		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED R 07/31/2019	
	MHL0411089					
NAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
CHATWICI	КНОМЕ		IATWICK DRIVE SBORO, NC 27407			
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	CTION SHOULD BE COMPLE THE APPROPRIATE DATE	
V 000	INITIAL COMMENTS		V 000			
	An annual and follow up survey was completed on 7/31/2019. A deficiency was cited.					
	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.					
V 114	27G .0207 Emergend	cy Plans and Supplies	V 114			
	AND SUPPLIES (a) A written fire plan area-wide disaster pl shall be approved by authority. (b) The plan shall be and evacuation proce posted in the facility. (c) Fire and disaster shall be held at least repeated for each sh under conditions that	7 EMERGENCY PLANS for each facility and an shall be developed and the appropriate local made available to all staff edures and routes shall be drills in a 24-hour facility quarterly and shall be ift. Drills shall be conducted simulate fire emergencies. have basic first aid supplies				
	facility failed to condu- each shift at least que Review on 7/30/2019 disaster logs reveale - No documentation of following shifts and que	ews and interviews, the uct fire and disaster drills on arterly. The findings are: 9 of the facility's fire and d: of fire drills during the				
	- January - March 20					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				B) DATE SURVEY COMPLETED	
		BERTH TO ATO THE BERT					
	MHL0411089		B. WING		R 07/31/2019		
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE			
CHATWIC	КНОМЕ		IATWICK DRIVE SBORO, NC 27407				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY 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) COMPLETI DATE	
V 114	Continued From page 1		V 114				
	following shifts and q - October - December - January - March 20 - April - June 20 Interviews on 7/30/20 revealed: - Clients #1, #2 and #	of disaster drills during the quarters: er 2018: 1st, 2nd & 3rd shifts 19: 1st, 2nd & 3rd shifts 19: 1st, 2nd & 3rd shifts 019 with clients #1 and #2 #3 were unable to articulate ut fire and disaster drills at					
	- Client #3 was only a	19 with client #3 revealed: able to respond "nope" when ster drills were conducted at					
		19 with staff #1 revealed: ills were probably conducted uarter.					
		9 with staff #2 revealed: rills were conducted one thly.					
	facility regularly; - The QP picked up t fire and disaster drills	vealed: fire and disaster drills at the the documentation regarding s every month; at every type of drill, including					
	- The Director's unde including fire drills we						

Division of Health Service Regulation STATE FORM

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Division of Health Service Regulation           STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA           AND PLAN OF CORRECTION         IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		MHL0411089	B. WING			R / <b>31/2019</b>
AME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
HATWIC	КНОМЕ		IATWICK DRIVE SBORO, NC 27407			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLET DATE
V 114	Continued From pag	e 2	V 114			
	This deficiency cons and must be correcte	titutes a re?cited deficiency ed within 30 days.				

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