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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
		MHL0411224	B. WING		09/24/2024		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STA	TE. ZIP CODE			
			ER STREET	,			
WICKER I	HOME		BORO, NC 2740	าง			
	OUR MAA DV OT						
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLI	ETE	
V 000	INITIAL COMMENTS	3	V 000				
	An annual survey was 24, 2024. A deficienc	s completed on September y was cited.					
	This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents.						
	-	d for 4 and has a current yey sample consisted of ents.					
	This Statement of Deficiencies was amended on October 4, 2024 due to additional information						
		ICAC 27G .0207 Emergency					
	Plans and Supplies/Tag V114 was amended from						
	an initial citation to ar	n amended citation.					
V 114	27G .0207 Emergence	cy Plans and Supplies	V 114				
	AND SUPPLIES	7 EMERGENCY PLANS					
		develop a written fire plan nd shall make a copy of					
	request. The plans sh	ncy services agencies upon nall include evacuation					
	procedures and route	es. e made available to all staff					
		edures and routes shall be					
	posted in the	adi es ana reales snan pe					
	facility.						
	_	drills in a 24-hour facility					
	shall be held at least	quarterly and shall be					
	repeated for each shi						
		eted under conditions that					
	simulate the facility's	response to fire					
	emergencies.	have a first aid kit					
	(d) Each facility shall accessible for use.	nave a nist alu Kit					

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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:		
		MHL0411224	B. WING		09	0/24/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	. ZIP CODE		
			CKER STREET	,		
WICKER I	HOME		ISBORO, NC 27403			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	FION SHOULD BE THE APPROPRIATE	COMPLETE DATE
V 114	Continued From page	e 1	V 114			
	This Rule is not met	as evidenced by:				
	Based on record reviews and interviews, the					
	facility staff failed to	conduct fire and disaster				
	drills once per shift p	er quarter. The findings are:				
	Review on 9/23/24 of	f the facility's fire and				
	disaster drills, from September 2023 to					
	September 2024, rev					
	-9/6/23 fire 6:10pm					
	-10/15/23 fire 3:36pm	ı				
	-11/16/23 fire 5:23pm	1				
	-12/16/23 fire 6:23pm	า				
	-12/28/23 power outa					
	-1/13/24 fire 12:00pm					
	-1/20/24 tornado 3:00					
	-2/18/24 gas leak 5:1	5pm				
	-2/24/24 fire 8:00pm					
	-3/9/24 fire 6:00am	00				
	-3/27/24 hurricane 7:	ooam				
	-4/6/24 fire 1:00pm -4/22/24 fire 3:28pm					
	-5/15/24 fire 6:20pm					
	-5/27/24 fire 5:00pm					
	-6/7/24 fire 8:00am					
	-6/29/24 fire 6:00am					
	-7/13/24 fire 12:00pm	1				
	-8/8/24 fire 5:00pm					
		onducted on third shift from				
	September 2023 to D					
	<u> </u>	re conducted on second or				
		mber 2023 to December				
	-No disaster drills we from April 2024 to Ju	re conducted on any shifts ne 2024				

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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	
		MHL0411224	B. WING		09/2	4/2024
NAME OF P	ROVIDER OR SUPPLIER		TE, ZIP CODE			
WICKER I	НОМЕ		ER STREET BORO, NC 2740	03		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
V 114	Continued From page 2		V 114			
	-No fire or disaster dr since his admission (  Interview on 9/23/24 - Had participated in comparticipated in	with client #2 revealed: in any disaster drills with client #3 revealed: ine fire drill and "it was nool that morning." in any disaster drills with staff #1 revealed: were to be conducted once ster drills were to be shift per quarter with staff #2 revealed: sporadically. I have not if fire drills when I work my asked to do them (disaster nce a month. I have not been ny shift." with the Director/Licensee Is were to be conducted shift. e of the drills were not nift. ills were conducted once per				

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