STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			3) DATE SURVEY COMPLETED	
71101211	or correction.	BERTH 10/11/01/NOMBER	A. BUILDING:	A. BUILDING: 01			
		HAL025035	B. WING			R 10/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE			
NEW BE	RN HOUSE		UNSWICK AV RN, NC 2856				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
{C 000}	Initial Comments		{C 000}				
	Survey by Billy S. B 05/10/2017. There are deficience	I Follow Up Construction ryant conducted on sies from the Biennial					
	Construction Surve	y that remain to be corrected.					
{C 101}	Existing Licensed F	ac- No less than '71 Rules	{C 101}				
	PHYSICAL PLANT The physical plant is care home shall be (2) Except where of licensed facilities of facilities shall meet requirements in effecting in service of renovation, or alterathe requirements for addition or renovation or renovation or requirements from addition or requirements from addition or renovation or requirements. The requirements from addition or renovation or renovation or requirements from addition or requirements.	O1 APPLICATION OF REQUIREMENTS requirements for each adult applied as follows: otherwise specified, existing reportions of existing licensed licensure and code ect at the time of construction, or bed count, addition, ation; however in no case shall or any licensed facility where wation has been made, be less ments found in the 1971 ired Standards and omes for the Aged and Infirm", available at the Division of					
	comply with the NC signage that states 15 seconds. Alarm	et as evidenced by: vation the exits failed to State Building Code requiring , "Push, this door will open in will Sound", be placed on elayed egress locking system					
		017: nage for the exit doors from hidden by blinds installed on					

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

(X6) DATE TITLE

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
		HAL025035	B. WING		05/1	₹ <mark>0/2017</mark>
	PROVIDER OR SUPPLIER	2915 BRU	DRESS, CITY, S INSWICK AV RN, NC 2856			
(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 101}	the doors. 2. Based on obserfailed to comply wit that requires an audoor when the Delainitiated. Finding 05/10/2017 a. The alarm for the	vation, a Delayed Egress exit th the NC State Building Code dible signal in the vicinity of the lyed Egress sequence is E Delayed Egress door in the bounded from the alarm for the	{C 101}			
{C 189}	SECTION .0300 - F 10A NCAC 13F .03 REQUIREMENTS (a) The building an 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	{C 189}			
	Egress exit doors w "Green Hall" (east v start the irreversabl second and failed to fire alarm system w as the only means of endanger all of the were a fire and the system did not unlo	et as evidenced by: vation, the all the Delayed vith magnetic locks on the wing of the building)would not e process and unlock in 15 o release and unlock when the vas activated leaving keypads to unlock the doors. This could occupants in the wing if there keypads and fire alarm ick the doors to allow the ute from the building wing.				

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STATE FORM PKTN22 If continuation sheet 2 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
	HAI 025035		B. WING		R 05/10/2017	
		HAL025035			05/1	0/2017
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S I NSWICK AV	STATE, ZIP CODE		
NEW BE	RN HOUSE		N, NC 2856			
(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 189}	Continued From pa	ge 2	{C 189}			
	Findings on 05/10/2017: a. Green Hall Corridor exit door near room 67 did not release upon activation of the fie alarm.					
	b. The Green Hall Corridor exit door adjacent to room #72 did not release upon activation of the fie alarm.					
		Corridor exit door adjacent to id not release upon activation				
		om the TV Room did not ation of the fie alarm.				
		om the Activity Room did not ation of the fie alarm.				
		m left side of the dining room n activation of the fie alarm.				
	room #52 did not re	Corridor exit door adjacent to elease upon activation of the ey pad also used to open the e.				
	stated that BMS ha months ago but had work. A 'Plan of Proprovider reviewed v submitted to the DH	s were disengaged as part of				
	been damaged by vand were being ren	vation, several rooms had water leaks several weeks ago ovated. The smoke and/or been removed from the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
			A. BOILBING. 01			R	
		HAL025035	B. WING	· · · · · · · · · · · · · · · · · · ·		0/2017	
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY, S	STATE, ZIP CODE			
NEW BE	RN HOUSE		NSWICK AV				
040.15	CLIMANA DV CTA		N, NC 2856		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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
{C 189}	Continued From pa	ge 3	{C 189}				
		aged rooms. Missing fire ould delay activation of the fire actual fire.					
	room but the detect	2017: detector was replaced in the for for the closet was not ng on the closet shelf					
	ceiling in the corrido	2017: r is not properly mounted to or closet near room 48, the connected to its mounting					
	ceiling in soiled utili	r is not properly mounted to ty near room 47, the heat nected to its mounting base.					
	n. There are small heat detector in the	holes in the ceiling beside the Activity room,					
	the ceiling in the ox	or is not properly mounted to ygen storage closet, the heat nected to its mounting base.					
	ceiling in corridor cl	not properly mounted to oset near room 13, the heat nected to its mounting base.					
	maintain the facility system devices in a Failure to maintain equipment in a safe	·					
		ull station at the exit door from					

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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 COMP	SURVEY LETED	
			B. WING 05/2			
		HAL025035	B. WING		05/1	0/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
NEW BE	RN HOUSE		NSWICK AV N, NC 2856			
(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 SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
{C 189}	Continued From pa	ge 4	{C 189}			
{C 189}	•	ge 4 hed from the wall and is held	{C 189}			

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