		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL001149	B. WING		09/0	9/2015
					1 00/0	0.2010
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LANE ST	LANE ST RETIREMENT HOME 625 LANE STREET BURLINGTON, NC 27217					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 000	Initial Comments		D 000			
	The Adult Care Lice annual survey on S	ensure Section conducted an eptember 9, 2015.				
D 074	10A NCAC 13F .03 Furnishings	06(a)(1) Housekeeping And	D 074			
	Furnishings (a) Adult care hom (1) have walls, ceil	06 Housekeeping And es shall: ings, and floors or floor n and in good repair;				
	failed to assure wal kept clean and in go rooms hallway, 2 of	et as evidenced by: on and interview, the facility ls, ceilings, and floors were nod repair for the resident 2 resident bathrooms (Ladies' and the front living room.				
	The findings are:					
	facility's long hallwa - Pieces of flooring missing or had brok	tile,12"x12", were completely				
	Bath revealed: - The room had one bathtub/shower The flooring tiles in cracks, were broken The flooring around baseboard was stained The cereamic tiles.	e toilet and sink and one in the Ladies's Bath had in, or had missing pieces. ind the toilet and at the wall ned and dirty. is between the toilet and the int and the grout was darkly				

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED	
		HAL001149	B. WING		09/0	9/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
		625 LANE		,			
LANE ST	RETIREMENT HOME		TON, NC 27	217			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)N	(X5)	
PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE	
				22.13.2.10.1			
D 074	Continued From pa	ge 1	D 074				
	stained and cracke	d.					
	01 11 0/0	/45					
	Bath revealed:	/15 at 10: 15 am of the Men's					
		sinks, two toilet stalls, and					
		n shower with hanging shower					
	curtain.	5 5					
		n the Men's Bath were stained					
		broken pieces over the whole					
	_	was stained a dark brown					
	color The mirrors above the sinks had 1-1/2" to 2"						
	high missing reflection glass at the bottoms of each mirror.						
	- The ceramic tiles between the sinks were						
	stained, had cracks in the grout, and had peeling paint on the tiles.						
	-	two toilet stalls had large					
	sections of peeling paint and stains starting at						
	the floor to halfway up each 6' wall.						
	- The walls behind each of the toilets also had						
		s, and was dirty in the corners.					
		curtain was covered in mold					
		om up and was stained. vas a faded yellow-brown color.					
		wall sides had missing grout					
		dy all along the base moulding					
		of the walls and had peeling					
	paint.	, ,					
		the shower was stained a					
		and was dirty along the edges.					
		om needed painting and the					
	sprinkier nozzies in rust.	the ceiling were covered in					
	Observation at 12: revealed:	30 pm of the front living room					
		looring tile was missing from					
		the sofa and other tiles had					
	cracks.						

6899

Division of Health Service Regulation STATE FORM

G7SX11 If continuation sheet 2 of 4

STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	HAL001149	B. WING		09/0	09/2015	
NAME OF PROVIDER OR SUP	LIER STREET A	ODRESS, CITY,	STATE, ZIP CODE			
LANE ST RETIREMENT	IOMF	E STREET GTON, NC 27	7 217			
PREFIX (EACH DEFI	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
sheetrock wal approximately of approximately of approximate. A 2-1/2' x 6" away from the - A similar size from the midd the room. Interview on 9 revealed: "The floors and bat used to the wa attention." Interview on 9 resident revealed: "I think the bare falling apart of the floors are falling apart. I have not he done." Interview on 9 resident revealed: The floors are for months in not been replaying the followed and the flooked good good th	hole punched through the beside the sofa that was 5-1/2' high and had a circumfrence by 7". Strip of wallpaper had been torn wall below the hole. d strip of wallpaper had been torn e of the wall on the other side of 9/15 at 1:15 pm with a resident y need to do some repairs to the grooms, but we (residents) are y it looks and don't pay that much 19/15 at 2:15 pm with a second ed: athrooms are nasty and the floors to a trip at 2:30 pm with a third ed: e not in good condition. The own the molded shower curtain had ced. 19/15 at 1:45 pm with the e (MA) and supervisor-in-charge is cor tiles were replaced where e entire house was painted; it en. The own the molded shower between the own stall a scraped before they were painted sidents had complained about the					

Division of Health Service Regulation

STATE FORM 6899 G7SX11 If continuation sheet 3 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED	
		HAL001149	B. WING		09/0	9/2015	
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
LANE ST	LANE ST RETIREMENT HOME 625 LANE STREET BURLINGTON, NC 27217						
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
D 074	Continued From pa	ige 3	D 074				
	the wall with his fist Telephone interview Administrator revea	ent who punched the hole in and tore the wallpaper. I on 9/9/15 at 1:55 pm with the aled: as called today and is coming					
	in this afternoon to done.	look at what needs to be ed today to start work on the					

6899

Division of Health Service Regulation STATE FORM