Division	of Health Service Re	egulation			FORM	APPROVED	
STATEMEN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED		
		HAL007014	B. WING			R 06/29/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
CLARA N	MANOR		ILICO STREE GTON, NC 27				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE	
{C 000}	Initial Comments		{C 000}				
		al Follow Up Construction a Fay conducted on Jun 29,					
		cies from the Biennial Follow urvey that remain to be					
C 107	Initial Licensure-Me	et NCSBC	C 107				
	SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0302 DESIGN AND CONSTRUCTION (a) Any building licensed for the first time as an adult care home shall meet the requirements of the North Carolina State Building Code for new construction. All new construction, additions and renovations to existing buildings shall meet the requirements of the North Carolina State Building Code for I-2 Institutional Occupancy if the facility houses 13 or more residents or the North Carolina State Building Code requirements for Large Residential Care Facilities if the facility houses seven to twelve residents. The North Carolina State Building Code, all applicable volumes, which is incorporated by reference, including all subsequent amendments may be purchased from the Department of Insurance Engineering Division located at 322 Chapanoke Road, Suite 200, Raleigh, North Carolina 27603 at a cost of three hundred eighty dollars						

rules of this Section.

offered in the facility.

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Based on observation and interview with

This Rule is not met as evidenced by:

(\$380.00). The facility shall also meet all of the

(b) Each facility shall be planned, constructed, equipped and maintained to provide the services

> (X6) DATE TITLE

Division of Health Service Regulation						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: 01		COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
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OLAKA	IANOR	WASHING	TON, NC 27	7889		
(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 APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 107	Continued From pa	ge 1	C 107			
		ed to plan, equip and maintain I in the facility at the time of				
	Findings on June 29, 2017: a. Manager Apartment - the Manager apartment is being leased as an apartment to the general public and the room has not been approved for that use.					
{C 164}	Housekeeping and	Furnishings-Clean, Repaired	{C 164}			
	SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0306 HOUSEKEEPING AND FURNISHINGS (a) Adult care homes shall: (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 facilities.					
	This Rule is not met as evidenced by: 1. Based on Observation, the facility failed to keep floors or floor coverings clean.					
	Findings on June 29, 2017: a. Right Side Back Exit - the floor tiles at the door are cracked and dirty. Interview with maintenance staff revealed that he was new and had not been given a copy of the report. The cracked tiles were not on the repair list he was given.					
	3. Based on obse keep ceiling clean a	rvation, the facility failed to and in good repair.				
	Findings on June 2	9, 2017:				

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		(X1) PROVIDER/SUPPLIER/CLIA	()		· - /	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: 01		COMPLETED		
		HAL007014	B. WING		R 06/29/2017		
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
CLARA I	MANOR		LICO STREE				
	011111111111111111111111111111111111111		TON, NC 27				
(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 APPROFILIENCY)	D BE	(X5) COMPLETE DATE	
{C 164}	Continued From pa	ge 2	{C 164}				
	have an excessive Interview with staff had not been notified b. Staff Bath - the excessive accumulation	exhaust fan cover, have an ation of dust/lint. Interview hat the cleaning staff had not					
{C 175}	Bedroom Furnishings-Clean Towel, Towel Bar		{C 175}				
	FURNISHINGS (b) Each bedroom s furnishings in good resident: (7) individual clean bar in the bedroom	PHYSICAL PLANT 06 HOUSEKEEPING AND shall have the following repair and clean for each towel, wash cloth and towel or an adjoining bathroom; and apply to new and existing					
	provide residents a	et as evidenced by: rvation, the facility failed to reas, with the required d/or towel bars for each					
	bedroom had one of Interview with staff only had one occup needed one towel b	9, 2017: athroom - this double occupant of its two towel bars broken. revealed that the bedroom ant and, therefore, only ar. However, the second bar eeds to be either repaired or					
{C 189}	Building Equipment	Maintained Safe, Operating	{C 189}				

