PRINTED: 12/20/2016 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING: 01

R

HAL034098

B. WING

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SALEM TERRACE

2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

WINSTON SALEM, NC 27127						
(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
{C 000}	Initial Comments	{C 000}				
	Report of Biennial Follow-up Construction Suby Frank Strickland on 12/02/2016:	ırvey				
	Some cited deficiencies have been field verif for correction. However, there are cited deficiencies that have not any corrective action A new Plan of Correction is required.					
{C 133}	Bathrooms-Hand Grips	{C 133}				
	SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0305 PHYSICAL ENVIRONMENT (e) The requirements for bathrooms and toile rooms are: (6) Hand grips shall be installed at all commodes, tubs and showers used by or accessible to residents;	et				
	This Rule is not met as evidenced by: Findings on 12/02/2016: Based on observation, there was no hand gri provided at the handicap tub in the handicap bathroom on the 200 Hall.					
{C 160}	Outside Premises-Clean, Safe	{C 160}				
	SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0305 PHYSICAL ENVIRONMENT (m) The requirements for outside premises a (1) The outside grounds of new and existing facilities shall be maintained in a clean and s condition;	ı				
	This Rule is not met as evidenced by: Findings on 12/020/2016:					

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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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				
		HAL034098	B. WING		12/0	≷ 2/2016			
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
SALEM .	SALEM TERRACE 2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127								
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE			
{C 160}	Continued From page 1 Based on observation, an exit sidewalk from the 400 Hall was overgrown and obstructed with vegetation. Obstructed exit paths could delay or prevent an evacuation in an emergency.		{C 160}						
{C 164}	SECTION .0300 - F	Furnishings-Clean, Repaired PHYSICAL PLANT 06 HOUSEKEEPING AND	{C 164}						

This Rule is not met as evidenced by: Findings on 12/02/2016:

(1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; (2) have no chronic unpleasant odors; (3) have furniture clean and in good repair; (e) This Rule shall apply to new and existing

(a) Adult care homes shall:

facilities.

- 1. Based on observation, ceilings were stained or the texture finish was falling off in places throughout the facility from water damage caused by chronic roof leaks.
- 2. Based on observation, a countertop was broken at the Assisted Living nurse station.

{C 165} Housekeeping and Furnishings-Sanitation Grade

SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0306 HOUSEKEEPING AND **FURNISHINGS** (a) Adult care homes shall:

- (4) have a North Carolina Division of Environmental Health approved sanitation classification at all times in facilities with 12 beds or less and North Carolina Division of Environmental Health sanitation scores of 85 or

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STATE FORM 6899 Q38022 If continuation sheet 2 of 3

{C 165}

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STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X3) DATE SURVEY COMPLETED								
			R								
	HAL034098	HAL034098 B. WING	12/02/2016								
NAME OF PROVIDER OR SUF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD										
SALEM TERRACE											
PREFIX (EACH DEFI	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	CY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION)	SHOULD BE COMPLETE								
more; (e) This Rule facilities. This Rule is Findings on 1 Based on obscurrent Sanita	nes in facilities with 13 beds or shall apply to new and existing ot met as evidenced by:	age 2 in facilities with 13 beds or I apply to new and existing net as evidenced by: 0/2016: tions, upon review of the Report clearly indicates a score									

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