STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
MHL043059			B. WING			07/29/2019	
NAME OF PROVIDER OR SUPPLIER PROFESSIONAL FAMILY CARE HOME #5 STREET ADDRESS, CITY, STATE, ZIP CODE 19 SUSIE CIRCLE CAMERON, NC 28326							
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	ΓS		V 000			
	An annual survey w 2019. Deficiencies of This facility is licens category 10A NCAC Living for Adults with	were cited. sed for the followin C 27G.5600C Supe	g service ervised				
V 114	27G .0207 Emergency Plans and Supplies 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 posted in the facility. (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. (d) Each facility shall have basic first aid supplies accessible for use.		V 114				
	This Rule is not me Based on record re facility failed to cond under conditions the least quarterly and findings are: Record review on 7 log revealed the foll -7/3/18- 3:25 p.m.	views and interview duct fire and disas at simulate emerge repeated for each	ws, the ter drills encies at shift. The				

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
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NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PROFES	SSIONAL FAMILY CAR	E HOME #5	19 SUSIE CAMERO	CIRCLE N, NC 28326	3		
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 114	Continued From paragraph 29/19/18- Blank 10/9/18- 4:19 p.m. 11/6/18- 4:27 p.m. 12/18/18- 4:15 p.m. 1/21/19- 1:27 p.m. 2/16/19- 3:07 p.m. 3/22/19- 5:00 p.m. 4/16/19- 4:10 p.m. 5/12/19- 3:28 p.m. 6/18/19- 4:15 p.m. 6/23/19- 9:00 p.m. 7/18/19- 5:37 p.m. Facility operated u There were no fire shift for the fourth continue of the first quarter of the first quarter there were no fire shift for the second Record review on 7 drill log revealed the 9/20/18- Blank 12/27/18- Blank 13/6/19- Bl	nder three shifts drills conducted juarter of 2018. drills conducted of 2019. drills conducted quarter of 2019. drills conducted quarter of 2019. drills conducted for the following: The what time/share conducted from the Quality and the QP anager was respertant disaster driving the QP anager was respertant driving the QP anager was resp	d for 1st or 3rd d for 3rd shift d for 1st or 3rd of for fill of for for fills were fogs at the	V 114			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
MHL043059			B. WING			07/29/2019	
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PROFESSIONAL FAMILY CARE HOME #5 19 SUSIE CI CAMERON,					3		
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V 114	Continued From page 2 conditions that simulate fire and disaster emergencies under each shift on each quarter.			V 114			
V 736	27G .0303(c) Facilit 10A NCAC 27G .03 EXTERIOR REQUI (c) Each facility and maintained in a safe manner and shall b odor.	603 LOCATION AN REMENTS I its grounds shall e, clean, attractive	ND be and orderly	V 736			
	This Rule is not me Based on observatifailed to ensure facin a clean, safe and findings are: Observation on 7/2: #1's bedroom reveal-Window blinds were wall and easily came. Observation on 7/2: #1's bathroom reveal-Cabinet under han and was falling apal-Window blinds bedroom reveal-Strong musky odor-There was a a base.	on and interview, ility grounds were attractive manne 9/19 at 11:50 A.M aled: re missing holding e off after trying to 9/19 at 11:55 A.M aled: d sink was missing the truind tub were bent 9/19 at 12:00 P.M aled: r.	the facility maintained or. The collection of client of client of client of client of client of the collection of client of the collection of client of client of client of client of client of client				
	near the wall and be -Door from from en	ehind bed's headb	ooard.				

Division of Health Service Regulation STATE FORM

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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V 736	Continued From particles of the was making a laconducted at the house. He was just made floor of client #2's bit was created. Broken table in the be thrown away. Thunsuccessful. Facility was resporant for the confirmed that maintained in a cleamanner.	9/19 at 12:05 P.Mevealed: ak was tarnished as shower area was 9/19 at 12:10 P.Med: missing door frames and finished. Draw not painted. 9/19 at 12:13 P.Med: an table tilted on it 12:18 P.Medical at 12:18 P.Medica	and opaque a soft. I. of the me from the ywall and I. of the s side. I. of the front on the ed the QP at this epairs to be a hole on the nknown how was going to a it, but it was ning home ere not	V 736			

Division of Health Service Regulation

STATE FORM 6899 I7FV11 If continuation sheet 4 of 4