(X3) DATE SURVEY

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: 01 B. WING HAL080013 12/11/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1915 MOORESVILLE ROAD **CARILLON ASSISTED LIVING OF SALISBURY** SALISBURY, NC 28147 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) C 000 Initial Comments C 000 Report of Biennial Construction Survey by Dennis Harrell and Frank Strickland on 12-11-2015. Records indicate this facility was first licensed on 9-3-1996, for 128 beds with 36 of those in a Special Care Unit. Therefore, we are requiring that this facility meet the 1996 Rules for Homes for the Aged and Disabled; Minimum Standards and Regulations, the applicable portions of the 2005 Rules for Adult Care Homes of Seven or More Beds and the 1996 edition of the North Carolina State Building Code Volume I - General Construction - Section 409 Institutional Occupancy (Group I). C 101 C 101 Existing Licensed Fac- No less than '71 Rules SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0301 APPLICATION OF PHYSICAL PLANT REQUIREMENTS The physical plant requirements for each adult care home shall be applied as follows: (2) Except where otherwise specified, existing licensed facilities or portions of existing licensed facilities shall meet licensure and code requirements in effect at the time of construction, change in service or bed count, addition, renovation, or alteration; however in no case shall the requirements for any licensed facility where no addition or renovation has been made, be less than those requirements found in the 1971 "Minimum and Desired Standards and Regulations" for "Homes for the Aged and Infirm", copies of which are available at the Division of Health Service Regulation at no cost; This Rule is not met as evidenced by: Based on observation, there was no systems

(X2) MULTIPLE CONSTRUCTION

Division of Health Service Regulation

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

TITLE (X6) DATE

Division of Health Service Regulation

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING: <b>01</b>			(X3) DATE SURVEY COMPLETED		
		HAL080013	B. WING		12/	11/2015	
NAME OF PROVIDER OR SUPPLIER  CARILLON ASSISTED LIVING OF SALISBURY  STREET ADDRESS, CITY, STATE, ZIP CODE  1915 MOORESVILLE ROAD  SALISBURY, NC 28147							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
C 101	adjacent to the fire	ge 1 n map provided under glass alarm system for the Special are as required by Building	C 101				
C 189	SECTION .0300 - F 10A NCAC 13F .03 REQUIREMENTS (a) The building an 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	C 189				
	emergency lights w Battery powered en work properly for at endanger the reside Findings include ma following locations: a. Porch in Special b. Dining in Special c. One lamp not wo  2. Based on observ fire rated walls and/ in several locations are not sealed with one-hour fire rated possibility that a fire	vation, some battery powered ould not work when tested. nergency lights that will not least 90 minutes could ents and staff. alfunctioning lights at the Care,					

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTIPL A. BUILDING:	· · · · · · · · · · · · · · · · · · ·		TE SURVEY MPLETED	
		HAL080013		B. WING		12/	11/2015	
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
CARILLO	ON ASSISTED LIVING	OF SALISBURY		ORESVILLE   RY, NC 2814				
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C 189	telephone room. b. A 3 inch PVC pip the water heater roo protected. c. The sprinkler es tightly fitted to the co protection in the Ma 3. Based on observiser room was obseculk that had sagg dried. Sprinkler hea spray properly in a 4. Based on observice covering a norelease switch faile. Warning devices the resident elopement 5. Based on observices the resident elopement 6. Based on observices mounted to bathroom. Loosely and cause injury. 6. Based on observices that the possibility begins in one space corridor and the rer 7. Based on observices that the possibility of the Service Hall present the possibility begins in one space corridor and the rer could affect all residency indexs fall, break	es (2) through the ceipe penetrating the ceom was not properly cutcheon was missing eiling complete the orangement of the ceiped down from the ceiped down from the ceiped down from the ceiped that are obstructed in the ceiped that are obstructed on the ceiped down from the ceiped sthat are obstructed fire.	illing of fire g or not ne-hour ead in the of fire gor not ne-hour ead in the of fire illing and ed cannot ounding orgency d. allow avatory is sould fall noles nen room for see that to the oerly ers. This re if elling the	C 189				

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
HAL080013		B. WING		12/11/2015			
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•		
CARILLO	ON ASSISTED LIVING	OF SALISBURY	RESVILLE I				
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C 189	Continued From page 3  A portable medical oxygen cylinder was stored in no container in the Nurse office.  8. Based on observation, several waste drains were not properly sealed. Improperly sealed waste drains allow noxious, combustible odors and possibly harmful bacteria to enter the facility. Findings include:  a. A sink had been removed in the utility closet and the wall drain left open.  b. A sink had been removed in the resident laundry in Special Care and the wall drain left open.  c. The hopper trap was dry in the utility room in Special Care.  9. Based on observation, the ice machine drain line was only 1 inch above the floor drain. Ice machine drain lines that are not maintained at least 2 inches above the floor or floor drain, as required by Code, could cause the ice to become contaminated.		C 189				
C 199	provided with exhautwo cubic feet per requirement does n	PHYSICAL PLANT 11 OTHER  ed in this Paragraph shall be ust ventilation at the rate of ninute per square foot. This not apply to facilities licensed with natural ventilation in inces: rage; toilet rooms;	C 199				

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Division of Health Service Regulation

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING: <b>01</b>		(X3) DATE SURVEY COMPLETED			
		HAL080013	B. WING		12/1	1/2015	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY,	STATE, ZIP CODE	<u>, , , , , , , , , , , , , , , , , , , </u>		
CARILLON ASSISTED LIVING OF SALISBURY  1915 MOORESVILLE ROAD							
SALISBURY, NC 28147						(X5)	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	COMPLETE DATE	
C 199	Continued From pa	ge 4	C 199				
	facilities with the ex which shall not appl This Rule is not me	apply to new and existing ception of Paragraph (e) ly to existing facilities.  et as evidenced by: on the facility failed to					
	maintain required e Non-functioning ext	xhaust in a working condition. naust could cause an f moisture and possibly					
	<ul> <li>a. Exhaust not wor</li> </ul>	king in the Spa, king in the resident laundry in					

Division of Health Service Regulation STATE FORM

7V6L21