| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|--|--|-------------------------------|--------------------------|
| | | MHL092-958 | B. WING | | | R 04/2020 |
| | PROVIDER OR SUPPLIER | STREET AD 3905 MAF | DDRESS, CITY, STATE, ZIP CODE RSH CREEK ROAD I, NC 27604 | | | |
| (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) | ILD BE | (X5) COMPLETE DATE |
| V 000 | INITIAL COMMENT | rs | V 000 | | | |
| | on February 4, 2020 This facility is licens | ow Up Survey was completed 0. Deficiencies were cited. sed for the following service C 27G. 5600A Supervised th Mental Illness. | | | | |
| V 114 | 27G .0207 Emerge | ncy Plans and Supplies | V 114 | | | |
| | AND SUPPLIES (a) A written fire pla area-wide disaster shall be approved be authority. (b) The plan shall be and evacuation pro posted in the facility (c) Fire and disaste shall be held at leas repeated for each se under conditions the | 207 EMERGENCY PLANS on for each facility and plan shall be developed and by the appropriate local one made available to all staff cedures and routes shall be developed. Our drills in a 24-hour facility st quarterly and shall be shift. Drills shall be conducted at simulate fire emergencies. Our all have basic first aid supplies | | | | |
| | failed to ensure fire | et as evidenced by: view and interview the facility and disaster drills were y for each shift. The findings | | | | |
| | Review on 2/4/20 o -"6/18/19- 6:00 PM -7/6/19- 5:50 PM -8/4/19- 11:00 AM -9/12/19- 9:50 AM | f Fire Drill log revealed: | | | | |

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 (X3 A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|---|---|------|-------------------------------|--|
| | | | | | F | | |
| | | MHL092-958 | B. WING | | 02/0 | 4/2020 | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRE | | | | STATE, ZIP CODE | | | |
| DIVINE S | SUPPORTIVE HOMES | | SH CREEK NC 27604 | ROAD | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETE DATE | |
| V 114 | -10/13/19- 10:00 AI -11/9/19- 11:00 AM -12/5/19- 6:00 PM -1/12/19- 8:00 AM -2/1/20- 9:00 AM" No evidence of Diss During interview on -He was not aware during the night tim -Will make sure dril | senter Drills conducted. 2/4/20 the Licensee stated: fire drills were not conducted e hours. Is are completed. | V 114 | | | | |
| V 115 | (a) Facilities that prassure that: (1) space and supe the safety and welfa (2) activities are sui and treatment/habil served; and (3) clients participal activities. (h) Facilities or progin these Rules as "2 available 24 hours a unless otherwise sp (c) Facilities that se clients shall ensure (d) When clients whare transported, the with secure adaptiv (e) When two or morequire special assi in a vehicle are transported and the same transported are transported and the same transported and the same transported and the same transported are transported and the same transported and the same transported and the same transported are transported and the same transported an | cost client services ovide activities for clients shall rivision is provided to ensure are of the clients; table for the ages, interests, itation needs of the clients are in planning or determining grams designated or described 24-hour" shall make services a day, every day in the year. Decified in the rule. The or prepare meals for that the meals are nutritious. The hour a physical handicap is equipment. The preschool children who stance with boarding or riding asported in the same vehicle, adult, other than the driver, to | V 115 | | | | |

Division of Health Service Regulation

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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 | |
|---|--|--|---|--|-------------------------------|--------------------------|
| | | | | | F | |
| | | MHL092-958 | B. WING | | 02/0 | 4/2020 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| DIVINE S | SUPPORTIVE HOMES | | SH CREEK | ROAD | | |
| (VA) ID | CHMMADV CTA | TEMENT OF DEFICIENCIES | NC 27604 | PROVIDER'S PLAN OF CORRECTION | N. | (VE) |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| V 115 | Continued From page 2 | | V 115 | | | |
| | failed to ensure me clients (#1, #2, #3, are: Observation on 2/4, and refrigerator rev-Large box of Roma-Several cans of be-Multiple loaves of the freezer. -Two bags of frozer During interview on stated: -They eat a lot of stated: -Eat Roman noodle-Last night for dinnewith an egg on top, that. -The beans, egg and | on and interview the facility als are nutritious for six of six #4, #5 & #6). The findings /20 at 11:30 AM of cabinets ealed: an noodles in cabinet. ans in cabinet. bread and hot dog buns in a vegetables in the freezer. 2/4/20 Clients #1, #2, #3 & #4 arches. as several times a week. ar staff #1 cooked rice, beans then poured a red sauce over ad rice was "disgusting." by could not eat the dinner and | | | | |
| | -Do not have fresh -Eat the same thing During interview on -He bought grocerie -It was time to buy | fruit or vegetables. y all the time. 2/4/20 The Licensee stated: es every two weeks. groceries in the next few days. | | | | |
| | -Tried to buy a varie | ety of items. | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING: | | | X3) DATE SURVEY COMPLETED | |
|---|---|--|---|---|---|------------------------------|--|
| | | | A. BUILDING. | | F | 2 | |
| | | MHL092-958 | B. WING | | | 4/2020 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | | |
| DIVINE S | DIVINE SUPPORTIVE HOMES 3905 MARSH CREEK ROAD RALEIGH, NC 27604 | | | | | | |
| (X4) ID | | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX TAG | | / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | | COMPLETE DATE | |
| V 736 | Continued From pa | ge 3 | V 736 | | | | |
| V 736 | 27G .0303(c) Facility and Grounds Maintenance | | V 736 | | | | |
| | EXTERIOR REQUI (c) Each facility and maintained in a saf | 803 LOCATION AND IREMENTS I its grounds shall be e, clean, attractive and orderly e kept free from offensive | | | | | |
| | failed to maintain the attractive manner. Observation on 2/4-Multiple kitchen case off and would not sepathroom #1 dirty, cleaning. Bathroom #1 floor vent area. Dirty baseboards tesecond client bath dirty. During interview on all the dirty area. Had tried to fix the would close, they all the direating the bath dirty. | ion and interview the facility he home in a clean, safe and The findings are: //20 at 11:30 AM revealed: //20 at 11:30 AM revealed: //20 at 10:30 AM revealed: //20 at 11:30 AM revealed: ///20 at 11:30 AM r | | | | | |
| | | | | | | | |

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Division of Health Service Regulation STATE FORM

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