Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                 |  |   |                           |  | E SURVEY<br>MPLETED |                          |
|--|--|---|---------------------------|--|---------------------|--------------------------|
|  |  | A. BOILDING. VI   |                           |  |                     |                          |
| HAL053026  |  | B. WING 05/01/2018  |                           |  | 1/2018              |                          |
| NAME OF F  | PROVIDER OR SUPPLIER   |   |                           | STATE, ZIP CODE  |                     |                          |
| MAGNOL   | IA HOUSE RETIREM   | IENT CENTER   | RTHAGE STR<br>D, NC 27330 |  |                     |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)    | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE               | (X5)<br>COMPLETE<br>DATE |
| C 000  | Initial Comments   |   | C 000                     |  |                     |                          |
|  |  | on Biennial Survey report by<br>nd Suzanna Fay on                                       |                           |  |                     |                          |
|  | This facility was licensed as an Adult Care Home on 05/01/1988. Therefore, we are requiring that this facility meet the 1987 Rules for Homes for the Aged and the applicable portions of the 2005 Regulations for Adult Care Homes of Seven or more beds. It is also required to meet the 1978 Edition of the North Caroling State Building Code Volume 1-Section 409. LICENSED AS A 85 BED SCU              |   |                           |  |                     |                          |
|  | Deficiencies were cited and a Plan of Correction is required.  |   |                           |  |                     |                          |
| C 132  | Bathrooms-Must P   | rovide Privacy  | C 132                     |  |                     |                          |
|  | SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0305 PHYSICAL ENVIRONMENT (e) The requirements for bathrooms and toilet rooms are: (5) The bathrooms and toilet rooms shall be designed to provide privacy. Bathrooms and toilet rooms with two or more water closets (commodes) shall have privacy partitions or curtains for each water closet. Each tub or shower shall have privacy partitions or curtains; |   |                           |  |                     |                          |
|  | 1-Based on observ  | et as evidenced by:<br>ration, this facility has failed to<br>by curtains in bathrooms. |                           |  |                     |                          |
| Findings 05/01/2018: Privacy curtains were not in place at the following locations: (a) Men's Community Bath |  |   |                           |  |                     |                          |

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

(X6) DATE TITLE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | ` '  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: <b>01</b> |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|--|--|--|--|--|-------------------------------|--------------------------|
| HAL053026  |  | B. WING  | B. WING  |  | 01/2018                       |                          |
| NAME OF F  | PROVIDER OR SUPPLIER   | STREET A   | DDRESS, CITY, S                                    | STATE, ZIP CODE  |                               |                          |
| MAGNOL   | IA HOUSE RETIREM   | ENT CENTER   | RTHAGE STR<br>RD, NC 27330                         |  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                                | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | JLD BE                        | (X5)<br>COMPLETE<br>DATE |
| C 132  | Continued From pa  | ge 1   | C 132  |  |                               |                          |
|  | (b) Bathroom between   | een Rooms 13/14.   |  |  |                               |                          |
| C 148  | Corridors-Handrails  | 3  | C 148  |  |                               |                          |
|  | SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0305 PHYSICAL ENVIRONMENT (g) The requirements for corridors are: (2) Handrails shall be provided on both sides of corridors at 36 inches above the floor and be capable of supporting a 250 pound concentrated load;  This Rule is not met as evidenced by: 1-Based on observation, this facility has failed to maintain the corridor handrails.  Findings 05/01/2018: The handrail supporting wall brackets are not secure to adjacent walls located in the Main Lobby. |  |  |  |                               |                          |
|  |  |  |  |  |                               |                          |
|  |  |  |  |  |                               |                          |
| C 164  | Housekeeping and   | Furnishings-Clean, Repaired  | C 164  |  |                               |                          |
|  | coverings kept clea<br>(2) have no chronic<br>(3) have furniture of  | 06 HOUSEKEEPING AND  |  |  |                               |                          |
|  | This Rule is not me<br>1-Based on observa<br>kept clean and in go  | ation, this facility has not beer  | ı  |  |                               |                          |

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPL<br>A. BUILDING:   | TIPLE CONSTRUCTION (X3) DATE SU COMPLE |   |        |                          |
|---|---|--|--|---|--------|--------------------------|
| HAL053026   |   | B. WING  |  | 05/01/2018  |        |                          |
| NAME OF F   | PROVIDER OR SUPPLIER  |  | DRESS CITY S                           | STATE, ZIP CODE   | 1 00/0 | 7172010                  |
|   | IA HOUSE RETIREM  | IENT CENTER 1115 CAR   | THAGE STR                              | EET   |        |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRODE DEFICIENCY) | JLD BE | (X5)<br>COMPLETE<br>DATE |
| C 164   | that have excessive the ceiling framing: (a) Hall outside Roo (b) Community Bat  2-Based on observ kept clean and in g  Finndings on 05/01 The wall construction damage at the follor (a) Laundry Room (b) Salon Room un  3-Based on observ kept clean and in g  Finndings on 05/01 The flooring behind | /2018: ollowing locations have ceilings e cracking and not secured to om 5 h Men's Hall ration, this facility has not been ood repair.  /2018: on is not in place due to water owing locations: behind washing machines der hair-washing sink ration, this facility has not been ood repair. | C 164                                  |   |        |                          |
| C 166   | SECTION .0300 - F<br>10A NCAC 13F .03<br>FURNISHINGS<br>(a) Adult care home<br>(5) be maintained<br>orderly manner, fre<br>hazards;<br>(e) This Rule shall<br>facilities.   | 606 HOUSEKEEPING AND   | C 166                                  |   |        |                          |

