

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-337	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/22/2023
NAME OF PROVIDER OR SUPPLIER FRIENDLY PEOPLE THAT CARE 6		STREET ADDRESS, CITY, STATE, ZIP CODE 7025 IDOLS ROAD CLEMMONS, NC 27012		
(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>INITIAL COMMENTS</p> <p>An annual and complaint survey was completed on 3/22/23. The complaint was substantiated (intake #NC00198757). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p> <p>This facility is licensed for 3 and currently has a census of 3. The survey sample consisted of audits of 3 current clients.</p>	V 000		
V 114	<p>27G .0207 Emergency Plans and Supplies</p> <p>10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES</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 interview, the facility failed to ensure fire and disaster drills were completed quarterly on each shift. The findings are:</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: MHL034-337	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/22/2023
NAME OF PROVIDER OR SUPPLIER FRIENDLY PEOPLE THAT CARE 6		STREET ADDRESS, CITY, STATE, ZIP CODE 7025 IDOLS ROAD CLEMMONS, NC 27012		
(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>Review on 3/22/23 of the facility's fire drill log revealed: -No documentation drills were completed during the quarter of April 2022 - June 2022 on 1st and 3rd shifts; -No documentation drills were completed during the quarter of July 2022 - September 2022 on 3rd shift; -No documentation drills were completed during the quarter of October 2022 - December 2022 on 3rd shift.</p> <p>Review on 3/22/23 of the facility's disaster drill log revealed: -No documentation drills were completed during the quarter of April 2022 - June 2022 on 1st and 3rd shifts; -No documentation drills were completed during the quarter of July 2022 - September 2022 on 3rd shift.</p> <p>Interview on 3/22/23 with the Qualified Professional revealed: -Not aware that facility staff were not completing and documenting fire and disaster drills; -Aware that fire and disaster drills were required to be completed quarterly on each shift.</p>	V 114		