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	
		HAL031006	B. WING		06/2	29/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
WINDHA	M HALL		PER STREET VILLE, NC 2			
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 000	Initial Comments		C 000			
	Miller and Bob Geto	aint Construction Survey by Ed chell on June 29 2016. A on Survey was performed at				
	a Home for the Age November 1, 1967. meet the 1971 and 2005 Rules for Lice and, the 1967 Nort	is facility was first licensed as ad serving 80 residents on Therefore the facility must the applicable portions of the ensing of Adult Care Homes, h Carolina State Building for Group "D"-Institutional				
	The complaint allegare creating hazard	led that renovation activities s to the residents.				
	Complaint was sub	stantiated.				
	Deficiencies were n Correction.	oted which require a Plan of				
C 150	Corridors-Free of e	quipment and Obstructions	C 150			
	of all equipment and would affect all resistlements or obstruction emergency. Findings on June 29	rvation, corridors were not free d other obstructions. This dents, staff and visitors by ng egress during an				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: <b>01</b>		COMPLETED	
					C	·
		HAL031006	B. WING			, 9/2016
					1 00/2	J. EU 10
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
WINDHA	МЫЛІ	329 COOF	PER STREET	•		
WINDHA	IVI HALL	KENANSV	ILLE, NC 2	8349		
(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 150	Continued From pa	ne 1	C 150			
0 100	·		0.00			
	clothing item and a	drop cloth in this corridor.				
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  (e) This Rule shall facilities.  This Rule is not me  1. Based on Obset keep walls, ceilings furniture clean and Findings on June 2	es shall: ings, and floors or floor n and in good repair; c unpleasant odors; elean and in good repair; apply to new and existing et as evidenced by: ervation, the facility failed to , floors or floor coverings and in good repair.				
	had a light coat of c					
C 183	Fire Extinguishers		C 183			
	(a) At least one five A-B-C type fire extile 2,500 square feet of (b) One five pound or CO/2 type is requapplicable, in the management of the control of the	O8 FIRE EXTINGUISHERS e pound or larger (net charge) nguisher is required for each f floor area or fraction thereof. or larger (net charge) A-B-C uired in the kitchen and, where aintenance shop.				
		et as evidenced by: vation, the facility failed to ne fire extinguishers and				

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associated equipment. This could hamper staffs ability to extinguish a small fire and permit it to

STATE FORM Y81D21 If continuation sheet 2 of 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER CLIA IDENTIFICATION NUMBER:  (X2) B. WING  (X3) DATE SURVEY COMPLETED  (X4) ID  (X4) ID  (X5) DATE SURVEY COMPLETED  (X6) DATE SURVEY COMPLETED  (X7) DATE SURVEY COMPLETED  (X8) DATE SURVEY COMPLETED  (X9) DATE SURVEY COMPLETED  (X9) DATE SURVEY COMPLETED  (X9) DATE SURVEY COMPLETED  (X1) DATE SURVEY COMPLETED  (X6) DATE SURVEY COMPLETED  (X7) DATE SURVEY COMPLETED  (X6) DATE SURVEY COMPLETED  (X7) DATE SURVEY COMPLETED  (X6) DATE SURVEY COMPLETED  (X7) DAT	Division of Health Service Regulation							
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  WINDHAM HALL  SUMMARY STATEMENT OF DEFICIENCIES KENANSVILLE, NC 28349  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  C 183  C 183  C 2 183  C 2 183  C 183								
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  WINDHAM HALL  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  C 183  C 183  C 283  C 183  C 184  C 185  C								
WINDHAM HALL    SUMMARY STATEMENT OF DEFICIENCIES   ID   PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   TAG			HAL031006	B. WING		06/2	9/2016	
CALCAN DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   CALCAN DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   CALCAN DEFICIENCY)   COMPLETE DATE      Calcan Deficiency Must be preceded by Full REGULATORY OR LSC IDENTIFYING INFORMATION)   CALCAN DEFICIENCY)   COMPLETE DATE     Calcan Continued From page 2   Calcan Deficiency   Calcan Def	NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	WINDHA	M HALL						
grow larger. This would affect all residents, staff and visitors by not identifying emergency equipment not in proper working order. Findings on June 29, 2016: a. Throughout the Building - The portable fire extinguisher were sitting on the floor, not	PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE	
	C 183	grow larger. This we and visitors by not in equipment not in profindings on June 29 a. Throughout the extinguisher were s	ould affect all residents, staff dentifying emergency oper working order. 9, 2016: • Building - The portable fire itting on the floor, not	C 183	DELITION TO THE PARTY OF THE PA			

Division of Health Service Regulation STATE FORM