PRINTED: 12/05/2024 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION		3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	EIED		
		MHL0411221	B. WING		12/0	5/2024		
NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
SAFE HAV	SAFE HAVEN HOMES FOR YOUTH 1030 ALAMANCE COURT							
		GREENSBO	ORO, NC 2740	96				
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE		
V 000	INITIAL COMMENTS		V 000					
	An annual survey was 2024. A deficiency was	s completed on December 5, as cited.						
	This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.							
	census of 3. The surv	d for 4 and has a current rey sample consisted of ents and 1 former client.						
V 114	2114 27G .0207 Emergency 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 in the facility. (c) Fire and disaster of shall be held at least repeated for each shill.	ncy services agencies upon hall include evacuation es. 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: 12/05/2024 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED				
		MHL0411221	B. WING		40/05/0	2024			
		WITLU411221			12/05/2	2024			
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
SAFE HAV	EN HOMES FOR YOUTH	1	MANCE COURT ORO, NC 2740						
	CLIMMA DV CT		1		NA I				
(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	(X5) COMPLETE DATE			
V 114	Continued From page	e 1	V 114						
	facility failed to condu	as evidenced by: ews and interviews, the act fire and disaster drills arter. The findings are:							
	Review on 12/4/24 of disaster drill logs reversible 10/12/24 9:45am fire -9/8/24 6:15pm fire -8/23/24 12:45pm fire -8/23/24 12:10am fire -7/26/24 9:45pm fire -6/28/24 8:34am fire -5/25/24 6:30am fire -5/25/24 1:07pm fire -4/24/24 9:08pm fire -3/21/24 5:45pm fire -3/21/24 7:15am fire -2/4/24 7:01am fire -2/3/24 4:35pm fire	ealed:							
	-2/27/24 6:05am fire -1/22/24 7:23pm fire -No documentation of to 11/30/24	f disaster drills from 12/1/23 f a fire drill in November							
		with client #2 revealed: aster drill once since he							
		with client #3 revealed: one tornado drill since his ity.							
	-"If there was a tornac	with client #4 revealed: do, we would line up in a s. I don't remember the last o drill."							

Division of Health Service Regulation

STATE FORM 6899 700Q11 If continuation sheet 2 of 3

PRINTED: 12/05/2024 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:			X3) DATE SURVEY COMPLETED	
		MHL0411221	B. WING		12	2/05/2024	
NAME OF PRO	OVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATI	E, ZIP CODE			
SAFE HAVE	EN HOMES FOR YOUTH	1	AMANCE COURT SBORO, NC 27406	3			
(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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 114	Continued From page	2	V 114				
	-Fire drills are done of -The clients went to the -The clients went to the -The clients went to the -The clients with the Direct -She was responsible conductedIt had been "a minute a disaster drill.						

Division of Health Service Regulation

STATE FORM 6899 700Q11 If continuation sheet 3 of 3