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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			
		MHL001-142	B. WING		09/24/2025			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
L & J HOMES- APPLE STREET 816 APPLE STREET								
		BURLINGT	ON, NC 27216	5				
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE			
V 000	INITIAL COMMENTS		V 000					
	on September 24, 20	aint survey was completed 25. The complaint (intake unsubstantiated. A deficiency						
	category: 10A NCAC	d for the following service 27G. 5600C. Supervised Developmental Disabilities.						
	-	d for 3 and currently has a rey sample consisted of ents, 1 former client.						
V 131	G.S. 131E-256 (D2) H Verification	HCPR - Prior Employment	V 131					
	REGISTRY (d2) Before hiring hea health care facility or health care facility sh	alth care personnel into a service, every employer at a all access the Health Care nd shall note each incident opriate business files.						
	facility failed to access Registry (HCPR) prior three audited staff (#Review on 9/24/25 of revealed:	ecord and interview the s the Health Care Personnel r to employment for one of						

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

(X6) DATE TITLE

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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						
		MHL001-142	B. WING		09/2	4/2025					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 816 APPLE STREET 816 APPLE STREET											
BURLINGTON, NC 27216											
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE					
V 131	-There was no evider prior to employment. Interview on 9/24/25 poincetor revealed: -The office manager of the HCPR for all new employment. He was responsibles manager completed to the did not know staff assessed prior to employment.	with the Client Services was assigned to assess the ployees. for ensuring that the office he task. f #1's HCPR was not	V 131								

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