STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED		
		FCL080024	B. WING		09/0	6/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LIBBY FA	AMILY CARE HOME			RBER ROAD		
			ND, NC 270			
(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 SHOU! CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 000	Initial Comments		C 000			
	Report by Luis Pad	illa				
	Survey on September 1:10 PM at the above records indicate the October 22, 2007 at three (3) ambulator and evacuate withous assistance during a Based on this information to maintain of the 2005 Rules 10.4 Homes and the 2005 Building Code - Research - Section R101.2. At the time of our virequire an acceptable deficiencies listed by	a Section conducted a Biennial per 6, 2018 from 11:35 AM to be referenced facility. DHSR is home was first licensed on a Family Care Home for y Residents (able to respond ut any physical or verbal fire or other emergency.) mation we are requiring the compliance with the following: NCAC 13G for Family Care 22 North Carolina State sidential (One & Two Dwelling) sit, we cited deficiencies that the plan of correction; all selow were discussed with the exit interview. The listed follows:				
C 101		lo Less than '71 Rules	C 101			
	PHYSICAL PLANT The physical plant r care home shall be (2) Except where of licensed homes or p homes shall meet li requirements in effecting in service of renovation or alterative requirements for no addition or renovation or	O1 APPLICATION OF REQUIREMENTS requirements for each family applied as follows: otherwise specified, existing portions of existing licensed				

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:					3) DATE SURVEY COMPLETED	
		FCL080024	B. WING		09/	06/2018
	PROVIDER OR SUPPLIER AMILY CARE HOME	4035 WOO		STATE, ZIP CODE RBER ROAD 113		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
C 101	"Minimum and Desi Regulations" for "Fa which are available Service Regulation Barbour Drive, Rale no cost; This Rule is not me 1.) The rule require specified, existing licensed ho code requirements construction, chang addition, renovation case shall the requirements for "Fa which are available Service Regulation Barbour Drive, Rale no cost: During our visit it was detectors of the hor connected to the hor connected to the hor compliant with the required to walk arc fires happen on a redeficiency has been also be documented been corrected prowatch as well as an Plan of Correction.	ired Standards and amily Care Homes", copies of at the Division of Health - Construction Section, 701 eigh, North Carolina 27603 at et as evidenced by: s Except where otherwise censed homes or portions of omes shall meet licensure and in effect at the time of it is in service or bed count, a or alteration; however, in no rements for any licensed dition or renovation has been those requirements found in and Desired Standards and amily Care Homes", copies of at the Division of Health - Construction Section, 701 eigh, North Carolina 27603 at eas observed that the smoke me were not permanently ouse current. This is not	C 101			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED		
	FCL080024		B. WING		09/06/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LIBBY F	AMILY CARE HOME		DDLEAF-BAI ND, NC 270	RBER ROAD 13		
(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 SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
C 101	existing licensed ho code requirements construction, chang addition, renovation case shall the requi home, where no ad made, be less than the 1971 "Minimum Regulations" for "Fa which are available Service Regulation Barbour Drive, Rale no cost: During our visit it we room of the home of treated with fire reta manufactures instru- with the rule.	icensed homes or portions of omes shall meet licensure and in effect at the time of the inservice or bed count, in or alteration; however, in no irements for any licensed dition or renovation has been those requirements found in and Desired Standards and amily Care Homes", copies of at the Division of Health - Construction Section, 701 eigh, North Carolina 27603 at as observed that the laundry did not seem to be properly ardant paint, per the actions. This is not compliant as to apply the fire retardant factures instructions. Once documentation in the form of	C 101			
C 111	Construction-Ceiling	g	C 111			
	SECTION .0300 - T 10A NCAC 13G .03 CONSTRUCTION (h) The ceiling sha one-half feet from t	02 DESIGN AND all be at least seven and				
	This Rule is not me 1.) The rule require seven and one-half	s the ceiling shall be at least				
	During our visit it wa	as observed that the in several				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
		FCL080024	B. WING		09/0	6/2018
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LIBBY F	AMILY CARE HOME		ND, NC 270	RBER ROAD 13		
(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 111	intent of the rule. To a serior of the rule. The reciling in the half be three locations is all three locations is all three locations is all three locations in the rule. The rule is a serior of the rule. The rule is a serior of the rule. The rule is a serior of the rule. The rule is a serior of the rule is a se	the ceiling did not meet the hese areas include: Bedroom hallway to the rear exit and the ath. The ceiling height for all bout 7 ft 2 in. Is to have the deficiency documentation in the form of all completed work. This was t survey on August 6, 2015.	C 111			
C 140	Storage Areas-Separate, Locked SECTION .0300 - THE BUILDING 10A NCAC 13G .0310 STORAGE AREAS (b) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be supervised while in use. This Rule is not met as evidenced by:		C 140			
	1.) The rule require locked areas for sto bleaches, pesticide may be hazardous During our visit it w cleaning agents be of the bathroom. The well. This is not cor	s there shall be separate bring cleaning agents, s, and other substances which if ingested, inhaled or handled: as observed that there were ing stored in the sink cabinet he cabinet was not locked as impliant with the rule.				
C 169	Fire Safety-Smoke	Detectors	C 169			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01			(X3) DATE SURVEY COMPLETED	
FCL080024		B. WING		09/0	06/2018	
NAME OF PF	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LIBBY FA	LIBBY FAMILY CARE HOME 4035 WO CLEVELA			RBER ROAD 113		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
	DISASTER PLAN (b) The building she detectors as require Building Code and I connected to a dedilocated in the attic a detectors shall be in provided with batter Note: Smoke detectinterconnected by the Rule permits the interconnected with not require it. This Rule is not med 1.) The rule require provided with smok North Carolina Statilisted heat detectors sounding device looksement. These connected and backup: During our visit it was detector in the attic battery. This is not consume the device is detector and that it device. Once compin the form of invoice 12.) The rule requires provided with smokes.	THE BUILDING 116 FIRE SAFETY AND nall be provided with smoke ed by the North Carolina State U.L. listed heat detectors icated sounding device and basement. These interconnected and be by backup. tors are required to be nis Rule. The application of the heat detectors to be smoke detectors, but does et as evidenced by: so the building shall be the detectors as required by the the Building Code and U.L. to so connected to a dedicated the attic and	C 169			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01			(X3) DATE SURVEY COMPLETED	
	FCL080024		B. WING		09/0	6/2018
				STATE, ZIP CODE RBER ROAD 113		
(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)	LD BE	(X5) COMPLETE DATE
C 169	listed heat detectors sounding device look basement. These conterconnected and backup: During our visit it was detector in the bath back up. This is not Make arrangements	s connected to a dedicated cated in the attic and detectors shall be be provided with battery as observed that the smoke room hallway was not battery compliant with the rule.	C 169			
C 174	SECTION .0300 - T 10A NCAC 13G .03 EQUIPMENT (a) The building ar mechanical, and plu care home shall be operating condition. (j) This Rule shall family care homes. This Rule is not me 1.) The rule require family care home sl and operating cond During our visit it wa the home (Bathroor	and all fire safety, electrical, ambing equipment in a family maintained in a safe and apply to new and existing et as evidenced by: so the building equipment in a hall be maintained in a safe ition: as observed that the doors for m, Bedroom 1, Bedroom 2, would not latch properly. This	C 174			
		s to have the deficiency documentation in the form of leted work.				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE COMF	SURVEY PLETED
	FCL080024		B. WING		09/0	06/2018
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LIBBY F	LIBBY FAMILY CARE HOME 4035 WOO			RBER ROAD 113		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 174	Continued From pa	age 6	C 174			
	The rule requires the building equipment in a family care home shall be maintained in a safe and operating condition: During our visit it was observed that there were					
	clasp locks being u	tilized on the two Bedroom ompliant with the rule.				
	Make arrangements to have the deficiency corrected; provide documentation in the form of photos for all completed work.					
		es the building equipment in a hall be maintained in a safe lition:				
	During our visit it was observed that a gate was being utilized to prevent residents and staff from using an inoperable door. There was also a steep ramp located in this area. The gate was found to be unlocked at the time of the survey. This is not compliant with the rule.					
	closed at all times.	s to ensure the gate remains Once completed provide ne form of photos for all				
		es the building equipment in a hall be maintained in a safe lition:				
	were being utilized around the refrigera	as observed that floor mats in the Kitchen, specifically ator and sink, presenting a trip e. This is not compliant with				
	Make arrangements to have the deficiency					

