

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601306	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/03/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HINDS' FEET FARM, INC-HART COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 14525 BLACK FARMS ROAD HUNTERSVILLE, NC 28070
---	---

(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 1/3/19. 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 records review and interviews, the facility failed to ensure Fire drills were held at least quarterly and were repeated for each shift. The findings are:</p> <p>Interview on 1/3/19 with the Qualified Professional(QP) revealed: -facility was closed for 2018 until re-opened 9/2018; -client #1 was admitted in 9/10/18.</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: MHL0601306	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/03/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HINDS' FEET FARM, INC-HART COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 14525 BLACK FARMS ROAD HUNTERSVILLE, NC 28070
---	---

(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>Interview on 1/3/19 with staff #1 revealed: -worked 12 hour shifts, day shift 6am/7am-6pm/7pm; -not done any disaster drills.</p> <p>Interview on 1/3/19 with staff #2 revealed she worked 12 hour shifts 7am-7pm or 7pm-7am.</p> <p>Review on 1/3/19 of the facility's fire and disaster drills log from 9/10/18-1/3/19 revealed: -only one fire drill conducted from 9/10/18-1/3/19.</p> <p>Further interview on 1/3/19 with the QP revealed the issue will be addressed and fire drills will be conducted as required.</p>	V 114		