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 _ HAL041049 04/12/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **3823 LAWNDALE DRIVE BROOKDALE LAWNDALE DRIVE** GREENSBORO, NC 27455 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 This report is of a Biennial Construction Survey done by Bob Getchell on April 12, 2016. This facility was first licensed as a Home for the Aged serving 70 residents on January 16, 1996. Therefore the facility must meet the 1996 and the applicable portions of the 2005 Rules for the Licensing of Adult Care Homes, and, the 1996 North Carolina State Building Code-Section 409-Institutional Unrestrained Occupancies and built as Type V-Protected construction. Deficiencies were noted which will require a new plan of correction. C 111 C 111 Must Have Current San. & Fire Safety Reports SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0302 DESIGN AND CONSTRUCTION(f) The facility shall have current sanitation and fire and building safety inspection reports which shall be maintained in the home and available for review. This Rule is not met as evidenced by: 1. Based on observation, current reports were not available at the time of the survey. Findings include: The following reports were not available at the time of the survey: a) Fire Marshalls Report. C 166 C 166 Housekeeping-Maintained Free of Hazards SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0306 HOUSEKEEPING AND

Division of Health Service Regulation

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

TITLE (X6) DATE

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
	HAI 044040		B. WING		0.4/4.0/00.4.6	
NAME OF 5		HAL041049			04/1	2/2016
	PROVIDER OR SUPPLIER	3823 I AW	INDALE DRI	STATE, ZIP CODE VF		
BROOKE	OALE LAWNDALE DR	IVF	BORO, NC 2			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE	(X5) COMPLETE DATE
C 166	Continued From pa	ge 1	C 166			
	orderly manner, fre hazards; (e) This Rule shall facilities.	in an uncluttered, clean and e of all obstructions and apply to new and existing				
	This Rule is not met as evidenced by: 1. Based on observation, the building was not maintained free of hazards by improper storage of oxygen cylinders. This would affect all residents by potentially exposing them to hazards from a ruptured cylinder.					
	Findings include: In Room 6 an oxygon the floor.	en bottle is being stored loose				
C 183	Fire Extinguishers		C 183			
	(a) At least one five A-B-C type fire extii 2,500 square feet of (b) One five pound	08 FIRE EXTINGUISHERS e pound or larger (net charge) nguisher is required for each of floor area or fraction thereof. or larger (net charge) A-B-C uired in the kitchen and, where				
	protection equipme the facility safe. The	vation, the building fire nt was not maintained to keep is would affect all residents by ection equipment operable for				
	Findings include: The inspection tags	on the fire extinguishers				

Division of Health Service Regulation

STATE FORM 6899 L87C21 If continuation sheet 2 of 8

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MI II TIDI	E CONSTRUCTION	(X3) DATE	SLID//EV	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED		
			A. DUILDING.	•1		
		HAL041049	B. WING		04/1	2/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DDOOKE		3823 LAW	NDALE DRI	VE		
BROOKL	OALE LAWNDALE DR	GREENSE GREENSE	BORO, NC 2	7455		
(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 183	Continued From pa	ge 2	C 183			
	indicate that routine being performed pe	e monthly inspections are not er NFPA 10				
C 189	Building Equipment	Maintained Safe, Operating	C 189			
	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				
	protection equipme operable to keep th	vation, the building fire nt was not maintained e facility safe. This would f the systems failed to detect				
	ceiling vents throug alarm, however who majority of the radia the open position. I advises reprogramm	idiation dampers in the HVAC hout the facility activated upon en the alarm was reset the ation dampers did not return to NOTE: Sprinkler report ming of dampers onto a dampers will stay open when				
	equipment was not safe. This would af	vation, the building HVAC maintained to keep the facility fect all residents by not attentions.				

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation							
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ` '			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: 01		COMP	LETED	
HAL041049		B. WING		04/1	2/2016		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
		3823 LAW	NDALE DRI	VE			
BROOKL	DALE LAWNDALE DR	GREENSE	BORO, NC 2	7455			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)	
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE	
TAG	REGULATORT OR L	SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	FRIAIE	DATE	
0.400	O and the control of		0.400				
C 189	Continued From pa	ge 3	C 189				
	Findings include:						
		ms throughout the building are					
		o the obstruction of ceiling					
		ucts by activated radiation					
	dampers.						
	3. Based on obser	vation, the building was not					
		e manner by not maintaining					
		ating of building components.					
		I residents by not containing					
	smoke and fire in the						
	compartment of original	gin.					
	Findings include:						
		loom ceiling has unprotected					
	penetrations by pipe and cable						
		ry has a ceiling split open.					
	c. The main Laundi covered with luan p	ry has a hole in the wall					
		ry room has an open junction					
	box in the ceiling	y room has an open junction					
		a hole in the wall behind the					
	entry door from the						
		unprotected penetrations in					
	the ceiling at the mo						
		in the attic over the fire panel					
		ted penetrations in the walls. in the attic over room 5 has					
	unprotected penetra						
		barrier wall at room 13 has					
		ations by cable, and the tape					
	is falling off.						
	j. The attic smoke	barrier wall at room 38 has					
		ations by cable, and the tape					
	is falling off						
		ons are missing in the Training					
	11 and in the Resid	oom 12, File Room near room					
		Room at room 47 the ceiling					
	i. Ili ulo Lieculoal I	toom at room +1 the centry	Ĭ				

