Division of Health Service Regulation

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION 01 | (X3) DATE COMF | SURVEY PLETED |
|--------------------------|--|---|---|--|-------------------|--------------------------|
| | | FCL054060 | B. WING | | 09/2 | 28/2016 |
| | PROVIDER OR SUPPLIER | 300 EAST | DRESS, CITY, S LENOIR AV , NC 28501 | STATE, ZIP CODE ENUE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| C 000 | Initial Comments | | C 000 | | | |
| | Survey on September 1:35 PM at the above records indicate the June 16, 1980 for fit This facility is licens Residents (able to eany physical or vertother emergency) where the emergency of the emergency of the emergency of the home to maintate following: the 1984 Minimum Standard portions of the 2005 Family Care Homes State Building Code Residential Care Family Car | a Section conducted a Biennial ore 28, 2016 from 12:20 PM to be referenced facility. DHSR is home was first licensed on the (5) ambulatory Residents. Seed for six (6) ambulatory evacuate and respond without the pal assistance during a fire or which indicates that the bed do to six sometime after April 1, is information we are requiring in compliance with the "Family Care Homes and Regulations," applicable 5 Rules 10A NCAC 13G for is and the 1978 North Carolina is - Section 409.1 (g) - | | | | |
| C 119 | have one full bathropersons including lib. If there is a questoefore April 1, 1984 bathrooms, the Diviresponsible for determined. | CAC 42C .2206) and as of April 1, 1984 must be por for each five or fewer ve-in staff and family. Stion whether a home licensed has a sufficient number of ision of Facility Services is ermining the size and number red based on the number of | C 119 | | | |

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

(X6) DATE TITLE

Division of Health Service Regulation

| DIVISION | Division of Health Service Regulation | | | | | | |
|--|--|--|---|--|------|--------------------------|--|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MUL | | ` ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 (X3) DATE : COMPI | | | | |
| | | FCL054060 | B. WING | | 09/2 | 8/2016 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | | |
| A NEW REGINNING | | LENOIR AV , NC 28501 | ENUE | | | | |
| (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 APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE | |
| C 119 | Continued From pa | ge 1 | C 119 | | | | |
| | privacy. A bathroom tub/shower must ha curtains. d. Entrance to the la kitchen, another pathroom. e. The bathroom monveniently as postedrooms. f. Hand grips must tubs and showers or residents. g. Nonskid surfacir in showers and bath h. The bathroom madequately ventilated. | t be installed at all commodes, on the floor level used by the ag or strips must be installed h areas. The well lighted and led. The word was a non-slippery | | | | | |
| | between the Den are handgrips at either handgrips for each documentation of the photos or receipts. 2. Observations result handgrip on the tube dining area and Bedhad some cracks. I damaged handgrip, a secure metal han toilet. Due to the present | vealed that the bathroom nd Kitchen did not have the tub or the toilet. Install | | | | | |
| | is not required. | | | | | | |

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3. Observations revealed that neither of the tubs

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Division of Health Service Regulation

