Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED			
		FCL011235	B. WING		02/1	7/2016		
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE				
SOUNDVIEW FAMILY CARE HOMES - UNIT H 134 CENTER AVENUE BLACK MOUNTAIN, NC 28711								
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE		
C 000	Initial Comments		C 000					
	Report by Glenn He	oppin						
	Survey on February 11:00am at the aborecords indicate the June 16, 1999 as a Residents with no r non-ambulatory (ur respond without an during a fire or othe information we are compliance with the Family Care Home Standards and Reg portions of the 2000 Family Care Home Carolina State Build Small Residential C	n Section conducted a Biennial y 17, 2016 from 9:30am until ove referenced facility. DHSR e home was first licensed on a Family Care Home for six (6) more than three (3) who are nable to evacuate and by physical or verbal assistance or emergency). Based on this requiring the home to maintain e following: 1992 "Rules for s Minimum and Desired gulations", the applicable 5 Rules 10A NCAC 13G for s, the 1996 (99 Rev) North ding Code - Section 419.3 - Care Facilities.						
		ble plan of correction. They						
C 100 New Construction, Modifications		C 100						
	PHYSICAL PLANT The physical plant care home shall be (1) New construct proposed for use a comply with the rec (3) New additions	301 APPLICATION OF						

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

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED		
FCL011235		B. WING		02/17/2016			
NAME OF F	PROVIDER OR SUPPLIER	-		STATE, ZIP CODE	02/1	112010	
SOUNDVIEW FAMILY CARE HOMES - UNIT H 134 CENTER AVENUE BLACK MOUNTAIN, NC 28711							
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	HOULD BE COMPLETE		
C 100	Continued From pa	age 1	C 100				
	Observations reveated conditioning system system does not had dampers and does rating required by a	et as evidenced by: aled that the heating and air n has been replaced. The ave the required radiation not meet the one hour fire a facility licensed for up to three esidents. Therefore, you have					
	1. Consult with your local building official, and have a qualified technician install radiation dampers on the HVAC system to meet the one hour rating requirement. Provide copies of all permits and approvals to the DHSR Construction Section.						
	amended to six all DHSR Licensure S	cation to have your license ambulatory clients to the section. Provide copies to the n Section when this is					
C 174	C 174 Building Equipment Maintained Safe, Operating		C 174				
	EQUIPMENT (a) The building a mechanical, and pl care home shall be operating condition	and all fire safety, electrical, lumbing equipment in a family emaintained in a safe and apply to new and existing					
	1. Observations rev	et as evidenced by: vealed that the ceiling is vay. Have a qualified					

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STATE FORM 6899 O8SF21 If continuation sheet 2 of 3 Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED				
		FCL011235	B. WING		02/1	7/2016		
NAME OF PROVIDER OR SUPPLIER SOUNDVIEW FAMILY CARE HOMES - UNIT H STREET ADDRESS, CITY, STATE, ZIP CODE 134 CENTER AVENUE BLACK MOUNTAIN, NC 28711								
(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 APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE		
C 174	technician repair or Provide photo docu Construction section 2. Observations revite the floor at the drye technician seal the photo documentation section when this is 3. Observations revidamper for the drye a qualified technicial backflow damper. to the DHSR Construction to the DHSR Construction of the DHSR Constructi	replace the peeling ceiling. Immentation to the DHSR In when this is complete. realed an open penetration in open penetration. Provide on to the DHSR Construction is complete. realed that the backflow open penetration in the DHSR Construction is complete. realed that the backflow open penetration is damaged. Have on repair or replace the provide photo documentation ruction Section when this is realed missing pickets on the qualified technician replace. Provide photo The DHSR Construction Section in when the provide photo The DHSR Construction Section in when the photo The DHSR Construction Section in the photo The DHSR Construction in the photo Th	C 174					

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