

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001025	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/30/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SPRINGVIEW - CROUSE BUILDING	STREET ADDRESS, CITY, STATE, ZIP CODE 613 W WHITSETT STREET GRAHAM, NC 27253
---	--

(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 000	<p>Initial Comments</p> <p>This report is of a Biennial Construction Survey done by Bob Getchell on July 29, 2015.</p> <p>This facility was first licensed as a Home for the Aged serving 12 ambulatory residents on 05/01/2000. Therefore the facility must meet the 1996 and the applicable portions of the 2005 Rules for the Licensing of Adult Care Homes, and, the 1996 North Carolina State Building Code - Section 419.5 for Large Residential Care Facility- Group R.</p> <p>Deficiencies were noted which will require a new plan of correction.</p>	C 000		
C 183	<p>Fire Extinguishers</p> <p>SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0308 FIRE EXTINGUISHERS (a) At least one five pound or larger (net charge) A-B-C type fire extinguisher is required for each 2,500 square feet of floor area or fraction thereof. (b) One five pound or larger (net charge) A-B-C or CO/2 type is required in the kitchen and, where applicable, in the maintenance shop.</p> <p>This Rule is not met as evidenced by: 1. Based on observation, the building fire protection equipment was not maintained to keep the facility safe. This would affect all residents by not having fire protection equipment operable for use in an emergency.</p> <p>Findings include: The inspection tags on the fire extinguishers indicate that required monthly checks ended in April, and from then until this survey the monthly checks were not being performed per NFPA 10</p>	C 183		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001025	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/30/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SPRINGVIEW - CROUSE BUILDING	STREET ADDRESS, CITY, STATE, ZIP CODE 613 W WHITSETT STREET GRAHAM, NC 27253
---	--

(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 189	Continued From page 1	C 189		
C 189	<p>Building Equipment Maintained Safe, Operating</p> <p>SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. (k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities.</p> <p>This Rule is not met as evidenced by: 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 affect all residents by not containing smoke and fire in the room or smoke compartment of origin.</p> <p>Findings include: a. The Dining Room ceiling has an unprotected penetration b. The back left exterior storage room has an unprotected penetration in the ceiling by wires.</p> <p>These unprotected openings are not in conformance with the requirement to use a through penetration fire stop system that has been tested in accordance with ASTM E-814.</p> <p>2. Based on observation, the facility components were not maintained operable by having doors that did not close completely and latch.</p> <p>Findings include: The following doors have</p>	C 189		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001025	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/30/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SPRINGVIEW - CROUSE BUILDING	STREET ADDRESS, CITY, STATE, ZIP CODE 613 W WHITSETT STREET GRAHAM, NC 27253
---	--

(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 189	<p>Continued From page 2</p> <p>issues:</p> <ul style="list-style-type: none"> a) Bedroom 3 door won't close and latch, and has a loose door knob, b) Dining Room doors on the corridor will not close and latch, c) Kitchen door tho the Dining Room scrubs frame and will not close and latch when released, d) Office door to the corridor scrubs frame and will not close and latch when released e) Bedroom 6 door won't close and latch <p>3. Based on observation, the building electrical system was not maintained to keep the facility safe by allowing residents to use outlet expansion devices in the outlets. This would affect all residents by potentially overloading electrical circuits in the bedrooms.</p> <p>Findings include: Outlet expansion devices were observed in the following locations:</p> <ul style="list-style-type: none"> a) Room 2 b) Room 5 <p>Provide a UL-listed, grounded power strip with over current protection per NFPA 70.</p> <p>4. Based on observation, the building Emergency Lighting was not maintained in a safe manner. This would affect all residents by not keeping the exits visible in an emergency.</p> <p>Findings include: Emergency lights are not working in the corridor near room 2.</p> <p>5. Based on observation, the building electrical system was not maintained to keep the facility safe. This would affect all residents by potentially overloading electrical circuits in the bedrooms.</p> <p>Findings include:</p>	C 189		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001025	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/30/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SPRINGVIEW - CROUSE BUILDING	STREET ADDRESS, CITY, STATE, ZIP CODE 613 W WHITSETT STREET GRAHAM, NC 27253
---	--

(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 189	Continued From page 3 a) The GFCI outlet will not trip in the toilet room near Room 1 b) The GFCI outlet will not trip in the toilet room near the Living Room	C 189		