FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:  FCL046021		(X2) MULTIPLE A BUILDING: ( B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NAME OF	PROVIDER OR SUPPLIER	J. C.	DDRESS, CITY, S			T
TEPHE	NSON FAMILY CARE	AHOSKI	ST RICHARD S E, NC 27910	TREET		*
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLET DATE
C 000	Survey on May 19, PM at the above re records indicate the November 23, 2005 five ambulatory Rerespond without an during a fire or other information we are compliance with the 10A NCAC 13G for 2009 North Carolin Section 421.2 - Research At the time of our visual records in the section of the section 421.2 - Research the time of our visual records in the section 421.2 - Research the time of our visual records in the section 421.2 - Research the sect	a Fay  a Section conducted a Biennia 2016 from 3:20 PM to 4:20 ferenced facility. DHSR is home was first licensed on 9 as a Family Care Home for sidents (able to evacuate and y physical or verbal assistance or emergency.) Based on this requiring the home to maintain its following: the 2005 Rules is Family Care Homes and the a State Building Code is sidential Care Homes.				
	CONSTRUCTION  (f) If the building is meet the following r  (1) Each floor shal feet in area if existir construction, shall r for R-4 occupancy i Building Code;  (2) Aged or disable housed on any floor (3) Required resid located on any floor and  (4) A complete fire	THE BUILDING 102 DESIGN AND 1 two stories in height, it shall	C 109			,

STATE FORM

Division of Health Service Regulation

2523325025 P.008 PRINTED: 0010372010 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL046021		A. BUILDING	PLE CONSTRUCTION 3: 01	(X3) DATE SURVEY COMPLETED	
NAME OF	DOGUEDES AD DURA (ED		_1=		05/19/2016
	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
STEPHE	NSON FAMILY CARE	HOME	ST RICHARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSSHEFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETE
C 109	Continued From pa	age 1	C 109		
	provided. The fire transmit an automa emergency fire dep	hroughout the building shall be alarm system shall be able to alic signal to the local partment dispatch center, rough a central station by connection.	е		
	Observations re have pull stations a a monitoring compo- technician install pu are audible through the fire department monitoring compan department. Providence	et as evidenced by: vealed that the facility did not it each level that transmitted t any. Have a qualified ill stations at each level that rout the facility and that signal directly or are covered by a y that notifies the fire le documentation of this m of receipts or work orders.		At this time I with the facility with	t the ull Station histime; te fire stalled W
C 137	Bathroom-Mechani	cal Ventilation	C 137	being licensed in	2000
2	foot candles of light mechanical ventilat feet per minute for These vents shall b outdoors.	ion BATHROOM s shall be lighted to provide 36 at floor level and have ion at the rate of two cubic each square foot of floor area e vented directly to the		The both rooms lighted at this time Administrator wo	ave well 5/35/16
	bathroom was not re qualified technician for the bathroom. F	at as evidenced by: vealed that the Client nechanically vented. Have a install mechanical ventilation Provide documentation of the of receipts or work orders.		Waiver for the in of the me chanical for the bathroom; Window in the ba	stallation Veutilation there is a
C 148	Outside Entrances/I	Exits-Free of Obstructions	C 148	that is often raise fresh air to flow since being bicensed	ed to allow 1
dsion of He	alth Service Regulation		L	since being Licensed	LIN 2009

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL046021		A BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B, WING _			
10000000000000000000000000000000000000	PROVIDER OR SUPPLIER	HOME 316 EAS	T RICHARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD BE COMPLETE HE APPROPRIATE DATE
	AND EXITS  (e) All entrances/ obstructions or implies and use in case  This Rule is not many and other items our ramp blocking pass stored items to many documentation of the photos.	THE BUILDING 312 OUTSIDE ENTRANCE dexits shall be free of all pediments to allow for full of fire or other emergency. The as evidenced by: This survey, there was a ladder attitude the door to the exterior sage to the ramp. Remove the clintain the exits. Provide the repairs in the form of		from tamp; Adn ensure that No block exits to H	tems will
C 169	documentation of the repairs in the form of photos.  C 169 Fire Safety-Smoke Detectors  SECTION .0300 - THE BUILDING 10A NCAC 13G .0316 FIRE SAFETY AND DISASTER PLAN (b) The building shall be provided with smoke detectors as required by the North Carolina State Building Code and U.L. listed heat detectors connected to a dedicated sounding device located in the attic and basement. These detectors shall be interconnected and be provided with battery backup. Note: Smoke detectors are required to be interconnected by this Rule. The application of the Rule permits the heat detectors to be interconnected with smoke detectors, but does not require it.  This Rule is not met as evidenced by: 1. Observations revealed two Staff bedrooms upstairs. Neither of the bedrooms had smoke detection. Have a qualified technician install smoke detectors in each bedroom wired to the		C 169	The Administration of Month	ed technician etectors upstairs

