Division of Health Service Regulation								
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING:	01	COMPLETED			
					F	,		
		HAL026054	B. WING			7/2016		
			00/1//2010					
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, STATE, ZIP CODE					
FAYETTE	VILLE MANOR		TOP DRIVE					
		FAYETTE	VILLE, NC 2	8311				
(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 APPROF DEFICIENCY)	I CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE			
{C 000}	Initial Comments		{C 000}					
	This report is of a followup survey done by Bob Getchell on June 17, 2016. The followup survey revealed that all deficiencies have not been corrected, therefore a new plan of correction is required.							
{C 164}	Housekeeping and Furnishings-Clean, Repaired		{C 164}					
	FURNISHINGS (a) Adult care home (1) have walls, ceil coverings kept clea (2) have no chronic (3) have furniture of	es shall: ings, and floors or floor n and in good repair;						
		et as evidenced by: ation the facility has failed to and in good repair:						
	Followup Findings	on June 17, 2016 include:						
	in Rooms 109, 112, building are in need	robes and dresser furnishings 125 and throughout the I of repair. Most are missing broken/missing, doors need nes are marred.						
{C 189}	Building Equipment	Maintained Safe, Operating	{C 189}					
	SECTION .0300 - F 10A NCAC 13F .03 REQUIREMENTS (a) The building an							

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

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
			A. DUILDING: VI		R		
HAL026054		B. WING		06/1	7/2016		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
FAYETTE	EVILLE MANOR		TOP DRIVE VILLE, NC 2	98311			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	(EACH CORRECTIVE ACTION SHOULD BE COMP CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE COMP DATE OF THE COMP DATE OF THE CROSS OF THE C		
{C 189}	Continued From page 1		{C 189}				
	care home shall be operating condition (k) This Rule shall facilities with the ex	umbing equipment in an adult maintained in a safe and apply to new and existing ception of Paragraph (e) ly to existing facilities.					
	equipment, compor operating condition	et as evidenced by: to maintain fire safety nents and systems in safe and as evidenced by gaps or e joints of the fire resistant					
	a. Women's Water Shower Room - The	on June 17, 2016 include: Heater Room Adjacent to ere is a gap around the water rates the fire resistant rated					
	equipment, compor operating condition	to maintain fire safety nents and systems in safe and as evidenced by emergency not consistently operate (open)					
	a. Activity Room - T operate to consiste lever type door han	on June 17, 2016 include: The door hardware does not ntly open the door, and the dle is mounted so that it has to d of down to open the door.					
	more than 15 pound	exit door - The door requires ds of force to open. The door ame and it has to be er to open the door.					
		to maintain fire safety nents and systems in safe and					

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Division of Health Service Regulation STATE FORM

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Division of Health Service Regulation							
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING: 01		COMPLETED		
					F	ξ	
HAL026054		B. WING			` 7/2016		
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NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
FAYETTE	VILLE MANOR		TOP DRIVE				
		FAYETTE	/ILLE, NC 2	88311			
(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 APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE	
{C 189}	Continued From page 2		{C 189}				
	operating condition as evidenced by doors that did not completely close and latch or could not be closed.						
	c. Kitchen - The doo	on June 17, 2016 include: or from the kitchen to the eld open with wedges driven f the door.					
	equipment, compor	to maintain fire safety nents and systems in safe and as evidenced by fire resistant re damaged.					
	Followup Findings on June 17, 2016 include: a. Men's Hall Cross Corridor Door - The wire reinforced glass view panel in the fire resistant rated door is cracked.						
		ation the facility failed to /AC equipment in safe and					
	a. The facility's HVA damaged as evider some are not opera units themselves re	on June 17, 2016 include: AC thru-wall units are aced by broken interior covers, ational and the interior of the equire cleaning. Units missing in 121, 126, 132, 134, 127. it room 125					

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