Division of Health Service Regulation

	IDENTIFICATION NUMBER	( -,	CONSTRUCTION		3) DATE SURVEY COMPLETED	
OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	= IED	
				R	1	
	MHL041-997	B. WING		10/2	9/2024	
ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE			
ELL HOUSE. INC						
	GREENSB	ORO, NC 2740	05			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETE DATE	
INITIAL COMMENTS		V 000				
category:10A NCAC 2	27G .5600A Supervised					
census of 1. The surv	ey sample consisted of					
27G .0207 Emergenc	y Plans and Supplies	V 114				
AND SUPPLIES  (a) Each facility shall and a disaster plan arthese plans available to the county emerge request. The plans sh procedures and route (b) The plans shall be and evacuation proceposted in the facility.  (c) Fire and disaster could shall be held at least repeated for each shird Drills shall be conducted simulate the facility's emergencies.	develop a written fire plan and shall make a copy of the copy of t					
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE INITIAL COMMENTS  An annual and follow on 10/29/24. Deficien  This facility is licensed category:10A NCAC 2 Living for Adults with 1. This facility is licensed census of 1. The survaudits of 1 current clie  27G .0207 Emergence  10A NCAC 27G .0207 AND SUPPLIES  (a) Each facility shall and a disaster plan at these plans available to the county emerge request. The plans shall be and evacuation proceed by The plans shall be and evacuation proceed in the facility.  (c) Fire and disaster can be and evacuation proceed in the facility.  (c) Fire and disaster can be and evacuation proceed in the facility.  (c) Fire and disaster can be and evacuation proceed in the facility.  (d) Fire and disaster can be and evacuation proceed in the facility.  (d) Fire and disaster can be and evacuation proceed in the facility.  (d) Fire and disaster can be and evacuation proceed in the facility.  (e) Fire and disaster can be a facility in the facility	ROVIDER OR SUPPLIER  STREET ADE  2805 NOR: GREENSB  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  An annual and follow up survey was completed on 10/29/24. Deficiencies were cited.  This facility is licensed for the following service category:10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness  This facility is licensed for 4 and has a current census of 1. The survey sample consisted of audits of 1 current client.  27G .0207 Emergency Plans and Supplies  10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes.  (b) The plans 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 the facility's response to fire emergencies.  (d) Each facility shall have a first aid kit	MHL041-997  B. WING  ROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STA  2805 NORTH O'HENRY B  GREENSBORO, NC 2740  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  An annual and follow up survey was completed on 10/29/24. Deficiencies were cited.  This facility is licensed for the following service category:10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness  This facility is licensed for 4 and has a current census of 1. The survey sample consisted of audits of 1 current client.  27G .0207 Emergency Plans and Supplies  10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes. (b) The plans 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 the facility's response to fire emergencies. (d) Each facility shall have a first aid kit	ROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  2805 NORTH O "HENRY BOULEVARD GREENSBORO, NC 27405  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  An annual and follow up survey was completed on 10/29/24. Deficiencies were cited.  This facility is licensed for the following service category: 10 A NCAC 27G .5600A Supervised Living for Adults with Mental Illness  This facility is licensed for 4 and has a current census of 1. The survey sample consisted of audits of 1 current client.  27G .0207 Emergency Plans and Supplies  V 114  10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes. (b) The plans 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. Dills shall be conducted under conditions that simulate the facility's response to fire emergencies. (d) Each facility shall have a first aid kit	MHL041-997    MHL041-997   B. WING	

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

TITLE (X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
					R	
		MHL041-997	B. WING		10/29/2024	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
BLACKWI	ELL HOUSE, INC		TH O'HENRY B			
0/0.15	SHIMMADV ST		ORO, NC 2740		J 0/5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  ( MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 114	Continued From page	:1	V 114			
	failed to complete disa	as evidenced by: ew and interview the facility aster drills and fire drills shift. The findings are:				
	revealed: - No fire nor disaster of and 3rd shifts in the fit No fire nor disaster of	drills were conducted on 1st rest quarter.  drills were conducted on 1st,				
	and 2nd shifts in the t	drills were conducted on 1st hird quarter. drills were conducted on 2nd				
	revealed: - The facility had 3 sh drills were to be comp - He had conducted o each quarter "I just did one (fire a	with the Licensee/staff #1  ifts when fire and disaster bleted each quarter. ne fire and one disaster drill and disaster drill) a quarter. Int of times I have done fire				
	drills were to be comp - "We try to do 2 (fire at least do 1 each qua	: ifts when fire and disaster lleted each quarter. drills) each quarter but we				
		een cited 3 times since the ober 21, 2021, and must be ays.				

