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						
		MHL001-083	B. WING		02/1	9/2020					
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE							
CEDARS DDA GROUP HOME 838 ROSS STREET BURLINGTON, NC 27217											
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE					
V 000	INITIAL COMMENTS		V 000								
	This facility is licenscategory: 10A NCAC 27G. 56	sed for the following service									
V 114	·	omental Disabilities. ency Plans and Supplies	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.										
	Based on interview management failed	et as evidenced by: and record review, the facility I to assure that fire and conducted quarterly on each are:									
	revealed the follow	of the facility fire/disaster log ing information; rills were completed during the									

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

(X6) DATE TITLE

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							
		MHL001-083	B. WING		02/1	9/2020						
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, STATE, ZIP CODE 02/19/2020									
CEDARS DDA GROUP HOME 838 ROSS STREET												
BURLINGTON, NC 2/21/												
(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)	HOULD BE COMPLETE							
V 114	4 Continued From page 1											
	Only 4 fire drills were completed during the past year.											
	revealed the facility 8:00 pm and 8:00 p	acility administrator on 2/18/20 has two shifts; 8:00 am to m to 8:00 am. During ned that the required ere not conducted.										

Division of Health Service Regulation STATE FORM