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		
		HAL074043	B. WING		10/0	4/2017
NAME OF PROVIDER OR SUPPLIER STREET ADI			ORESS, CITY, S	STATE, ZIP CODE		
RIVER O	AKS ASSISTED LIVIN	IG 716 WALL GRIFTON,	STREET NC 28530			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON SHOULD BE COMPLET DATE	
C 000	Initial Comments		C 000			
		action Section Biennial Survey and Ed Miller conducted on				
	02/01/1980. The fac 80 Beds. Therefore conformance with the Adult Care Homes of applicable portions North Carolina Build Occupancy, and the	is facility was first licensed on cility is currently licensed for the facility was surveyed for the 2005 Rules for Licensing of of Seven or More Beds and of the 1978 Edition of the ding Code(s), Institutional e 1977 Rules for Licensing of of Seven or More Beds in initial licensure.				
C 164	Housekeeping and	Furnishings-Clean, Repaired	C 164			
	FURNISHINGS (a) Adult care home (1) have walls, ceili coverings kept clea (2) have no chronic (3) have furniture of	es shall: ings, and floors or floor n and in good repair;				
	This Rule is not me 1. Based on observ the ceiling clean an	ation the facility has not kept				
	corridors have beer moisture accumulate	arious locations in the front n damaged by water leaks and tion. Repairs to those leas need to be completed to				

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

(X6) DATE TITLE

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: 01 B. WING _ HAL074043 10/04/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **716 WALL STREET RIVER OAKS ASSISTED LIVING** GRIFTON, NC 28530 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) C 166 C 166 Continued From page 1 C 166 Housekeeping-Maintained Free of Hazards C 166 SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0306 HOUSEKEEPING AND **FURNISHINGS** (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and (e) This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: 1. Based on observation there is a failure to maintain the facility free from hazards. Means of egress or exit paths that are obstructed or blocked could delay or hinder emergency evacuation of the occupants from the facility. Finding on 10/04/2017: a. Dining Room - The exit door was blocked and being held open by a dining room chair. Note: Corrected while surveyor was on site. 2. Based on observation the facility was not maintained free from hazards. Finding on 10/04/2017: a. 200 Hall Shower, Adjacent to Room 204 - The bottom of the hollow metal door frame for entrance door has rusted away leaving sharp and jagged edges. 3. Based on observation the facility was not maintained free from hazards. Oxygen bottles that are improperly stored may present a danger to the occupants of the facility.

Division of Health Service Regulation STATE FORM

Finding on 10/04/2017:

DIVISION	of Health Service Re	egulation				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED		
		HAL074043	B. WING		10/0	04/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RIVER OAKS ASSISTED LIVING 716 WALL GRIFTON,			STREET , NC 28530			
(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 166	Continued From pa	ge 2	C 166			
	were stored standing	Storage - Oxygen cylinders ag upright and without any so prevent them from falling				
	maintained free from the building code re electrical panels an	ration the facility is not m hazards. Encroaching upon equired clearance of 36" from d could delay timely operation rs in an emergency situation.				
		ectrical Room - Access to the nels is obstructed by items				
C 189	Building Equipment	Maintained Safe, Operating	C 189			
	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				
	failure to maintain t alarm system devic operating condition	ration and testing there is the facility's emergency fire es and equipment in a safe. All the occupants of the exted if the equipment failed to in case of a fire.				

Division of Health Service Regulation STATE FORM

6899 If continuation sheet 3 of 6 NHXX21

Division	of Health Service Re	egulation				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED		
		HAL074043	B. WING		10/04/201	17
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	41/0 40010TTD 1 11/11	716 WALI	STREET			
RIVERO	AKS ASSISTED LIVIN	GRIFTON	, NC 28530			
(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 CON	(X5) MPLETE DATE
C 189	Continued From pa	ge 3	C 189			
	a. There are a total lights in the facility.	of seven fire alarm strobe Five of the strobe lights did the fire alarm system was				
		I Renovated Bathrooms - The at detectors have been				
	maintain the facility safe operating cond compartment could doors have gaps or	ration there is a failure to 's fire safety equipment in a dition. Occupants in the smoke be exposed to smoke or fire if do not completely close and e spread of smoke or fire to				
	partition doors's ast	nt to Room 112 - f the top of the double smoke tragal is broken creating a gap oors which would allow smoke				
		t to Room 115 - The fire s contact each other and will e and latch.				
	c. Room 119 - Whe closed it did not late	en the door to the corridor was ch to remain shut.				
	Dutch door has a b	ffice - The top half of the arrel bolt type lock installed natically latch to remain closed				
	maintain electrical e equipment in safe of	ration the facility did not emergency/safety lighting operating condition. This could the facility if egress paths and				

Division of Health Service Regulation

STATE FORM 6899 If continuation sheet 4 of 6 NHXX21

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPI	E CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: 01		(X3) DATE SURVEY COMPLETED		
			A. DOILDING. VI			
		HAL074043	B. WING		10/0	4/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DIVED O	AKS ASSISTED LIVIN	716 WALL	STREET			
RIVER O	ANS ASSISTED LIVIN	GRIFTON	NC 28530			
(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 189	Continued From pa	ge 4	C 189			
	exits were not illum	inated during a power outage.				
		2017: 114 & 116 - When tested on all mounted emergency light				
		s at the exit doors from the iminate when switched to the				
		ration some of the the facility's nt has not been maintained.				
	portable fire extingu	017: rd that monthly checks of the uishers or the kitchen hood fire have been conducted.				
		ation HVAC electrical been maintained in a safe				
		thout overload protection was de electrical power to a				
C 199	Exhaust Ventilation		C 199			
	provided with exhautwo cubic feet per n requirement does n	ed in this Paragraph shall be ust ventilation at the rate of ninute per square foot. This lot apply to facilities licensed with natural ventilation in				

Division of Health Service Regulation STATE FORM

NHXX21 If continuation sheet 5 of 6

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 COMP	SURVEY LETED	
		HAL074043	B. WING		10/0	4/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
RIVER C	AKS ASSISTED LIVIN	1/2	STREET , NC 28530			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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)	JLD BE	(X5) COMPLETE DATE
C 199	(1) soiled linen sto (2) soil utility room (3) bathrooms and (4) housekeeping (5) laundry area. (k) This Rule shall facilities with the exwhich shall not app This Rule is not med 1. Based on observe maintain the exhause.	rage; toilet rooms; closets; and apply to new and existing apply to Paragraph (e) ly to existing facilities. et as evidenced by: vation the facility failed to st ventilation equipment.	C 199			

Division of Health Service Regulation STATE FORM

NHXX21