		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
AND FLAN OF CORRECTION		IDENTIFICATION NOMIDER.	A. BUILDING:		R 06/13/2025	
	MHL034-313		B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	Y PEOPLE THAT CA	RF 3	IDGEWOOD R			
		CLEMMO	DNS, NC 2701	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMEN	ſS	V 000			
	completed on 6/13/ unsubstantiated (in complaint was subs NC00230135). Det This facility is licens category: 10A NCA for Adults with Deve The facility is licens census of 3. The s	ficiences were cited. sed for the following service C .5600C Supervised Living elopmental Disabilities. sed for 3 and has a current urvey sample consisted of an				
V 108	audit of 3 current cl 27G .0202 (F-I) Per	ients. rsonnel Requirements	V 108			
	(g) Employee train	cation shall be documented. ing programs shall be minimum, shall consist of the				
	delineated in 10A N 10A NCAC 26B; (3) training to mee	nt rights and confidentiality as ICAC 27C, 27D, 27E, 27F and t the mh/dd/sa needs of the n the treatment/habilitation tious diseases and				
	bloodborne pathoge (h) Except as perm .5602(b) of this Sub member shall be av times when a client member shall be tra	ens. itted under 10a NCAC 27G ochapter, at least one staff vailable in the facility at all : is present. That staff ained in basic first aid				
	to provide cardiopu	anagement, currently trained Imonary resuscitation and lich maneuver or other first aid				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED R 06/13/2025	
		MHL034-313	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
FRIENDL	Y PEOPLE THAT CA	RF 3	IDGEWOOD RO DNS, NC 27012			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLET DATE
V 108	Continued From pa	age 1	V 108			
	the American Heart equivalence for reli (i) The governing k implement policies reporting, investiga	s those provided by Red Cross t Association or their eving airway obstruction. body shall develop and and procedures for identifying ting and controlling infectious diseases of personnel and				
	failed to ensure at I was trained in basic resuscitation (CPR all times when a cli	et as evidenced by: eview and interview, the facility least one staff member who c first aid and cardiopulmonary) was available in the facility at ent was present for 1 of 3 #1). The findings are:				
	- A hire date of 4	of staff #1's record revealed: //12/19 as a Paraprofessional basic first aid and CPR expired	ł			
	Worked aloneNo one had ma	5 with staff #1 revealed: on third shift ade her aware that her training PR was expiring on 5/27/25				
	5/24/25 that she ne class on 5/29/25 at - Staff #1 had fai directed	led: otified via text message on eeded to attend a first aid/CPR				

STATE FORM

IJWY11

If continuation sheet 2 of 4

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED R 06/13/2025	
		MHL034-313				
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
FRIENDL	Y PEOPLE THAT CAI	RF 3	IDGEWOOD R DNS, NC 2701			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 108	Continued From pa	ge 2	V 108			
	until she completed	l the training				
V 114	27G .0207 Emerge	ncy Plans and Supplies	V 114			
	AND SUPPLIES (a) Each facility sha and a disaster plan these plans availab to the county emerge request. The plans procedures and rou (b) The plans shall and evacuation pro posted in the facility. (c) Fire and disaster shall be held at lease repeated for each s Drills shall be condu- simulate the facility emergencies.	gency services agencies upon shall include evacuation ites. be made available to all staff cedures and routes shall be r drills in a 24-hour facility st quarterly and shall be shift. ucted under conditions that				
	failed to ensure disa	et as evidenced by: view and interview, the facility aster drills were held at least ted for each shift. The				
	from 4/1/2024-5/18	f the facility's disaster drill /25 revealed: disaster drill was held on the				

IJWY11

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA UDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY		
		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		MHL034-313	B. WING		R 06/13/2025	
AME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	Y PEOPLE THAT CA	RF 3				
		CLEMM	ONS, NC 2701			
(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 ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
V 114	Continued From page 3		V 114			
	 quarter of 2024 (Ag No evidence a first, second or thir of 2024 (July 2024 No evidence a first, second or thir of 2024 (October 2 Interview on 6/9/25 revealed: He had been c disaster drill had to Believed he no as he was holding Interview on 6/11/2 Professional revea Would ensure required 	w had a better understanding the drills as required 5 with the Qualified led: disaster drills were held as eficiency and must be	r			

IJWY11