STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-461						(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		R		
		B. WING		07/10/2019			
ame of PF	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE			
LHC RES	IDENTIAL PROGRAM	FOR WOMEN AND CI	RING DRIVE R, NC 27529				
(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 ACT CROSS-REFERENCED TO T DEFICIENC	ACTION SHOULD BE		
V 000	INITIAL COMMENTS		V 000				
	An annual and follow up survey was completed on July 10, 2019. Deficiencies were cited.						
	category: 10A NCAC Recovery Programs	ed for the following service 2 27G .4100 Residential For Individuals With sorder & Their Children.					
V 114	27G .0207 Emergen	cy Plans and Supplies	V 114				
	<ul> <li>AND SUPPLIES</li> <li>(a) A written fire plan area-wide disaster p shall be approved by authority.</li> <li>(b) The plan shall be and evacuation proce posted in the facility.</li> <li>(c) Fire and disaster shall be held at least repeated for each sh under conditions that</li> </ul>	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 nift. Drills shall be conducted t simulate fire emergencies. I have basic first aid supplies					
	failed to conduct fire quarterly for each sh During an interview of Assistance reported	iew and interview, the facility and disaster drills at least ift. The findings are: on 7/10/19, the Administrative the staff schedule used for s was 1st shift: 6:00am -					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-461			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED R 07/10/2019	
		B. WING				
IAME OF PF	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE,	ZIP CODE		
LHC RES	DENTIAL PROGRAM F		RING DRIVE R, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 114	Continued From page 1		V 114			
	June, 2019 revealed: - 1/25/19 no spe in box for 5:00pm - 9 - 3/24/19 check	ecific time noted but checked				
	June, 2019 revealed: - 1/18/19 check 5:00pm (Actual Medi - 1/20/19 check 5:00pm (Ice Storm) - 6/20/19 6:15pr - 6/29/19 check 7:00pm (Power Failu	ed in box for 8:00am - cal) ed in box for 8:00am - n (Power Failure) ed in box for 5:00pm -				
	reported: - the facility had half of 2018 and they clients by July, 2018. and they were able to admitting clients again Because of this, there	an 7/10/19, the Director almost closed down the last had discharged all their Circumstances changed o remain open. They began in in December, 2018. were no drills between July she thought they had been equired.				
V 752	EQUIPMENT (b) Safety: Each faci constructed and equi	Water Temperatures 4 FACILITY DESIGN AND lity shall be designed, pped in a manner that safety of clients, staff and	V 752			

STATE FORM

GOZK11

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
	MHL092-461		B. WING		R 07/10/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
	SIDENTIAL PROGRAM F	OR WOMEN AND CI	RING DRIVE R, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
V 752	Continued From page	e 2	V 752			
	exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit.					
	This Rule is not met as evidenced by: Based on observation and interviews the facility failed to ensure the water temperatures were maintained between 100-116 degrees Fahrenheit. The findings are:					
	2:30pm revealed: - Apartment # 19 - Kitchen -12 - Downstairs - Upstairs B - Apartment # 18 - Kitchen -12 - Downstairs - Upstairs B - Apartment # 19 - Kitchen - 9 - Downstairs	22 degrees Fahrenheit (F) s Bathroom - 120 degrees F athroom -120 degrees F 848: 20 degrees F s Bathroom - 125 degrees F athroom - 120 degrees F 958				
	9:30am - 10:30am re - Apartment # 11 - Kitchen - 1 - Bathroom - Apartment # 11 -Kitchen - 1 <sup>2</sup>	6B: 22 degrees F - 122 degrees F 8D:				
	Supervisor stated the she has submitted so	7/10/19 the Client Care apartments are very old ome maintenance request water temperatures and will n.				

STATE FORM

GOZK11

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Division of Health Service Regu STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		BERTIN IO, THOIT HOMBER.						
		MHL092-461	B. WING		07	R 7/ <b>10/2019</b>		
AME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
LHC RES	IDENTIAL PROGRAM	FOR WOMEN AND CI	RING DRIVE					
		GARNE	R, NC 27529					
(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) COMPLE <sup>-</sup> DATE		

GOZK11