PRINTED: 10/23/2023 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY	(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _					
		MHL041-997	B. WING		10/23/202	23		
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE				
BLACKWELL HOUSE. INC				TH O'HENRY BOULEVARD ORO, NC 27405				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COI	(X5) MPLETE DATE		
V 000	INITIAL COMMENTS		V 000					
	on October 23, 2023.	up survey was completed Deficiencies were cited.						
	This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.							
	The survey sample co current client.	onsisted of audits of 1						
V 114	27G .0207 Emergend	y Plans and Supplies	V 114					
	10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (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. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility							
	shall be held at least repeated for each shi under conditions that	quarterly and shall be ft. Drills shall be conducted simulate fire emergencies. have basic first aid supplies						
		ew and interview, the facility and disaster drills once per						
		of the facility's fire and ctober 2022 to October 2023						

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

(X6) DATE TITLE

PRINTED: 10/23/2023 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		MHL041-997	B. WING		10	/23/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
DI ACKWI	ELL HOUSE INC	2805 NO	RTH O'HENRY BO	JLEVARD		
BLACKWI	ELL HOUSE, INC	GREENS	SBORO, NC 27405			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 114	Continued From page 1		V 114			
	-No fire or disaster dri August 2023, April 20					
	-Was aware fire and conducted once per s	with the Licensee revealed: disaster drills were to be hift per quarter e-in staff" at the facility				
	This deficiency consti and must be corrected	tutes a re-cited deficiency d within 30 days.				
V 736	27G .0303(c) Facility	and Grounds Maintenance	V 736			
		EMENTS				
		s and interviews, the facility a safe, clean, attractive				
	Observations on 10/1 outside of the facility o					
	wood on bottom of do	orm door had dry rot on or frame the facility's front windows				
	-A large bush was over facility and covered po- The middle window in 3 wasp's nests and a -On the right side of the	ergrown on the side of the art of the front window in the front of the facility had spider web ne facility's front step area gn that jutted vertically out				

Division of Health Service Regulation

STATE FORM 6899 02R111 If continuation sheet 2 of 3

PRINTED: 10/23/2023 FORM APPROVED

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	
		MHL041-997	B. WING		10/2	3/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BLACKW	BLACKWELL HOUSE, INC 2805 NORTH O'HENRY BOULEVARD GREENSBORO, NC 27405					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
V 736	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		V 736			

Division of Health Service Regulation

STATE FORM 6899 02R111 If continuation sheet 3 of 3