PRINTED: 11/15/2024 FORM APPROVED

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ′ | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | | | | | |
|--|---|--|---------------------|--|--------------------------|------------|-------------------------------|--|--|--|--|--|--|
| | | | | | | | ₹ | | | | | | |
| MHL032-578 | | | B. WING | | 11/0 | 11/07/2024 | | | | | | | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | | | | | | | | | |
| NC START CENTRAL RESPITE HOME 3817 CHEEK ROAD DURHAM, NC 27704 | | | | | | | | | | | | | |
| (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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | (X5) COMPLETE DATE | | | | | | | | |
| V 000 | INITIAL COMMENTS | | | V 000 | | | | | | | | | |
| | An annual and follow up survey was completed on November 7, 2024. A deficiency was cited. | | | | | | | | | | | | |
| | This facility is licensed for the following service category: 10A NCAC 27G .5100 Community Respite Services for Individuals of all Disability Group. | | | | | | | | | | | | |
| | | sed for four and has a ne survey sample consi ner clients. | | | | | | | | | | | |
| V 114 | 4 27G .0207 Emergency Plans and Supplies | | s | 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. Drills shall be conducted under conditions that simulate the facility's response to fire emergencies. (d) Each facility shall have a first aid kit accessible for use. | | | | | | | | | | | | |
| | | | | | | | | | | | | | |

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

(X6) DATE TITLE

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Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|--|--|-------------------|--|-----------------------|---|-----------------------------------|--------------------------|
| MHL032-578 | | | B. WING | | | R 11/07/2024 | |
| NAME OF | PROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| NC STAF | RT CENTRAL RESPIT | E HOME | | EK ROAD , NC 27704 | | | |
| (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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| V 114 | Continued From page 1 | | | V 114 | | | |
| | This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure fire and disaster drills were completed quarterly on each shift. The findings are: Review on 11/5/24 of the facility fire and disaster drill long from October 2024 thru October 2023 revealed: -Shifts for the drills were 1st shift 6am-2pm, 2nd shift 2pm-10pm and 3rd shift 10pm-6amThere was no fire drills conducted for the 4th quarter (October, November, December) of 2023There was no disaster drill conducted for the 4th quarter (October, November December) of 2023. Interview on 11/5/24 with the Resource Center Director revealed: -The former Resource Center Director did not complete any drillsShe became aware of the missing fire and disaster drills during the recent fire inspectionShe acknowledged the fire and disaster drills were not completed for the 4th quarter. This deficiency constitutes a re-cited deficiency | | | | | | |
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| | and must be correct | ted within 30 day | S. | | | | |

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Division of Health Service Regulation STATE FORM

87SZ11 If continuation sheet 2 of 2