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	01	COMPLETED	
		FCL080024	B. WING		09/0	6/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
				RBER ROAD		
LIBBY F	AMILY CARE HOME		ND, NC 270			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				,		
C 174	Continued From pa	ge 7	C 174			
	corrected; provide of	documentation in the form of				
	photos for all comp					
	5) The rule require	s all fire safety equipment in a				
		hall be maintained in a safe				
	and operating cond					
	During our visit it wa	as observed that the Fire				
		e home were not being				
	maintained properly. These include:					
	a. Outside the Staff	Bedroom a Fire Extinguisher				
	was missing its tag	3				
	b. Fire Extinguisher the floor and last m	in the laundry room was on aintained in 2001				
		ishers all throughout the home ntained on a monthly basis.				
	Make arrangements to have the deficiencies corrected. Once completed provide documentation in the form of photos for all completed work.					
		s all fire safety equipment in a hall be maintained in a safe ition:				
	detector in the kitch	as observed that the heat en would not activate when ompliant with the rule.				
	Make arrangements to correct this deficiency; once completed provide documentation in the form of invoices for all completed work.					
		s all electrical equipment in a hall be maintained in a safe ition:				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 (X3) DAT CON			TE SURVEY MPLETED	
FCL080024		B. WING 09/0			06/2018	
LIBRY FAMILY CARE HOME 4035 WO				STATE, ZIP CODE RBER ROAD 013		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
Dur core laur con Mal core	d was being use ndry room to pow npliant with the r ke arrangements	as observed that an extension d as permanent wiring in the wer the refrigerator. This is not ule. Is to have the deficiency documentation in the form of	C 174			

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