Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
			-		R					
MHL032-404		MHL032-404	B. WING	03/19/2024						
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STA	TE, ZIP CODE						
DON'S ADULT CARE GROUP HOME 2015 ELLIS ROAD DURHAM, NC 27703										
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE					
V 000	0 INITIAL COMMENTS		V 000							
	An annual and follow-up survey was completed on March 19, 2024. A deficiency was cited.									
	This facility is licensed for the following service category: 10A NCAC 27G. 5600A Supervised Living for Adults with Mental Illness									
	The facility is licensed census of 5. The survey sample cocurrent clients.	I for 5 and currently has a								
V 114	27G .0207 Emergenc	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 quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies.  (d) Each facility shall have basic first aid supplies accessible for use.									
		ew and interview the facility ster drills on each shift at								

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

PRINTED: 03/19/2024 FORM APPROVED

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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				
		MHL032-404	B. WING		II	R <b>19/2024</b>				
NAME OF PROVIDER OR SUPPLIER  DON'S ADULT CARE GROUP HOME  STREET ADDRESS, CITY, STATE, ZIP CODE  DURHAM, NC 27703										
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE				
V 114	Review on 3/19/24 of revealed: -There were no disas 4/2023There were no disas -Disaster drills were nat least quarterly. Interview on 3/19/24 or revealed:	the facility's disaster drills ter drills conducted since ter drills conducted in 2024. tot conducted on each shift with the Assistant Manager saster drills were conducted	V 114							

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STATE FORM SYLS11 If continuation sheet 2 of 2