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION (X3) DATE COMPI		
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HAL007014		B. WING		06/2	9/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CLARA I	MANOR		LICO STREI			
	OLIMAN DV OTA		TON, NC 27			
(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 APPROF	D BE	(X5) COMPLETE DATE
{C 189}	Continued From pa	ge 3	{C 189}			
	mechanical, and plucare home shall be operating condition (k) This Rule shall facilities with the ex which shall not app	and all fire safety, electrical, cumbing equipment in an adult maintained in a safe and apply to new and existing acception of Paragraph (e) ly to existing facilities.				
	1. Based on obse	rvation, the interior doors were safe and operating condition.				
	preventing it from c closes and latches, the floor rises at this trip hazard. Intervie that the floor has not a time consuming it the job long enough b. Kitchen - the dopreventing it from c closes and latches, the floor rises at this trip hazard. Intervie that the floor has not a time consuming it	the corridor door hits the floor, losing and latching. The door but still hits the floor because is location creating a possible with maintenance revealed of been repaired because it is tem and he has not been on in to complete this repair. For to Dining hits the floor, losing and latching. The door but still hits the floor because is location creating a possible lew with maintenance revealed of been repaired because it is tem and he has not been on in to complete this repair.				
	maintained in a safe because the electric being operated or n reliable illumination	rvation, the Building was not e and operating condition, cal lighting system was not naintained safely, providing. This could affect all visitors if walking areas and				

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA					ATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: 01		COMPLETED		
		HAL007014	B. WING		R 06/2	9/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CLARA N	MANOR	1218 PAM	LICO STREE	ĒΤ		
O E A I O A I			TON, NC 27			
(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 APPROFILIENCY)	D BE	(X5) COMPLETE DATE
{C 189}	Continued From pa	ge 4	{C 189}			
	tripping hazards or Findings on June 29 a. Right Side From was not operating to Interview with main light had not been repended that the b. Left Side Exitnot operating to illuming with maintenance so not been repaired been repaired been repaired that this was as Based on obsessafety was not main	9, 2017: It Exit - the exterior light fixture of illuminate the steps. It tenance staff revealed that the epaired because he had not have soon the report. It the exterior light fixture was minate the steps. Interview that the light had ecause he had not been soon the report. Invations, the Building fire entained in a safe and operating lid expose residents, all to intained in Room or				
	Findings on June 2st a. Old Manageme several cable penel fire-resistance-rated corrected before Cotthe site. Interview was revealed that this its the Owner is leasing outside client and the facility. The apafire wall and, thereforeed to be sealed. 4. Based on observe equipment was not operating conditionaresidents, staff, and	9, 2017: nt Apartment- the closet has				

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missing parts.

Division of Fleath Service Regulation						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: 01		COMPLETED	
		HAL007014	B. WING		R 06/29/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE	-	
TV WIL OF	NOVIDEN ON OUT LIEN		LICO STREI			
CLARA I	MANOR		TON, NC 27			
(Y4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)N	(X5)
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{C 189}	Continued From pa	ge 5	{C 189}			
	commode's "L" sha loosely connected to maintenance reveal hand grip when he b. New citation: L bedroom 12 - when	m near bedroom 12 - the ped hand grip (grab bar) was o the structure. Interview with led that he had missed this was working on the facility. adies Bathroom near the water was turned on in rown water and debris				
{C 195}	Hot Water System		{C 195}			
	provide an adequate kitchen, bathrooms closets and soil utilistemperature at all fibe maintained at a (38 degrees C) and F (46.7 degrees C). (k) This Rule shall facilities with the ex	system shall be of such size to e supply of hot water to the laundry, housekeeping ty room. The hot water xtures used by residents shall minimum of 100 degrees F shall not exceed 116 degrees				
	maintain the hot wa used by residents to degrees Fahrenheit degrees Fahrenheit	ervation, the Facility failed to ter temperature at all fixtures to be a minimum of 100 and shall not exceed 116				
	Findings on June 29 a. Ladies Bathroo	9, 2017: m - the sink had a hot water				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BOILDING. 01		R	
HAL007014			B. WING 06/29/2017			
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CLARA	MANOR		LICO STRE STON, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROF) BE	(X5) COMPLETE DATE
{C 195}	temperature of 92 of with staff revealed that this item was of clogged and the was	degrees Fahrenheit. Interview that he had not been notified on the list. Note: the sink was atter could not be run for a very to test the temperature	{C 195}			

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