Division of Health Service Pegulation

Division of Fleath Service Regulation						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: 01		COMPLETED		
					F	2
		FCL046004	B. WING			4/2015
<u> </u>				STATE ZID CODE		
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
DELOAT	CH'S REST VILLA I		VISTOWN R			
		MURFREE	ESBORO, NO	27855		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF		COMPLETE DATE
170			IAG	DEFICIENCY)		
(C 000)	Initial Comments		{C 000}			
	Report by Suzanna	Fay				
	A D'					
		p Survey was conducted on				
		m 12:50 p.m. to 1:22 p.m. Not				
		cited deficiencies were				
	corrected. Thereto	re, further action is required.				
	The remaining deficiencies are as follows:					
(C 110)	Dadraama		(C 110)			
{C 110}	Bedrooms		{C 118}			
	IV. The Building					
		nment				
	C. Physical Environment4. Bedrooms (10 NCAC 42C .2205)a. There must be bedrooms sufficient in number					
		e individual needs according				
		ne residents, the administrator				
		arge, other live-in staff and any				
		in the home. Residents are				
		oms with staff or other live-in				
	non-residents.					
	b. Only rooms auth	norized as bedrooms are to be				
	used for resident 's					
		ccess is through a bathroom,				
	kitchen, or another	bedroom will not be approved				
	for a resident 's be	droom.				
	d. There must be a	minimum area of 100 square				
	feet, excluding vest	ibule, closets or wardrobe				
	space, in rooms occ	cupied by one person and one				
		O square feet per bed,				
		, closet or wardrobe space, in				
		two or three persons.				
	e. The total number of residents assigned to a					
		exceed the number authorized				
	for that particular be					
	_	not be occupied by more than				
	three residents.					
	l a Hach resident he	droom must be ventilated with	I			

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

window(s) and well lighted. The window area

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
FCL046004		B. WING		R 03/24/2015		
NAME OF I	PROVIDER OR SUPPLIER		ORESS CITY S	STATE, ZIP CODE	03/2	4/2013
	CH'S REST VILLA I		VISTOWN R			
DLLOAI			SBORO, NO			
(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 APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
{C 118}	Continued From pa	ge 1	{C 118}			
	floor space. The wito see outdoors from maximum 36 inch sh. Bedroom closets enough to provide of 48 cubic feet of hanging space by This Rule is not me 1. During this surve	s or wardrobes must be large each resident with a minimum langing clothing storage space feet deep by three feet wide y eight feet high). et as evidenced by: ey, it was observed that the				
	private (single bed) resident bedroom is an interior bedroom. At some time, an addition was constructed creating a living room on the front of the house. The living room extends past the single bedroom so that the window opens into the living room. Therefore, this room does not meet the lighting and ventilation requirements, emergency exiting requirements nor the visual requirements of both the NCSBC and the 1984 Licensure Rules. It was observed that there are four private bedrooms on the opposite end of the hall that could be used for a Resident bedroom. This bedroom cannot be used as a bedroom. Provide another room for the Resident or modify the license to have five Residents. Send a revised plan to DHSR/Construction Section or submit a Change of Capacity request to Licensure. 3/24/15: SF-At the time of the follow up survey, a bedroom was prepared for the Resident, but he was still residing in the interior bedroom. Relocate the Resident and his belongings to the new location. Provide verification of the move.					

Division of Health Service Regulation STATE FORM

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			
AND PLAN OF CORRECTION		IDENTIFICATION NOWIDER.	A. BUILDING: 01					
		FCL046004	B. WING		03/2	₹ 4/2015		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE				
DELOAT	CH'S REST VILLA I		VISTOWN RO					
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)		
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE		
{C 123}	Continued From pa	ge 2	{C 123}					
{C 123}	Outside Entrances/	Exits	{C 123}					
	Continued From page 2 Outside Entrances/Exits IV. The Building C. Physical Environment 8. Outside Entrances/Exits (10 NCAC 42C .2209) a. All floor levels must have at least two exits. If there are only two, the exits must be as remote from each other as reasonably possible. b. At least one entrance/exit door must be a minimum clear width of three feet and another must be a minimum clear width of two feet and eight inches. c. At least two outside entrances/exits for the residents' floor level must be at ground level or accessible by ramp with a 1 inch rise for each 12 inches of length of the ramp. If there are only two entrances/exits, the entrances/exits must be as remote from each other as reasonably possible. (The requirement for the ramp at exits not at ground level applies to homes which have at least one resident who needs personal assistance in getting up or down steps.) d. All exit door locks must be easily operable, by a single hand motion, from the inside at all times without keys. e. All entrances/exit must be free of all obstructions or impediments to allow for full instant use in case of fire or other emergency. f. All steps, porches, stoops and ramps must be provided with handrails and guardrails. This Rule is not met as evidenced by: 1. The back exit storm door has thumb latches that, when engaged, prohibit single action exiting. Remove or dismantle the storm door thumb latch. Remove any hook and eye latches from the storm door. These are not single action. Provide							

6899

Division of Health Service Regulation STATE FORM

verification of the correction.

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY DMPLETED		
		FCL046004	B. WING			२ 24/2015		
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
DELOAT	DELOATCH'S REST VILLA I 104 E LEWISTOWN ROAD MURFREESBORO, NC 27855							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE		
{C 123}	3/24/15: SF-At the the hook and eye la storm door still had Remove or disman verification of the read bolt latch which action exiting requir an aluminum framir that the stile is only Have a qualified pe provide single action 3/24/15: SF-At the the Provider has be and has not been a hardware to fit the comanufacturers of the see if a single action.	time of the follow up survey, atch had been removed. The a working thumb latch. tle the thumb latch. Provide	{C 123}					

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