PRINTED: 10/11/2018 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL046021			. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
		B. WING	B. WING		09/28/2018		
			ADDRESS, CITY, S	DDRESS, CITY, STATE, ZIP CODE			
STEPHE	NSON FAMILY CARE	HOME	AST RICHARD S KIE, NC 27910	TREET			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLET DATE	
C 000	Initial Comments		C 000				
	Report by Greg Williams						
	Survey on Septemb 10:30 AM at the ab records indicate the November 23, 2009 five (5) ambulatory evacuate and respo verbal assistance of emergency.) Base requiring the home the following: the 20 for Family Care Ho Carolina State Build Residential Care H	n Section conducted a Bienn ber 28, 2018 from 9:00 AM to ove referenced facility. DHS e home was first licensed on 9 as a Family Care Home for Residents (who are able to ond without any physical or luring a fire or other d on this information we are to maintain compliance with 005 Rules (10A NCAC 13G) mes and the 2009 North ding Code - Section 421.2 - omes. isit, we cited deficiencies that ble plan of correction. They	o SR				
C 116	Construction-Meet	Sanitary Requirements	C 116				
	CONSTRUCTION (m) The building s requirements as de Carolina Departme	THE BUILDING B02 DESIGN AND shall meet sanitation etermined by the North nt of Environment and Natur n of Environmental Health.	al				
	1. At the time of the the facility has a be is in violation of sar accordance with DI VERMIN CONTRO	et as evidenced by: e survey it was observed that d bug infestation. The facilit hitation regulations in ENR Form 2094 Section 14 PREMISES: Outside y screened or otherwise	ty				

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AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING		(X3) DATE SURVEY COMPLETED 09/28/2018	
		FCL046021	B. WING				
			ET ADDRESS, CITY, ST	DDRESS, CITY, STATE, ZIP CODE			
STEPHE	NSON FAMILY CARE	HOME	EAST RICHARD S SKIE, NC 27910	TREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE	
C 116	Continued From page 1		C 116				
	and other vermin; a used; premises nea litter and vermin ha The rule requires th requirements as de Carolina Departme	nt; effective control of roder approved pesticides proper at, clean, drained and free inborages and breading are building to meet sanitation etermined by the North nt of Environment and Nation of Environmental Health.	ly of eas. on ural				
C 117	Have Current San. And Fire Safety Approvals		C 117				
	CONSTRUCTION (n) The home sha fire and building sa	THE BUILDING 302 DESIGN AND Il have current sanitation a fety inspection reports whic I in the home and available	ch				
	1. At the time of the the facility did not h report available for facility to maintain of compliance with ap	et as evidenced by: e survey it was observed th have a current fire inspection review. The rule requires documented evidence of oplicable fire, sanitation and uding an annual fire inspec	n the				
C 174	Building Equipment	t Maintained Safe, Operatir	ng C 174				
	EQUIPMENT (a) The building a mechanical, and pl care home shall be operating condition	B17 BUILDING SERVICE nd all fire safety, electrical, umbing equipment in a fam maintained in a safe and apply to new and existing					

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL046021		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
		B. WING		09/28/2018		
		DRESS, CITY, S	TATE, ZIP CODE	09/20/2010		
	NSON FAMILY CARE	316 FAS	T RICHARD S			
	NJON FAMILI CARE	AHOSKIE	, NC 27910			1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
C 174	Continued From page 2		C 174			
	 At the time of the the Exhaust hood is when tested and n replaced. This rule equipment to be moperating condition At the time of the glass oven door needs to be repaire requires the mechamintained in a satisfier of the documentation of ophotographs, received and the glass oven door and the glass oven door needs to be repaire requires the mechamintained in a satisfier of the glass oven door needs to be repaire requires the mechamintained in a satisfier of the glass oven door needs to be repaire requires the mechamintained in a satisfier of the glass oven door needs to be repaired to be rep	e survey it was observed that or had been broken out and ed or replaced. This rule anical equipment to be fe and operating condition. es listed above provide completed work in the form of ipts, invoices, etc. ed above were discussed with				
vision of H	ealth Service Regulation		6899	Γ0Υ21		ation sheet

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