STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL054-155 NAME OF PROVIDER OR SUPPLIER		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED R		
						DDRESS, CITY, ST
			24 NORTHFORK	4124 NC	RTHFORK DR	IVE
			NGE, NC 2855			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMENTS		V 000			
	An annual and follow up survey was completed on April 5, 2022. Deficiencies were cited.					
	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.					
	This facility is licensed for 5 and currently has a census of 3. The survey sample consisted of audits of 3 current clients.					
V 114	27G .0207 Emerge	ncy 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 lease repeated for each s under conditions th	207 EMERGENCY PLANS an for each facility and plan shall be developed and by the appropriate local we made available to all staff cedures and routes shall be y. 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 failed to ensure fire	et as evidenced by: view and interview the facility and disaster drills were held ated on each shift. The				
	Review on 4/04/22	of the facility's fire and				

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL054-155		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
		B. WING			R 04/05/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ABHS 41	24 NORTHFORK		RTHFORK DR NGE, NC 2855			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 114	Continued From pa	ige 1	V 114			
	disaster drill documentation revealed: - No fire drill documented for third shift for the fourth quarter (October - December) 2021. - No disaster drill documented for third shift for the third or fourth quarters (July - December) 2021.					
	During interview on 4/04/22 the Qualified Professional stated the facility operates with 3 shifts: 1st 7:00 am - 3:00 pm; 2nd 3:00 pm - 11:00 pm; and 3rd 11:00 pm - 7:00 am.					
	Professional/Co-Ov drills was provided	4/05/22 the Qualified wner stated a schedule for for staff; a fire drill and a o be conducted on each shift s.				
V 736	27G .0303(c) Facili	ty and Grounds Maintenance	V 736			
	EXTERIOR REQU (c) Each facility and maintained in a saf	803 LOCATION AND IREMENTS d its grounds shall be e, clean, attractive and orderly e kept free from offensive	,			
	Based on observati	et as evidenced by: ion and interview the facility I in a safe, clean, attractive ngs are:				
	10:30 am revealed:	04/22 between 9:30 am and : ne wall by the dining room				

Division of Health Service Regulation 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:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NOMBER.	A. BUILDING:				
		MHL054-155	B. WING			R 04/05/2022	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
BHS 41	24 NORTHFORK		RTHFORK DR NGE, NC 2855				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN(THE APPROPRIATE	COMPLE DATE	
V 736	Continued From pa	ige 2	V 736				
	table.						
	- Splatter stains on	the kitchen wall between the					
	upper cabinets and	the counter top by the sink.					
	- An approximate 1/2 inch gap between the door knob and the wooden kitchen door to the laundry						
	area.						
	- The air return grate in the hallway was very						
	dusty and rusted.						
	- A brown stain on the hallway wall extended from the doorbell chime down the wall toward the floor.						
			-				
		dust and lint on the floor near					
	the baseboards in client #1 and #3's bedroom. - The window blinds in client #1 and #3's						
	bedroom had a heavy coat of dust.						
	- Metal hardware for curtains but no curtains						
	above client #1 and #3's bedroom windows. - Client #1 and #3's mirrored closet door had a large crack at the bottom.						
		ebs in the ceiling corners of					
	client #1 and #3's b						
	- Client #1 and #3's	bathroom door knob was					
	loose.						
		all bathroom had black matter					
	around the toilet.						
		hower and the shower walls					
	-	consistent with mildew build					
	up.	shout the facility were ducty					
	and had black stair	ghout the facility were dusty					
		oughout the facility were					
	scuffed and scratch						
		ighout the facility contained					
	organic matter including dead insects and leaves. - An extension cord was stretched across the						
		m a wall outlet toward an					
	electric lift recliner.						
		el was pinned to cover the					
	window inside the f						
		oor had no closer or chain					
	attached and swun	g freely when opened; the					

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL054-155		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		IDENTIFICATION NOMBER.	A. BUILDING: B. WING			R 04/05/2022	
		MHL054-155					
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
ABHS 41	24 NORTHFORK		RTHFORK DRI NGE, NC 2855				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN (
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN(THE APPROPRIATE	COMPLET DATE	
V 736	Continued From page 3 storm door would not latch securely when closed. - A large wooden deck/porch turned on its side in the backyard.		V 736				
	During interview on 4/05/22 the Qualified Professional/Co-Owner stated she had discussed the need to have the facility painted with the property owner. She would have staff clean the facility.						
		been cited 4 times since the 0/17 and must be corrected					

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