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                  | (X2) MULTIPL<br>A. BUILDING: | E CONSTRUCTION  01   | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|---|---|------------------------------|--|-------------------------------|--------------------------|
| HAL053026   |   | B. WING   |                              | 05/0   | 05/01/2018                    |                          |
| NAME OF I   |   |   |                              | CTATE ZID CODE   | 03/0                          | 71/2010                  |
|   | PROVIDER OR SUPPLIER  | 1115 CAR  | THAGE STR                    | STATE, ZIP CODE<br>R <b>FFT</b>  |                               |                          |
| MAGNOI  | LIA HOUSE RETIREM   | ENT CENTER  | D, NC 27330                  |  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDERS) CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE                        | (X5)<br>COMPLETE<br>DATE |
| C 166   | Continued From pa   | ige 3   | C 166                        |  |                               |                          |
|   | obstructions and ha   | azards.   |                              |  |                               |                          |
|   | Finndings on 05/01<br>Oxygen bottles at the tobe not secured in (a) Eye-wash Station (b) Room 24  | he folling locations were found n approved racks:                                   |                              |  |                               |                          |
| C 189   | Building Equipment Maintained Safe, Operating   |   | C 189                        |  |                               |                          |
|   | SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. (k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities. |   |                              |  |                               |                          |
|   |   | ation, this facility has failed to ety equipment in a safe and                      |                              |  |                               |                          |
|   | Findings 05/01/201<br>The emergency light<br>not illuminate when  | nt located in the Dining Hall did   |                              |  |                               |                          |
|   |   | ation, this facility has failed to ety equipment in a safe and                      |                              |  |                               |                          |
|   | cracked at the door   | ed Laundry Room door is   |                              |  |                               |                          |

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: <b>01</b>  |  | (X3) DATE SURVEY<br>COMPLETED          |  |                          |
|--|--|---|--|--|--|--------------------------|
| HAL053026  |  | B. WING   |  | 05/01/2018                             |  |                          |
| MAGNOLIA HOUSE RETIREMENT CENTER 1115 CAR  |  |   | DRESS, CITY, S<br>THAGE STR<br>D, NC 27330 |  |  |                          |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |   | ID<br>PREFIX<br>TAG                        | (EACH CORRECTIVE ACTION SHOULD BE COMP |  | (X5)<br>COMPLETE<br>DATE |
| C 189  | Continued From pa  | ge 4  | C 189                                      |  |  |                          |
|  | 3-Based on observation, this facility has failed to maintain all fire-safety equipment in a safe and operating condition.  |   |  |  |  |                          |
|  | Findings 05/01/2018: The corridor door leading into the TV Room drags on the carpet that makes it difficult to close.  |   |  |  |  |                          |
|  | 4-Based on observation, this facility has failed to maintain all plumbing equipment in a safe and operating condition.  Findings 05/01/2018: The sink is not secure to the wall located Women's Spa. |   |  |  |  |                          |
|  |  |   |  |  |  |                          |
|  | 5-Based on observation, this facility has failed to maintain all fire-safety equipment in a safe and operating condition.  |   |  |  |  |                          |
|  | Findings 05/01/2018:<br>The door for Room 42 does not latch.   |   |  |  |  |                          |
| C 199  | Exhaust Ventilation  |   | C 199                                      |  |  |                          |
|  | provided with exhautwo cubic feet per 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 ces: rage; toilet rooms; |  |  |  |                          |

Division of Health Service Regulation

STATE FORM 6899 KLJZ21 If continuation sheet 5 of 6

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPL<br>A. BUILDING:   | E CONSTRUCTION<br>: 01   | (X3) DATE<br>COMP  | SURVEY<br>LETED |                          |
|--|---|--|--------------------------|--|-----------------|--------------------------|
| HAL053026  |   | B. WING  |                          | 05/01/2018   |                 |                          |
| NAME OF  | PROVIDER OR SUPPLIER  |  | DRESS, CITY, S           | STATE, ZIP CODE  | ,1 3333         |                          |
| MAGNO  | LIA HOUSE RETIREM   | IENI CENTER  | THAGE STR<br>D, NC 27330 |  |                 |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | _D BE           | (X5)<br>COMPLETE<br>DATE |
| C 199  | (5) laundry area. (k) This Rule shall facilities with the exwhich shall not app  This Rule is not many and the shall not app  This Rule is not many area.  1-Based on observe maintain exhaust value feet per minute. | apply to new and existing acception of Paragraph (e) bly to existing facilities.  et as evidenced by: ation, this facility has failed to entilation at the rate of two the per square foot.  8: thaust ventilation for the | C 199                    |  |                 |                          |

Division of Health Service Regulation STATE FORM