| | IT OF DEFICIENCIES | | (V2) MULTIPL | E CONSTRUCTION | (V2) DATE | CLIDVEV |
|--------------------------|---|---|---------------------|---|-------------------|--------------------------|
| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | (X3) DATE COMP | LETED |
| | | | A. BUILDING: | UT | | |
| | | FOI 054000 | B. WING | | 00/0 | 0/0046 |
| | | FCL054060 | | | 09/2 | 8/2016 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| A NFW F | BEGINNING | | LENOIR AV | ENUE | | |
| | | KINSTON | , NC 28501 | | | |
| (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 119 | Continued From pa | ge 2 | C 119 | | | |
| | surface in the tub or prevent slipping. Pre | or decals. Provide a nonstick r provide rubber mats to rovide documentation of the of photos or receipts. | | | | |
| C 123 | Outside Entrances/ | Exits | C 123 | | | |
| | IV. The Building C. Physical Environment 8. Outside Entrances/Exits (10 NCAC 42C .2209) a. All floor levels must have at least two exits. If there are only two, the exits must be as remote from each other as reasonably possible. b. At least one entrance/exit door must be a minimum clear width of three feet and another must be a minimum clear width of two feet and eight inches. c. At least two outside entrances/exits for the residents' floor level must be at ground level or accessible by ramp with a 1 inch rise for each 12 inches of length of the ramp. If there are only two entrances/exits, the entrances/exits must be as remote from each other as reasonably possible. (The requirement for the ramp at exits not at ground level applies to homes which have at least one resident who needs personal assistance in getting up or down steps.) d. All exit door locks must be easily operable, by a single hand motion, from the inside at all times without keys. e. All entrances/exit must be free of all obstructions or impediments to allow for full instant use in case of fire or other emergency. f. All steps, porches, stoops and ramps must be provided with handrails and guardrails. | | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 | | (X3) DATE SURVEY COMPLETED | | |
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| | | FCL054060 | B. WING | | 09/2 | 8/2016 |
| NAME OF F | PROVIDER OR SUPPLIER | | DRESS, CITY, S | STATE, ZIP CODE | | 0.2010 |
| A NFW B | EGINNING | | LENOIR AV | ENUE | | |
| ANEW | | | NC 28501 | | | |
| (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 APPROF | D BE | (X5) COMPLETE DATE |
| C 123 | Continued From pa | ge 3 | C 123 | | | |
| | second means of e items to maintain th | exit from the upper level gress. Remove the stored le path of egress. Provide ne repairs in the form of | | | | |
| | second exit upstairs was sticking at the damaged. Have a replace the door. F | s survey, the door to the swould not open. The door bottom and appeared to be qualified technician repair or rovide documentation of the of receipts or work orders. | | | | |
| C 125 | Floors | | C 125 | | | |
| | material and so cor cleanable. b. Scatter or throw | | | | | |
| | maintained in good | et as evidenced by: vealed that the floor was not repair. The floor was numerous locations. These | | | | |
| | dining is uneven an b. There is a te | Id between the kitchen and d the floor is ripped and torn. ear in the floor of the dining able and the door to the | | | | |
| | c. In the bathro | oom between the den and etween the tub and toilet is soft e vinyl is pulling away at the | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 | | (X3) DATE SURVEY COMPLETED | | |
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| | | FCL054060 | B. WING | | 09/2 | 8/2016 |
| NAME OF I | PROVIDER OR SUPPLIER | | DRESS, CITY, S | STATE, ZIP CODE | 1 00/2 | 0.2010 |
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| ANEW | | | NC 28501 | | | |
| (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) | _D BE | (X5) COMPLETE DATE |
| C 125 | Continued From pa | ge 4 | C 125 | | | |
| | Bedroom 3, the floot tub is very soft and floor vent is heavily floor and the corner e. The vinyl floo and curling at the ef. In Bedroom corner between the section of the shoethe corner and the g. There was a hallway vinyl floor bback of the stairs. Have a qualified tecthe damaged flooring | or around the fireplace is torn dges. #1, the vinyl is torn in the fire place and side wall and a molding is broken between window. In approximately 6" tear in the etween the front door and the chnician repair or replace all of an and subflooring as required. Ition of the repairs in the form | | | | |
| C 134 | .2213) 3. The home must station U.L. listed so locations as determ Services and U.L. liand basement. The wired to the house of the house of the light of the ligh | provide automatic, single moke (ionization) detectors in tined by the Division of Facility sted heat detectors in the atticese detectors must be directly current. | C 134 | | | |

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: 01 B. WING _ FCL054060 09/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **300 EAST LENOIR AVENUE** A NEW BEGINNING KINSTON, NC 28501 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) C 134 Continued From page 5 C 134 Provide verification of the detector in the form of photos. C 139 The Building-Maintained Safety C 139 IV. The Building F. Housekeeping and Furnishings (10 NCAC 42C .2212) 1. The building and all fire safety, electrical, mechanical, and plumbing equipment must be maintained in a safe and operating condition. This Rule is not met as evidenced by: 1. Observations revealed that the bathroom outlets had several coats of paint which poses an electrical hazard. If the paint cannot be removed, have a qualified technician replace the outlets. Provide documentation of the repairs in the form of photos, receipts or work orders. C 140 Housekeeping and Furnishings C 140 IV. The Building F. Housekeeping and Furnishings (10 NCAC 42C .2212) 2. Each home must: a. have walls, ceilings, and floors or floor coverings kept clean and in good repair; b. have no unpleasant odors: c. have furniture clean and in good repair; d. have a sanitary grade of 90 or above at all times. e. be maintained in an uncluttered, clean orderly manner, free of all obstructions and hazards; f. have an adequate supply of bath soap, clean towels, washcloths, sheets, pillow cases, blankets, and additional coverings on hand at all

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g. make available the following items as needed

times:

