STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		MHL074-086	B. WING		07/1	? 7/2025		
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 0771	112020		
THE VILI	THE VILLAGE II 3354/3362			22 FRONT GATE DRIVE (VARIOUS SUITES) VILLE, NC 27834				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE		
V 000	INITIAL COMMENT	TS .	V 000					
		w up survey was completed eficiencies were cited.						
	This facility is licensed for the following service category: 10A NCAC 27G .4100 Residential Recovery Programs for Individuals with Substance Abuse Disorders and their Children.							
		sed for 31 and has a current survey sample consisted of clients.						
V 114	27G .0207 Emerge	ncy Plans and Supplies	V 114					
	AND SUPPLIES (a) Each facility sha and a disaster plan these plans availab to the county emerg request. The plans procedures and rou (b) The plans shall and evacuation proposted in the facility. (c) Fire and disaste shall be held at least repeated for each so Drills shall be condisimulate the facility' emergencies.	gency services agencies upon shall include evacuation ites. be made available to all staff cedures and routes shall be r drills in a 24-hour facility st quarterly and shall be hift.						

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:	<u> </u>	_	,
		MHL074-086	B. WING		7 07/1	7/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE VIL	LAGE II		PRONT GAR LLE, NC 278	TE DRIVE (VARIOUS SUITES) 834		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 114	Continued From pa	ge 1	V 114			
	This Rule is not met as evidenced by: Based on record review and interviews the facility failed to have fire and disaster drills held at least quarterly and repeated on each shift. The findings are: Review on 7/16/25 of the facility's records for fire and disaster drills revealed: -No fire or disaster drill held on 1st shift, 2nd shirt or 3rd shift in the 3rd quarter (July - September) and 4th quarter (October - December) of 2024No fire or disaster drill held on 1st shift, 2nd shirt or 3rd shift in the 1st quarter (January - March) and 2nd quarter (April - June) of 2025.					
		5 client #1 stated: ed in a fire drill the last week. ed in two fire drills since				
	Interview on 7/16/2	-				
	Interview on 7/16/2 She had not particip "yet."	5 client #3 stated: pated in a fire or disaster drill				
	-Fire and Disaster of -She "misplaced" a documentationShe had start new	5 the Facility Manager stated: drills were held monthly. Il the fire and disaster drill documentation for July 2025. cility were: 1st 8am - 5pm, d 3rd 12am-8am.				
	-Fire and Disaster of each shift.	5 the Program Director: drills were held monthly on e of the fire and disaster drill				

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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	
		MHL074-086	B. WING			R 1 7/2025	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE			
THE VIL	LAGE II		2 FRONT GAT ILLE, NC 278	E DRIVE (VARIOUS SUITE 34	S)		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 114	Continued From pa	ge 2	V 114				
	documentation beir	ng misplaced.					
V 736	27G .0303(c) Facili	ty and Grounds Maintenance	V 736				
	exterior requirements (c) Each facility and maintained in a safe manner and shall b odor.	I its grounds shall be e, clean, attractive and orderly e kept free from offensive					
	was not maintained	et as evidenced by: on and interviews the facility I in a safe, clean and attractive om offensive odors. The					
	12:50pm a tour of the Building 3354 -Unit #15 toilet seat -Unit #16 - vacant surnersUnit #19 - vacant hunder dishes in the items scattered on -Unit #20 - vacant hunder was filled above the -Unit #21 - had cray bathroom and the cunit #6 - faucet sin and the laundry are -Unit #7 - vacant, count hunder was filled above the -Unit #6 - faucet sin and the laundry are -Unit #7 - vacant, count hunder was filled above the -Unit #22 - the stove burnerUnit #10 - vacant, for the bathroom light was a surner was a	was broken. stove was missing the 2 back had clothes, hair and other s on the living room floor, he sink and miscellaneous the table. had a foul odor and trashcan e rim. yon marks on the wall in the closet doors. hk in the bathroom was loose ha light was blown. booked food on the stove and					

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STATE FORM 6899 T04X11 If continuation sheet 3 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		MHL074-086	B. WING			R 17/2025		
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	•			
				2 FRONT GATE DRIVE (VARIOUS SUITES) ILLE, NC 27834				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE		
V 736	light fixture covers vand brownish stains living/laundry. The a Interview on 7/16/29. The vacant units not the facility had to sto the property man	were missing, paint peeling son the ceiling in the above unit had a water leak. The facility Manager stated: eeded to be cleaned, submit maintenance request agement company for repairs.	V 736					

6899

Division of Health Service Regulation STATE FORM

T04X11 If continuation sheet 4 of 4