DIVISION	of Health Service Re	egulation					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: 01		COMPLETED		
		HAL007014	B. WING 1		11/0	11/04/2014	
	200 (IDED OD OUDD) IED			2747F 7ID 00DF	1		
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
CLARA N	MANOR		ILICO STREI				
			STON, NC 27	7889		I	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
C 000	Initial Comments		C 000				
	done by Bob Getch	Biennial Construction Survey ell on November 4, 2014.					
	Records indicate this facility was first licensed or submitted on September 1, 1962, as a Home for the Aged (HA) housing 20 beds. Therefore the facility must meet the 1971 and the applicable portions of the 2005 Rules for the Licensing of Adult Care Homes, and, the 1967 North Carolina State Building Code(s) for Group D Institutional. Deficiencies were noted which will require a plan of correction.						
C 101	Existing Licensed F	ac- No less than '71 Rules	C 101				
	PHYSICAL PLANT The physical plant is care home shall be (2) Except where of licensed facilities of facilities shall meet requirements in effection of addition or renovation, or alterative requirements for no addition or renovation or renovation or requirements "Minimum and Des Regulations" for "H copies of which are Health Service Reg	01 APPLICATION OF REQUIREMENTS requirements for each adult applied as follows: otherwise specified, existing reportions of existing licensed licensure and code ect at the time of construction, or bed count, addition, ation; however in no case shall or any licensed facility where wation has been made, be less nents found in the 1971					
	This Rule is not met as evidenced by: 1. Based on observation, the building fire						

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

protection equipment was not maintained in a

(X6) DATE TITLE

PRINTED: 11/20/2014

Division	of Health Service Re	egulation			FORM	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
		HAL007014	B. WING		11/0	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
CLARA	MANOR		ILICO STRE STON, NC 2	= 		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES H DEFICIENCY MUST BE PRECEDED BY FULL LATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
C 101	Continued From pa	age 1	C 101			
	not detecting smok Findings on 11/04/2 a) Room 9 has a d ceiling by the wires	letector hanging from the ,b) The Living Room Activity a room that is open to the				
C 123	Bedroom Location-	Outside Wall, Access To	C 123			

SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0305 PHYSICAL **ENVIRONMENT**

(d) The requirements for the bedroom are:

(4) Bedrooms shall be located on an outside wall and off a corridor. A room where access is through a bathroom, kitchen, or another bedroom shall not be approved for a resident's bedroom;

This Rule is not met as evidenced by:

1. Based on observation, the bedroom was not maintained in accordance with this Rule.

Followup Findings 11/04/2014:

a) The private bedroom on the front left side of the building does not meet the requirement that all bedrooms be located off a corridor.

C 164 Housekeeping and Furnishings-Clean, Repaired

SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0306 HOUSEKEEPING AND **FURNISHINGS**

(a) Adult care homes shall:

- (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair;
- (2) have no chronic unpleasant odors;
- (3) have furniture clean and in good repair;

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C 164

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL			DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: 01		COMPLETED		
		HAL007014	B. WING		11/04/2014		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
CLARA I	MANOR		ILICO STREI STON, NC 27				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
C 164	Continued From pa	ge 2	C 164				
	(e) This Rule shall facilities. This Rule is not me 1. Based on observation and the shall residue to let a shall	apply to new and existing et as evidenced by: vation, the building was not rdance with this Rule because cose from the floor. This dents using the toilets by eaks and odors from a broken co14: Toilets are coming loose of following locations: a) on #2 has a toilet coming loose Bathroom of private apartment loose. c) Front right hall toilet					
C 189	SECTION .0300 - F 10A NCAC 13F .03 REQUIREMENTS (a) The building an mechanical, and plu care home shall be operating condition. (k) This Rule shall facilities with the ex which shall not app. This Rule is not me 1. Based on observe equipment was not by allowing cross con	d all fire safety, electrical, umbing equipment in an adult maintained in a safe and apply to new and existing ception of Paragraph (e) by to existing facilities. Let as evidenced by: wation, the building plumbing maintained in a safe manner connects. This would effect all fally siphoning waste water ter system.	C 189				

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DY1Z21 If continuation sheet 3 of 7

