Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: 0		(X3) DATE SURVEY COMPLETED			
						R-C	
	HAL034084		B. WING		09/	09/12/2017	
NAME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE			
FORSYTI	H VILLAGE		NSING DRIVE N SALEM, NC	27105			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
{C 000}	Initial Comments		{C 000}				
		t Follow Up Construction larrell on 9-12-2017.					
	Deficiencies were of Plan of Correction.	ited that will require a new					
C 110	Construction-Meet Sanitary Requirements		C 110				
	disposal and dietar the rules of the North Carolina Division which are incorporal subsequent amend the Sanitation of Ho Homes, Sanitarium Educational and Ot 18A .1300 are avail Department of Envi Resources, Division 2728 Capital Boule Copies may be obta Health Services Se						
	"Rules Governing t Care Facilities" Spe (a) [which requires	in compliance with The he Sanitation of Residential ecifically 15A NCAC 18A .1317 that] Effective measures shall vermin out of and to prevent					
vision of He	-	have effective measures in					

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE		E SURVEY PLETED		
			A. BUILDING: 01			R-C
		HAL034084	B. WING			12/2017
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
ORSYT	H VILLAGE		NSING DRIVE N SALEM, NC	27105		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
C 110	Continued From pa	ge 1	C 110			
	place to prevent an facility.	d/or remove bed bugs in the				
	Control company ha documentation, dat identifying the follow a. Bedroom 2, Aler b. Bedroom 12, Liv c. Bedroom 19, Ale d. Bedroom 34, Ale Inspection of the be the following; Bedbug carcasses walls in bedroom 12 the evidence was o	nentation showed the Pest ad provided the facility with ed 8-17-2017, of an inspectior ving bed bug alerts. t on bed, re bugs found, ert on bed by door,				
{C 164}	SECTION .0300 - F 10A NCAC 13F .03 FURNISHINGS (a) Adult care home (1) have walls, ceil coverings kept clea (2) have no chronic (3) have furniture o (e) This Rule shall facilities.	06 HOUSEKEEPING AND es shall: ings, and floors or floor n and in good repair; c unpleasant odors; clean and in good repair; apply to new and existing	{C 164}			
	keep walls, ceilings furniture clean and	ervation, the facility failed to , floors or floor coverings and				

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING: 01		COMP	COMPLETED	
		B. WING			R-C 09/12/2017		
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
FORSYT	H VILLAGE		SING DRIVE	27105			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)	
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETE DATE	
{C 164}	Continued From pa	ge 2	{C 164}				
	commode to the flo leaking out. New fi 2017: The tank top is now Finding on 5-2-2017 9-12-2017: ab. Tub Room near platform, which is c some of the corner	7 and 7-12-2017 and r Bedroom 24 - the tub overed with FRP, is missing moldings that protect p edges and prevents tub					
{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 which shall not app This Rule is not me Based on observati not being maintaine condition. Fire alar	11 OTHER ad all fire safety, electrical, umbing equipment in an adult maintained in a safe and apply to new and existing acception of Paragraph (e) ly to existing facilities. et as evidenced by: on, the fire alarm system was ed in a safe and operating m systems that do not work all residents and staff.	{C 189}				
	a. The corridor sm	oke detector near bedroom 30 ed with smoke but failed to n system .					

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE		(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NOMBER.	A. BUILDING: 01			
		HAL034084	B. WING			R-C 12/2017
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ORSYT	H VILLAGE		NSING DRIVE N SALEM, NC	27105		
(X4) ID			ID PROVIDER'S PLAN (
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	THE APPROPRIATE	
{C 189}	Continued From pa	age 3	{C 189}			
	the display states it the following need to i. 023 Duct ii. 030 Duct, 2 He iii. 62 DS 3 iv. 074 Duct v. 112 Duct Alarm vi. 001 FCPS Sup Because the fire ala Plan of Protection v facility agreed to be	eat nervision arm system was impaired, a was accepted in which the egin a fire watch to continue system is repaired and certified				

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