(X3) DATE SURVEY

Division of Health Service Regulation

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: 01 B. WING _ HAL080013 11/01/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1915 MOORESVILLE ROAD **CARILLON ASSISTED LIVING OF SALISBURY** SALISBURY, NC 28147 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 000 Initial Comments C 000 Report of Construction Section Biennial Survey by Dennis Harrell and Suzanna Fay on 11-1-2017. Records indicate this facility was first licensed on 9-3-1996, for 128 beds with 36 of those in a Special Care Unit. Therefore, we are requiring that this facility meet the 1996 Rules for Homes for the Aged and Disabled; Minimum Standards and Regulations, the applicable portions of the 2005 Rules for Adult Care Homes of Seven or More Beds and the 1996 edition of the North Carolina State Building Code Volume I - General Construction - Section 409 Institutional Occupancy (Group I). C 153 C 153 Exit Door Locks-Single Hand Motion SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0305 PHYSICAL **ENVIRONMENT** (h) The requirements for outside entrances and exits are: (3) All exit door locks shall be easily operable, by a single hand motion, from the inside at all times without keys; and This Rule is not met as evidenced by: Based on observation, the facility failed to provide single hand motion locks at all exits equipped with exit signs. Findings include: a. The exit door from the media room was equipped with a dead bolt lock and a lever latch. b. The exit door from A Hall near the personal laundry was equipped with a dead bolt lock and a lever latch.

(X2) MULTIPLE CONSTRUCTION

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 (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE SURVEY COMPLETED	
		HAL080013	B. WING		11/0	1/2017	
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
CARILLO	CARILLON ASSISTED LIVING OF SALISBURY 1915 MOORESVILLE ROAD SALISBURY, NC 28147						
(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)	LD BE	(X5) COMPLETE DATE	
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 hazards; (e) This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: 1. Based on observation, the stoves in the kitchen had been moved forward so that the range hood fire suppression nozzles were now pointed at the stoves' storage shelves rather than at the cooking surface. With the stoves miss-positioned, the range hood fire suppression system may not be capable of suppressing a range fire as designed. Note; This deficiency was corrected during the survey.		C 166				
	wand at the tub in t enough to reach the that there was no v Hoses on water fixt reach the flood rim possibility of siphor	vation, the hose on the shower he Spa on D Hall was long e sink basin and it appeared acuum breaker provided. Fures that are long enough to of the fixture present the hing contaminated water into nless a vacuum breaker is					
C 189	Building Equipment SECTION .0300 - F 10A NCAC 13F .03 REQUIREMENTS		C 189				

Division of Health Service Regulation

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				OATE SURVEY OMPLETED	
		HAL080013	B. WING		11/0	1/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
CARILLO	ON ASSISTED LIVING	OF SALISBURY	RESVILLE RY, NC 2814				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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)	LD BE	(X5) COMPLETE DATE	
C 189	Continued From pa	ge 2	C 189				
	mechanical, and plicare home shall be operating condition (k) This Rule shall facilities with the expension of the condition	and 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.					
	devices on the cros partition doors relea activation but then alarm system was s devices that re-ene	vation the magnetic hold open as-corridor fire and smoke ased the doors on fire alarm re-energized when the fire silenced. Magnetic hold open rgize before the fire alarm t could allow smoke and fire to					
	(magnetic locking) doors on fire alarm when the fire alarm Magnetic lock device	vation the Special Locking on the exit doors unlocked the activation but then locked system was silenced. ces that re-energize before the fully reset could delay an mergency.					
	sprinkler accelerate	vation, it appeared the or was turned off. Sprinkler ot maintained fully functional properly in a fire.					
	fire rated walls and in locations. Holes sealed with materia one-hour fire rated possibility that a fire	vation the required one-hour /or ceilings were compromised and penetrations that are not als approved for use in construction present the e that begins in one space can ther areas of the facility.					

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				B) DATE SURVEY COMPLETED		
			B 14/10					
		HAL080013	B. WING		11/0	1/2017		
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
CARILLO	ON ASSISTED LIVING	UE GVI IGBLIDA	DRESVILLE RY, NC 2814					
(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 APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE		
C 189	Continued From pa	ige 3	C 189					
C 189	a. Hole in the wall Country Kitchen, b. Smoke detector in the Garden Place corrected during the c. Gypsum componail heads in the cest. 5. Based on obser "screamer," protect switch was not wornear room C1. Maccould allow residen 6. Based on obser prevented from clost the passage doors that do not clost the possibione space can quick the remainder of the Findings include; a. The latchbolt was mop closet off the leb. The door to bed	behind the door to the C Hall loosely mounted to the ceiling e. Note; This deficiency was e survey. und was missing from many eiling on D Hall. vation, the warning device, ring the emergency release king at the exit from C Hall lifunctioning warning devices t elopement. vation, corridor doors are sing quickly and latching to of fire and smoke. Corridor ose completely and latch lity that a fire that begins in ekly spread to the corridor and e facility. s missing on the door to the	C 189					
	7. Based on obser men's bathroom wa	vation, the sink in the public as not tightly mounted to the unted sink could fall and cause						
C 199	Exhaust Ventilation		C 199					
	SECTION .0300 - F 10A NCAC 13F .03 REQUIREMENTS (g) The spaces list							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED	
		HAL080013	B. WING		11/0	1/2017	
	PROVIDER OR SUPPLIER ON ASSISTED LIVING	OF SALISBURY 1915 MOC	DDRESS, CITY, STATE, ZIP CODE ORESVILLE ROAD JRY, NC 28147				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (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 199	two cubic feet per requirement does repetitive specified spatchese	ust ventilation at the rate of minute per square foot. This not apply to facilities licensed it, with natural ventilation in nices: rage; toilet rooms; closets; and apply to new and existing apply to existing facilities.	C 199				

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