		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01			(X3) DATE SURVEY COMPLETED	
					R		
		FCL080024	B. WING			01/2019	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST				
IBBY F	AMILY CARE HOME		ODLEAF-BAR AND, NC 2701				
(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 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
{C 000}	Initial Comments		{C 000}				
	Report by Luis Padilla						
	Follow-up Survey o AM to 9:50 AM at th Not all of the previo corrected. Therefo	n Section conducted a Biennial n February 1, 2019 from 9:00 ne above referenced facility. usly cited deficiencies were re, further action is required.					
	The remaining deficiencies are as follows:						
{C 169}	Fire Safety-Smoke	Detectors	{C 169}				
	DISASTER PLAN (b) The building sh detectors as require Building Code and P connected to a ded located in the attic a detectors shall be in provided with batter Note: Smoke detect interconnected by th the Rule permits the	a16 FIRE SAFETY AND hall be provided with smoke ed by the North Carolina State U.L. listed heat detectors icated sounding device and basement. These hterconnected and be					
	provided with smok North Carolina Stat listed heat detectors sounding device loo basement. These of	s the building shall be e detectors as required by the e Building Code and U.L. s connected to a dedicated cated in the attic and					

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING: 0	COM	PLETED	
		B. WING		R 02/01/2019		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
	AMILY CARE HOME		ODLEAF-BAR			
			ND, NC 2701			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
{C 169}	Continued From pa	ge 1	{C 169}			
	During our visit it was observed that the heat detector in the attic was chirping and had a dying battery. This is not compliant with the rule.					
	Make arrangements to correct the deficiency, ensure the device is a 192-212 rated heat detector and that it is on a dedicated sounding device. Once completed provide documentation in the form of invoices for all completed work.					
	LAP 02/01/2019					
	observed that this o	ollow Up survey it was leficiency had not been ot compliant with the rule.				
{C 174}	Building Equipment Maintained Safe, Operating		{C 174}			
	EQUIPMENT (a) The building ar mechanical, and plu care home shall be operating condition	b17 BUILDING SERVICE and all fire safety, electrical, umbing equipment in a family maintained in a safe and apply to new and existing				
		s the building equipment in a hall be maintained in a safe				
	the home (Bathroor	as observed that the doors for n, Bedroom 1, Bedroom 2,) would not latch properly. This h the rule.				
	LAP 02/01/2019					

Division of Health Service Regulation STATE FORM

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE COM	E SURVEY PLETED
	FCL080024	B. WING			R 01/2019
PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
AMILY CARE HOME					
SUMMARY STA				CORRECTION	(X5)
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	COMPLET
Continued From pa	age 2	{C 174}			
observed that the d Staff Bedroom (bes not latch properly. rule. Make arrangement corrected; provide d	loors for the Bathroom and the side the rear entrance) would This is not compliant with the as to have the deficiency documentation in the form of				
	TOF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER AMILY CARE HOME SUMMARY STA (EACH DEFICIENC' REGULATORY OR L Continued From pa At the time of the F observed that the c Staff Bedroom (bes not latch properly. rule. Make arrangement corrected; provide	OF CORRECTION IDENTIFICATION NUMBER: FCL080024 PROVIDER OR SUPPLIER STREET AL 4035 WO CLEVELA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 At the time of the Follow Up survey it was observed that the doors for the Bathroom and the Staff Bedroom (beside the rear entrance) would not latch properly. This is not compliant with the	IT OF DEFICIENCIES OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:(X2) MULTIPLE A. BUILDING: CFCL080024B. WINGPROVIDER OR SUPPLIERSTREET ADDRESS, CITY, STAMILY CARE HOME4035 WOODLEAF-BAR CLEVELAND, NC 2701SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)ID PREFIX TAGContinued From page 2{C 174}At the time of the Follow Up survey it was observed that the doors for the Bathroom and the Staff Bedroom (beside the rear entrance) would not latch properly. This is not compliant with the rule. Make arrangements to have the deficiency corrected; provide documentation in the form of	IT OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AMILY CARE HOME 4035 WOODLEAF-BARBER ROAD CLEVELAND, NC 27013 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF O (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCY Continued From page 2 {C 174} C174} At the time of the Follow Up survey it was observed that the doors for the Bathroom and the Staff Bedroom (beside the rear entrance) would not latch properly. This is not compliant with the rule. KC 174} Make arrangements to have the deficiency corrected; provide documentation in the form of ID ID ID PREFIX	IT OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 (X3) DATE COM PROVIDER OR SUPPLIER FCL080024 B. WING 02/ PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 02/ AMILY CARE HOME 4035 WOODLEAF-BARBER ROAD CLEVELAND, NC 27013 02/ SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 2 {C 174} 40 174 40 174 At the time of the Follow Up survey it was observed that the doors for the Bathroom and the Staff Bedroom (beside the rear entrance) would not latch properly. This is not compliant with the rule. Make arrangements to have the deficiency corrected; provide documentation in the form of 40 174

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