## PRINTED: 08/12/2021 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		MHL001-184	B. WING		08	8/05/2021
IAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
		NG 509 FER	NWAY DRIVE			
		BURLIN	GTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLE D THE APPROPRIATE DATE	
V 000	INITIAL COMMENTS	;	V 000			
	on August 5, 2021 ( I complaint was unsub cited.	laint survey was completed ntake # NC00178937). The stantiated. Deficiencies were d for the following service				
	category: 10A NCAC	27G .5600C Supervised Developmental Disabilities.				
V 108	.0202 (F-J) Personne	el Requirements	V 108			
	(g) Employee trainin	tion shall be documented.				
	<ol> <li>general organiza</li> <li>training on client</li> <li>training on client</li> <li>delineated in 10A NC</li> <li>10A NCAC 26B;</li> </ol>	rights and confidentiality as AC 27C, 27D, 27E, 27F and				
	() U	the mh/dd/sa needs of the the treatment/habilitation ous diseases and				
	.5602(b) of this Subc	is. ed under 10a NCAC 27G hapter, at least one staff ilable in the facility at all				
		ned in basic first aid nagement, currently trained				
	trained in the Heimlic	nonary resuscitation and h maneuver or other first aid nose provided by Red Cross, association or their				
	equivalence for reliev (i) The governing bo	ring airway obstruction.				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PO5Z11

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES UND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-184		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED			
			A. BUILDING:				
		MHL001-184	B. WING		08/05/2021		
AME OF PF	OVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE			
LACKWE		NG	RNWAY DRIVE				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF		(,(c))		
PREFIX TAG	<b>`</b>	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLE DATE	
V 108	Continued From page 1		V 108				
	reporting, investigating and controlling infectious and communicable diseases of personnel and clients.						
	This Rule is not met as evidenced by: Based on record review and interview the facility failed to assure one of one staff (#2, and #3) had complete personnel records. The findings are:						
	Review on 8/5/21 of the staff personnel and training records revealed:						
	revealed: - her hire date was 6, - There was docume indicating her cardiop	ntation in staff #2's record oulmonary resuscitation and s conducted on 6/5/21,					
	revealed: - her hire date was 10 - there was documen indicating her cardiop	tation in staff #3's record oulmonary resuscitation and conducted on 6/5/21,					
		8/5/21 the Licensee stated: ed a virtual First Aid and CPR #2 and staff #3.					
V 114	.0207 (A-D) Emerger	ncy Plans and Supplies	V 114				
	10A NCAC 27G .020 AND SUPPLIES (a) A written fire plan	7. EMERGENCY PLANS					

STATE FORM

PO5Z11

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Division of Health Service Regulatio STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHI 001_194	B. WING		08/05/2021		
VAME OF PROVIDER OR SUPPLIER STREET A			ADDRESS, CITY, STATE,	08	6/05/2021		
		509 FER	NWAY DRIVE				
BLACKW	ELL'S COMMUNITY LIVI	NG BURLIN	GTON, NC 27217				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T( DEFICIE	ACTION SHOULD BE COMPLE TO THE APPROPRIATE DATE		
V 114	Continued From page 2		V 114				
	<ul> <li>shall be approved by authority.</li> <li>(b) The plan shall be and evacuation proceed posted in the facility.</li> <li>(c) Fire and disaster of shall be held at least repeated for each shill under conditions that (d) Each facility shall accessible for use.</li> <li>This Rule is not met Based on record revier facility failed to assure conducted at least que finding is:</li> <li>During record review - written documentation being conducted, how quarterly basis on ear During interview on 8 stated they were not stated they w</li></ul>	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 as evidenced by: ew and interviews, the e fire and disaster drills were iarterly on each shift. The on 8/5/21 revealed: on of fire and disaster drills wever; not at least on a					

PO5Z11