP/LP for the development of this PCP. The signature indicates agreement with the services/supports to be provided."         -Group Home Coordinator had the initials "QP" placed after her signature.         Interview on 6/17/25 with the Group Home Coordinator/QP revealed: -She had worked for the agency for over 30 years.         -She had worked for the agency for over 30 years.         -She had been assigned the duties of the QP a few years ago.         -She had been assigned the duties of the QP a few years ago.         -She had been assigned the duties of the QP a few years ago.         -The highest level of education she completed was high school.	OREOTV		BURLING	TON, NC 2	27217		
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V 109     Continued From page 2     V 109       the QP/LP for the development of this PCP. The signature indicates agreement with the services/supports to be provided."     -Group Home Coordinator had the initials "QP" placed after her signature.       Review on 6/17/25 of Client #2's record revealed:     -Admission date of 4/120.       -Diagnoses of Schizophrenia; Obesity; Sinus tachycardia (secondary to Clozapine); Chronic Constipation; Hypertriglyceridemia; Metrorrhagia; Vitamin Deficiency; High Blood Pressure; Overactive Bladder; Seasonal Allergies.       -Person Centered Plan was signed by the Group Home Coordinator/QP under Section 2.       "PERSON RESPONSIBLE FOR THE PCP: The following signature confirms the responsibility of the QP/LP for the development of this PCP. The signature indicates agreement with the services/supports to be provided."       -Group Home Coordinator Ad the initials "QP" placed after her signature.       Interview on 6/17/25 with the Group Home Coordinator/QP revealed:       -She had worked for the agency for over 30 years.       -She had been assigned the duties of the QP a few years ago.       -She kod of the dication she completed was high school.       Interview on 6/17/25 with the Clinical Director revealed:       -The highest level of education she completed was high school.       Interview on 6/17/25 with the Clinical Director revealed:       -She had not been aware that the Group Home Manager was not able to be the QP due to her					(EACH CORRECTIVE ACTION SHOUL	DBE	COMPLETE
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Vision of Health Service Regulation		alth Service Regulation					

Di STATE FORM

Division of Health Service I STATEMENT OF DEFICIENCIES		CIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)		DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING: B. WING		COMPLETED		
	MHL001-014				06/1	7/2025	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CODE	00/1	172020	
CRESTV	IEW GROUP HOME #	2 635 CRE	STVIEW DR	IVE			
		BURLING	TON, NC 2	27217			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLE DATE	
V 109	Continued From page	ge 3	V 109				
	completed survey a -Agency was active the this facility and s -She acknowledged	Intil last week when surveyor t sister facility. ly searching for a QP to cover sister facility next door. the QP did not meet the ment for the MH/DD/SAS					
V 121	27G .0209 (F) Media	cation Requirements	V 121				
	governing body or op for obtaining a review regimen at least eve shall be to be perform physician. The on-sit the client's physician the review when med (2) The findings of th	v: ves psychotropic drugs, the perator shall be responsible w of each client's drug ry six months. The review med by a pharmacist or te manager shall assure that is informed of the results of dical intervention is indicated. te drug regimen review shall ient record along with					
l f s r F	facility failed to obtain six months for 3 of 3 received psychotropic Review on 6/17/25 of Admission date of 3/	views and interview, the o drug regimen reviews every clients (#1, #2 and #3) who c drugs. The findings are: Client #1's record revealed:		This deficiency will be addressed b updating the Policy and Procedure Manual: Medical Policies and Procedures P Number III.2 Medication Reviews	•	6-26-25	

STATE FORM

#### Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED MHL001-014 B. WING 06/17/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **635 CRESTVIEW DRIVE CRESTVIEW GROUP HOME #2** BURLINGTON, NC 27217 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 121 Continued From page 4 V 121 The amended update will be: 6-26-25 Medications and Peer Review will be Hypothyroidism; Chronic Back/Knee Pain, conducted every six months. -Physician's order dated 7/14/24: -Aripiprazole 30 milligrams (mg) An update reminder will be placed in (Schizophrenia)- Take one tablet daily. the Master Notebook for the MARS. -Physician's order dated 3/11/25: -Clonazepam 1 mg- Take one tablet at night. The medical staff of RTSA will schedule Discontinued on 5/22/25. the medication / peer reviews in order to -Physician's order dated 5/21/25: comply with the six month requirement. -Olanzapine 10 mg (Schizophrenia)- Take one tablet at night. It should be noted the review for this -Physician's order dated 5/22/25: facility was completed on 06-18-25. -Clonazepam 1 mg (Anxiety)- Take 1/2 tablet at night (0.5 mg). -The last time a six month psychotropic drug review was conducted was 4/25/24. -There was no evidence of a current six month psychotropic drug review. Review on 6/17/25 of the April 1, 2025 through June 16, 2025 Medication Administration Record (MAR) revealed: -Staff documented Client #1 was administered the above medication from April 1, 2025 through June 16, 2025. Review on 6/17/25 of Client #2's record revealed: -Admission date of 4/1/20. -Diagnoses of Schizophrenia; Obesity; Sinus tachycardia (secondary to Clozapine); Chronic Constipation; Hypertriglyceridemia; Metrorrhagia; Vitamin Deficiency; High Blood Pressure; Overactive Bladder; Seasonal Allergies. -Physician's orders dated 5/29/25: -Clozapine 100 mg (Schizophrenia)- Take one tablet twice a day. -Lithium Carbonate 300 mg (Schizophrenia, Bipolar)- Take one tablet twice a day. -Haloperidol 10 mg (Schizophrenia)- Take two tablets at night. -Clozapine 25 mg- Take one tablet at night. Division of Health Service Regulation

