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	
		MHL0411169	B. WING		04/	15/2025
NAME OF F	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY,	STATE, ZIP CODE		
QUALITY	CARE III, LLC/BRIDI	-ORD HOME	BRIDFORD PAR NSBORO, NC 2	•		
(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 000	INITIAL COMMENT	rs .	V 000			
	This facility is licens category: 10A NCA	sed for the following service C 27G .5600B Supervised				
	The facility is licens census of 2. The s		es.			
V 114	census of 2. The survey sample consisted of audits of 2 current clients. 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 accessible for use.		on ff			

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE TITLE

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			
		MHL0411169		B. WING		04/	15/2025	
NAME OF	PROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, S	STATE, ZIP CODE			
QUALITY	Y CARE III, LLC/BRIDI	-ORD HOME			KWAY, UNIT C			
	T			ORO, NC 2				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE ACTOR CROSS-REFERENCED TO	L'S PLAN OF CORRECTION (X5) ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY) (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 held at least quarterly and repeated for each shift. The findings are:							
	Review on 4/9/25 of the facility's fire drill log from 4/14/24 - 2/8/25 revealed: No fire drills were held on first or third shift during the second quarter (April - June) of 2024 No fire drills were held on first or third shift during the third quarter (July - September) of 2024 No fire drills were held on first or third shift during the fourth quarter (October - December) of 2024 No fire drills were held on first or third shift during the first quarter (January - March) of 2025							
	Review on 4/9/25 of the facility's disaster drill log from 4/20/24-2/22/25 revealed: No disaster drills were held on second or third shift during the second quarter (April - June) of 2024 No disaster drills were held on second or third shift during the third quarter (July - September) of 2024 No disaster drills were held on second or third shift during the fourth quarter (October - December) of 2024 No disaster drills were held on second or third shift during the first quarter (January - March) of 2025							
	revealed: - Shifts were as f 4 pm - 12 am (2nd shift)	5 with the House Man follows: 7 am - 4 pm (shift) and 12 am - 7 a fire and disaster drills	1st shift); m (3rd					

Division of Health Service Regulation

STATE FORM 6899 RV0R11 If continuation sheet 2 of 3

Division of Health Service Regulation

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			COMPLETED		
		MHL0411169		B. WING		04/	15/2025
	PROVIDER OR SUPPLIER Y CARE III, LLC/BRIDI	FORD HOME	1446 BRII		STATE, ZIP CODE KWAY, UNIT C 17407		
(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 T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 114	Interview on 4/15/29 Professional reveal - Unclear as to widrills as required as	5 with the Qualified ed: hy staff had not con staff had been provention as to how an	rided with	V 114			

6899

Division of Health Service Regulation STATE FORM