		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
		HAL081014	B. WING		08/1	9/2015
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET AD			STATE, ZIP CODE		
BROOKI	DALE FOREST CITY		Y RIDGE RO			
	I		CITY, NC 28		1011	
(X4) ID PREFIX TAG	(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
C 000	Initial Comments		C 000			
		l Construction Survey by Billy nis Harrell conducted on				
	Records indicate this facility was first licensed or submitted for licensure on 05/27/1997 as a HA. The facility is currently licensed for 76 Beds including a 22 Bed Special Care Unit. Therefore the facility was surveyed for conformance with the applicable portions of the 2005 Rules for Licensing of Adult Care Homes of Seven or More Beds and applicable portions of the 1996 (1997 Revision) Edition of the North Carolina Building Code(s), Institutional Occupancy and the 1996 Rules for Licensing of Adult Care Homes of Seven or More Beds in effect at the time of initial licensure.					
C 166	SECTION .0300 - F 10A NCAC 13F .03 FURNISHINGS (a) Adult care home (5) be maintained i orderly manner, fre hazards; (e) This Rule shall facilities. This Rule is not me I. Based on observa maintain the facility Emergency means kept clear of obstru and not used for sto	es shall: in an uncluttered, clean and e of all obstructions and apply to new and existing et as evidenced by: ation there is a failure to free from hazards. of egress/pathways must be ctions and encroachments orage. In the event of an	C 166			
	emergency requiring obstructing or encre	g evacuation from the facility, paching on the means of buld effect occupants of the				

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

TITLE (X6) DATE

	or realth Service IN		0.00 1	E CONCEDUCTION	0(0) 5:55	OLIDA (E.) (
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND I DAN OF CONTROL OF THE PROPERTY.		A. BUILDING: 01			·· ==	
		1141 20404	B. WING			0/004=
		HAL081014	D. WING		08/1	9/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BROOKE	ALE FOREST CITY		RIDGE RO			
		FOREST (CITY, NC 28	043		T
(X4) ID PREFIX		TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	•	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP		DATE
				DEFICIENCY)		
C 166	Continued From pa	ge 1	C 166			
	facility by delaying e	evacuation.				
	in an analysis of the second o					
	A. Findings on 08/1					
	egress.	o oboutdoing the path of				
	_					
	stored items that are obstructing the path of					
	egress.					
	II. Based on observation there is a failure to					
	maintain the facility free from hazards. Doors					
	must latch and remain closed when shut to resist					
	the passage of smoke. In the event of a fire, doors that do not latch and remain closed when					
		e occupants of the facility by				
	allowing smoke and	gases to migrate from the				
	area of origin.					
	Δ Findings on 09/1	9/2015				
		nardware in order for the door				
	to remain shut whe					
	2 Kitchen Service (Corridor The deer hardware				
	when closed.	do. 151 the door to remain shut				
		vation there is a failure to				
		moke in the event of a fire.				
		n fire resistant rated ceilings				
		supants of the facility by				
		loke to spread beyond the				
	1. Special Care Unia. The exit vestibule stored items that aregress. b. The exit vestibule stored items that aregress. li. Based on observing maintain the facility must latch and remained the passage of smoodors that do not lashut could effect the allowing smoke and area of origin. A. Findings on 08/1 1. Employee's Lourn automatic latching in the remain shut where to remain shut where closed. lii. Based on observing in the facility resistant rated ceiling penetrations and or spread of fire and should effect the occurrence of the store of t	9/2015: t e adjacent to room #409 has e obstructing the path of e adjacent to room #412 has e obstructing the path of ation there is a failure to free from hazards. Doors ain closed when shut to resist oke. In the event of a fire, tch and remain closed when e occupants of the facility by d gases to migrate from the 9/2015: tge - The door does not have hardware in order for the door on closed. Corridor - The door hardware der for the door to remain shut vation there is a failure to free from hazards. Fire tigs must be free of the penings in order to resist the moke in the event of a fire. In fire resistant rated ceilings				

Division of Health Service Regulation STATE FORM

6899 1NDX21 If continuation sheet 2 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED		
		HAL081014	B. WING		08/1	9/2015
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY, S	STATE, ZIP CODE	•	
BBOOKE	ALE FOREST CITY		RIDGE RO			
BROOKL	OALE FOREST CITY	FOREST (CITY, NC 28	043		
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C 166	Continued From page	ge 2	C 166			
	A. Findings on 08/19/2015: 1. Storage Room - The ends of the sleeve for the data cables is open to the attic space.					
C 189	Building Equipment	Maintained Safe, Operating	C 189			
	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. This Rule is not met as evidenced by: I. Based on observation there is failure to maintain the electrical equipment in a safe manner. Failure to maintain electrical equipment in a safe manner could effect those who would use the equipment or device.					
	A. Finding on 08/19 1. Activity Room - T not have overload p	he electrical power strip does				
	2. Room # 110 - The reset when tested.	e GFCI electrical outlet did not				
	maintain electrical e equipment in opera maintain electrical e in operable conditio	ation there is failure to emergency/safety related ting condition. Failure to emergency safety equipment n could effect occupants of iipment did not function when				

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
		HAL081014	B. WING		08/1	9/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
BROOK	DALE FOREST CITY		Y RIDGE RO. CITY, NC 28			
(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
C 189	Continued From pa	ge 3	C 189			
	illuminated direction light is not working. 2. Special Care Unioutside the dining a	Room - The combination hal exit sign and emergency it - From the short corridor area an illuminated directional ble at the double doors				
C 199	Exhaust Ventilation		C 199			
	SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (g) The spaces listed in this Paragraph shall be provided with exhaust ventilation at the rate of two cubic feet per minute per square foot. This requirement does not apply to facilities licensed before April 1, 1984, with natural ventilation in these specified spaces: (1) soiled linen storage; (2) soil utility room; (3) bathrooms and toilet rooms; (4) housekeeping closets; and (5) laundry area. (k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities.					
	required mechanica not limited to the ex Failure to exhaust a could effect the occ	et as evidenced by: n of failure to provide the al exhaust as evidenced but camples cited in the findings. air from the designated areas cupants of the facility by not mes or other contaminates				

Division of Health Service Regulation STATE FORM

	AND DUAN OF CODDECTION IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 (X3)		(X3) DATE COMP	X3) DATE SURVEY COMPLETED	
		HAL081014	B. WING		08/1	9/2015	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/1	0.2010	
BROOKE	DALE FOREST CITY		Y RIDGE RO				
(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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
C 199	Continued From pa	ige 4	C 199				
	A. Findings on 08/1 1. Bio-Hazard Roor the room.	9/2015: m - There is no exhaust fan in					
	2. Room 101 - The bathroom is not wo	exhaust fan in the resident rking.					

6899

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