AND BLAN OF CORRECTION TO IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED		
		FCL068028	B. WING		06/1	0/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LIVEWE	LL ASSISTED LIVING		LINE DRIVE HILL, 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 APPROPERTION OF T	D BE	(X5) COMPLETE DATE
C 000	Initial Comments		C 000			
	Report by Greg Will	iams				
	Survey on June 10, 2:30PM at the above records indicate the May 10, 2011 as a lambulatory Resider respond without any during a fire or other we are requiring the with the following: 13G for Family Carolina State Build Section 421.2 - Resident At the time of our vi	a Section conducted a Biennial 2015 from 12:30 PM to be referenced facility. DHSR shome was first licensed on Family Care Home for six (6) and that (able to evacuate and by physical or verbal assistance or emergency). Based on this shome to be in compliance the 2005 Rules 10A NCAC be Homes and the 2006 North ling Code - Building Cod				
C 105	SECTION .0300 - T 10A NCAC 13G .03 CONSTRUCTION (a) Any building lic family care home sl requirements of the Code. All new cons renovations to exist requirements of the Code for One and T Residential Care Fa applicable volumes Building Code, whice reference, including may be purchased in Insurance Engineer	HE BUILDING	C 105			

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01			(3) DATE SURVEY COMPLETED	
	FCL068028	B. WING		06/1	10/2015	
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE			
LIVEWELL ASSISTED LIVING		LINE DRIVE HILL, NC 27				
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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	
dollars (\$380.00). (b) Each home shate equipped and maint offered in the home. This Rule is not metal.) This Home as it Section 421.2 of the Building Code as all can house up to a maresidents. At the time residents ambulator facility staff and deteresidents would be conceeding verbal or particular fields of the second of	cost of three hundred eighty all be planned, constructed, cained to provide the services at as evidenced by: stands is Classified under 2006 North Carolina State Residential Care Home and naximum of six all ambulatory are of our visit we assessed the ry status with the help of termined that four of the six considered non ambulatory ohysical assistance during a tency). Based on our findings y one of the following three low; one of these following mplemented to ensure the and staff alike; Please indicate tight hand side of your Plan of the an estimated completion the facilities licensed capacity (3). This will put you under the North Carolina State hich does not have any mbulation status of residents overned by Section 421.2 of Building Code which requires	C 105				

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Division of Health Service Regulation
STATE FORM

AND BLAN OF CORRECTION TO TRANSPORT TO A NUMBER OF THE PROPERTY OF THE PROPERT		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING: 01			X3) DATE SURVEY COMPLETED	
		FCL068028	B. WING		06/1	0/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LIVEWEL	L ASSISTED LIVING		LINE DRIVE HILL, NC 27			
(V4) ID	SHMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
C 105	Continued From pa	ge 2	C 105			
	toilets, closets, pan spaces. This would non-ambulatory reschoose to sprinkle is submit plans to our to beginning any wo (3) Your third optionon-ambulatory rescan better serve the ambulatory residen licensed for. *Please Note that if Non-Ambulatory Relicensure rules required.	areas including bathrooms, tries, storage and utility allow you to keep up to six sidents. (NOTE if you do the home you are required to office for a written review prior ork). In would be to remove all of the sidents to another home that heir needs and only serve all the as you are currently If you do choose to allow the esidents to remain, that he are two ramps for resident the as possible to each other.				
C 137	foot candles of light mechanical ventilat feet per minute for	THE BUILDING	C 137			
	was not an exhaust Residents Bedroom exhaust fan installe exhausted to the ou	e survey it was noted that there is fan in the Bathroom off of in #3 (front left). Have an in the Residents Bathroom, atdoors and provide ur office when completed.				

Division of Health Service Regulation STATE FORM

RFF421 If continuation sheet 3 of 5

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
		FCL068028	B. WING		06/1	0/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LIVEWE	LL ASSISTED LIVING		LINE DRIVE HILL, NC 27	514		
(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 171	Continued From pa	ge 3	C 171			
C 171	Fire Safety- Evacua	ation Plan	C 171			
	DISASTER PLAN (d) A written fire evidiagrammed drawing the local code enformation on each floor reviewed with each shall be a part of the This Rule is not med. It was noted during the Evacuation Plan possible and several other and directing residents in discharge. Have the	vacuation plan (including a ng) which has the approval of reement official shall be rint and posted in a central for. The plan shall be resident on admission and e orientation for all new staff.				
C 174	Building Equipment	Maintained Safe, Operating	C 174			
	EQUIPMENT (a) The building at mechanical, and plucare home shall be operating condition	and all fire safety, electrical, umbing equipment in a family maintained in a safe and apply to new and existing				
	(front left) the sink of the front and right s	et as evidenced by: off of residents bedroom #3 cabinets finish was peeling on side of the cabinet. Have the replaced and provide				

Division of Health Service Regulation

STATE FORM 6899 RFF421 If continuation sheet 4 of 5

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6720 PAULINE DRIVE CHAPEL HILL, NC 27514 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) C 174 Continued From page 4 B. WING	AND DUAN OF CODDECTION DEPOTE OF AND DUAN OF CODDECTION OF		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED		
LIVEWELL ASSISTED LIVING 6720 PAULINE DRIVE CHAPEL HILL, NC 27514 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE			FCL068028	B. WING		06/1	0/2015
CHAPEL HILL, NC 27514 (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CHAPEL HILL, NC 27514 CHAPEL HILL, NC 27514 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMPLETE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	LIVEWE	LL ASSISTED LIVING					
C 174 Continued From page 4 C 174	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
documentation to our office when corrected. 2. In the bathroom off of residents bedroom #1 (back right) there was an open outlet box on the wall next to the toilet. Have a blank cover installed on the outlet box and provide documentation to our office when completed.	C 174	documentation to o 2. In the bathroom of (back right) there we wall next to the toiled on the outlet box ar	ur office when corrected. off of residents bedroom #1 ras an open outlet box on the et. Have a blank cover installed and provide documentation to	C 174			

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Division of Health Service Regulation STATE FORM