

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL019-023	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/30/2018
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GRIFFIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 323 MARTIN LUTHER KING BOULEVARD SILER CITY, NC 27344
--	---

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	<p>INITIAL COMMENTS</p> <p>An annual and follow-up survey was completed on November 30, 2018. A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p>	V 000		
V 114	<p>27G .0207 Emergency Plans and Supplies</p> <p>10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES</p> <p>(a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority.</p> <p>(b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.</p> <p>(c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies.</p> <p>(d) Each facility shall have basic first aid supplies accessible for use.</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure that fire and disaster drills were conducted quarterly on each shift. The findings are:</p> <p>Review on 11/28/18 of the facilities fire and disaster logs from October 2017 through October 2018 revealed the following information; -- Only 3 fire drills were conducted on second</p>	V 114		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL019-023	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/30/2018
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GRIFFIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 323 MARTIN LUTHER KING BOULEVARD SILER CITY, NC 27344
--	---

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 114	<p>Continued From page 1</p> <p>shift.</p> <p>-- Only 2 fire drills were conducted on third shift.</p> <p>-- Only 4 disaster drills were conducted on second shift.</p> <p>-- Only 1 disaster drill was conducted on third shift.</p> <p>During interview on 11/30/18 the Executive Director confirmed the above information.</p> <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 114		