

Division of Health Service Regulation

|  |  |  |   |
|--|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>HAL034084</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: <b>01</b><br><br>B. WING: _____ | (X3) DATE SURVEY COMPLETED<br><br><b>01/04/2017</b> |
|--|--|--|---|

|  |  |
|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>FORSYTH VILLAGE</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5100 LANSING DRIVE<br/>WINSTON SALEM, NC 27105</b> |
|--|--|

| (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<br><br>Report of Construction Section Biennial Survey by Danna Harrell on 1-4-2017.<br><br>Records indicate that this 60 bed facility was first licensed on 12-1-1989. Based on this information, we are requiring the facility to meet the 1978 NC State Building Code, with revisions, the 1987 Minimum Standards and Regulations for Homes for the Aged and Disabled and the applicable portions of the current Rules for Adult Care Homes of Seven or More Beds.                                       | C 000 |   |         |
| C 111 | Must Have Current San. & Fire Safety Reports<br><br>SECTION .0300 - PHYSICAL PLANT<br>10A NCAC 13F .0302 DESIGN AND CONSTRUCTION<br>f) The facility shall have current sanitation and fire and building safety inspection reports which shall be maintained in the home and available for review.<br><br>This Rule is not met as evidenced by:<br>Based on a review of documents, the most recent Sanitation inspection for the building was dated 8-5-2015. Buildings must be inspected and approved annually as required. | C 111 | Health Department came out on 1/25/2017 to do their Annual Inspection | 1/25/17 |
| C 133 | Bathrooms-Hand Grips<br><br>SECTION .0300 - PHYSICAL PLANT<br>10A NCAC 13F .0305 PHYSICAL ENVIRONMENT<br>(e) The requirements for bathrooms and toilet rooms are:<br>(6) Hand grips shall be installed at all commodes, tubs and showers used by or accessible to residents;  | C 133 | Hand rails have been put back up after repairs were made 2/1/17       |         |

Division of Health Service Regulation

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

TITLE

(X6) DATE

STATE FORM

*Jessica M. Thomas*

*AIC*

*2/08/17*

5888

BUFK21

If continuation sheet 1 of 7

## Division of Health Service Regulation

|  |   |  |   |   |
|--|---|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>HAL034084</b>  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: 01<br><br>B. WING: _____                            |   | (X3) DATE SURVEY COMPLETED<br><br><b>01/04/2017</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>FORSYTH VILLAGE</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5100 LANSING DRIVE<br/>WINSTON SALEM, NC 27105</b> |   |   |
| (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 133  | Continued From page 1<br><br>This Rule is not met as evidenced by:<br>1. Based on observation, there was no hand grip provided at the toilet, tub or shower in the community bathroom on C Hall.<br><br>2. Based on observation, there was no hand grip provided at the toilet or shower in the community bathroom near bedroom 17.   | C 133  | Hand rails have been put back up after repairs were made.   | 2/1/17  |
| C 166  | Housekeeping-Maintained Free of Hazards<br><br>SECTION .0300 - PHYSICAL PLANT<br>10A NCAC 13F .0306 HOUSEKEEPING AND FURNISHINGS<br>(a) Adult care homes shall:<br>(5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards;<br>(e) This Rule shall apply to new and existing facilities.<br><br>This Rule is not met as evidenced by:<br>1. Based on observation, the required inspection tags on the fire extinguishers had last been replaced in October of 2015. Fire extinguishers must be inspected annually by an outside vendor.<br><br>2. Based on observation, there was no documentation of the required monthly inspections for the fire extinguishers since October of 2015. Fire extinguishers must be inspected monthly and the inspections must be documented, such as on the tag provided on the extinguisher.<br><br>3. Based on observation, there was no documentation of monthly inspections provided on the range hood fire suppression system | C 166  | Administrator has contacted Liberty Fire protection to come out to services the fire extinguishers and the hooded | 2/18/17   |

PRINTED: 01/24/2017  
FORM APPROVED

Division of Health Service Regulation

|  |  |   |   |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>HAL034084</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: 01<br><br>B. WING: _____ | (X3) DATE SURVEY COMPLETED<br><br><b>01/04/2017</b> |
|--|--|---|---|

|  |  |
|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>FORSYTH VILLAGE</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5100 LANSING DRIVE<br/>WINSTON SALEM, NC 27108</b> |
|--|--|

| (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 188 Continued From page 2

inspection tag since May of 2016. Range hood fire suppression systems must be inspected monthly and the inspections must be documented, such as on the tag provided at the system pull.

4. Based on observation and interview, staff were not aware of the location or use of the system pull for the range hood fire suppression system. Staff must be trained about the range hood fire suppression system and the system pull.

5. Based on observation, the ice machine drain line extended into the floor drain. Ice machine drain lines that are not maintained at least 2 inches above the floor or floor drain, as required by Code, could cause the ice to become contaminated.