STATE FORM 6899 If continuation sheet 4 of 8 L87C21

Division of Health Service Regulation		r				
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: 01		COMPLETED	
HAL041049		B. WING		04/12/2016		
NAME OF	PROVIDER OR SUPPLIER	etdeet ad	DDESS CITY O	STATE, ZIP CODE	-	
INAIVIE OF	PROVIDER OR SUPPLIER					
BROOKI	DALE LAWNDALE DR	IVF	NDALE DRI			
	I		BORO, NC 2			
(X4) ID		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG	`	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
C 189	Continued From pa	age 4	C 189			
0.00	-					
	nas unprotected pe conduit.	netrations by cable and				
		Doom near room 4 the soiling				
		Room near room 4 the ceiling en to the attic, and is not				
	protected by a radia					
		aundry the sprinkler				
	escutcheon is miss					
		3				
		openings are not in				
		he requirement to use a				
		fire stop system that has				
	been tested in acco	ordance with ASTM E-814				
	4. Based on observation, the building mechanical					
		maintained in a safe manner				
		n dampers in ceiling				
		would affect all residents by				
	-	ke and fire in the room or				
	smoke compartmen					
	Findings include:					
		were missing ceiling radiation				
	dampers:					
	a. Clean Linen Roo b. Staff Lounge,	, אווו,				
	c. Kitchen					
	d. Med Room					
	e. Salon					
	f. Pantry					
	Ensure an adequate Fire Barrier has been provided at these ceiling penetrations.					
		at the ceiling membrane were				
		itted from areas required to be				
		996 NCSBC Section 409.1.5 -				
		zardous Areas and provided				
	with Fire Barriers to	тие гоот аеск.				
	5 Based on obser	vation, the facility components				
		d operable by having doors				
		ompletely and latch.				

Division of Health Service Regulation

STATE FORM 6899 L87C21 If continuation sheet 5 of 8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
	HAL041049		B. WING		04/12/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
BROOK	DALE LAWNDALE DR	IVF	'NDALE DRI' BORO, NC 2			
(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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 189	Continued From pa	ge 5	C 189			
	square feet, has had disconnected. b) Downstairs backframe and will not october and the background state of the background sta	ry, which is greater than 100 id the reqiored door closer k right bedroom door scrubs				
C 191	in the following loca a) Exit sign near robattery backup, b) Exit sign near robackup c) Emergency Lighworking on battery Unvented & Portab SECTION .0300 - F 10A NCAC 13F .03	oom 15 is not working on boom 8 is not working on battery at #12 near the Salon is not backup le Elec. Heaters Prohibited PHYSICAL PLANT	C 191			
	maintain 75 degree winter design condi	a heating system sufficient to es F (24 degrees C) under tions. In addition, the y to heaters and cooking				

Division of Health Service Regulation

STATE FORM 6899 L87C21 If continuation sheet 6 of 8

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE COMP	SURVEY LETED
			D. WING			
HAL041049			B. WING		04/1	2/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BROOKI	DALE LAWNDALE DR	IVF	/NDALE DRI [*] BORO, NC 2			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
C 191	Continued From page 6		C 191			
	portable electric he (k) This Rule shall facilities with the ex which shall not app This Rule is not me 1. Based on obser maintained in a saf electric heaters in the Findings include: Portable electric he following locations: a) Kitchen Office	vation, the facility was not e manner by having portable use.				
C 199	Exhaust Ventilation		C 199			
	provided with exhautwo cubic feet per requirement does repeter before April 1, 1984 these specified space (1) soiled linen sto (2) soil utility room (3) bathrooms and (4) housekeeping (5) laundry area. (k) This Rule shall facilities with the exwhich shall not app	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 aces: rage; toilet rooms; closets; and apply to new and existing aception of Paragraph (e) ly to existing facilities.				

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 : COMPI			SURVEY LETED	
		HAL041049	B. WING		04/1	2/2016
	PROVIDER OR SUPPLIER	3823 I AW	DRESS, CITY, S	STATE, ZIP CODE VE		
BROOKL	DALE LAWNDALE DR	GREENSE	BORO, NC 2	27455		
(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)	ILD BE	(X5) COMPLETE DATE
C 199	Continued From pa	ge 7	C 199			
	ventilation was not this Rule.	maintained in accordance with				
	Findings include: a. The exhaust fan working. b. Numerous exha	in room 26 bathroom is not ust fans are not working ding due to activated radiation he exhaust ducts.				

6899

Division of Health Service Regulation STATE FORM