STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL019-023 NAME OF PROVIDER OR SUPPLIER STREET A					(X3) DATE SURVEY COMPLETED 11/10/2021	
		MHL019-023				
		ADDRESS, CITY, STATE, ZIP CODE				
GRIFFIN	HOUSE			KING BOULEVARD		
			TY, NC 27344			
(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 C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMENTS		V 000			
	An annual survey was completed on November 10, 2021. Deficiencies were cited.					
	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.					
V 114	27G .0207 Emergency Plans and Supplies		V 114			
	AND SUPPLIES (a) A written fire pla area-wide disaster shall be approved b authority. (b) The plan shall b and evacuation pro posted in the facility (c) Fire and disaster shall be held at lea repeated for each s under conditions th	er drills in a 24-hour facility st quarterly and shall be shift. Drills shall be conducted at simulate fire emergencies. all have basic first aid supplies				
	Based on record re facility failed to con that simulate emerg repeated for each s	et as evidenced by: eviews and interviews, the duct fire drills under conditions gencies at least quarterly and shift. The findings are: 11/10/21 of the the facility's evealed:				
	-6/3/21- Disast -5/11/21-Disast					

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PRINTED: 11/12/2021 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL019-023			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		B. WING		11/10/2021			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
		323 MAI	RTIN LUTHER I	KING BOULEVARD			
SKIFFIN	HOUSE	SILER C	ITY, NC 27344	L			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF COR				
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLET DATE	
V 114	Continued From page 1		V 114				
	-4/8/21- Disaste	er.					
	-3/10/21-Disast						
	-2/17/21- Disas						
	-1/21/21- Disas	ter.					
	-12/1/20- Disaster.						
	-Second Shift.						
	-6/3/21- Disaster.						
	-5/11/21- Disaster.						
	-4/13/21- Disaster.						
	-3/12/21- Disaster.						
	-2/10/21- Disaster.						
	-1/12/21- Disaster.						
	-12/7/20- Disaster.						
	-11/11/20- Disaster.						
	-Third Shift.						
	-9/17/21- Blank. 6/9/21 Disaster						
	-6/9/21- Disaster. -4/13/21- Disaster.						
	-4/13/21- Disaster. -3/12/21- Disaster.						
	-2/10/21- Disas						
	-1/12/21- Disas						
	-12/10/20- Disa						
	-11/18/20- Disa						
	-Fourth Shift.						
	-6/5/21- Disaste	er.					
	-5/15/21- Disas						
	-4/3/21- Disaste	er.					
	-3/13/21- Disas	ter.					
	-2/13/21- Disas						
	-1/2/21- Disaster.						
	-Fifth Shift.						
	-6/6/21- Disaste						
	-5/16/21- Disas						
	-4/4/21- Disaste						
	-3/14/21- Disas						
	-2/14/21- Disas						
	-1/3/21- Disaste						
	-12/13/20- Disa						
	I here were no disa	aster drills conducted for the				1	

STATE FORM

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If continuation sheet 2 of 4

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL019-023		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		B. WING		11/	11/10/2021		
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		11/10/2021	
GRIFFIN	HOUSE		RTIN LUTHER I	KING BOULEVARD			
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
V 114	Continued From pa	age 2	V 114				
	1st, 2nd, 3rd, 4th, 5th shift for the third quarter of 2021.						
	revealed: -Facility operated u -1st shift was from -2nd shift was from -3rd shift was from -4th shift was for S -5th shift was for S -She confirmed sta	6:30 AM to 7:00 AM. 7:00 AM to 9:00 AM. 3:00 PM to 9:00 PM. aturday. unday. Iff failed to conduct drills under ulate fire emergencies under					
V 736	10A NCAC 27G .03 EXTERIOR REQU (c) Each facility and maintained in a saf	ity and Grounds Maintenance 303 LOCATION AND IREMENTS d its grounds shall be fe, clean, attractive and orderly be kept free from offensive	V 736				
	Based on observat failed to ensure fac in a clean, safe and findings are: Observation on 11/ Kitchen revealed:	et as evidenced by: ion and interview, the facility cility grounds were maintained d attractive manner. The 10/21 at 2:35 PM of the hions were stained and dirty.					

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL019-023				(X3) DATE SURVEY COMPLETED			
			A. BUILDING:				
		MHL019-023	B. WING		11/	11/10/2021	
AME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
RIFFIN	HOUSE		TIN LUTHER H TY, NC 27344	(ING BOULEVARD			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF			
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
V 736	Continued From page 3 Observation on 11/10/21 at 2:40 PM of the first Living Room revealed: -Cushions from leather sofa and clothed sofa had patches of white paint on them. Interview on 11/10/21 with the Case Manager revealed:: -She would take pictures of the chairs and send to owner.		V 736				
	-She confirmed the	facility failed to ensure stained in a clean, safe and					

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