		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: 0			(X3) DATE SURVEY COMPLETED	
				71		R	
		HAL001149	B. WING		10/	22/2015	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE			
LANE ST	RETIREMENT HOM		E STREET GTON, NC 272	217			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
{C 000}	Initial Comments		{C 000}				
	This report is of a f Getchell on Octobe	ollowup survey done by Bob er 22, 2015.					
		y revealed that all deficiencies ected, therefore a new plan of ed.					
{C 111}	Must Have Current	San. & Fire Safety Reports	{C 111}				
	CONSTRUCTION(f) The facility shall fire and building sa	02 DESIGN AND					
	1. Based on obser	et as evidenced by: vation, current reports were time of the survey.					
{C 126}	Bedrooms-Window	/S	{C 126}				
	(9) Each resident I with one or more w operable and well I be equivalent to at						

Division	of Health Service Re	egulation			FURIV	IAPPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001149		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING			E SURVEY PLETED	
					R 22/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
LANE S	T RETIREMENT HOME	E 625 LANE BURLING	STREET TON, NC 272	217		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
{C 126}	window opening ma opening to inhibit re The windows shall outdoors from the b 36 inch sill height; a This Rule is not me 1. Based on obser was not maintained bedroom windows the Followup Findings of The window will not locations: a) Room 5 window b) Room 4 window c) Room 3 window d) Room 2 window	ay be restricted to a six-inch esident elopement or suicide. be low enough to see bed and chair, with a maximum and et as evidenced by: vation, egress from all areas l in a safe manner by having that will not remain open. on October 22, 2015 t stay open in the following r won't stay open rs won't stay open, s won't stay open,	{C 126}			
{C 160}	SECTION .0300 - F 10A NCAC 13F .03 ENVIRONMENT (m) The requireme (1) The outside gro facilities shall be ma condition; This Rule is not ma 1. Based on obsert was not maintained Followup Findings of a) The exit ramp of become overgrown	PHYSICAL PLANT 05 PHYSICAL ents for outside premises are: bunds of new and existing aintained in a clean and safe et as evidenced by: vation, the outside premesis	{C 160}			

STATEMEN	of Health Service Re T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
			A. BUILDING:	UI		
HAL001149		HAL001149	B. WING		R 10/22/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
LANE ST	RETIREMENT HOMI		E STREET TON, NC 272	217		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLETE DATE
{C 160}	Continued From pa	ge 2	{C 160}			
	building.					
	b) The exit ramp o	n the left side of the facility has				
		the boards creating cut and				
	d) The exit ramp o	n the back of the facility has i)				
		the boards creating cut and				
	•	ne boards that are worn, loose oose and missing pickets.				
{C 164}	Housekeeping and	Furnishings-Clean, Repaired	{C 164}			
	SECTION .0300 - F 10A NCAC 13F .03					
	FURNISHINGS (a) Adult care home	es shall:				
	(1) have walls, ceil	ings, and floors or floor				
		n and in good repair; c unpleasant odors;				
		clean and in good repair;				
	(e) This Rule shall facilities.	apply to new and existing				
	This Rule is not main the second seco	vation, the facility furnishings				
		on October 22, 2015: ot maintained in the following				
		ken handle on chest of				
	-	hest of drawers with a broken				
	drawer, c) Room 4 has an	end table missing the handle,,				
	d) Room 3 has i) a	n endtable missing handles, ii)				
	a chest of drawers	with loose handles, iii) a				
	broken neadboard,	and iiii) blinds not secured.				

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001149		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
		B. WING		R 10/22/2015		
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
LANE ST	RETIREMENT HOMI		E STREET GTON, NC 272	217		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
{C 164}	Continued From pa	age 3	{C 164}			
	e) Dining Room ha	as worn tables.				
	2. Based on obser not maintained in g	vation, the facility floors were ood condition.				
	The floor tile is dan locations:	near room 1,				
{C 189}	Building Equipment	t Maintained Safe, Operating	{C 189}			
	mechanical, and pl care home shall be operating condition (k) This Rule shall facilities with the ex	and all fire safety, electrical, umbing equipment in an adult maintained in a safe and				
	maintained in a saf	et as evidenced by: /ation, the building was not e manner by not maintaining rating of building components.				
		on October 21, 2015: barrier wall over the cross				

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001149			. ,			E SURVEY PLETED
			A. BUILDING: 01			R
		HAL001149	B. WING			22/2015
AME OF PROVID	ER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE		
ANE ST RETI	REMENT HOMI		E STREET STON, NC 272	217		
	EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
{C 189} Cont	inued From pa	ige 4	{C 189}			
pene b) R has a c) R d) R close e) R that f and i f) Th ii) ha g) Tr unpro ii) un h) T feet, I) Th Thes confo throu been 2. Ba were Follo a) In corrio floor, show 3. Ba comp havir latch	tration by a sp oom 5 has a c a gap revealing oom 4 has a h oom 2 has an it ceiling oom 1 has i) a has a gap revealing oom 1 has i) a has a gap revealing i) unprotected e Living Room s a door with a he Electrical / Notected penetry protected penetry protected penetry protected penetry protected penetry protected penetry for a door with a le Dining Roor e unprotected ormance with t gh penetration tested in accord ased on obser not maintaine wup Findings of the Womens dor doors i) a t and ii) there is penetry hose ased on obser ponents were r ing doors that d	om 106 has an unprotected rinkler pipe. loset sprinkler escutcheon that g an opening to the attic. ole in the wall, unprotected penetration in the a closet sprinkler escutcheon ealing an opening to the attic, penetrations in the wall. i) has a hole in the wall, and a closer that is wedged open Mechanical room has i) ations in the ceiling, and etrations in the ceiling, and etrations in the ceiling, and etrations in the ceiling, and etrations in the wall. on, which exceeds 100 square oser removed from the door n door is wedged open openings are not in he requirement to use a n fire stop system that has ordance with ASTM E-814. vation, the plumbing fixtures d in a safe manner. on October 22, 2015: bathroom by the cross oilet is coming loose from the s no anti siphon device on the mounted on the tub. vation, the facility interior not maintained operable by id not close completely and				

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001149		(X2) MULTIPLE		(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NOMBER.	a. Building: (01		
		B. WING			R 22/2015	
IAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ANE ST	RETIREMENT HOME		E STREET GTON, NC 272	217		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5) COMPLET
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	DATE
{C 189}	Continued From pa	ge 5	{C 189}			
	door scrubs frame	s a loose door knob, and ii) the and will not close and latch, or has damaged hinges and itch,				
	4. Based on observation, the facility electrical system was not maintained in a safe manner					
	a) Room 2 has a lob) Room 1 has twod) The Mens Bathroutlet that will not tr	on October 22, 2015: pose outlet coverplate b broken outlet coverplates room near room 1 has a GFCI ip and washing sink, the GFCI				
	5. Based on observerse was not maintained	vation, the Emergency Lighting I operable.	3			
		on October 22, 2015: light at room 5 is not working				