Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL063-092	B. WING		09/0	08/2022	
NAME OF I			DDECC OITY (CTATE ZID CODE	1 00/1	0.2022	
NAME OF I	PROVIDER OR SUPPLIER		TH GREEN S	STATE, ZIP CODE			
GREEN S	STREET		3, NC 27325	DIRECT			
(X4) ID	SUMMARY STA	PROVIDER'S PLAN OF CORRE	CORRECTION (X5)				
PRÉFIX	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE	DATE	
V 000	INITIAL COMMENTS		V 000				
	An annual and follow survey was completed on						
		. Deficiencies were cited.					
	, , ,						
		ed for the following service					
	category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.						
	Living for Addits wit	ii bevelopiiiettai bisabiiites.					
		sed for six beds and currently					
	has a census of six. The survey sample consisted of audits of three current clients.						
	consisted of audits	of three current clients.					
V 114	27G .0207 Emerge	ncy Plans and Supplies	V 114				
	10A NCAC 27G .02	07 EMERGENCY PLANS					
	AND SUPPLIES						
	(a) A written fire plan for each facility and						
		plan shall be developed and by the appropriate local					
	authority.	у пе арргорнате юсаг					
		e made available to all staff					
		cedures and routes shall be					
	posted in the facility	/. r drills in a 24-hour facility					
		st quarterly and shall be					
		hift. Drills shall be conducted					
		at simulate fire emergencies.					
		Ill have basic first aid supplies					
	accessible for use.						
	This Rule is not me	at as evidenced by:					
		view and interviews, the					
	facility failed to con-	duct fire and disaster drills					
		at simulate emergencies					
	quarterly and for ea	ch shift. The findings are:					
	Review on 8/7/22 of	f the facility's fire drill log					

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		MHL063-092	B. WING		09/0	08/2022		
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 250 SOUTH GREEN STREET ROBBINS, NC 27325							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE		
V 114	revealed: -8-8-22 2nd shift -7-1-22 1st shift -6-2-22 3rd shift -5-22 No drill -4-7-22 1st shift -3-3-22 3rd shift -1-22 No drill -12-2-21 3rd shift -11-3-21 2nd shift -10-4-21 1st shift -9-2-21 3rd shift -There was no fire of for the 1st quarter of the 2nd quarter Review on 8/7/22 or evealed: -8-8-22 2nd shift -7-1-22 1st shift -6-2-22 3rd shift -7-1-22 1st shift -5-22 No drill -4-7-22 1st shift -3-3-22 3rd shift -1-22 No Drill -12-2-21 3rd shift -1-22 No Drill -12-2-21 3rd shift -1-21 3rd shift -1-22 No Drill -11-3-21 2nd shift -11-3-21 2nd shift -1-4-21 1st shift -9-2-1-21 3rd shift -10-4-21 1st shift -9-2-1-21 3rd shift	drill performed for the 1st shift of 2022. drill performed for the 2nd shift of 2022. f the facility's disaster log ster drill performed for the 1st rter of 2022. ster drill performed for the 2nd	V 114					

Division of Health Service Regulation

STATE FORM SLL911 If continuation sheet 2 of 3

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL063-092	B. WING		09/0	8/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GREEN	STREET		H GREEN S , NC 27325	TREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 114	-She reviewed her edocumentation for cof January and May-She must have not drills were complete. Interview on 8/7/22 Manager revealed: -Currently the compdownShe was certain th-"There is a checks to ensure drills are access because of Interview on 8/8/22 revealed: -The system was defilesThe system had be but IT was getting the She was unsure where and disaster drills under the system of the system of the system had be but IT was getting the system of th	emails and did not have drills completed for the months of 2022. It worked during the days the ed for those months. with the Group Home outer system for agency was e drills had been completed, and balance process in place completed monthly but can the system crash." with the VP of Operation own and unable to access een down for the past week,	V 114			

6899

Division of Health Service Regulation STATE FORM

SLL911 If continuation sheet 3 of 3