

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/09/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G057		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2025	
NAME OF PROVIDER OR SUPPLIER HAYWOOD COUNTY GROUP HOME #3				STREET ADDRESS, CITY, STATE, ZIP CODE 401 WOODLAWN CIRCLE CLYDE, NC 28721			
(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) COMPLETION DATE
W 440	<p>EVACUATION DRILLS CFR(s): 483.470(i)(1)</p> <p>at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on review of record and interview, the facility failed to show evidence quarterly fire drills were conducted with each shift of personnel relative to first, second and third shift. The findings are:</p> <p>Review of the facility fire drill reports from 11/24 through 01/24 revealed missing fire drills for 12/24, 10/24, 8/24, 4/24, and 2/24. Further review of the fire drill reports revealed first shift drills conducted on 7/22/24, 5/11/24, and 1/26/24; second shift drills conducted on 11/8/24, 9/30/24, and 3/14/24, and a third shift drill completed on 6/5/24. There was no additional documentation available about conducting first, second and third shift drills during the review year.</p> <p>Interview with the program coordinator (PC) on 01/08/2025 confirmed facility fire drills should have been conducted quarterly for each shift. Continued interview with the PC confirmed there was no additional documentation to reflect the missing drills were conducted during the review year.</p>			W 440			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE				TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.