PRINTED: 02/19/2019 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
				A. BOILDING.			₹	
MHL0411110			B. WING 02			14/2019		
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
WATLING	STON'S FAMILY CARI	E HOMES #3		RROD-WATI	LINGTON CIRCLE			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIE		ID ID	PROVIDER'S PLAN OF CORRE		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE COMPLE DEFICIENCY)			
V 000 INITIAL COMMENTS			V 000					
		ow-Up Survey was o 19. A deficiency was						
	This facility is licensed for the following service category:							
	- 10A NCAC 27 for Developmentally	G .5600C: Supervisy Disabled Adults	sed Living					
V 114	27G .0207 Emerge	ncy Plans and Supp	lies	V 114				
	10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (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. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be							
	shall be held at least repeated for each sunder conditions the	r drills in a 24-hour t st quarterly and shal shift. Drills shall be c at simulate fire eme	I be onducted rgencies.					
	accessible for use.	all have basic first aid	a supplies					
		and record review, fire drills and disaste						
	Review on 2-14-19 logs revealed:	of the fire and disas	ster drill					

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

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
					R		
		MHL0411110	B. WING		02/1	4/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STATE, ZIP CODE				
WATLING	GTON'S FAMILY CAR	F HOMES #3	RROD-WATI BORO, NC 2	LINGTON CIRCLE 7406			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	VE ACTION SHOULD BE COMPLÉTE DATE		
V 114	TON'S FAMILY CARE HOMES #3		V 114	DETICIENCY)			
		9 with Co-Director sional (CD2/QP) revealed: ills, fire and disaster					

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STATE FORM 6899 KMKZ11 If continuation sheet 2 of 3

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/S IDENTIFICATI	SUPPLIER/CLIA ION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
				A. BOILDING.			₹	
		MHL0411	110	B. WING			4/2019	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
WATLINGTON'S FAMILY CARE HOMES #3 1401 SHERROD-WATLINGTON CIRCLE GREENSBORO, NC 27406								
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	(X5) COMPLETE DATE		
- h doing a - "I they'r them b	all drills have a bette e supposed etter now." eficiency cor	staff to make s	ng now of how b, we ' II monitor ed deficiency	V 114				

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