Division of Health Service Regulation

STATE FORM 56899 JCK511 If continuation sheet 2 of 5

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION				
		A. BUILDING:		COMPLETED			
					R		
		MHL041-997	B. WING		10/29/2024		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
2805 NORTH O'HENRY BOULEVARD							
BLACKWELL HOUSE, INC  GREENSBORO, NC 27405							
(VA) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	, , , , , , , , , , , , , , , , , , ,	PROVIDER'S PLAN OF CORRECTION	M (VE)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE		
V 289	Continued From page	e 2	V 289				
V 289	27G .5601 Supervise	d Living - Scope	V 289				
	provides residential s home environment will these services is the rehabilitation of individillness, a development or a substance abuse supervision when in the facility serves eith (1) one or more (2) two or more (2) two or more (2) two or more (3) two or more (4) two or more (5) two or more (6) two or more (7) two or more (8) two or more (9) two or more (10) two or more (11) two or more (12) two or more (13) two or more (14) two or more (15) t	is a 24-hour facility which ervices to individuals in a here the primary purpose of care, habilitation or duals who have a mental ntal disability or disabilities, a disorder, and who require he residence.  In gracility shall be licensed if her:  It minor clients; or a adult clients.  Its shall not reside in the living facility shall be pecific population as tion means a facility which primary diagnosis is mental have other diagnoses; tion means a facility which primary diagnosis is a lity but may also have other ution means a facility which primary diagnosis is a lity but may also have other ution means a facility which primary diagnosis is a lity but may also have other ution means a facility which primary diagnosis is a lity but may also have other ution means a facility which primary diagnosis is hendency but may also have					

Division of Health Service Regulation

STATE FORM 6899 JCK511 If continuation sheet 3 of 5

Division of Health Service Regulation

Bivioloti	i Health Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLI	ETED	
MIII 044 007		B. WING		R		
		MHL041-997	B. WING		10/2	9/2024
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
			TH O'HENRY B			
BLACKWE	ELL HOUSE, INC					
		GREENSE	BORO, NC 2740	J5		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG	REGOLATORT ORE	100 IDENTIFY THE INTORNATION	TAG	DEFICIENCY)	W/\ L	
			-			
V 289	Continued From page	e 3	V 289			
	(6) "F" designat	tion means a facility in a				
	` ,	ich serves no more than				
	•					
		ose primary diagnoses is				
	mental illness but may	-				
		dult clients or three minor				
	clients whose primary					
	•	lities but may also have				
		live with a family and the				
	, .	ervice. This facility shall be				
	•	wing rules: 10A NCAC 27G				
	.0201 (a)(1),(2),(3),(4)					
		; (8); (11); (13); (15); (16);				
		AC 27G .0202(a),(d),(g)(1)				
		203; 10A NCAC 27G .0205				
	(a),(b); 10A NCAC 27	'G .0207 (b),(c); 10A NCAC				
	27G .0208 (b),(e); 10a	A NCAC 27G .0209[(c)(1) -				
	non-prescription medi	ications only] (d)(2),(4); (e)				
	(1)(A),(D),(E);(f);(g); a	and 10A NCAC 27G .0304				
	(b)(2),(d)(4). This fac	ility shall also be known as				
		g or assisted family living				
	(AFL).					
	,					
	This Rule is not met	as evidenced by:				
		ew and interviews. the				
		te under the scope for which				
	•	•				
		fected one of one client (#1).				
	The findings are:					
	Peview on 10/20/24 o	of facility's license royallod:				
		of facility's license revealed:				
	. •	and description: 5600A				
	Supervised Living for	Adults with Mental Illness				
	D : 10/00/6:	6 15 1 1/41				
	Review on 10/29/24 of	of client #1's record				

