PRINTED: 12/02/2019 FORM APPROVED

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						
		MHL012-137	B. WING		11/1	9/2019					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
PARK PLACE 109 PARKER LANE MORGANTON, NC 28655											
(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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	(X5) COMPLETE DATE						
V 000	INITIAL COMMENTS		V 000								
	An annual survey was completed on 11/19/19. A deficiency was cited.										
	category: 10A NCA	sed for the following service C 27G .1300 Residential ren or Adolescents.									
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 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								
	facility failed to hold each shift at least of Review on 11/14/19 October 2018- Octo- No documentation conducted during:	et as evidenced by: view and interviews, the If fire and disaster drills on puarterly. The findings are: Of fire and disaster drills from ober 2019 revealed: of fire drills having been ember 2018 through January									

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

(X6) DATE TITLE

PRINTED: 12/02/2019 FORM APPROVED

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							
		MHL012-137	B. WING		11/1	9/2019						
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE, ZIP CODE									
PARK PLACE 109 PARKER LANE MORGANTON, NC 28655												
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE						
V 114	Continued From page 1		V 114									
	-No documentation conducted on:3rd shift from Nov 20191st shift from May1st shift from Aug 2019. Interview on 11/15/Professional (QP) r-Began as Home M	of disaster drills having been rember 2018 through January 2019 through July 2019. ust 2019 through October										

6899

Division of Health Service Regulation STATE FORM

TR2311 If continuation sheet 2 of 2