Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (3) DATE SURVEY COMPLETED | |
|--|---|--|-------------------------------|--|-------------------|------------------------------|--|
| AND I DIN OF CONNECTION | | | A. BUILDING: 01 | | | | |
| HAL041081 | | B. WING | | R 09/02/2016 | | | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DDRESS, CITY, STATE, ZIP CODE | | | | |
| RICHLAN | ID PLACE | | NDALE DRI' BORO, NC 2 | NDALE DRIVE | | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID ID | PROVIDER'S PLAN OF CORRECTION | 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 APPROF DEFICIENCY) | HOULD BE COMPLETE | | |
| {C 000} | Initial Comments Report of a Follow-Up Construction Survey by Billy S. Bryant conducted on 08/26/2016. | | {C 000} | | | | |
| | | | | | | | |
| | Deficiencies cited during the previous Follow-Up from 06/15/2016 remain to be corrected. | | | | | | |
| {C 189} | Building Equipment Maintained Safe, Operating | | {C 189} | | | | |
| | mechanical, and plu care home shall be operating condition (k) This Rule shall facilities with the ex | 11 OTHER d all fire safety, electrical, umbing equipment in an adult maintained in a safe and | | | | | |
| | maintained in a safe the fire-resistance r | vation, the building was not e manner by not maintaining rating of building components. I residents by not containing ne room or smoke | | | | | |
| | d. The main Laundr box in the ceiling h. The HVAC room unprotected penetra j. The attic smoke | ry has a ceiling split open. ry room has an open junction in the attic over room 5 has | | | | | |

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

These unprotected openings are not in

(X6) DATE TITLE

Division of Health Service Regulation

| | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | |
|---|--|--|-------------------------------|---|-------------------|--|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING: 01 | | COMPLETED | | |
| HAL041081 | | B. WING | | R 09/02/2016 | | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DDRESS, CITY, STATE, ZIP CODE | | | |
| RICHLAN | ND PLACE | | /NDALE DRIVE | | | |
| 10011270 | | | BORO, NC 27455 | | | |
| (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 CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY) | HOULD BE COMPLETE | |
| {C 189} | Continued From page 1 | | {C 189} | | | |
| | conformance with the requirement to use a through penetration fire stop system that has been tested in accordance with ASTM E-814 | | | | | |
| | 4. Based on observation, the building mechanical systems were not maintained in a safe manner by omitting radiation dampers in ceiling penetrations. This would affect all residents by not containing smoke and fire in the room or smoke compartment of origin. | | | | | |
| | Findings on June 15, 2016: The following areas were not equipped with ceiling radiation dampers: a. Clean Linen Room, c. Kitchen d. Med Room e. Salon f. Pantry Note: Fire dampers at the ceiling membrane were permitted to be omitted from areas required to be separated by the 1996 NCSBC Section 409.1.5 - Protection from Hazardous Areas and provided with Fire Barriers to the roof deck. Ensure these | | | | | |
| | Barriers. 5. Based on observ | within spaces with Fire vation, the facility components doperable by having doors ompletely and latch. | | | | |
| | square feet, has ha disconnected. | | | | | |

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 | | (X3) DATE SURVEY COMPLETED | |
|---------------------------|--|-----------------------------|---|---|-----------------------------------|--|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | | | |
| HAL041081 | | B. WING | | R 09/02/2016 | | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DDRESS, CITY, STATE, ZIP CODE | | | |
| RICHI AI | ND PLACE | | VNDALE DRIVE | | | |
| KIOHLAI | ND I LAGE | GREENSE | BORO, NC 2 | 7455 | | |
| (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) | TION SHOULD BE THE APPROPRIATE | |
| {C 199} | Continued From page 2 | | {C 199} | | | |
| {C 199} | Exhaust Ventilation | | {C 199} | | | |
| | . • | | | | | |

Division of Health Service Regulation STATE FORM