

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BECKY REST HOME 1	STREET ADDRESS, CITY, STATE, ZIP CODE 316 LOWER BUSH CREEK ROAD FLETCHER, NC 28732
--	--

(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	<p>Initial Comments</p> <p>Report of Biennial Construction Survey by Dennis Harrell on 6-22-2016.</p> <p>Records indicate this facility was first licensed or submitted on 8-1-1982. The facility is currently licensed for 12 residents. Based on this information we are requiring the facility to meet the 1977 Minimum and Desired Standards and Regulations for Homes for the Aged and Infirm, the current Rules for Adult Care Homes of Seven or More Beds and the 1978 NC State Building Code.</p>	C 000		
C 111	<p>Must Have Current San. & Fire Safety Reports</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on a review of documents, the most recent fire alarm system inspection report was dated in 12-17-2013. Fire alarm systems must be inspected and approved annually as required to ensure the system can operate properly an actual fire.</p>	C 111		
C 189	<p>Building Equipment Maintained Safe, Operating</p> <p>SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult</p>	C 189		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BECKY REST HOME 1	STREET ADDRESS, CITY, STATE, ZIP CODE 316 LOWER BUSH CREEK ROAD FLETCHER, NC 28732
--	--

(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 189	<p>Continued From page 1</p> <p>care home shall be maintained in a safe and operating condition.</p> <p>(k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities.</p> <p>This Rule is not met as evidenced by:</p> <ol style="list-style-type: none"> 1. Based on observation, the sampling tube for the duct mounted smoke detector was dirty. Sampling tubes that are not periodically inspected and cleaned can endanger all residents and staff because the duct detector may fail to operate properly. 2. Based on observation the required one-hour fire rated walls and/or ceilings were compromised in locations. Holes and penetrations that are not sealed with materials approved for use in one-hour fire rated construction present the possibility that a fire that begins in one space can quickly spread to other areas of the facility. Findings include: <ol style="list-style-type: none"> a. Holes in the ceiling of the mop room, b. Holes in the ceiling of the laundry. 	C 189		