C 188

Administrator In charge will train all staff on the location and the use of the system pull for the Range hood fire suppression system; staff will Document and Date when they have completed their training 2/10/17

C 185 Fire Safety-Rehearsals on Each Shift

SECTION .0300 - PHYSICAL PLANT  
10A NCAC 13F .0309 PLAN FOR EVACUATION

(b) There shall be rehearsals of the fire plan quarterly on each shift in accordance with the requirement of the local Fire Prevention Code Enforcement Official.

(c) Records of rehearsals shall be maintained and copies furnished to the county department of social services annually. The records shall include the date and time of the rehearsals, the shift, staff members present, and a short description of what the rehearsal involved.

(f) This Rule shall apply to new and existing facilities.

This Rule is not met as evidenced by:  
1. Based on review of documents, fire drill

C 188

Business office manager Keep records of all rehearsal quarterly on each shift in accordance with the requirement of the local fire Prevention Code Enforcement official. Business will send all copies furnished to the county department of social service annually 1/10/17

PRINTED: 01/24/2017  
FORM APPROVED

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>HAL034084</b>  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: <b>01</b><br><br>B. WING: _____                     |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/04/2017</b> |
|--|---|--|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>FORSYTH VILLAGE</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5100 LANSING DRIVE<br/>WINSTON SALEM, NC 27105</b> |  |   |
| (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 185  | Continued From page 3<br><br>rehearsals are not being done regularly with at least one per shift each quarter. Failure to rehearse the fire plan could lead to confusion and delay in an actual emergency.<br>Findings include:<br>a. In the 1st quarter of last year, there was no rehearsal done during the 3rd shift.<br>b. In the 2nd quarter of last year, there was no rehearsal done during the 1st shift.<br>c. In the 3rd quarter of last year, there were no rehearsals done during the 2nd or 3rd shifts.<br>d. In the 4th quarter of last year, there were no rehearsals done at all.<br>2. Based on a review of documents, the only records available onsite included no description of what the rehearsal involved.   | C 185  | Business's office Manager keep records of all rehearsal quarterly on each shift in accordance with the requirement of the local Fire Prevention code Enforcement official. Business will send all copies furnished to the County Department of <del>Service</del> Social Service annually. | 11/04/17  |
| C 189  | Building Equipment Maintained Safe, Operating<br><br>SECTION .0300 - PHYSICAL PLANT<br>10A NCAC 13F .0311 OTHER REQUIREMENTS<br>(a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition.<br>(k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities.<br><br>This Rule is not met as evidenced by:<br>1. Based on observation, the corridor smoke detector near bedroom 30 failed to activate when tested with smoke. Smoke detectors that do not work properly endanger all residents and staff.<br>2. Based on observation, the battery powered emergency lights in the corridor near room 36, in | C 189  | <del>Contacted</del> Administrator In charge<br>Contacted Leonard's Alarm Company to come out to replace smoke detector.<br><br>Maintenance Department will be Replacing THE EMERGENCY Lights in THE CORRIDOR NEAR Room 36, in the CORRIDOR near the dining room and in the Dining room.   | 2/28/17<br><br>2/18/17                              |

PRINTED: 01/24/2017  
FORM APPROVED

Division of Health Service Regulation

|  |  |   |   |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>HA1034084</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: 01<br><br>B. WING: _____ | (X3) DATE SURVEY COMPLETED<br><br><b>01/04/2017</b> |
|--|--|---|---|

|  |  |
|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>FORSYTH VILLAGE</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5100 LANSING DRIVE<br/>WINSTON SALEM, NC 27105</b> |
|--|--|

| (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 |
|--------------------|--|---------------|---|--------------------|
|--------------------|--|---------------|---|--------------------|

FED #100  
Fire  
Coated

|       |  |       |   |        |
|-------|--|-------|---|--------|
| C 189 | <p>Continued From page 4</p> <p>the corridor near the dining room and in the dining room would not work when tested. Battery powered emergency lights that will not work properly for at least 90 minutes could endanger the residents and staff.</p> <p>3. Based on observation the required one-hour fire rated walls and/or ceilings were compromised in several locations. Holes and penetrations that are not sealed with materials approved for use in one-hour fire rated construction present the possibility that a fire that begins in one space can quickly spread to other areas of the facility. Findings include:</p> <ul style="list-style-type: none"> <li>a. Hole in the ceiling by the heat detector in the pantry,</li> <li>b. Unsealed penetration at wires through the ceiling of the Activity room,</li> <li>c. Hole in the ceiling in the outside AC room near the maintenance room.</li> <li>d. New high efficiency gas furnaces were installed in all 4 outside AC rooms in 2008 or later. The furnace flues are 3 inch PVC pipes that extend up through the one-hour fire protected ceilings. None of the flues were protected with a listed fire collar as required.</li> </ul> <p>4. Based on observation, some corridor doors will not close and/or latch to resist the passage of fire and smoke. Corridor doors that do not close completely and latch present the possibility that a fire that begins in one space can quickly spread to the corridor and the remainder of the facility. Findings include the following doors:</p> <ul style="list-style-type: none"> <li>a. The doors to bedrooms 8, 24 and 33 would not latch when closed.</li> <li>b. The doors to bedrooms 14 and 18 do not fit the opening properly to be resistant to the passage of smoke,</li> <li>c. The door to the community bathroom on C</li> </ul> | C 189 | <p>Maintenance Department will be replacing the emergency lights in the corridor near room 36, in the corridor near the dining room and in the dining room</p> <p>Maintenance Department have</p> <p>The Maintenance Department have 2/8/17 sealed the hole in the ceiling by the heat detector in the pantry</p> <p>Maintenance Department have repair the unsealed penetration at wires through the ceiling of the activity room 2/8/17</p> <p>Maintenance Department will repair the hole in the ceiling in the outside AC room near the maintenance room on FEB 2017 2/18/17</p> <p>Maintenance Department have repaired the doors in 8, 24, and 33, 14, and 18 maintenance Department will monitor all doors weekly to insure that all doors are latching to resist the passage of fire and smoke.</p> | 2/8/17 |
|-------|--|-------|---|--------|

