PRINTED: 01/14/2022 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: MHL0411217 VAME OF PROVIDER OR SUPPLIER STREET			(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED		
		MU 0444247					
		ADDRESS, CITY, STATE	 U 1	/14/2022			
	OUSE OF CARE	5709 WA	ATERPOINT DRIVE S SUMMIT, NC 272				
(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	TION SHOULD BE THE APPROPRIATE	BE COMPL	
V 000	INITIAL COMMENTS		V 000				
	An annual survey was completed on January 14, 2022. A deficiency was cited.						
	This facility is licensed for the following service category: 10A NCAC 27G. 5600C Supervised Living for Adults with Developmental Disabilities.						
	The survey sample consisted of audits of 2 current clients, 0 former clients, 0 deceased clients.						
V 114	27G .0207 Emergency Plans and Supplies		V 114				
	 AND SUPPLIES (a) A written fire plan area-wide disaster pl shall be approved by authority. (b) The plan shall be and evacuation proce posted in the facility. (c) Fire and disaster shall be held at least repeated for each sh under conditions that 	7 EMERGENCY PLANS for each facility and an shall be developed and the appropriate local 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					
	facility failed to ensur conducted once per s findings are:	ews and interviews, the re fire and disaster drills were shift per quarter. The					
sion of Hea	Review on 1/14/22 of	f the facility's fire and					

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Division of Health Service Regu STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL0411217	B. WING		01	/14/2022
NAME OF PROVIDE	ER OR SUPPLIER		ADDRESS, CITY, STATE,	ZIP CODE		
ROYAL HOUSE	OF CARE		ATERPOINT DRIVE IS SUMMIT, NC 272	14		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 114 Cont	tinued From pag	e 1	V 114			
disat -No cond -On -On 3:00 -No cond -On time -On was -On -On am. -On was -On -On am. -On -On am. -On -On time -On -On -On -On -On -On -On -On -On -On	ster drills, from 1 documentation of ducted in January 2/15/21, a fire dri 3/1/21, a tornado pm documentation of ducted in the moti 6/21/21, a fire dri 7/1/21, tornado of was documented 8/15/21, a fire dri documented. 9/6/21, a tornado 10/5/21, a fire dri documentation of ducted in the moti he 8 drills conducted to conducted by the view on 1/13/22 d not conducted by the view on 1/13/22 d not conducted for the seen ducting fire and view on 1/13/22 h fire and disaster thly "usually the th." e drills had been cause we rotate view on 1/13/22 aled: d participated in a	<pre>/1/21 to 1/14/22 revealed: of fire or disaster drills y 21 rill was conducted at 11:00pm o drill was conducted at 11:00pm o drill was conducted at 11:00pm o drill was conducted at 11:00pm drill was conducted at 5:00pm drill was conducted but no time o was conducted but no time o was conducted at 3:00 pm. rill was conducted at 10:00 rill was conducted at 5:00pm. of fire or disaster drills nth of December 21 locted in a 12-month period, 7 he same staff. with staff #1 revealed: fire or disaster drills on his lucky and missed that disaster drills)." with staff #2 revealed: er drills were conducted middle or the end of the o done in the dark around 6 or</pre>				

Division of Health Service Regu STATE FORM

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 01/14/2022	
	MHL0411217					
AME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE		
OYAL H	OUSE OF CARE		S SUMMIT, NC 272	14		
(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) COMPLE ⁻ DATE
V 114	Continued From pag	e 2	V 114			
	-Was unable to recal or disaster drills. -Staff had never com- hours. Interview on 1/13/22 Professional reveale -The facility had thre -The drills were supp -"I know I have put fo drills in a sleeve in a conducted. I was not conducted as require conducted as require conducting the drills. Inside the AFL book, to do, why you do the Interview on 1/13/22 -Was not aware fire a conducted once per -"I will make sure the	d: e shifts bosed to do every month. brms for fire and disaster notebook so they could be a aware drills were not being ed. I can help staff with " we have a sleeve as to what em with Licensee revealed: and disaster drills were not shift per quarter. e staff are conducted the drills sure the forms are in the				

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