PRINTED: 11/07/2024 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:		
			A. BOILDING		R	
		MHL044-036	B. WING		10/29/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
HAYWOO	D COUNTY GROUP HOM	185 FAR	LEY STREET			
HAIWOO	D COUNTY GROUP HOW	WAYNES	SVILLE, NC 2878	5		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
V 000	000 INITIAL COMMENTS		V 000			
	completed on Octobe	and follow up survey was r 29, 2024. The complaint (intake #NC00220751). A				
		d for the following service .5600C Supervised Living opmental Disability.				
		d for 6 and has a current rey sample consisted of ents.				
V 114	27G .0207 Emergence	y Plans and Supplies	V 114			
	AND SUPPLIES  (a) Each facility shall and a disaster plan at these plans available to the county emerge request. The plans ship procedures and route (b) The plans shall be and evacuation procedures and evacuation procedures and evacuation procedures and disaster of the facility.  (c) Fire and disaster of shall be held at least repeated for each ship	ncy services agencies upon all include evacuation s. e made available to all staff edures and routes shall be drills in a 24-hour facility quarterly and shall be ft. ted under conditions that response to fire				

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

TITLE (X6) DATE

PRINTED: 11/07/2024 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:		
						R
		MHL044-036	B. WING		10	/29/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, STATE	E, ZIP CODE		
HAYWOO	D COUNTY GROUP HON	IE #4	LEY STREET			
	CUMMADVCT		VILLE, NC 28786	DDOV/DEDIC DI AM O	F CORRECTION	
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
V 114	Continued From page 1		V 114			
	facility failed to ensur	as evidenced by: ew and interviews, the e fire and disaster drills were nift at least quarterly. The				
	disaster drill logs for -No documentation of following shifts and q -October - Decer -January - March -April - June 202 -July - September -No documentation of following shifts and q -January - March	uarters: mber 2023: 1st & 2nd shifts. n 2024: 2nd shift. 4: 2nd shift. er 2024: 1st & 2nd shifts. f disaster drills during the uarters:				
	-She participated in fi -All the clients particip would go to the end c -All the clients particip and in the event of a	pated in the fire drills and				
	Professional (DSP) # -The House Manager and disaster drillsShe participated in fi -During a fire drill she the end of the drivew until the drill was ove	re and disaster drills. e and the clients would go to ay and across the bridge f. Il tornado scenario she				

Division of Health Service Regulation

STATE FORM 39PD11 If continuation sheet 2 of 3

PRINTED: 11/07/2024 FORM APPROVED

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
						R		
		MHL044-036	B. WING		10	/29/2024		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
HAYWOO	HAYWOOD COUNTY GROUP HOME #4 WAYNESVILLE, NC 28786							
(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 ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE		
V 114	appropriately to the d Interview on 10/28/24 -1st shift was 12pm-1 -2nd shift was 12am She was responsible disaster drills for the framework of the framework	rill.  with the HM revealed: 2am. 12pm. to schedule the fire and facility. bout the quarterly and disaster drills to be nift.  with the Qualified realed: gned off on the completed	V 114	DEFICIENCY				
ı								

Division of Health Service Regulation

STATE FORM 39PD11 If continuation sheet 3 of 3