Division of Health Service Regulation

PRINTED: 09/08/2015 FORM APPROVED

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 01 B. WING 08/19/2015 HAL081014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 493 PINEY RIDGE ROAD BROOKDALE FOREST CITY FOREST CITY, NC 28043 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) C 000 C 000 Initial Comments Report of a Biennial Construction Survey by Billy S. Bryant and Dennis Harrell conducted on CONSTRUCTION SECTION 08/19/2015. OCT 0.5 2015 Records indicate this facility was first licensed or submitted for licensure on 05/27/1997 as a HA. RECEIVED 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 C 166 Housekeeping-Maintained Free of Hazards SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0306 HOUSEKEEPING AND FURNISHINGS (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and (e) This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: I. Based on observation there is a failure to maintain the facility free from hazards. Emergency means of egress/pathways must be kept clear of obstructions and encroachments and not used for storage. In the event of an emergency requiring evacuation from the facility, obstructing or encroaching on the means of egress/pathways could effect occupants of the Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDED SUPPLIER REPRESENTATIVE'S SIGNATURE

Executive Director

9/23/15

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If continuation sheet 1 of 6

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Division	Division of Health Service Regulation						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: 01		Comittee 1			
		HAL081014	B. WING		08/19	9/2015	
NAME OF F	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE			
ppookr	493 PINEY RIDGE ROAD						
BROOKE	ALE FOREST CITY	FOREST	ITY, NC 28				
(X4) ID PREPIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFIX TAG			COMPLETE DATE	
C 166	Continued From pa	ge 1	C 166				
	facility by delaying e	evacuation.				Ì	
	stored items that ar egress.  b. The exit vestibule stored items that ar egress.  II. Based on observ maintain the facility must latch and rem the passage of smo doors that do not la			Boyes of incontinue products moved to exit, westi buses no on day of survey be stored appropriate in Storage areas.	gee rom hed Wiff etely	8/19/15	
	allowing smoke and area of origin.  A. Findings on 08/1  1. Employee's Lour	gases to migrate from the 9/2015:  nge - The door does not have		Hardware with auto	matic	8/31/15	
	automatic latching to remain shut whe	hardware in order for the door n closed.		latoning on woor and	Lam	5. 9-9/3	
		Corridor - The door hardware der for the door to remain shut		latering on wor and is kept shut at all Closure repaired so? abor automatically	Hat	8/31/15	
	maintain the facility resistant rated ceili penetrations and o spread of fire and s Holes or openings could effect the occ	vation there is a failure to free from hazards. Fire ngs must be free of penings in order to resist the smoke in the event of a fire. in fire resistant rated ceilings cupants of the facility by noke to spread beyond the		Shuts ampletely a Instry. Nohitoxed routinely in In Tech as fart at i			

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No. 1931 P. 4 PRINTED: 09/08/2015

FORM APPROVED

Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: 01 08/19/2015 B. WING HAL081014 SYREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 493 PINEY RIDGE ROAD BROOKDALE FOREST CITY FOREST CITY, NC 28043 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES COMPLETÉ (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG free repaired to ensure 8/20/18 free from open area. through closing Organs nonthorea by meen. C 186 Continued From page 2 A. Findings on 08/19/2015: Storage Room - The ends of the sleeve for the data cables is open to the attic space. C 189 C 189 Building Equipment Maintained Safe, Operating 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: 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 08/19/2015: Activity Room - The electrical power strip does not have overload protection. Room # 110 - The GFCI electrical outlet did not reset when tested. II. Based on observation there is failure to maintain electrical emergency/safety related equipment in operating condition. Failure to maintain electrical emergency safety equipment in operable condition could effect occupants of the facility if the equipment did not function when

and as required.

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. No. 1931 P. 5 PRINTED: 09/08/2015 FORM APPROVED

Division of Health Service Regulation   CON MULTIPLE CONSTRUCTION   CON DATE SURVEY							
STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(AZ) MOLTIFEE CONSTRUCTION			COMPLETED	
AND PLAN OF CORRECTION IDE		DENTIFICATION NUMBER	A. BUILDING:	01	1		
HAL081014		B. WING		08/19/2015			
				TITE TO CODE			
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  493 PINEY RIDGE ROAD						
BROOKE	ALE FOREST CITY		CITY, NG 28			1	
	D SUMMARY STATEMENT OF DEFICIENCIES		in in	PROVIDER'S PLAN OF CORRECT	ON	(X.6)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	PRIATE	DATE	
IAG				DEFICIENCY)			
C 189	Continued From pa	age 3	C 189			- 1	
						لمراريات	
	A. Finding on 08/18	9/2015:		units repaired.	la la	PH// <b>3</b>	
	Physical Therap     Illuminated direction	y Room - The combination nal exit sign and emergency		7	/ /	′ /	
	light is not working.			Units repaired. Additional illuminative characters and light significant light significant light significant light significant.	- 4	1	
	2 Special Care Un	it - From the short corridor		Additional Ulumn	rated	, ,	
	outside the dining	area an illuminated directional		disectional list SI	an s	8/3//19	
	exit sign is not visit	ble at the double doors		action the des	' [7	797.5	
	adjacent to the uni	t entrance.		installed.		1	
C 199	Exhaust Ventilation	1	C 199				
	SECTION 0300 -	PHYSICAL PLANT	1		1		
	10A NCAC 13F .0311 OTHER				1	1	
	REQUIREMENTS (g) The spaces listed in this Paragraph shall be		1			- 1	
	provided with exha	aust ventilation at the rate of			1	- 1	
	two cubic feet per	minute per square foot. This			1		
	requirement does	not apply to facilities licensed 4, with natural ventilation in					
	these specified sp	aces:					
	(1) soiled linen st	orage;					
	(2) soil utility room	n;					
	(3) bathrooms an (4) housekeeping	d tollet rooms;					
	(5) Jaundry area.		1	,	,		
	(k) This Rule sha	Il apply to new and existing	1	· ·			
	facilities with the e	exception of Paragraph (e) ply to existing facilities.	1				
	This Rule is not n	net as evidenced by:					
i	I. There is a palte	rn of failure to provide the cal exhaust as evidenced but					
	not limited to the	examples cited in the findings.					
	Failure to exhaus	t air from the designated areas					
	could effect the o	ccupants of the facility by not fumes or other contaminates					
	from the facility.	unica of other sometimes					
1			1				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
	D PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: 01		COMPLETED	
	HAI cores		8. WING			
NAME OF PROVIDER OR SUPPLIER STREET ADD					08/19/2015	
				STATE, ZIP CODE		
BROO	KDALE FOREST CITY		Y RIDGE RO			
(X4) I	3UMMARY STA	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (XS)				
PREFI TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	D BE COMPLETE	
				DEFICIENCY)	I I	
C 1	99 Continued From pa	Continued From page 4				
				Tachanet Con man	. 1   01 .	
	A. Findings on 08/1	9/2015:		EXPLANT TOP TELLING	20 med 8/21/10	
	the room.	n - There is no exhaust fan in		una nowranenons p	10/10/19 10/19	
	2 Para 404 75			11 1/2 1/2	[// , , , ]	
	bathroom is not wo	exhaust fan in the resident		Unit Replaced	. 18/24/15t	
		naig.		Monitored by MICE	3 . / / /	
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				المسار أو بسارها		
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