STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
MHL001-148			A. BUILDING:			
		B. WING			R 08/21/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
RESTOR	ATIONS		GERS STREET GTON, NC 272			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLET DATE
∨ 000	INITIAL COMMENTS		V 000			
	An annual and follow up survey was completed on August 21, 2024. A deficiency was cited.					
	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.					
		sed for 3 and has a current urvey sample consisted of clients.				
V 114	27G .0207 Emergency Plans and Supplies		V 114			
	AND SUPPLIES (a) Each facility sha and a disaster plan these plans availab to the county emerge request. The plans procedures and rou (b) The plans shall and evacuation pro posted in the facility. (c) Fire and disaster shall be held at lease repeated for each se Drills shall be cond simulate the facility emergencies.	gency services agencies upon shall include evacuation utes. be made available to all staff ocedures and routes shall be er drills in a 24-hour facility st quarterly and shall be shift. ucted under conditions that 's response to fire all have a first aid kit				
	ealth Service Regulation / DIRECTOR'S OR PROVID			TITLE		(X6) DATE

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE MHL001-148		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL001-148	B. WING			R 08/21/2024
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
RESTOR	ATIONS		BERS STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE DEFICIENCY)	
V 114	Continued From page 1		V 114			
	facility failed to con- under conditions the least quarterly and findings are: Review on 8/21/24 records for the last -There were no fire the 4th quarter of 20 -There were no fire quarter of 2024. -There were no fire the 2nd quarter of 20 Review on 8/21/24 records for the last -There were no disa 4th quarter of 2023 -There were no disa for the 1st quarter of 2024 Interview on 8/21/24 -She was not aware drill per shift each of -She used to do the her policy. -She acknowledged	views and interview, the duct fire and disaster drills at simulate emergencies at repeated for each shift. The of the facility's fire drills 12 months revealed: drills for 1st and 2nd shift for 023. drills for 1st shift for the 1st drills for 1st and 2nd shift for 2024. of the facility's disaster drills 12 months revealed: aster drills for 1st shift for the sater drills for 1st and 2nd shift of 2024. aster drills for 1st and 2nd shift of 2024. aster drills for 1st and 2nd shift of 2024. aster drills for 2nd shift for the the drills for 2nd shift for the drills for 2nd shift for the drills for 2nd shift for the drills for 2nd shift for the drills for 2nd shift for the drills for 2nd shift for the drills for 2nd shift for the drills for 2nd shift for the drills for 2nd shift for 2nd shift for the drills for 2nd shift for 2nd s				

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