Division of Health Service Regulation

PRINTED: 01/24/2017  
FORM APPROVED

|  |  |  |  |   |
|--|--|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>HAL034084</b>   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: 01<br><br>B. WING: _____                            |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/04/2017</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>FORSYTH VILLAGE</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5100 LANSING DRIVE<br/>WINSTON SALEM, NC 27105</b> |  |   |
| (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 189  | <p>Continued From page 5</p> <p>Hall was damaged and would not close and latch.</p> <p>5. Based on observation, the GFCI type receptacle in the bathroom off bedroom 34 would not trip when tested, GFCI type receptacles that do not work properly present a shock or electrocution risk.</p> <p>6. Based on observation, the sink was clogged in the bathroom off bedroom 38.</p> <p>7. Based on observation, there was no key onsite to unlock the doors to the closet off the Activity room, the resident supply closet and bedroom 29. Without a key, the room could not be surveyed to verify there is not a hazard in the room.</p> <p>8. Based on observation, the exterior door knob was broken off the exit door near the beauty salon. The missing knob exposed sharp edges that could be a laceration hazard.</p> <p>9. Based on observation, 2 switch plates were missing in the dining room. Missing electrical plates expose energized wires and parts.</p> | C 189  | <p>Maintenance Department have repaired the Door 3 <del>the 103</del> Bedroom 14 and 18 <del>that</del></p> <p>Maintenance Department have already unclogged the Bathroom off Bedroom 38</p> <p>Administrabr In charge will insure there are keys on site to do</p> <p>Maintenance Department have repaired Door knob that was Broken off the Exit Door near the Beauty Salon.</p> | 2/18/17   |
| C 199  | <p>Exhaust Ventilation</p> <p>SECTION .0300 - PHYSICAL PLANT<br/>10A NCAC 13F .0311 OTHER REQUIREMENTS</p> <p>(g) The spaces listed in this Paragraph shall be provided with exhaust ventilation at the rate of two cubic feet per minute per square foot. This requirement does not apply to facilities licensed before April 1, 1984, with natural ventilation in these specified spaces:<br/>(1) soiled linen storage;<br/>(2) soil utility room;</p>   | C 199  | <p>Maintenance Department will be installing exhaust ventilation in soiled linen storage; soil utility room; Bathroom and toilet room; housekeeping closets; and laundry area on FEB. 18, 2017</p>   | 2/18/17   |

Division of Health Service Regulation

PRINTED: 01/24/2017  
FORM APPROVED

|  |  |  |   |
|--|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>HAL034084</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: 01<br><br>B. WING:                                  | (X3) DATE SURVEY COMPLETED<br><br><b>01/04/2017</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>FORSYTH VILLAGE</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5100 LANSING DRIVE<br/>WINSTON SALEM, NC 27105</b> |   |

| (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 198              | <p>Continued From page 6</p> <p>(3) bathrooms and toilet rooms;<br/>(4) housekeeping closets; and<br/>(5) laundry area.<br/>(k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities.</p> <p>This Rule is not met as evidenced by:<br/>Based on observation the facility failed to maintain required exhaust in a working condition. Non-functioning exhaust could cause an unhealthy buildup of moisture and possibly bacteria.<br/>Findings include:<br/>a. The exhaust system was not working in the bathroom off bedroom 34.<br/>b. The exhaust system was not working in the corridor bathroom near room 14.</p> | C 100         | <p>Maintenance Department will be installing exhaust ventilation in soiled linen storage; Soiled utility room; Bathroom AND toilet room; Housekeeping Closets; and laundry area on FEB 18, 2017</p> <p>Maintenance Department will be installing exhaust ventilation in Bathroom off Bedroom 34 and the Corridor bathroom near room 14.</p> | <p>2/19/17</p> <p>2/18/17</p> |