Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
HAL078095		B. WING		09/14/2017		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HOPE SI	PRINGS	104 HOPE RED SPR	ELANE INGS, NC 28	3377		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y 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)	D BE	(X5) COMPLETE DATE
C 000	Initial Comments		C 000			
	Construction Section Biennial Survey report by Frank Strickland on 09/14/2017:					
	The facility was first licensed on 02/01/1973 with an addition approved on 02/20/1990. This facility is licensed for Sixty-Three (63) residents. Based on this information, we are requiring that this facility to meet the 1971 Minimum and Desired Standards and Regulations for Homes for the Aged and Infirm and the 1967 North Carolina State Building Code- Institutional Occupancy; the addition is being required to meet the 1987 Minimum Standards and Regulations for Homes for the Aged and Disabled and the 1978 North Carolina State Building Code; and the entire facility is required to meet the applicable portions of the 2005 Rules for Adult care Home of Seven or More Beds. Deficiencies have been cited and a Plan of Correction is required.					
C 166	Housekeeping-Mai	ntained Free of Hazards	C 166			
	orderly manner, fre hazards;	06 HOUSEKEEPING AND				
	1-Based on observ maintained free of	et as evidenced by: ation, this facility has not hazards. This could affect all by potentially exposing them ruptured cylinder.				

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

TITLE (X6) DATE Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED			
			A. BOILDING.	VI				
HAL078095		B. WING		09/14/2017				
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
HOPE SPRINGS 104 HOPE LANE RED SPRINGS, NC 28377								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y 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)	D BE	(X5) COMPLETE DATE		
C 166	Continued From page 1		C 166					
	Helium gas storage upright and unsecu or secured to the action	ed Room, there was a 112 ML e cyclinder that was standing red, not in an approved rack djacent wall by a chain.						
C 189	C 189 Building Equipment Maintained Safe, Operating		C 189					
	mechanical, and plicare home shall be operating condition (k) This Rule shall facilities with the expension of the condition	11 OTHER and all fire safety, electrical, umbing equipment in an adult maintained in a safe and						
	provide fire protecti	ation, this facility has failed to ion in all HVAC air distrubution the the ceilings that a part of the g assemblies.						
	The HVAC supply of HALL/RCC Office of	grille that is located in the 200 does not have any fire etrates the ceiling through a						
C 199	Exhaust Ventilation		C 199					
	SECTION .0300 - F 10A NCAC 13F .03							

6899

Division of Health Service Regulation STATE FORM

NLNS21 If continuation sheet 2 of 3

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 (X3)			(X3) DATE SURVEY COMPLETED	
		HAL078095	B. WING		09/14/2017		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
HOPE SI	PRINGS						
	0.0000000000000000000000000000000000000				011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
C 199	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		C 199				

Division of Health Service Regulation STATE FORM