STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	E CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: 01		COMPLETED	
		HAL031006	B. WING			R 08/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	<u>.</u>	
WINDHAI	M HALL					
			/ILLE, NC 28		000000000	
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
{C 000}	Initial Comments		{C 000}			
	by Bob Getchell on Complaint Followu same time. The followup surve	Biennial Followup Survey done a September 8, 2016. A p Survey was performed at the ey revealed that all deficiencies				
	correction is requir	ected, therefore a new plan of ed.				
{C 101}	Existing Licensed I	Fac- No less than '71 Rules	{C 101}			
	PHYSICAL PLANT The physical plant care home shall be (2) Except where of licensed facilities of facilities shall meet requirements in eff change in service of renovation, or alter the requirements for no addition or reno than those requirer "Minimum and Des Regulations" for "H	301 APPLICATION OF REQUIREMENTS requirements for each adult e applied as follows: otherwise specified, existing or portions of existing licensed t licensure and code fect at the time of construction, or bed count, addition, ration; however in no case shall or any licensed facility where wation has been made, be less ments found in the 1971 sired Standards and lomes for the Aged and Infirm", e available at the Division of				
	2 Based on obse	et as evidenced by: ervation, the building did not ments at time of construction				
	Followup Findings	on September 7, 2016 include:				
	a. Bulk Laundry -	the HVAC return air at this				

YBNR22

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
and plan	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: (D1		
		HAL031006	B. WING			R 08/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
WINDHA	M HALL		OPER STREET			
(X4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
{C 101}	Continued From pa	ge 1	{C 101}			
	foot chase from floo plywood, and not 5/ resistance rating of b. Bedroom 39 - t location consists of foot chase from floo plywood, and not 5/ resistance rating of This is not in accord	he HVAC return air at this an approximately 3 foot by 3 or to ceiling constructed of 8 gypsum to maintain the fire				
{C 148}	Corridors-Handrails	i	{C 148}			
	(2) Handrails shall corridors at 36 inch					
	providing handrails support 250 pounds residents, staff and handrails by not pro stability/balance, and these devices. Findings on June 2 a. Corridor near B was loose and may concentrated load. b. Corridor between	rvation, the building was not in the corridor that could s. This deficiency affects visitors who use unstable oviding increase safety, ad maneuverability provide by				

Division of Health Service Regulation STATE FORM

YBNR22

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA NID RI AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: 01		COMPLETED	
		HAL031006	B. WING		R 09/08/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	
WINDHAI	M HALL				
			SVILLE, NC 28	PROVIDER'S PLAN OF	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLE THE APPROPRIATE DATE
{C 148}	Continued From pa	ge 2	{C 148}		
		l load. edrooms 20 - the handrail not support a 250 pound			
{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	06 HOUSEKEEPING AND es shall: ings, and floors or floor n and in good repair;			
		ervation, the facility failed to , floors or floor coverings and			
	Followup Findings	on September 8, 2016 include	:		
		Building - the corridor and dirt accumulated next to the r frames.			
{C 189}	Building Equipment	Maintained Safe, Operating	{C 189}		
	mechanical, and plu	11 OTHER d all fire safety, electrical, umbing equipment in an adult maintained in a safe and			
		apply to new and existing			

Division of Health Service Regul STATE FORM

YBNR22

If continuation sheet 3 of 5

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01			(X3) DATE SURVEY COMPLETED		
			A. BUILDING: 01				
		HAL031006	B. WING			R 09/08/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
WINDHA	M HALL		OPER STREET SVILLE, NC 28				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
{C 189}	Continued From pa	age 3	{C 189}				
		cception of Paragraph (e) ly to existing facilities.					
	2. Based on obse	et as evidenced by: rvations, the fire safety was safe and operating condition.					
	Followup Findings on September 8, 2016 include:		:				
	cable not firestop a fire-resistance-rate of fire and smoke j. Housekeeping applying extra force frame, preventing it which allows the pa z. Electrical Room cable and holes not	d firewall, allowing the spread near Bedroom 26 - without e, the corridor door hits its t from closing thus latching, assage of smoke. n - there were gaps around a t firestop as they penetrate the d ceiling assembly, allowing					
{C 199}	Exhaust Ventilation		{C 199}				
	provided with exhant two cubic feet per r requirement does r	and OTHER ted in this Paragraph shall be ust ventilation at the rate of minute per square foot. This not apply to facilities licensed 4, with natural ventilation in acces: rage; ; toilet rooms;					

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED		
		A. BUILDING: (01				
		HAL031006	B. WING			R 08/2016	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
VINDHA	M HALL						
(X4) ID	ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION						
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	(X5) COMPLET DATE	
{C 199}	Continued From pa	age 4	{C 199}				
	 (k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities. This Rule is not met as evidenced by: 1. Based on Observation and testing with a thin plastic sheet, the facility failed to maintain the ventilation system in proper working order. 						
	Followup Findings	on September 8, 2016 include	:				
	exhaust ventilation	m near Bedroom 22 - the loca system was running, but did uired air to dissipate the odors					

YBNR22