

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 01 B. WING HAL053027 09/10/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1107 CARTHAGE STREET ROYAL OAKS ASSISTED LIVING SANFORD, NC 27350 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION! CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) (C 000): Initial Comments (C 000) Report of Follow-up Survey by Frank Strickland and Billy Bryant on 09/10/2015: Noted deficiencies require corrective action and a new Plan of Correction is required. (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. pholes are repaired

To fire roted corkins 11.2015

Completed by 11.2015 (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 the required one-hour. fire rated walls and/or ceilings were compromised in several locations. Holes and penetrations that are not sealed with materials approved for use in one-hour fire rated construction and inoperable or Maintance will check missing ceiling radiation dampers present the possibility that a fire that begins in one space can daily for any holes, and repair. Administrator quickly spread to other areas of the facility. Findings include: There were no listed ceiling radiation dampers provided in the HI-LO combustion air inlet ducts penetrating the cailing in the sprinkler riser room will oversee as needed and terminating in the attic. Fire damper will be Based on observation, the sprinkler system is not maintained in a safe and operating condition. installed by 11.2015 Failure to properly maintain the sprinkler system could delay or prevent the system from working in Division of Health Service Regulation LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE 10.975

aux c

31BD22

If continuation sheet 1 of 2

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER A. BUILDING: 01 COMPLETED B. WING HAL053027 09/10/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1107 CARTHAGE STREET ROYAL OAKS ASSISTED LIVING SANFORD, NC 27350 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION BD. PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)-COMPLETE PREFIX EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) (C 189) Continued From page 1 (C 189) 11.20.15 in Riser room. an actual fire. Findings include: The sprinkler inspection report stated that the Sprinkler reports valves at the backflow preventer were leaking. b. The sprinkler inspection report stated that the backflow preventer could not be tested because all system passed the valves were leaking. There was a significant build-up of lint on the sprinkler head in the laundry. and is properly Based on a review of documents, the range Maintained see hood fire suppression system is not being inspected monthly as required. Failure to perform report. System will be inspected as monthly and as monthly safety inspections could cause the system to fail to work when needed Findings include: The last documented safety inspection of the hood fire suppression system was in February. needed, sprokler neads checked and Cleared of Dust sprintly Heads will be Checked over seen by Helmin, Hood will be inspected monthly required by man Hance Division of Health Service Regulation

STATE FORM

318D22(1) | STATE (TOTAL SECTION )

If continuation sheet 2 of 2