| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|----------------------------|--|-------------------------------|--------------------------|
| AND PLAN OF CORRECTION | | IDENTIFICATION NOMBER. | A. BUILDING: 01 | | COM | LLILD |
| FCL011294 | | B. WING | | 05/11/2016 | | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| NORTH F | RIDGE ASSISTED LIV | ING # 4 26 MELO | DY ROSE LA | ANE | | |
| NORTH | NDOL AGGIOTED LIV | ASHEVIL | LE, NC 2880 | 04 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | NTEMENT 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 APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| C 000 | C 000 Initial Comments | | | | | |
| | Report by Suzanna | Fay | | | | ļ |
| | Survey on May 11, AM at the above rerecords indicate the March 1, 1988 as a ambulatory Resider respond without anduring a fire or other information we are compliance with the Revision) Family Castandards and Registre 2005 Rules 104 Homes and the 197 State Building Code Residential Care Factorial Care Fact | n Section conducted a Biennial 2016 from 8:30 AM to 9:45 ferenced facility. DHSR e home was first licensed on a Family Care Home for six nts (able to evacuate and y physical or verbal assistance or emergency.) Based on this requiring the home to maintain the following: the 1984 (1987 are Homes Minimum gulations, applicable portions of A NCAC 13G for Family Care 78 (Revision 8) North Carolina to - Section 409.1 (g) - accilities. Isit, we cited deficiencies that ble plan of correction. They | | | | |
| C 105 Initial Licensure-Meet NCSBC | | C 105 | | | | |
| | family care home s requirements of the Code. All new cons renovations to exist requirements of the Code for One and Residential Care Fa applicable volumes Building Code, which | | | | | |

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

TITLE (X6) DATE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | ATE SURVEY DMPLETED | | |
|---|---|---|---------------------|--|--|------------------------|--|--|
| ECI 044204 | | FCL011294 | B. WING | | 05/11/2016 | | | |
| NAME OF I | | | | CTATE ZID CODE | 05/1 | 1/2010 | | |
| NAME OF F | NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 26 MELODY ROSE LANE | | | | | | | |
| NORTH I | NORTH RIDGE ASSISTED LIVING # 4 ASHEVILLE, NC 28804 | | | | | | | |
| (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) | ON SHOULD BE COMPLETE E APPROPRIATE DATE | | | |
| C 105 | may be purchased Insurance Engineer Chapanoke Road, 3 Carolina 27603 at a dollars (\$380.00). (b) Each home shequipped and main offered in the home This Rule is not me 1. Observation rev windows had safety | from the Department of ring Division located at 322 Suite 200, Raleigh, North a cost of three hundred eighty all be planned, constructed, tained to provide the services e. | C 105 | | | | | |
| C 174 | Remove or disable windows can open documentation of the photos or receipts. | the safety catches so that the easily and fully. Provide ne repairs in the form of | C 174 | | | | | |
| | EQUIPMENT (a) The building all mechanical, and plucare home shall be operating condition | and all fire safety, electrical, umbing equipment in a family maintained in a safe and apply to new and existing | | | | | | |
| | in Bedrooms #1 and low batteries. The #5 was replaced du not locate another b | is survey, the smoke detectors d #5 were chirping indicating smoke detector in Bedroom uring the survey. Staff could pattery for Bedroom #1. V. Provide documentation of | | | | | | |

Division of Health Service Regulation

STATE FORM 6899 W21V21 If continuation sheet 2 of 4

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|---|--|--|--|
| FCL011294 | | B. WING | | 05/11/2016 | | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| NORTH I | RIDGE ASSISTED LIV | 'ING # 4 | DY ROSE LA LE, NC 2880 | | | |
| (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) | CTION SHOULD BE COMPLE O THE APPROPRIATE DATE | |
| C 174 | Continued From page 2 | | C 174 | | | |
| | over the door in Be technician repair ar documentation of the photos, receipts or 3. Observations reclosed door of Bedre penetrated the parapatch the hole in the documentation of the photos, receipts or 4. Observations reconstructions of the boards near the endose. Secure the documentation of the photos, receipts or 5. Observations reconstructions reconstructions receipts or | vealed a small hole in the oom #5 where the hinge stop el. Have a qualified technician e door. Provide he repairs in the form of work orders. vealed that several of the deck d of the front porch ramp were boards. Provide he repairs in the form of work orders. vealed that the crawl space | | | | |
| | cover was rotting a edges. Have a qua cover. Provide doc | nd deteriorating at the outer alified technician repair the cumentation of the repairs in receipts or work orders. | | | | |
| | near the kitchen ex was dripping throug below. Have a qua gutter. Provide doo | vealed that the gutter seam it had fallen off and rain water gh the opening onto the deck lified technician repair the cumentation of the repairs in receipts or work orders. | | | | |
| | boards at the side of deteriorating. Have the damaged board | vealed that several of the deck exit were rotting and e a qualified technician replace ds. Provide documentation of orm of photos, receipts or work | | | | |

Division of Health Service Regulation STATE FORM

| | | (X1) PROVIDER/SUPPL IDENTIFICATION N | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 (X3) DATE COM | | SURVEY PLETED | |
|--|--|--|------------------|---|--|-----------------------------------|--------------------------|
| | | FCL011294 | | B. WING | | 05/ | 11/2016 |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | | | |
| NORTH RIDGE ASSISTED LIVING # 4 26 MELODY ROSE LANE ASHEVILLE, NC 28804 | | | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCI MUST BE PRECEDED B SC IDENTIFYING INFORM | Y FULL | ID PREFIX TAG | PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| | Continued From pa 8. Observations rethe right corner of the soffit. Remove the to the exterior finish the repairs in the fo | vealed a vine sprea ne facility and up in vine before it cause nes. Provide docum | to the es damage | C 174 | | | |

6899

Division of Health Service Regulation STATE FORM