STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED	
			A. BOILDING. VI				
		HAL047011	B. WING		04/0	6/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THE CRO	DSSINGS AT WAYSID	F	ETTEVILLE I D, NC 28376				
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
C 000	Initial Comments		C 000				
		al Construction Survey by Billy anna Fay conducted on					
	04/23/2015. The fa 75 Beds. Therefore conformance with a Edition of the North Institutional Occupa Licensing of Adult (nis facility was first licensed on cility is currently licensed for the facility was surveyed for applicable portions of the 2012 in Carolina Building Code(s), ancy, and the 2005 Rules for Care Homes of Seven or More the time of initial licensure.					
C 101	Existing Licensed F	Fac- No less than '71 Rules	C 101				
	care home shall be (2) Except where of licensed facilities of facilities shall meet requirements in effection and a service of the requirements for no addition or renovation or requirements "Minimum and Des Regulations" for "H	REQUIREMENTS requirements for each adult applied as follows: otherwise specified, existing reportions of existing licensed clicensure and code ect at the time of construction, or bed count, addition, ation; however in no case shall or any licensed facility where vation has been made, be less ments found in the 1971 ired Standards and omes for the Aged and Infirm", e available at the Division of					
	1. Based on observ	et as evidenced by: vation the facility did not meet equirements for special					

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
		HAL047011	B. WING		04/0	6/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
THE CRO	DSSINGS AT WAYSID		ETTEVILLE I), NC 28376			
(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)	LD BE	(X5) COMPLETE DATE
C 101	Continued From pa	ge 1	C 101			
	Finding on 04/06/2017: a. A wiring diagram and system components location plan of the special locking system was not displayed adjacent to the fire alarm panel.					
C 111	Must Have Current	San. & Fire Safety Reports	C 111			
	fire and building sat	02 DESIGN AND				
	calendar year) requ	et as evidenced by: to have a current (within the lired fire marshal's inspection eview by the surveyor.				
	having jurisdiction i	017: rshal's or the local authority nspection report was not at the facility at the time of the				
C 164	Housekeeping and	Furnishings-Clean, Repaired	C 164			
	coverings kept clea (2) have no chronic (3) have furniture of	06 HOUSEKEEPING AND				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE SURVEY COMPLETED	
		HAL047011	B. WING		04/0	6/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	•		
THE CRO	DSSINGS AT WAYSID		ETTEVILLE I), NC 28376				
(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 164	Continued From pa	ge 2	C 164				
	chronic unpleasant Finding on 04/06/20 Room 309 - The ro	the facility was not free from odors. 017: om had a strong unrine odor the room into the immediate					
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 ad all fire safety, electrical, ambing equipment in an adult amaintained in a safe and					
	maintain the facility safe operating cond corridor doors are r and latch in the eve the smoke compart doors do not compl	et as evidenced by: ration there is a failure to 's fire safety equipment in a dition. Smoke resisting cross required to close completely ent of a fire. The occupants in ment could be effected if etely close and latch to help smoke or fire to the area of					
		or fire resistant rated door did closed when released from its					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
			D WING		0.4/0.5/	
		HAL047011	B. WING		04/0	6/2017
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE CRO	DSSINGS AT WAYSID	-	ETTEVILLE I D, NC 28376			
(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 SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 189	Continued From pa	ge 3	C 189			
	maintain the buildin a safe operating co device that is used impediment to quic containing smoke a the facility could be	ration there is a failure to gs's fire safety components in ndition. Any unapproved to keep a door open is an kly closing a door to aid in and/or fire. The occupants in effected if doors cannot be so as to limit the spread of o the area of origin.				
		017: rea Dining Room - The dining eld open with a kick down type				
	has not been maint Failure to maintain	ration the electrical equipment ained in a safe manner. electrical equipment is a safe t the safety of person exposed tion.				
		017: Room - The ground fault ectical outlet is detaching from				
C 199	Exhaust Ventilation		C 199			
	provided with exhautwo cubic feet per rrequirement does r	ed in this Paragraph shall be ust ventilation at the rate of ninute per square foot. This not apply to facilities licensed with natural ventilation in ces:				

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	of Health Service Re		()(0)	E CONOTRUCTION	()(0) 5 4 7 7	OLIDVEY.
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: 01			
		HAL047011	B. WING		04/0	6/2017
NAME OF	PROVIDER OR SUPPLIER	STATE, ZIP CODE				
TUE 004	2001100 47 144	_ 8398 FAYE	TTEVILLE	ROAD		
THE CRO	OSSINGS AT WAYSID	RAEFORD), NC 28376	;		
(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 APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 199	Continued From pa	ge 4	C 199			
	(2) soil utility room: (3) bathrooms and (4) housekeeping of (5) laundry area. (k) This Rule shall facilities with the extended by the required equipment in space exhausted by rule. Finding on 04/06/20 a. 100 Hall - The confunctioning in room b. 200 Hall - Storage	toilet rooms; closets; and apply to new and existing apply to new and existing acception of Paragraph (e) ly to existing facilities. Let as evidenced by: ration the facility failed to dexhaust ventilation as required to be mechanically control exhaust system was not				

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