

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL047-155</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PRECIOUS HAVEN INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>181 BOSTIC ROAD RAEFORD, NC 28376</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	<p><b>INITIAL COMMENTS</b></p> <p>An annual survey was completed on September 16, 2022. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1800 Intensive Residential Treatment for Children or Adolescents.</p> <p>This facility is licensed for 12 and currently has a census of 11. The survey sample consisted of audits of 3 current clients.</p>	V 000		
V 114	<p><b>27G .0207 Emergency Plans and Supplies</b></p> <p><b>10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES</b></p> <p>(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.</p> <p>(b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.</p> <p>(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.</p> <p>(d) Each facility shall have basic first aid supplies accessible for use.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure fire and disaster drills were done quarterly on each shift. The findings are:</p> <p>Review on 9/16/22 of the facility's fire drill log</p>	V 114		

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL047-155</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PRECIOUS HAVEN INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>181 BOSTIC ROAD RAEFORD, NC 28376</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>revealed:</p> <ul style="list-style-type: none"> <li>-There were no 3rd shift drill for the 3rd, 2nd or 1st quarter of 2022.</li> <li>-There were were no 1st or 3rd shift drills for the 4th quarter of 2021.</li> </ul> <p>Review on 9/16/22 of the facility's disaster drill log revealed:</p> <ul style="list-style-type: none"> <li>-There were no 3rd shift drill for the 3rd, 2nd or 1st quarter of 2022.</li> <li>-There were were no 1st or 3rd shift drills for the 4th quarter of 2021.</li> </ul> <p>Interview on 9/15/22 with client #1 revealed:</p> <ul style="list-style-type: none"> <li>-She lived at the facility for over a year.</li> <li>-They did fire and disaster drills with staff. She wasn't sure how often the drills were conducted.</li> <li>-She wasn't sure when staff did the last fire or disaster drill with them.</li> </ul> <p>Interview on 9/15/22 with client #2 revealed:</p> <ul style="list-style-type: none"> <li>-She was admitted to the facility last month.</li> <li>-She had not done any fire and disaster drills with staff.</li> <li>-Staff did talk to her about the fire and disaster drills.</li> </ul> <p>Interview on 9/15/22 with client #3 revealed:</p> <ul style="list-style-type: none"> <li>-She lived at the facility for about five months.</li> <li>-Staff had not done any fire and disaster drills with them.</li> </ul> <p>Interview on 9/16/22 with the Licensee revealed:</p> <ul style="list-style-type: none"> <li>-The facility had three separate staff shifts.</li> <li>-She thought staff were doing fire and disaster drills during 3rd shift with the clients.</li> <li>-The clients were complaining about staff waking them up during 3rd shift.</li> <li>-She wasn't sure why staff were not documenting fire and disaster drills were being conducted</li> </ul>	V 114		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL047-155</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PRECIOUS HAVEN INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>181 BOSTIC ROAD RAEFORD, NC 28376</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  during 3rd shift. -She confirmed staff failed to ensure fire and disaster drills were done quarterly on each shift.	V 114		