

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/18/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HARVEST HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 1470 MAPLE GROVE CHURCH ROAD DUNN, NC 28334
--	---

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	<p>INITIAL COMMENTS</p> <p>An annual survey was completed on August 18, 2021. A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600E Supervised Living for Adults whose Primary Diagnosis is Substance Abuse Dependency.</p>	V 000		
V 114	<p>27G .0207 Emergency Plans and Supplies</p> <p>10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES</p> <p>(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.</p> <p>(b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.</p> <p>(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.</p> <p>(d) Each facility shall have basic first aid supplies accessible for use.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews the facility failed to have fire and disaster drills held at least quarterly and repeated on each shift. The findings are:</p> <p>Review on 8/18/21 of facility records from 7/1/20 - 6/30/21 revealed: - 1st quarter (4/01/21 - 6/30/21): No fire drills documented on 5th shift.</p>	V 114		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/18/2021
NAME OF PROVIDER OR SUPPLIER HARVEST HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 1470 MAPLE GROVE CHURCH ROAD DUNN, NC 28334		
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 114	<p>Continued From page 1</p> <ul style="list-style-type: none"> - 3rd quarter (10/01/20 - 12/31/20): No disaster drills documented on 5th shift. <p>Interview on 8/18/21 client #1 stated:</p> <ul style="list-style-type: none"> - He had only been with facility for approximately 1 month. - He had completed a fire drill. - There were diagrams in the rooms with exit points labeled in case of fire and staff had reviewed the exit strategies with him. <p>Interview on 8/18/21 client #2 stated:</p> <ul style="list-style-type: none"> - He had only been with facility for approximately 2 weeks. - He had not completed a fire drill or disaster yet. - Staff had pointed out exit areas upon admission and there were diagrams in rooms with exit points. <p>Interview on 8/18/21 the Residential Clinical Manager stated:</p> <ul style="list-style-type: none"> - There were 3 shifts Monday - Friday and 2 weekend shifts. - Fire and disaster drills rotated between all 5 shifts on a quarterly basis. 	V 114		