If continuation sheet 3 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL045021		(X2) MULTIF A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DORESS, CITY.	STATE, ZIP CODE	
STEPHE	NSON FAMILY CARE	HOME	T RICHARD E, NC 27910		*
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETE
C 169	house current, inte	rconnected with the other the facility and with battery ocumentation of the repairs in	C 169		
C 174	SECTION .0300 - 10A NCAC 13G .03 EQUIPMENT (a) The building a mechanical, and pleare home shall be operating condition (j) This Rule shall family care homes.  This Rule is not meaning to the shall period of the metal strip to produmentation of the photos or receipts.  2. Observations rethe window in Roor qualified technician window is easy to coff the repairs in the sathroom was at the opening. Install size of the vent operations of the vent operations.	and all fire safety, electrical, umbing equipment in a family maintained in a safe and apply to new and existing		The Strip in the has new been verture to man this will stay in vepairs.  The handle on in Room I will be and maintained Administrator.  The floor vents i both replaced - and will replaced - and will man to veal to y the	cpaired— 5/20/2016 itor, that ifor, that good the window 8/30/2016 by  Nothe Side been 5/25/2016
	4. Observations rev	realed a 1/2" board nailed to		to remain in gi	and repair

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Division	of Health Service R				FORM APPROVED
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		FCL046021	B. WING _		05/19/2016
	PROVIDER OR SUPPLIER	HOME 316 EAS	DRESS, CITY TRICHARI , NC 2791		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETE
C 174	the floor in front of poses a tripping had edge cover or pate tripping. Provide dithe form of photos,  5. Observations rethe right sink in the was not properly fit wallpaper was torn a qualified technicia countertop and rep documentation of the photos, receipts or  6. At the time of the bathroom sink did in qualified technician Provide documents of receipts or work  7. Observations restringer of the extense a qualified technician Provide documents of receipts or work  8. At the time of the bathroom sink did in qualified technician Provide documents of receipts or work  9. Observations restringer of the extense a qualified technician provide documents of receipts or work  1. Observations restringer of the extense a qualified technician provide documents of receipts or work	the right sink. The board izard. Install a flat or beveled he the floor properly to prevent ocumentation of the repairs in receipts or work orders.  Invealed that the countertop for bathroom was not secure and ted to the cabinet. The at the edge of the sink. Have an fit and secure the air the damaged wall. Provide he repairs in the form of work orders.  It is survey, the outlet at the right not have power. Have a repair or replace the outlet. Into of the repairs in the form orders.  It wealed that the outside rior stair had sheared off and alt at the intermediate landing. Chnician repair the stair.	C 174	The board en'y in the bathroom removed and re with a proper si Administrator will be right sink in the has now been se wall paper will be by technician - Ad will continue to the authroom sink u repaired by qualified to choice a faministrator.  Administrator was a faministrator.  Administrator was a faministrator.	has been place 5/25/2011 Le Vent Continue for the both woon cured- replaced ministrator 8/20/16 Monitor he right XII be fied tored by
	SECTION .0300 - T 10A NCAC 13G .03 EQUIPMENT (f) Where the bedi located in a separar bedrooms, an elect shall be provided of bedroom to the live	THE BUILDING THE BUILDING THE BUILDING SERVICE TOOM of the live-in staff is the area from residents' rically operated call system connecting each resident in staff bedroom. The activator shall be such that it	C 180	qualified techni repair stair-Adi voill continue to	ninistrator monitor

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Divisio	n of Health Service R	Regulation		1	. 11 1	FORMA	APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01			(X3) DATE SURVEY COMPLETED	
	FCL046021		B. WING		<u>id</u> .	05/19/2016	
NAME O	F PROVIDER OR SUPPLIER	STREET AC	ORESS, CITY,	STATE, ZIP CODE			
STEPH	ENSON FAMILY CARE	HOME	T RICHARD , NC 27910	45° 754 14 60 60 11	ji. j		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS REFERE	PLAN OF CORRECTI CTIVE ACTION SHOUL NCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 18	can be activated won until deactivated activator shall be whis bed.  (j) This Rule shall family care homes  This Rule is not made to the shall family care homes  This Rule is not made to the shall shall shall the family care all system in according requirements. Progregative in the form	with a single action and remain d by staff. The call system within reach of resident lying on apply to new and existing	C 180	The Admi like to a Call System has a ca System in	sk for t on to be o me; the fa	hi6 Waived acility	
TATE ECOM		8897 5	SV4U21		If continueti	on sheet 6 of 6	
						9	