

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-903	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/25/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER G & S WILLIAMS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 115 HALPEN DRIVE CARY, NC 27513
--	---

(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 survey was completed on 02-25-19. A deficiency was cited.</p> <p>This facility is licensed for the following service 10A NCAC. 27G .5600F Supervised Living/Alternative Family Living.</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 record review and interview the facility failed to ensure the Fire and Disaster Drills were completed quarterly for each shift. The findings are:</p> <p>Review on 2/25/19 the Fire/Disaster Drills revealed the following: -2/3/18-11:25 AM- Natural Disaster -3/3/18- 10:00 AM- Fire Drill -6/16/18- 10:25 AM- Fire Drill</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: MHL092-903	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/25/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER G & S WILLIAMS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 115 HALPEN DRIVE CARY, NC 27513
--	---

(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> <ul style="list-style-type: none"> -9/1/18- 10:00 AM- Fire Drill -11/9/18- 2:20 PM- Medical Emergency -1/31/19- No time indicated- Fire Drill." <p>Interview on 2/25/19 The Licensee stated:</p> <ul style="list-style-type: none"> -Had been doing Fire Drills every few months. -Had only completed a few Disaster Drills. -Was not aware of how often the drills needed to be completed. 	V 114		