STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
HAL001149		B. WING		R 05/09/2016			
NAME OF I			DESS CITY S	STATE ZID CODE	1 00/0	3/2010	
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 625 LANE STREET						
LANE ST RETIREMENT HOME BURLING				217			
(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 000}	Initial Comments		{C 000}				
	Report of a Follow-Miller May 9, 2016.	Up Construction Survey by Ed					
	Follow-Up Construct satisfactorily correct	encies cited during the ction Survey, have not been ted and will require a new A new citation was added.					
{C 126}	Bedrooms-Windows	s	{C 126}				
	(9) Each resident be with one or more wi operable and well libe equivalent to at I space and be provide window opening material opening to inhibit result outdoors from the based on observation of the windows that will not be supported by the support of the windows that will not be supported by the support of the support	ots physical Ints for the bedroom are: Dedroom shall be ventilated Indows which are maintained Indows which are shall I least eight percent of the floor I ded with insect screens. The I ded with insect s					

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	
			A. BUILDING. VI		R	
HAL001149		B. WING		05/09/2016		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LANE ST RETIREMENT HOME 625 LANE BURLING			STREET TON, NC 27	217		
(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 APPRO DEFICIENCY)	ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE	
{C 160}	Continued From pa	ge 1	{C 160}			
{C 160}	Outside Premises-Clean, Safe		{C 160}			
	(1) The outside gro					
	This Rule is not me 1. Based on obser- was not maintained	vation, the outside premesis				
	Findings on January 14, 2016:					
		n the back of the facility has the boards creating cut and				
	Additional Findings	on May 9, 2016:				
	back of the facility a wood badly weathe splinters and nail ba exposed all along, t	n the exit ramp/walkway at the are in poor condition, with the red that was generating acking out of the boards the top rails. A new top rail on the last set of steps,				
{C 164}	Housekeeping and	Furnishings-Clean, Repaired	{C 164}			
	FURNISHINGS (a) Adult care home (1) have walls, ceil coverings kept clea	06 HOUSEKEEPING AND				

Division of Health Service Regulation

STATE FORM 6899 WOOM24 If continuation sheet 2 of 4

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUI		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING: 01		COMPLETED	
HAL001149		B. WING		R 05/09/2016		
NAME OF PROVIDER OR SUPPLIER STREET ADD				STATE, ZIP CODE		
LANE ST	RETIREMENT HOME	625 LANE	_			
		BURLING	TON, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
{C 164}	Continued From page 2		{C 164}			
	 (3) have furniture clean and in good repair; (e) This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: 1. Based on observation, the facility furnishings were not maintainied in good repair. 					
	Followup Findings of	on May 9, 2016:				
	d) Room 3 ii) a chest of drawer iii) a broken headbo	rs with loose handles, pard				
	2. Based on observation, the facility floors were not maintained in good condition.					
	Findings on May 9, 2016:					
		s damaged in the following ile loose and/or curling at the				
	d) Room 5,					
{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				

Division of Health Service Regulation STATE FORM

WOOM24 If continuation sheet 3 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION 01		(X3) DATE SURVEY COMPLETED	
HAL001149		B. WING			R 05/09/2016	
	PROVIDER OR SUPPLIER	625 LANE	DRESS, CITY, SE STREET	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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
{C 189}	This Rule is not me 1. Based on observe maintained in a safe the fire-resistance of the fir	et as evidenced by: ation, the building was not e manner by not maintaining ating of building components. 2016: om, which exceeds 100 square reinstalled but the door does in door was dragging on the vation, the facility interior not maintained operable by id not close completely and 2016: In have issues: or is cracked and broken and be repairable to close, latch,	{C 189}			

6899

Division of Health Service Regulation STATE FORM