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		
		MUI 057 044	B. WING		F		
		MHL057-014	B. Willo		03/0	3/2023	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
MADISON COUNTY GROUP HOME 36 MOUNTAIN HEIGHTS AVENUE HOT SPRINGS, NC 28743							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
V 000	V 000 INITIAL COMMENTS						
	on 3/3/23. Deficien This facility is licens category: 10A NCA	w up survey was completed cies were cited. sed for the following service C 27G .5600C Supervised h Developmental Disabilities.					
		sed for 6 and currently has a urvey sample consisted of 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 disaste shall be held at leas repeated for each s under conditions the	n for each facility and plan shall be developed and by the appropriate local e made available to all staff cedures and routes shall be to dills in a 24-hour facility st quarterly and shall be shift. Drills shall be conducted at simulate fire emergencies.					
	facility failed to hold each shift at least q	et as evidenced by: views and interviews, the I fire and disaster drills on uarterly. The findings are: If fire and disaster drills					

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

(X6) DATE TITLE

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		MHL057-014	B. WING			R 03/2023	
NAME OF PROVIDER OR SUPPLIER MADISON COUNTY GROUP HOME STREET ADDRESS, CITY, STATE, ZIP CODE HOT SPRINGS, NC 28743							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 114	-There was no doctobeen conducted on October - December - There was no doctober - December - There was no doctober - December - Did not have a madrillsWill work with the sea schedule and adapt to better meet requirements.	umentation of fire drills having 2nd shift in the quarter from er 2022. umentation of disaster drills cted on 2nd shift in the quarter ember 2022. with the Executive Director ster schedule to follow for new safety manager to create apt their current documentation	V 114				
	Verification G.S. §131E-256 HEREGISTRY (d2) Before hiring health care facility chealth care facility of health care facility of access in the appropriate of access in the access in the appropriate of access in the appropriate of access in the access	EALTH CARE PERSONNEL ealth care personnel into a or service, every employer at a shall access the Health Care and shall note each incident oropriate business files.	V 131				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
					R		
		MHL057-014	B. WING		03/0	3/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
MADISO	MADISON COUNTY GROUP HOME 36 MOUNTAIN HEIGHTS AVENUE HOT SPRINGS, NC 28743						
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V 131	Continued From pa	 ige 2	V 131				
	(QP). The findings are:						
	Record review on 3 -Date of Hire- 12/9/ -Date of HCPR veri Record review on 3 -Date of Hire- 7/1/2 -Date of HCPR veri Interview on 3/4/23 -He was responsibl check for Staff #1 a Director at that time documents to their the HCPR for Staff papers. Interview on 3/4/23 revealed: -The QP was initiall Director by their Bo know specifically w	8/4/23 for Staff #1 revealed: /21. ification- unable to locate. 8/4/23 for the QP revealed:					

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