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 | | (X3) DATE SURVEY COMPLETED | | |
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| | | FCL054060 | B. WING | | 09/2 | 8/2016 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | • | |
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| 240.15 | CUIMMA DV CTA | | NC 28501 | DDOVIDEDIC DI ANI OF CODDECTI | ON | 0/5 |
| (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) | D BE | (X5) COMPLETE DATE |
| C 140 | Continued From pa | ge 6 | C 140 | | | |
| | personal funds of re Special Assistance- (1) protective shee and smooth pads; (2) bedpans, urinal caps; (3) bedside commonwheelchairs; | ts and clean, absorbent soft s, hot water bottles, and ice | | | | |
| | were not maintaine | et as evidenced by: vealed that the kitchen walls d or in good repair. The were observed in the kitchen: | | | | |
| | window of the back b. There were running from the up ceiling. c. The plaster was cracked and pu d. There was h | the wainscoting below the wall was flaking and peeling. two large cracks in the plaster oper kitchen cabinets to the wall above the range hood uckering. The left of the back window. | | | | |
| | damaged walls. Pr | chnician repair and paint the ovide documentation of the of photos, receipts or work | | | | |
| | the right of the sink dining room and Be a couple of boards damage. Have a q | vealed that the lower wall to in the bathroom between the edroom #3 was damaged and were roughly nailed over the ualified technician remove the he damaged wall. Provide | | | | |

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|---|--|---|---------------------|---|------|--------------------------|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | |
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING: 01 | | COMPLETED | | |
| | | | D 14/11/0 | | | |
| | | FCL054060 | B. WING | | 09/2 | 8/2016 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| A NEW B | EGINNING | 300 EAST | LENOIR AV | ENUE | | |
| ANEWE | CONTINUO | KINSTON | , NC 28501 | | | |
| (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 APPROF DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| C 140 | Continued From pa | ge 7 | C 140 | | | |
| | photos, receipts or | | | | | |
| | had fall off the wall machine. The structure damage and an attained the wall. The wall to machine was stained qualified technician washing machine. | vealed that the plaster finish to the right of the washing cture was exposed behind the ached shelf had collapsed with the teleft of the washing and cracked. Have a repair the walls around the Provide documentation of the of photos, receipts or work | | | | |
| | conditioned with wir below the units in e and the finish was f qualified technician units. In the upstair unit is heavily dama and there is a large window trim. Have the wall and patch t | ne repairs in the form of | | | | |
| | wall to the left of the crack is about 3' lor vent to the door frantechnician repair the | vealed a large crack in the e door to Bedroom #3. The ng and curves up from the wall me. Have a qualified e wall. Provide documentation form of photos, receipts or | | | | |
| | of the upstairs door damaged. Have a | vealed that the wall to the left to the second exit was heavily qualified technician repair the mentation of the repairs in the | | | | |

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form of photos, receipts or work orders.

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| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 | | (X3) DATE SURVEY COMPLETED | |
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| | | | | | | |
| | | FCL054060 | B. WING | | 09/2 | 8/2016 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| A NEW B | EGINNING | | LENOIR AV | ENUE | | |
| | OLUMBA DV OTA | | NC 28501 | DECLUBERIO DI ALI CE CORRECTIO | 211 | |
| (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 APPROFILE OF THE APPROFI | D BE | (X5) COMPLETE DATE |
| C 140 | Continued From pa | ge 8 | C 140 | | | |
| | and flaking on the ir and paint the interior documentation of the photos, receipts or a second secon | vealed that the inside face of stained and the finish was e hardware edge. Clean and the front door. Provide the repairs in the form of | | | | |
| | enough room betwee open the door fully. repair or replace the and rearrange the from get into their cloud of the repairs in the work orders. | een the door and furniture to Have a qualified technician e door, secure the hardware urniture so that the Resident oset. Provide documentation form of photos, receipts or | | | | |
| | door to Bedroom #3 and the door hardw qualified technician paint the door. Pro | evealed that the paint on the 3 was scratched and flaking are was loose. Have a tighten the door hardware and vide documentation of the of photos, receipts or work | | | | |
| | hardware was loose Bedroom #3. Tighte | evealed that the door e on the closet door of en the hardware. Provide he repairs in the form of work orders. | | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 | | (X3) DATE SURVEY COMPLETED | |
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| | FCL054060 | B. WING | | 09/2 | 8/2016 |
| NAME OF PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| A NEW BEGINNING | | LENOIR AV , NC 28501 | ENUE | | |
| PREFIX (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5) COMPLETE DATE |
| looking substance in between the dining at to remove the substance in the repairs in the door had fallen out. documentation of the photos, receipts or value of the photos, receipts or value in the front wall. There appears are. Observed in the form the damages are. Observed in the form of the photos, receipts or value in the form the form the form of the photos, receipts or value in the form the form the form the form the form of the form the form of the form the form of the form the form of the form of the form the form of the | evealed a large yellow waxy in the tub in the bathroom area and Bedroom #3. Clean cance. Provide documentation form of photos. evealed that a 2" piece of the dining room near the kitchen Repair the ceiling. Provide in repairs in the form of | C 140 | | | |