STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING: 01			
		FCL035018	B. WING		03/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AJINDA	FAMILY CARE HOME		TON ROAD RG, NC 275	49		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
C 000	Initial Comments		C 000			
		Fay Section conducted a Biennial 2016 from 10:54 AM to 12:22				
	PM at the above re records indicate the September 6, 2007 six ambulatory Res respond without an during a fire or othe information we are compliance with the 10A NCAC 13G for	ferenced facility. DHSR home was first licensed on as a Family Care Home for idents (able to evacuate and y physical or verbal assistance er emergency.) Based on this requiring the home to maintain e following: the 2005 Rules Family Care Homes and the a State Building Code -				
	Section 421.2 - Res At the time of our v	isit, we cited deficiencies that ple plan of correction. They				
C 137	Bathroom-Mechani	cal Ventilation	C 137			
	foot candles of light mechanical ventilat feet per minute for					
	were being ducted roof. The duct for t was currently being plumbing vents car facility. Attaching the	et as evidenced by: vealed that the exhaust fans into the plumbing vents to he master bath had fallen and ducted into the attic. The ry sewer gases out of the he exhaust fan duct could to go back into the facility				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED		
		FCL035018	B. WING		03/0	1/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AJINDA	FAMILY CARE HOME	ll .	TON ROAD RG, NC 275	49		
(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 APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 137	Have a qualified ted separately to an ex in the plumbing ver escaping. Provide	Id potentially cause illness. chnician route the fan ducts terior vent. Repair any holes its to prevent gas from documentation of the repairs	C 137			
C 149	in the form of photos, receipts or work orders. Outside Entrances/Exits-Handrails At Porches SECTION .0300 - THE BUILDING 10A NCAC 13G .0312 OUTSIDE ENTRANCE AND EXITS (f) All steps, porches, stoops and ramps shall be provided with handrails and guardrails. This Rule is not met as evidenced by: 1. Observations revealed a concrete patio at the rear of the facility. The patio has a ramp and two sets of steps leading from the patio. There is also a set of steps leading from the garage to the patio. None of the steps nor the ramp have handrails. Have a qualified technician install handrails either side of the ramp and stairs. Provide documentation of the repairs in the form of photos, receipts or work orders. 2. Observations revealed a set of steps leading from the kitchen hall to the garage floor. Previously, the garage was not accessible to the Residents. A pool table has been installed in the garage for the Residents' use and, therefore, the steps are now being utilized and will need handrails. Have a qualified technician install handrails at the steps leading to the garage. Provide documentation of the repairs in the form		C 149			
C 152	Floors		C 152			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED		
		FCL035018	B. WING		03/0	1/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AJINDA	FAMILY CARE HOME	II .	TON ROAD RG, NC 275	49		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 152	smooth, non-skid methode to be easily cleanal (b) Scatter or throward (c) All floors shall. This Rule is not med 1. Observations reand living area. Redocumentation of the photos. 2. Observations rehad cracked and we the living room. Als cracked and broken bedroom about the with Staff revealed was scheduled. Have repair or replace the flooring. Provide details of the control of	anily care home shall be of naterial and so constructed as ble. w rugs shall not be used. be kept in good repair.	C 152			
C 168	DISASTER PLAN (a) Fire extinguish meet these minimu care home: (1) one five pound type centrally located (2) one five pound type located in the	ers shall be provided which m requirements in a family or larger (net charge) "A-B-C" ed; or larger "A-B-C" or CO/2 kitchen; and ion as determined by the code	C 168			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01			(X3) DATE SURVEY COMPLETED	
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AJINDA	FAMILY CARE HOME	II .	TON ROAD RG, NC 275	49		
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C 168	This Rule is not mo 1. At the time of th at the end of the ha servicing. Reinstal	et as evidenced by: is survey, the fire extinguisher illway had been removed for I the extinguisher when documentation of the repairs in	C 168			
C 174	SECTION .0300 - 1 10A NCAC 13G .03 EQUIPMENT (a) The building at mechanical, and plucare home shall be operating condition (j) This Rule shall family care homes. This Rule is not med. At the time of the in the front corner be battery backup. Insulatory back	and all fire safety, electrical, umbing equipment in a family maintained in a safe and . apply to new and existing	C 174			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED		
		FCL035018	B. WING		03/0	1/2016
	PROVIDER OR SUPPLIER FAMILY CARE HOME	1359 SUT	DRESS, CITY, S TON ROAD RG, NC 275	STATE, ZIP CODE		
(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 174	replace the outlet. repairs in the form of the side exit stairs of Clean the stairs to rethem safe for exiting the repairs in the form. 5. Observations respindles on the side the base and were technician repair the documentation of the photos, receipts or the commentation of the left side of the technician repair the documentation of the photos, receipts or the commentation of the photos, receipts or the commentation of the photos, receipts or the commentation of the photos, receipts or the photos, recei	Provide documentation of the of receipts or work orders. vealed a build-up of moss on out of the corner bedroom. The move the moss and keep of the documentation of the document	C 174			

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