PRINTED: 10/17/2023 FORM APPROVED

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				
AND PLAN OF CORRECTION		IDENTIFICATION NOMBER.	A. BUILDING:		COMI LETED				
		MHL023-154	B. WING		10/12/2023				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE									
CHARLES	ROAD B	829-1 CHAF SHELBY, N	RLES ROAD B IC 28152						
(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	INITIAL COMMENTS		V 000						
	An annual survey was 2023. A deficiency was	s completed on October 12, as cited.							
	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.								
	<u>-</u>	d for 2 and currently has a vey sample consisted of ents.							
V 114	27G .0207 Emergence	cy Plans and Supplies	V 114						
	AND SUPPLIES (a) A written fire plan area-wide disaster plashall be approved by authority. (b) The plan shall be and evacuation proceposted in the facility. (c) Fire and disaster coshall be held at least repeated for each shi under conditions that	an shall be developed and							
	facility failed to condu quarterly for each shirt Review on 10-11-23 of	ews and interviews, the uct fire and disaster drills							

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

TITLE (X6) DATE

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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	
		MHL023-154	B. WING		10/12/2023	
NAME OF PROVIDER OR SUPPLIER STREET.		STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CHARLES	ROAD B		ARLES ROAD B	1		
(X4) ID PREFIX TAG	SHELBY, N 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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 114	Continued From page 1		V 114			
	REGULATORY OR LSC IDENTIFYING INFORMATION)					

Division of Health Service Regulation

STATE FORM 6899 0FYQ11 If continuation sheet 2 of 2