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						
			D WING		F						
HAL053027			B. WING		09/10/2015						
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE							
ROYAL OAKS ASSISTED LIVING 1107 CARTHAGE STREET											
SANFORD, NC 27350											
(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 SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	TION SHOULD BE COMPLETE THE APPROPRIATE DATE						
{C 000}	Initial Comments		{C 000}								
	Report of Follow-up and Billy Bryant on	Survey by Frank Strickland 09/10/2015:									
	Noted deficiencies new Plan of Correct	require corrective action and a tion is required.									
{C 189}	Building Equipment	Maintained Safe, Operating	{C 189}								
	mechanical, and plu care home shall be operating condition. (k) This Rule shall facilities with the ex	11 OTHER d all fire safety, electrical, umbing equipment in an adult maintained in a safe and									
	fire rated walls and/in several locations are not sealed with one-hour fire rated missing ceiling radia possibility that a fire quickly spread to ot Findings include: a. There were no li provided in the HI-L	vation the required one-hour for ceilings were compromised. Holes and penetrations that materials approved for use in construction and inoperable or ation dampers present the e that begins in one space can her areas of the facility. sted ceiling radiation dampers to combustion air inlet ducts ng in the sprinkler riser room									
	not maintained in a Failure to properly r	vation, the sprinkler system is safe and operating condition. maintain the sprinkler system ent the system from working in									

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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HAL053027			B. WING 09/1			0/2015						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
ROYAL OAKS ASSISTED LIVING 1107 CARTHAGE STREET SANFORD, NC 27350												
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLE DATE							
{C 189}	an actual fire. Findings include: a. The sprinkler insvalves at the backflb. The sprinkler insbackflow preventer the valves were leac. There was a sig sprinkler head in th 7. Based on a review hood fire suppressing inspected monthly amonthly safety inspected monthly system to fail to wo Findings include: The last documente	spection report stated that the ow preventer were leaking. spection report stated that the could not be tested because king. nificant build-up of lint on the e laundry. ew of documents, the range on system is not being as required. Failure to perform ections could cause the	{C 189}									

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