Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	(X3) DATE SURVEY COMPLETED		
		MHL011-214	B. WING		08/26/2025	
NAME OF D	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E ZIR CODE	1 00/20/2020	
NAME OF FI	NOVIDER OR SUFFLIER		ARVIEW TERRAC			
CLEARVIE	EW TERRACE		LE, NC 28801	<del>-</del>		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5)  COMPLETE DATE		
V 000	INITIAL COMMENTS		V 000			
	An annual survey was 2025. A deficiency was	s completed on August 26, as cited.				
	category: 10A NCAC	d for the following service 27G .5600C Supervised Developmental Disability.				
	-	d for 6 and currently has a vey sample consisted of ents.				
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		V 114			
		ews and interviews, the act fire and disaster drills				

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

TITLE (X6) DATE 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			
		MHL011-214	B. WING		08	/26/2025			
NAME OF PROVIDER OR SUPP	LIER		DDRESS, CITY, STA						
CLEARVIEW TERRACE 521 CLEARVIEW TERRACE ASHEVILLE, NC 28801									
PREFIX (EACH D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (X5)  (EACH CORRECTIVE ACTION SHOULD BE COMPLETI  CROSS-REFERENCED TO THE APPROPRIATE DATE  DEFICIENCY)					
drills revealed -No fire and of during the for November, D -No fire drills second quart  Interviews on -Participated -Knew what to a fire or disas  Interview on 8 Professional -"We always done, the form -"We have a secheduled. So once complet -"Don't want to have the pap -Was respons	20/25 of: isaster rth qua ecembe for first er 2025 8/26/25 n fire a o do and ter. s/21/25 evealed to them n just di ealenda aff will e." o say werwork to ible for	drills for the second shift rter 2024 (October, er). and second shift during the (April, May, June).  with Clients #1-3 revealed: nd disaster drills. d where to go in the event of with the Qualified d: n (drills). If a form doesn't get idn't get done." r where they (drills) are mark 'done' on the calendar we did something if we don't	V 114						

Division of Health Service Regulation

STATE FORM UCDV11 If continuation sheet 2 of 2