PRINTED: 06/06/2025 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL049-059			R <b>06/05/202</b> 9	R <b>06/05/2025</b>	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  148 JAMES FARM ROAD  STATESVILLE, NC 28625							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES  ID  PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			BE COMP	PLETE		
V 000	INITIAL COMMENT An annual, complain completed on 6/5/2 unsubstantiated (int deficiency was cited) This facility is licens category: 10A NCAL Living for Adults with the facility is licens census of 4. The standits of 1 discharge 27G .0303(c) Facility 10A NCAC 27G .03 EXTERIOR REQUITION (c) Each facility and maintained in a safe manner and shall be odor.  This Rule is not me Based on observation of the facility manner and orderly manner observation of the funtil 3:30 pm reveal Client #2's bathroor - A 4' by 4' (approbetween the sink arbeen plastered but	Int and follow up survey was 5. The complaint was 6. The complaint was 6. The following service C 27G .5600C Supervised in Developmental Disabilities.  Interest of and has a current curvey sample consisted of 6 ded client and 2 current clients.  Interest of any sample consisted of 6 ded client and 2 current clients.  Interest of any sample consisted of 6 ded client and 2 current clients.  Interest of any sample consisted of 6 ded client and 2 current clients.  Interest of any sample consisted of 6 ded client and 2 current clients.  Interest of any sample consisted of 6 ded client and 6 d	V 000		will dinator mely conitor ents s and ture,		
lacksquare	(rectangular in shap but remained unpai - The wall beside	eximate in size) portion of wall be) which had been plastered inted and behind client #2's toilet be paint was chipped and					

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

(X6) DATE

TITLE

IDD Regional Administrator 6/11/25

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
			7. BOILDING.		   F			
MHL049-059		B. WING		06/05/2025				
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE				
JAMES F	JAMES FARM HOME  148 JAMES FARM ROAD  STATESVILLE, NC 28625							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE		
V 736	Continued From page 1		V 736					
	peeling from the wall  - The top of the baseboards underneath the areas of the peeling wall paint were light brown in color with the remainder of the baseboard being white in color							
	middle panel of the - A cracked area middle panel of the - A circular area	above the top of the left bedroom door near the top of the right bedroom door around the bedroom doorknob hite which was in contrast to						
		iling tiles ig tile (a white U shaped d be observed from where the						
	Basement bathroor - A stained ceiling - Three pieces of hanging from the ce	g tile f a torn white vinyl-like material						
	Lead revealed: - Work orders ha the needed repairs - Some of the wo	with the Residential Team ad been submitted regarding ork had not been completed iles) due to ongoing repairs upstairs bathroom						
	Developmental Disa Administrator revea - She would ensu							

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	(3) DATE SURVEY COMPLETED		
			A. BUILDING:	·				
		MHL049-059	B. WING		06/0	5/2025		
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
JAMES FARM HOME 148 JAMES FARM ROAD								
STATESVILLE, NC 28625  (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OULD BE COMPLETE			
V 736	Continued From pa	ge 2	V 736					
	This deficiency has	been cited two times since e of 7/31/23 and must be						

6899

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