STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>		E SURVEY PLETED	
		HAL064029	B. WING		05/	05/17/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
SOMERS	ET COURT OF ROCH		TWOOD DRIV				
(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 ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
C 000	Initial Comments		C 000				
		on Biennial Survey report by nducted on 05/17/2019:					
	currently licensed for facility was surveyed 2005 Rules for Lice Seven or More Bed the 1996 Edition of Code(s), Institution Rules for Licensing	ensed on 10/21/1996 and is or 60 Beds. Therefore, this d for conformance with the ensing of Adult Care Homes of Is and applicable portions of the North Carolina Building al Occupancy, and the 1996 of Adult Care Homes of Is in effect at the time of initial					
	Deficiencies have b Correction is requir	een cited and a Plan of ed.					
C 164	Housekeeping and	Furnishings-Clean, Repaired	C 164				
	FURNISHINGS (a) Adult care home (1) have walls, ceil coverings kept clea (2) have no chronic (3) have furniture of	06 HOUSEKEEPING AND					
		et as evidenced by: ation, this facility has failed to ring coverings and being kept					
		2019: nas come unfastened that is in he bathroom that is shared					

VHYH21

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>		E SURVEY PLETED	
		HAL064029	B. WING		05/17/2019		
AME OF F	AME OF PROVIDER OR SUPPLIER STREET A		ADDRESS, CITY, STATE, ZIP CODE				
OMERS	ET COURT OF ROC	KY MOUNT	STWOOD DRIV MOUNT, NC 2				
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
C 164	Continued From page 1		C 164				
	between Rooms 225/226 and is a trip hazard.						
	2-Based on observation, this facility has failed to maintain clean flooring coverings and being kept in good repair.						
	Findings on 05/17/2019: There is debris and grease build-up on the floor under the dishwasher unit in the Main Kitchen.						
		ation, this facility has failed to clean and in good repair.					
		nd adjacent to the following ve excessive grease build-up Main Kitchen: yer					
		ration, this facility has failed to the cooking appliances and					
		nd backs of the combination riddle have excessive grease					
		ration, this facility has failed to the cooking appliances and					
	Findings on 05/17/ The range hood fill build-up in the Mai	ers has excessive grease					
C 166	Housekeeping-Ma	ntained Free of Hazards	C 166				
aion of LL	ealth Service Regulation						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>		(X3) DATE SURVEY COMPLETED		
		HAL064029	B. WING		05/	05/17/2019	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, SI	TATE, ZIP CODE			
SOMERS	SET COURT OF ROCI		STWOOD DRIV MOUNT, NC 2				
(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 DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
C 166	Continued From pa	ige 2	C 166				
	FURNISHINGS (a) Adult care home (5) be maintained orderly manner, fre hazards;	06 HOUSEKEEPING AND					
	1-Based on observ	et as evidenced by: ation, this facility has not beer an and orderly manner, free o I hazards.					
		2019: piled up the ceiling on the top Storage Closet blocking the					
C 189	Building Equipmen	t Maintained Safe, Operating	C 189				
	mechanical, and pl care home shall be operating condition (k) This Rule shall facilities with the ex	11 OTHER ad all fire safety, electrical, umbing equipment in an adult maintained in a safe and					
	1-Based on observ	et as evidenced by: ation, this facility has failed to fety components in a safe and	ł				

STATEMENT OF DEFICIENCIES (X1)				(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>		E SURVEY PLETED
		HAL064029	B. WING		05/	17/2019
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		03/	17/2015
		918 WES	TWOOD DRIV			
OWERS		ROCKY	MOUNT, NC 2	7802		
(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 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
C 189	Continued From pa	age 3	C 189			
	Findings on 05/17/2019: The astragal has come on fastened at the base of the LH smoke barrier door as one enters the Dining Hall from the corridor allowing the passage of smoke and/or fire. 2-Based on observation, this facility has failed to		•			
	maintain the fire safety components in a safe and operating condition. Findings on 05/17/2019:					
	The entry door for Room 219 does not latch because the top door hinge is not secure.					
		ation, this faciltity has failed to fety components in a safe and				
	preventing the spre (a) Activity Room-1	or doors are wedged open not ad of smoke and/or fire:				
		ation, this facility has failed to anical exhaust system in a condition.				
		2019: has excessive particulate washer exhaust hood in the				
		ation, this facility has failed to ing fixtures in a safe and				
	Findings on 05/17/2 The toilet is not see	2019: cured to the floor in the shared				

If continuation sheet 4 of 5

STATEMENT OF DEFICIENCIES (X1) F AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: <b>(</b>	CONSTRUCTION	(X3) DATE COM	(X3) DATE SURVEY COMPLETED	
		HAL064029	B. WING		05/17/2019		
AME OF F	ROVIDER OR SUPPLIER		ADDRESS, CITY, S <sup>-</sup>	TATE, ZIP CODE	03/	1772015	
		918 WE	STWOOD DRIV MOUNT, NC 2	E			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE	
C 189	Continued From pa	ige 4	C 189				
	bathroom between	Rooms 215/216.					
	ealth Service Regulation					<u> </u>	