Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			,
		MHL024-011	B. WING		08/1	4/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WHITEVILLE GROUP HOME 168 SWEET FA						
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	on August 14, 2025 This facility is licens	ow up survey was completed 5. A deficiency was cited. sed for the following service				
	categories: 10A NCAC 27G .5100 Community Respite Services for Individuals of All Disability Groups and 10 A NCAC 27G .5600 Supervised Living for Adults with Mental Illness.					
		sed for 6 and currently has a urvey sample consisted of 3				
V 114	27G .0207 Emerge	ency Plans and Supplies	V 114			
	AND SUPPLIES (a) Each facility sha	207 EMERGENCY PLANS all develop a written fire plan				
	and a disaster plan and shall make a copy of these plans available					
		gency services agencies upon shall include evacuation				
	(b) The plans shall	be made available to all staff ocedures and routes shall be				
	(c) Fire and disaste shall be held at lear repeated for each s Drills shall be cond	ucted under conditions that				
	simulate the facility emergencies. (d) Each facility sha accessible for use.	all have a first aid kit				
	Based on record re	et as evidenced by: eview and interviews the facility and disaster drills held at least				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OI CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					F	₹
		MHL024-011	B. WING		08/1	4/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
TW WILL OF T	NOVIDEN ON GOLF EIEN		ET FARM RC			
WHITEV	LLE GROUP HOME		LLE, NC 284			
040.15	CLIMMA DV CTA		1		DNI .	()(5)
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL	OULD BE COMPLÉTE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				DEFICIENCY)		
V 114	Continued From page 1		V 114			
	quarterly and repeated on each shift. The findings are:					
	illialigo arc.					
	Review on 8/13/25	of the facility's documented				
	fire and disaster dri	lls for 7/01/24 - 6/30/25				
	revealed:					
		25 - 3/31/25); no 3rd shift				
	disaster drill documented.					
	-Third quarter (7/01/24 - 9/30/24); no 1st shift fire or 3rd shift disaster drills documented.					
	or ord strift disaster	ums documented.				
	Interview on 8/13/25 client #1 stated: -He had lived at the group home for a long timeHe would go outside if there were a fire in the house.					
	-He would stay inside the house if there were a					
	hurricane or tornado.					
	Interview on 8/13/25 client #2 stated: -He had lived at the group home for "800 years." -He would run out of the house if there was a fire.					
	Interview on 8/13/25 client #3 stated: -He had lived at the group home for a long timeHe would go outside if there were a fire in the					
	house.	ae ii there were a lire in the				
		allway if there were a tornado.				
	Jaia yo to a ii	a, a.o.o woro a torridao.				
	Interview on 8/13/25	5 staff #1 stated:				
		ith the agency for 12 years.				
	-Fire and disaster d	rills were completed monthly.				
	Interview 0/40/04	E stoff #2 stated:				
	Interview on 8/13/25	b staff #2 stated: h the agency for 7 years.				
		rills were completed monthly.				
	. no and diodotol d	Horo completed monthly.				
	Interview on 8/13/25	5 the Program Manager				
	stated:					
		rills were completed monthly.				
	-There were three s	shifts that fire and disaster				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMF	(X3) DATE SURVEY COMPLETED		
		MHL024-011	B. WING			R 1 <i>4/2</i> 025		
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
WHITEV	WHITEVILLE GROUP HOME 168 SWEET FARM ROAD WHITEVILLE, NC 28472							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE		
V 114	drills were schedule (8am - 4pm, 4pm - Interview on 8/13/2stated: -Fire and disaster dand rotated to inclu- -She would ensure	ed to be completed within 12am, and 12am - 8am). 5 the Qualified Professional Irills were completely monthly	V 114					

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