(X3) DATE SURVEY

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: 01 B. WING HAL064005 08/18/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1251 S. WINSTEAD AVENUE SPRING ARBOR OF ROCKY MOUNT **ROCKY MOUNT, NC 27804** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) C 000 Initial Comments C 000 Report of Biennial Construction Survey by Frank Strickland and Billy Bryant on 08/18/2016: Information obtained from the DHSR database indicates that the Spring Arbor of Rocky Mount facility was either first licensed or submitted for licensure on 05/31/1995. Based on this information, this facility is required to meet the 1994 Rules for the Licensing of Adult Care Homes, the applicable components of the 2005 Licensing of Adult Care Homes of Seven or More Beds, and the 1991 (w/revisions) North Carolina State Building Code(s) for Group I - Institutional Unrestrained Occupancy, LICENSED FOR 84 BEDS (74 BED AL & 20 BED SCU) Deficiencies were cited and a Plan of Correction is required. C 136 Bathrooms-Must Be Mechanically Ventilated C 136 SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0305 PHYSICAL **ENVIRONMENT** (e) The requirements for bathrooms and toilet rooms are: (11) Toilets and baths shall be well lighted and mechanically ventilated at two cubic feet per minute. The mechanical ventilation requirement does not apply to facilities licensed before April 1, 1984, with natural ventilation: This Rule is not met as evidenced by: 1-Based on observation, this facility failed to provide an environment in accordance with this Rule by not providing ventilation where odors are generated. This could affect residents and staff by subjecting them to house-keeping odors.

(X2) MULTIPLE CONSTRUCTION

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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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>		(X3) DATE SURVEY COMPLETED		
		HAL064005	B. WING		08/1	8/2016	
NAME OF F	PROVIDER OR SUPPLIER		INDESS CITY S	STATE ZIP CODE	1 00/1	0/2010	
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  1251 S. WINSTEAD AVENUE						
SPRING	SPRING ARBOR OF ROCKY MOUNT ROCKY MOUNT, NC 27804						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
C 136	Continued From pa	age 1	C 136				
	interior air in the fol (a) All of the Reside 200 Halls.	chaust fans are not exhausting flowing locations: ent Bathrooms in the 100 & n's Guest bathrooms in 100 nk Closet.					
C 164	Housekeeping and	Furnishings-Clean, Repaired	C 164				
	coverings kept clea (2) have no chronic (3) have furniture of	806 HOUSEKEEPING AND					
	1-Based on observ maintained in a saf of oxygen cylinders	et as evidenced by: ration, this facility has not fe manner by improper storage s. This could affect all by potentially exposing them ruptured cylinder.					
	Room 210 and 1/3	2016: en bottles in the corner of of the bottles were not in the k that was being shared with					
	2-Based on observ	rations, this facility has failed to					

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maintain the quality of the Resident Room

FORM 6899 C23021 If continuation sheet 2 of 5

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING: <b>01</b>			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.	•			
		HAL064005	B. WING		08/1	8/2016	
				STATE, ZIP CODE			
SPRING	ARBOR OF ROCKY N	MOUNT	/INSTEAD A\ IOUNT, 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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
C 164	Continued From pa	ge 2	C 164				
	environment.						
	Findings on 08/18/2016: Resident Room 105 had excessive urine odor at the sitting area.  3-Based on observation, the facility has not maintained and serviced the HVAC supply and return air grilles.						
		2018: have excessive particulate Room 112 & Kitchen.					
	maintained the exte	ation, this facility has failed erior doors and wood trim. a hazard as one passes openings.					
		2016: I is rotten and unfastened to rior in the Sunroom in the 200					
		ation, this facility has failed to door finishes from the rs.					
	,	walls in the vestibule in Room markings due to contact with					
		ation, this facility has failed to finishes in all habitable					
	Finding on 08/18/20 The ceiling finishes Rooms 207,209 & 3	are damaged to moisture in					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

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		
		HAL064005	B. WING		08/1	8/2016	
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
SPRING	ARBOR OF ROCKY	MOUNT 1251 S. W					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y 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 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 exwhich shall not app  This Rule is not moderated the shall not app  This Rule is not moderated the shall not app  This Rule is not moderated the shall not app  This Rule is not moderated the shall not app  This Rule is not moderated the shall not app  This Rule is not moderated the shall not app  This Rule is not moderated the shall not app  There is a sheet round the shall not app  Findings on 08/18/2 There is a sheet round the shall not app  There is a sheet round the shall not app  There is a sheet round the shall not app  There is a sheet round the shall not app  There is a sheet round the sheet app  There is a sheet round the sheet round the sheet app  There is a sheet round the sheet app  There is a sheet round the sheet round the sheet app  There is a sheet round the sheet appearance the sheet round the s	and all fire safety, electrical, numbing equipment in an adult maintained in a safe and apply to new and existing acception of Paragraph (e) ly to existing facilities.  Let as evidenced by: ations, this facility has failed to ans due to breaches through ion invalidated the integrity of This could affect all residents and that a fire and/or smoke is from or compartment of origin.  Let as evidenced by: ations, this facility has failed to ome or compartment of origin.  Let a sevidenced by: ations, this facility has failed to the for egress. This could guests and staff in an event of	C 189				

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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		
		HAL064005	B. WING		08/	18/2016	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
SPRING	SPRING ARBOR OF ROCKY MOUNT  1251 S. WINSTEAD AVENUE  ROCKY MOUNT, NC 27804						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
C 189	an emergency.  Findings on 08/18/2 The exit sign was n located next to Roc 4-Based on oberva control the use of e SCU. This could a Findings on 08/18/2 The back burner of	2016: not illuminated at the exit om 403 (Cottage). tions, this facility has failed to electrical appliances in the ffect residents. 2016: I the stove was left on and is event a resident from getting	C 189				

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