Division of Health Service Regulation

- Admission date: 8/4/11

STATE FORM JCK511 If continuation sheet 4 of 5

Division of Health Service Regulation

MHL041-997    IL WIND   R.   NAME OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY			
NAME OF PROVIDER OR SUPPLIER  BLACKWELL HOUSE, INC  2805 NORTH O'HENRY BOULEVARD GREENSBORO, NC 27405  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 289  Continued From page 4  - Diagnoses: Bipolar Affective Disorder; Seizure Disorder; Traumatic Brain Injury; and Schizophrenia  Interview on 10/29/24 with the Licensee/staff #1 revealed: - Client #1 had been the only staff who worked in the facility, since 2021 Since 2021 he had been the only staff who worked in the facility and was the only staff who worked because he was unable to afford additional staff.  Interview on 10/29/24 with the Qualified Professional revealed: - The Licensee/staff #1 had been the only staff who had worked in the home for the past 2 years "Yes, [Licensee/staff #1] lives in the group home twenty-four/seven (24 hours a day/7 days a							R		
BLACKWELL HOUSE, INC  2805 NORTH O'HENRY BOULEVARD GREENSBORO, NC 27405    CAU ID PREFIX TAGS   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAGS   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)    V 289   Continued From page 4   - Diagnoses: Bipolar Affective Disorder; Seizure Disorder; Traumatic Brain Injury; and Schizophrenia   Interview on 10/29/24 with the Licensee/staff #1 revealed:			MHL041-997	B. WING		10	/29/2024		
CALL HOUSE, INC   GREENSBORO, NC 27405	NAME OF PR	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   TAG   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DEFICIENCY)   PREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)    V 289   Continued From page 4   V 289    - Diagnoses: Bipolar Affective Disorder; Seizure Disorder; Traumatic Brain Injury; and Schizophrenia   Interview on 10/29/24 with the Licensee/staff #1 revealed: - Client #1 had been the only client who had lived in the facility since 2021 Since 2021 he had been the only staff who worked in the facility He lived in the facility He lived in the facility and was the only staff who worked because he was unable to afford additional staff.   Interview on 10/29/24 with the Qualified Professional revealed: - The Licensee/staff #1 had been the only staff who had worked in the home for the past 2 years "Yes, [Licensee/staff #1] lives in the group home twenty-four/seven (24 hours a day/7 days a	BLACKWE	BLACKWELL HOUSE, INC							
- Diagnoses: Bipolar Affective Disorder; Seizure Disorder; Traumatic Brain Injury; and Schizophrenia  Interview on 10/29/24 with the Licensee/staff #1 revealed: - Client #1 had been the only client who had lived in the facility since 2021 Since 2021 he had been the only staff who worked in the facility He lived in the facility and was the only staff who worked because he was unable to afford additional staff.  Interview on 10/29/24 with the Qualified Professional revealed: - The Licensee/staff #1 had been the only staff who had worked in the home for the past 2 years "Yes, [Licensee/staff #1] lives in the group home twenty-four/seven (24 hours a day/7 days a	PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP	HOULD BE	COMPLETE		
	V 289	- Diagnoses: Bipolar Disorder; Traumatic E Schizophrenia  Interview on 10/29/24 revealed: - Client #1 had been in the facility since 20 - Since 2021 he had worked in the facility He lived in the facility worked because he wadditional staff.  Interview on 10/29/24 Professional revealed: - The Licensee/staff # who had worked in the "Yes, [Licensee/staff twenty-four/seven (24)	Affective Disorder; Seizure Brain Injury; and  with the Licensee/staff #1 the only client who had lived 21. been the only staff who ty and was the only staff who vas unable to afford  with the Qualified d: #1 had been the only staff the home for the past 2 years. If #1] lives in the group home	V 289					

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