Division	of Health Service Re	egulation				APPROVEL	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING		(X3) DATE SURVEY COMPLETED 05/23/2017		
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREE		ADDRESS, CITY, STATE, ZIP CODE			05/25/2017	
	REST HOME #1		ROLLTOWN I				
601031	REST HOWE #1	MACON, I	NC 27551				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TION SHOULD BE COMPLET THE APPROPRIATE DATE		
C 000	Initial Comments		C 000				
	Report by Paul Dixon						
	Survey on May 23, 2017 from 12:20 PM to 1:30 PM at the above referenced facility. DHSR records indicate the home was first licensed on November 1, 1962 as a Family Care Home for five (5) ambulatory Residents (able to evacuate and respond without any physical or verbal assistance during a fire or other emergency). Based on this information we are requiring the home to maintain compliance with the following: the 1971 "Rules for Family Care Homes Minimum and Desired Standards and Regulations", the applicable portions of the 2005 Rules 10A NCAC 13G for Family Care Homes, the 1958 North Carolina Uniform Residential Building Code, Appendix I of the 1958 North Carolina State Building Code.						
		isit, we cited deficiencies that ble plan of correction. They					
	Building Equipment	Maintained Safe, Operating	C 174				
	EQUIPMENT (a) The building and mechanical, and plucare home shall be operating condition	B17 BUILDING SERVICE and all fire safety, electrical, umbing equipment in a family maintained in a safe and					
	light fixtures in bed	et as evidenced by: g the survey showed that the room 2A are each missing a					
	ealth Service Regulation / DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE	

N89T21

PRINTED: 06/14/2017 FORM APPROVED

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL093001 NAME OF PROVIDER OR SUPPLIER			(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
		FCI 093001	B. WING		05/23/2017	
		DDRESS, CITY, SI	03/	03/23/2017		
OYD'S	REST HOME #1		ROLLTOWN R NC 27551	OAD		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
C 174	Continued From page 1		C 174			
	Provide copies of a	ing light bulbs in the fixtures. Il photographs and any other entation concerning this repair.				
C 183	Outside Premises-Clean, Safe		C 183			
	(a) The outside gr	318 OUTSIDE PREMISES rounds of new and existing shall be maintained in a clean				
	Observations durin front and kitchen er damaged screens. Provide copies of a	et as evidenced by: g the survey showed that the ntrance screen doors have Have the screens repaired. Il photographs and any other entation concerning this repair.				

N89T21