Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE SURVEY COMPLETED	
			A. BUILDING.	A. BUILDING. 01			
HAL056006		B. WING		07/07/2016			
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
FRANKL	IN HOUSE		CENTER STI N, NC 28734				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE		
C 000	Initial Comments		C 000				
	Report of Biennial Construction Survey by Dennis Harrell on 7-7-2016.						
	10-24-2014, as a H beds, 40 of which a Based on this informathe current Rules for of Seven or More B	is facility was first licensed on lome for the Aged with 70 are in a Special Care Unit. mation, the facility must meet or the Licensing of Adult Care leds and the 2012 NC State institutional Occupancies.					
C 166	Housekeeping-Main	ntained Free of Hazards	C 166				
	FURNISHINGS (a) Adult care home (5) be maintained i orderly manner, fre hazards;	06 HOUSEKEEPING AND					
	maintained in a saft handling portable m could affect all resid cylinders fall, break cylinder and turning Findings include: Several portable me stored in unapprove	et as evidenced by: ion, the building was not e manner by not properly nedical oxygen cylinders. This dents, staff and visitors if ing their valves, propelling the g it into a dangerous projectile. edical oxygen cylinders were ed beverage crates, in r in no container at all.					
C 185	Fire Safety-Rehear	sals on Each Shift	C 185				
	SECTION .0300 - F	PHYSICAL PLANT					

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:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING: <b>01</b>			(X3) DATE SURVEY COMPLETED		
		HAL056006	B. WING		07/0	7/2016		
NAME OF				STATE ZID CODE	1 0770	772010		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  186 ONE CENTER STREET								
FRANKL	IN HOUSE		N, NC 28734					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE		
C 185	10A NCAC 13F .03 EVACUATION (b) There shall be quarterly on each s requirement of the Enforcement Officia (c) Records of rehe and copies furnishes social services ann include the date and shift, staff members description of what (f) This Rule shall a facilities.  This Rule is not me Based on a review	rehearsals of the fire plan hift in accordance with the local Fire Prevention Code al. earsals shall be maintained ed to the county department of ually. The records shall d time of the rehearsals, the spresent, and a short the rehearsal involved. apply to new and existing et as evidenced by: of documents, the only nsite included no description	C 185					
C 189	SECTION .0300 - F 10A NCAC 13F .03 REQUIREMENTS (a) The building an mechanical, and plucare home shall be operating condition (k) This Rule shall facilities with the ex which shall not app  This Rule is not mean to be a shall on the shall not sha	11 OTHER ad all fire safety, electrical, umbing equipment in an adult maintained in a safe and apply to new and existing aception of Paragraph (e) ly to existing facilities.	C 189					

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	Health Service Re					1
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		.SERVII 10, WISH HOMBER	A. BUILDING: <b>01</b>		COIVIF LE I ED	
			D. WING			
HAL056006		B. WING		07/0	7/2016	
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
FRANKLIN	HOUSE	186 ONE (	ENTER ST	REET		
FRANKLIN	HOUSE	FRANKLIN	I, NC 28734	l .		
(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)	D BE	(X5) COMPLETE DATE
C 189	Continued From page 2		C 189			
poth Fanbco 2fiir sopq Fanbo cdc	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)					

Division of Health Service Regulation STATE FORM