Division of Health Service Regulation						
STATEMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
	HAL007014		B. WING		11/04/2014	
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
CLARA I	MANOR		LICO STREI TON, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 189	Continued From pa	ge 3	C 189			
	The spray hose on vacuum breaker. b apartment shower h	need a vacuum breaker: a) the Beauty Shop sink has no) Spray hose in private nas no vacuum breaker.				
	2. 1. Based on observation, the building was not maintained in a safe manner by not maintaining the fire-resistance rating of building components. This would effect all residents by not containing smoke and fire in the room or smoke compartment of origin.					
	Findings on 11/04/2014: a. There is a door with missing door hardware separating the office from the private apartment.					
	b. The 1-hour fire resistance rated ceiling located in the private apartment was penetrated by an attic access hatch that has a single layer of gypsum resting on wood casing that does not maintain the fire resistance rating of the roof ceiling assembly.					
		private apartment closet has ations by CATV cable.				
	has unprotected pe HVAC duct, and the	e exterior mechanical room netrations by exhaust flue, e joints are not sealed to sistance rating of the ceiling.				
	open to the attic burradiation dampers of	ceiling of the mop room are t are not equipped with or other alternative means of ain the fire resistance rating of				
	f. The office utility repending	oom has an unprotected wall e.				

6899

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

Division of Health Service Regulation						
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
		HAL007014	B. WING		11/04/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CLARA N		1218 PAM	LICO STRE	ET		
		WASHING	TON, NC 2	7889		1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
C 189	Continued From pa	ge 4	C 189			
	g) The kitchen has a dutch door to the corridor that has no automatic flush bolt, and no astrigal or rabbet to seal the door so it can resist the passage of smoke.					
	3. Based on observation, egress from all areas was not maintained in a safe manner by having a door that could be locked in the direction of egress. This would effect one resident by not allowing free egress in an emergency.					
	Findings on 11/04/2 The private bedroom has a dead bolt late	m has an exterior door that				
	This is not in conformance with the requirement that all doors in the path of egress must remain operable without the use of a key or special knowledge.					
	4. Based on observation, the building electrical system was not maintained in a safe manner by allowing residents to use two-wire extension cords and expansion blocks in the outlets. This would effect all residents by potentially overloading electrical circuits in the bedrooms.					
	devices were obser a) Room 17 has ar	l/2014: cords and outlet expansion ved in the following locations: n outlet expansion device, b) -wire extension cord.				
	5. Based on observation, the building exit signage and emergency lighting was not maintained in a safe manner. This would effect all residents by not keeping the exits visible in an emergency.					

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Findings on 11/04/2014:

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) DATE SURVEY COMPLETED	
		HAL007014	B. WING		11/04/2014		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1170	4/2014	
			LICO STREE	,			
CLARA	MANOR	WASHING	TON, NC 27	7889			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
C 189	Continued From pa	ge 5	C 189				
	The Exit sign/Emer Station is not working	gency light at the Nurse ng.					
	6. Based on observation, the building plumbing equipment was not maintained in a safe manner by allowing the ice machine drain line to be in contact with the floor drain. This would effect all residents by potentially contaminating the ice.						
	Findings on 11/04/2014: The drain line on the kitchen ice machine is resting on the floor drain.						
	7. Based on observation, the building was not maintained in a safe manner by allowing the improper storage of oxygen bottles. This would effect all residents by exposing them to potential injury when unsecured cylinders fall over.						
		2014: gen bottles that are not a holder designed for that					
C 191	Unvented & Portab	le Elec. Heaters Prohibited	C 191				
	maintain 75 degree winter design condi following shall apply appliances. (2) Unvented fuel to portable electric he (k) This Rule shall facilities with the expense of the condition of the condi						

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY OMPLETED	
HAL007014		B. WING		11/04/2014		
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	_	
CLARA M	ANOR		LICO STREI			
			TON, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
C 191	Continued From pa	ge 6	C 191			
	maintained in a safe electric heaters wer residents in the eve heater was the sour Findings on 11/04/2 heaters were found	vation, the building was not e manner because portable re in use. This would effect all ent that a portable electric				

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