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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE SURVEY COMPLETED	
AND PLAN OF CONNECTION			A. BUILDING: <b>01</b>		,		
HAL067023		B. WING		C <b>10/14/2015</b>			
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
ONSLOW HOUSE 34 MCDANIEL DRIVE  JACKSONVILLE, NC 28546							
(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	Initial Comments		C 000				
	Report of a Complaint Investigation by Billy S. Bryant and Frank Strickland conducted on 10/14/2015.						
	Records indicate this facility was first licensed on 01/31/1997. The facility is currently licensed for 160 Beds. 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 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.						
	The complaint alleg number of resident	ges there is mold present in a rooms.					
	The complaint was	substantiated.					
C 166	Housekeeping-Main	ntained Free of Hazards	C 166				
	orderly manner, fre hazards;	06 HOUSEKEEPING AND					
	maintained in a clear as evidenced by the	et as evidenced by: ration the facility has not been an manner and free of hazards e growth of mold in resident cant or planned for renovation					

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

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,			(X3) DATE SURVEY COMPLETED	
THE PERIOD CONTROL			A. BUILDING: 01		С		
		HAL067023	B. WING		10/14/2015		
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
ONSLOW HOUSE 34 MCDANIE				29546			
JACKSONVI				PROVIDER'S PLAN OF CORRECTI	ON	(X5)	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRRECTIVE ACTION SHOULD BE COMPLET FERENCED TO THE APPROPRIATE DATE		
C 166	Continued From page 1		C 166				
	facility clean and fre	urvey. Failure to keep the ee of potential health hazards the could effect the health of the cility.					
	not limited to the sp	2015: Mold was present in but becific locations listed below: es and ceilings in Rooms 16, 32, 35, and 37.					
C 189	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.						
	maintained mechar condition. In the rocunits were inoperate rooms the PTACS on. Failure to provid failure to operate H conditioned air is puthe residents by proresident rooms.	rations the facility has not nical equipment in operating oms with mold growth PTAC ole or in some cases in vacant were operable but not turned de operating HVAC units or VAC units to provide resenting a health hazard to omoting mold growth in					
		2015: In the rooms specifically to those noted below PTAC ole or turned off.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING: <b>01</b>		(X3) DATE COMP	X3) DATE SURVEY COMPLETED		
			A. BOILDING. VI		С			
HAL067023			B. WING			10/14/2015		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
ONSLOW HOUSE 34 MCDANIEL DRIVE  JACKSONVILLE, NC 28546								
(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 APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE		
C 189	Continued From page 2		C 189					
	a. Rooms 16, 17, 26, 27, 28, 30, 32, 35, and 37.							

6899

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