PRINTED: 10/09/2018 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: MHL0601102 NAME OF PROVIDER OR SUPPLIER STREET A			(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 09/26/2018	
		MHI 0601102				
		ADDRESS, CITY, STATE	, ZIP CODE	03	5/20/2018	
		10025 N	ORTHWOODS FOR	EST DRIVE		
KERR HO	NES	CHARLO	OTTE, NC 28214			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLET O THE APPROPRIATE DATE	
V 000	INITIAL COMMENTS		V 000			
	An annual and complaint survey was completed on 9/26/18. The complaint was unsubstantiated (Intake #NC142290). Deficiencies were cited.					
	category: 10A NCAC	ed for the following service C 27G .5600C Supervised Developmental Disabilities.				
V 114	27G .0207 Emergen	cy Plans and Supplies	V 114			
	 AND SUPPLIES (a) A written fire plan area-wide disaster p shall be approved by authority. (b) The plan shall be and evacuation proce posted in the facility. (c) Fire and disaster shall be held at least repeated for each sh under conditions that 	D7 EMERGENCY PLANS a for each facility and lan shall be developed and y the appropriate local e made available to all staff redures and routes shall be drills in a 24-hour facility t quarterly and shall be hift. Drills shall be conducted t simulate fire emergencies. I have basic first aid supplies				
	facility failed to ensu per shift per quarter.	view and interviews, the re fire drills were conducted The findings are:				
		with staff #1 revealed he sometimes worked third				
		with staff #2 revealed he also filled in on second and				

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHI 0601102	B. WING		09/26/2018	
MHL0601102 NAME OF PROVIDER OR SUPPLIER STREET			ADDRESS, CITY, STATE,	08	1/20/2010	
KERR HO	MES		ORTHWOODS FOR OTTE, NC 28214	EST DRIVE		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN		(,(0)	
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO DEFICIE	O THE APPROPRIATE	DATE
V 114	Continued From page 1		V 114			
	third shift as needed.					
	Interview on 9/17/18 with the Home Manager revealed the facility operated three shifts.					
	forms for the facility f revealed the following -one fire drill conduct no other fire drills cor 10/1/17-12/31/17; -one fire drill conduct other fire drill conduct other fire drills conduct other fire	g documented: ed at 9:00am on 11/14/17, nducted from ed at 3:30pm on 1/8/18 and ed at 3:00pm on 2/5/18, no cted from 1/1/18-3/31/18; ed at 5:00pm on 5/7/18, no cted from 4/1/18-6/30/18. 9/20/18 with Home Manager y instructed her to do seven s a quarter; the disaster drills and was equirements for the fire drills agency had different				
V 752	-will ensure me drifts by rule. 27G .0304(b)(4) Hot	are conducted as required	V 752			
V TOZ	 10A NCAC 27G .030 EQUIPMENT (b) Safety: Each faci constructed and equi ensures the physical visitors. (4) In areas of exposed to hot water 	4 FACILITY DESIGN AND lity shall be designed, pped in a manner that safety of clients, staff and the facility where clients are the temperature of the ained between 100-116				

Division of Health Service Regulation STATE FORM

6899

6L5M11

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601102		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			E SURVEY PLETED
		DDRESS, CITY, STATE		09	09/26/2018	
			ORTHWOODS FOR			
KERR HO	MES	CHARLO	DTTE, NC 28214			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
V 752	Continued From page 2		V 752			
	degrees Fahrenheit.					
	interviews, the facility the facility where clie water, the temperatu	ns, records review and / failed to ensure in areas of nts were exposed to hot				
	-hot water temperatu was 126 degrees; -hot water temperatu bathroom sink was 1 -hot water temperatu bedroom bathroom s Review on 9/17/18 of	22 degrees; re reading in the back ink was 123 degrees. f facility incident reports from led no client injuries as a				
	revealed: -just got hot water he -been in the process	with the Home Manager eater replaced at the facility; of trying to adjust hot water; aperature within required				

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