	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01			E SURVEY PLETED
FCL011196		B. WING		08/	29/2018	
NAME OF F	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
EVERGR	EEN LIVING HOME #	11	ILY RIDGE RO ER, NC 28748			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
C 000	Initial Comments		C 000			
	Report by Luis Pad	illa				
	PM at the above re records indicate the October 16, 1997 at (6) Residents with a residents (unable to without physical or or other emergency requiring the home following: The 1992 Regulations for Far applicable portions Care Homes 10A N Carolina State Build Small Residential C At the time of our v require an acceptal deficiencies listed b	isit, we cited deficiencies that ble plan of correction; all below were discussed with the exit interview. The listed				
C 154	SECTION .0300 - 1		C 154			
	FURNISHINGS (a) Each family ca (4) have a North (Environmental Hea classification at all s	Carolina Division of Ith approved sanitation				
	This Rule is not me	et as evidenced by:				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01			(X3) DATE SURVEY COMPLETED		
			B. WING				
				08/	29/2018		
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST				
EVERGF	REEN LIVING HOME #	11	ER, NC 28748				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
C 154	Continued From pa	ge 1	C 154				
	have a North Caroli	s each family care home shall ina Division of Environmental anitation classification at all					
	dead flies/bugs loca	as observed that there were ated in the back left Bathroom s not compliant with the rule.					
	corrected; provide t	s to have the deficiency to our office a new Sanitation along with your plan of					
C 174	Building Equipment	Maintained Safe, Operating	C 174				
	EQUIPMENT (a) The building ar mechanical, and plu care home shall be operating condition	BUILDING SERVICE and all fire safety, electrical, umbing equipment in a family maintained in a safe and					
		s all plumbing equipment in a hall be maintained in a safe					
		as observed that the toilet in was broken at its base. This is he rule.					
		s to have the deficiency documentation in the form of leted work.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011196		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: (E CONSTRUCTION 01		E SURVEY PLETED	
		B. WING		08/	08/29/2018		
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
EVERGR	EEN LIVING HOME #	11	ILY RIDGE RO ER, NC 2874				
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
C 174	Continued From pa	ge 2	C 174				
		s all plumbing equipment in a hall be maintained in a safe ition:					
		as observed that the in the re was a hole in the tub. This h the rule.					
	Make arrangements to have the deficiency corrected; provide documentation in the form of photos for all completed work.						
		s all building equipment in a hall be maintained in a safe ition:					
	loose handrail in the	as observed that there was a e back right Bathroom of the ompliant with the rule.					
		s to have the deficiency documentation in the form of leted work.					
		s all fire safety equipment in a hall be maintained in a safe ition:					
	Extinguishers for th	as observed that the Fire e home were not being hthly basis by staff. This is not rule.					
		s to have the deficiency documentation in the form of leted work.					
C 180	Building Service Ec	uipment-Call System	C 180				
ision of H	ealth Service Regulation						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL0111196			(X2) MULTIPLE A. BUILDING: ((X3) DATE SURVEY COMPLETED	
		ECI 011196	B. WING		08/	29/2018	
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		00/	29/2010	
		351 FAM	ILY RIDGE RO				
EVERGR	EEN LIVING HOME #	LEICEST	ER, NC 28748	3			
(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 AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
C 180	Continued From pa	ige 3	C 180				
	EQUIPMENT (f) Where the bed located in a separa bedrooms, an elect shall be provided co bedroom to the live resident call system can be activated wi on until deactivated activator shall be w his bed. (j) This Rule shall family care homes.	B17 BUILDING SERVICE room of the live-in staff is te area from residents' rically operated call system onnecting each resident -in staff bedroom. The n activator shall be such that it th a single action and remain I by staff. The call system ithin reach of resident lying on apply to new and existing et as evidenced by:					
	live-in staff is locate residents' bedroom system shall be pro- resident bedroom t During out visit it w system for the hom not compliant with t	s where the bedroom of the ed in a separate area from s, an electrically operated call ovided connecting each o the live-in staff bedroom: as observed that the call e was not functional. This is the rule. s to have the deficiency					
0.440	corrected; provide o invoices/receipts fo	documentation in the form of r all completed work.	0.440				
C 118	more operable wind 30 foot candles of I						

STATE FORM

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: 0	CONSTRUCTION		E SURVEY PLETED	
		B. WING		08/	08/29/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
EVERGR	REEN LIVING HOME #	11 351 FAMI	LY RIDGE RO	AD		
_		LEICEST	ER, NC 28748			
(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	(X5) COMPLET DATE
C 118	Continued From pa	ge 4	C 118			
		The windows must be low oors from the bed and chair, inch sill height.				
	have one or more o	et as evidenced by: s each resident bedroom must operable windows and be 0 foot candles of light at floor				
	for Bedroom #4 and	as observed that the window d #5 was not operating t compliant with the rule.				
		s to have the deficiency documentation in the form of leted work.				
C 138	Outside Entrances/	Exits-Single Hand Motion	C 138			
	(d) All exit doors lo	NTRANCES AND EXITS ocks must be easily operable, otion, from the inside at all				
	This Rule is not me	at as evidenced by:				
	1.) The rule require	s all exit doors locks must be a single hand motion, from the				
	entrance door for th	as observed that the side he home is not single hand compliant with the rule.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: 0		(X3) DATE COM	(X3) DATE SURVEY COMPLETED	
				1		
		FCL011196	B. WING		08/	29/2018
IAME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, ST			
VERGR	EEN LIVING HOME #	11	IILY RIDGE RO FER, NC 28748			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
C 138	Continued From page	ge 5	C 138			
		s to have the deficiency documentation in the form of leted work.				

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