STATE FORM

# Division of Health Service Regulation

			A. BUILDING		COM	PLETED	
		MHL001-014 B. WING _		WING			
	PROVIDER OR SUPPLIER				06/	17/2025	
		645 ODE	STVIEW DRIV	TATE, ZIP CODE			
CREST	IEW GROUP HOME #	2	TON, NC 272				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	OBRECTION		
PRÉFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE	
V 121	Continued From page	ge 5	V 121				
	-The last time a six review was conduct	month psychotropic drug ed was 4/25/24. ence of a current six month					
	Review on 6/17/25 of the April 1, 2025 through June 16, 2025 Medication Administration Record (MAR) revealed: -Staff documented Client #2 was administered the above medication from April 1, 2025 through June 16, 2025.						
	-Admission date of 9 -Diagnoses of Schize Depressive Disorder -Physician's order da -Aripiprazole 400 2 milliliters (ml) every -Physician's order da -Mirtazapine 30 m tablet at night. -Lorazepam 1 m twice a day. -Physician's orders d -Aripiprazole 20 m day. -Haloperidol Dec (Schizophrenia)- Injee	ophrenia, Unspecified; Major , Recurrent, Moderate. ted 10/1/24: ) mg (Schizophrenia)- Inject / 28 days. ted 5/8/25: mg (Depression)- Take one g (anxiety)- Take one tablet ated 5/20/25: mg- Take 1/2 tablet twice a anoate 100 ml injection ct every four weeks. nce of a current six month					
	Review on 6/17/25 of June 16, 2025 Medic (MAR) revealed: -Staff documented CI	the April 1, 2025 through ation Administration Record ient #3 was administered from April 1, 2025 through					

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
AME OF	PROVIDER OR SUPPLIER			Y, STATE, ZIP CODE		
CRESTV	IEW GROUP HOME #	2	STVIEW DF			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION	
PRÉFIX TAG	(EACH DEFICIENC) REGULATORY OR L	YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5 COMPL DAT
V 121	Continued From pa	ge 6	V 121			
	-Facility was awaitin the psychotropic dru -She was under the psychotropic drug re only once a year. -She acknowledged reviews for Clients # conducted every six Interview on 6/10/25 revealed: -She was aware tha facility had not been -Drug reviews were (6/18/25). -She was not aware reviews needed to b months until surveyo week. -She acknowledged	impression that the eviews were to be conducted the psychotropic drug #1, #2 and #3 had not been months. with the Clinical Director t the drug reviews for the completed. scheduled for tomorrow the drug psychotropic drug e conducted every six or visited sister facility last the psychotropic drug 1, #2 and #3 had not been				
             	10A NCAC 27G .030 EXTERIOR REQUIR (c) Each facility and i maintained in a safe, manner and shall be odor. This Rule is not met	EMENTS ts grounds shall be clean, attractive and orderly kept free from offensive as evidenced by:	V 736	This deficiency will be address development of a Bathroom Log to be monitored by the G Home Manager and first shift weekly basis. This log will provide a checkli cleaning of the bathrooms to shower, tub, toilets, floors, ca and grout. Group Home staff will be resp	Cleaning Group staff on a staff on a include include ulking	7-30-2
F		and interview the facility		Group notifie start will be rest	onsible	
v r	was not maintained in manner. The findings	n and interview, the facility n a clean, attractive, orderly are: 25 at approximately 1:00 pm		for cleaning the bathrooms and and dating the bathroom log. The logs will be maintained in		

#### Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: MHL001-014 B. WING 06/17/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **635 CRESTVIEW DRIVE CRESTVIEW GROUP HOME #2** BURLINGTON, NC 27217 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 736 Continued From page 7 V 736 revealed: -Bathroom between bedrooms #1 and #2 (Bathroom with Shower): -The shower seat had organic matter growing all along the edges of the shower seat. -Organic matter was growing on the left back corner inside the shower. -Black stains between the tiles inside the shower. -Bathroom between bedrooms #3 and #4 (Bathroom with tub): -There were black stains on the caulk separating the tub and the walls inside the shower/tub area. -There were black stains on the grout between the tiles on the floor outside the tub. -Bathroom between bedrooms #5 and #6 (Bathroom with tub): -There were black stains on the caulk separating the tub and the walls inside the shower/tub area. -There were black stains on the grout between the tiles on the floor outside the tub. -There were rust spots on top of the door frame separating room #6 and the bathroom. Interview on 6/17/25 with the Group Home Coordinator/Qualified Professional revealed: -Clients were supposed to let staff know when the bathrooms needed to have a deep cleaning. -Clients were not able to clean/scrub the showers due to their physical conditions. -She was not aware that the showers/tubs were in need of a deep cleaning. -Clients had not informed her. -When needed, staff used bleach products to clean the showers/tubs and everything cleared up well afterwards. -She would let staff know about the bathroom situations. Division of Health Service Regulation

STATE FORM

Division	of Health Service Re	egulation			FURM APPROV	VLD
STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	MHL001-014		B. WING		06/17/2025	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
CRESTV	IEW GROUP HOME #	COE CDE				
	IEW GROOP HOWE #	BURLING	STON, NC 27	217		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ETE
V 736	Continued From pa	ge 8	V 736			
	revealed: -She was not aware conditions.	5 with the Clinical Director a about the shower/tubs a bathrooms cleaned."				
vision of Hea	Ith Service Regulation					