

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mhl036-049</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>10/05/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>YORK-CHESTER GROUP HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>417 WEST 10TH AVENUE GASTONIA, NC 28052</b>		
(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	INITIAL COMMENTS  An annual survey was completed on 10-5-21. Deficiencies were cited.  This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for for Adults with Developmental Disabilities.	V 000	A revision will be made to the procedures for conducting a drill to include the perimeters of time for each shift.  Staff will recieve training on the Emergency drill and the training will incldue the time time parameters for each shift.  The House Manager and the Director of Supervised Living will ensure the drills are conducted for each shift and that the drills will be conducted in the correct time parameter for the shift indicated on the form. The review will occur monthly.	11.1.2021  11.30.2021  12.2.2021
V 114	27G .0207 Emergency Plans and Supplies  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.  This Rule is not met as evidenced by: Based on interview and record review, the facility failed to complete fire and disaster drills at least quarterly and repeated for each shift. The findings are:  Review on 9-30-21 of the facility's Fire and Disaster Drill Logs from September 2020 through August 2021 revealed: -Hours for each shift: 1st shift - 6am-2pm, 2nd	V 114		

RECEIVED  
OCT 27 2021

DHSR-MH Licensure Sect

Division of Health Service Regulation

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

TITLE

(X6) DATE

*Wenay House*

*Director of Supervised Living*

*10/25/2021*

STATE FORM

6899

5D5K11

If continuation sheet 1 of 3

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mhl036-049</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>10/05/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>YORK-CHESTER GROUP HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>417 WEST 10TH AVENUE GASTONIA, NC 28052</b>		
(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> <p>shift - 2pm-10pm, 3rd shift - 10pm-6am; -no 3rd shift Fire Drill was completed for 1st quarter (January-March) 2021; -no 3rd shift Disaster Drill was completed for 1st quarter (January-March) 2021; -no 3rd shift Fire Drill was completed for 2nd quarter (April-June) 2021; -no 3rd shift Disaster Drill was completed for 2nd quarter (April-June) 2021.</p> <p>Interview on 10-5-21 with Client #1 revealed: -the facility conducted Fire and Disaster Drills on a monthly basis and evacuated the facility during each Fire Drill.</p> <p>Interview on 10-5-21 with Client #2 revealed: -the facility conducted Fire and Disaster Drills on a monthly basis and evacuated the facility during each Fire Drill; -the drills rotate shifts each month.</p> <p>Interview on 10-5-21 with Staff #1 revealed: -employed full time as a Direct Support Staff since March 2021; -the facility conducted Fire and Disaster drills; -was not sure how often the drills were conducted.</p> <p>Interview on 10-5-21 with Staff #4 revealed: -employed part time as a Direct Support Staff since September 2021; -had only worked in the facility a few weeks; -had a Fire and Disaster drill at the facility a few days ago; -was not sure how often the drills were conducted.</p> <p>Interview on 10-5-21 with the House Manager revealed: -employed for nearly 20 years at the facility;</p>	V 114		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mhl036-049</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>10/05/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>YORK-CHESTER GROUP HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>417 WEST 10TH AVENUE GASTONIA, NC 28052</b>		
(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	Continued From page 2  -was responsible for the monthly completion of Fire and Disaster Drills; -fire and disaster drills are to be held every month, rotating shifts between 1st shift, 2nd shift, and 3rd shift each quarter; -conducted one of the drills when she came in on 3rd shift at 8pm and it should not have been conducted until the 3rd shift hours which started at 10pm; -believed the other drill was conducted while she was out on medical leave; -"in the future will make sure that drills fall within the proper time frame."	V 114		