

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

enough

TITLE

(X6) DATE

If continuation sheet 1 of 3

The Plan of Correction with addendum was reviewed and acknowledged on 12/12/25. SG Refer to addendum on page 1 of this Statement of Deficiencies.

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/04/2025
NAME OF PROVIDER OR SUPPLIER YOUR GRACE AND MERCY FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 119 ELM STREET BURLINGTON, NC 27217		
(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
C 120	Continued From page 1 Review of the facility's license revealed: -The facility was licensed effective 01/01/25 for a capacity of 3 ambulatory residents. -The expiration date of the facility's license was 12/31/25. Observation of the facility on 11/04/25 at 8:15am revealed: -There was one resident in the facility. -The Administrator was the only staff member in the facility. Interview with the Administrator on 11/04/25 at 8:25am revealed: -There were currently two residents that resided in the facility. -One resident was out at dialysis and would return later in the afternoon. Review of the facility's fire rehearsal logs on 11/04/25 at 9:27am revealed: -There was documentation a fire drill was conducted on 02/24/25 at 6:00pm. -The Administrator conducted the fire drill. -The evacuation time was 3 minutes. -The residents were in their rooms. -When the alarm went off, everyone got out of the facility. -There was documentation a fire drill was conducted on 05/25/25 at 6:45am. -The Administrator conducted the fire drill. -The evacuation time was 2 minutes. -The residents were getting ready for breakfast, and when the alarm sounded, they all got out of the facility. -There was documentation a fire drill was conducted on 08/20/25 at 4:15pm. -The Administrator conducted the fire drill. -The evacuation time was 3 minutes.	C 120		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/04/2025
NAME OF PROVIDER OR SUPPLIER YOUR GRACE AND MERCY FAMILY CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 919 ELM STREET BURLINGTON, NC 27217		
(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	
C 120	Continued From page 2 -Residents were in the living room and one in the bathroom when the alarm sounded. -The drill went well. Interview with the Administrator on 11/04/25 at 1:30pm revealed: -She thought the rule was confusing. -She conducted fire drills quarterly and did them on different shifts. -She was not aware there had to be four fire drills conducted on each shift yearly.	C 120			