		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	R: A. BUILDING: 01		(X3) DATE SURVEY COMPLETED		
						R	
		HAL034104	B. WING		06/	26/2019	
IAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE			
RANQU	ILITY CARE		NSING DRIVE	27105			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	SHOULD BE COMPLE	
{C 000}	Initial Comments		{C 000}				
	Report of a Biennial Follow Up Construction Survey by Ed Miller, conducted on June 26, 2019.						
	Deficiencies were cited that will require a new Plan of Correction.						
{C 143}	Janitor's Closets-Locked		{C 143}				
	closets are: (B) There shall be storing cleaning ag and other substance	05 PHYSICAL tts for storage rooms and separate locked areas for ents, bleaches, pesticides, ses which may be hazardous if r handled. Cleaning supplies					
	1. Based on obse maintained in a saf separate locked are be hazardous if ing This deficiency affe	et as evidenced by: rvation, the building was not e manner by not having eas for substances that may ested, inhaled or handled. ects all residents, who my ome in contact with one of ubstances.					
	corridor door to this but the door is wide bleaches, and othe accessible to reside	, 2019: Closet near Bedroom 15 - the s room now has a lock now, e open and cleaning agents, r hazardous substances are ents. In addition, at the time of ff were in or around the room.					
(C 190)	Building Equipment	t Maintained Safe, Operating	{C 189}				

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Division of Health Service Reg STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING		(X3) DATE SURVEY COMPLETED
		HAL034104			R 06/26/2019
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	
TRANQL	JILITY CARE		NSING DRIVE N SALEM, NC	27105	
(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 AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE COMPI THE APPROPRIATE DAT
{C 189}	Continued From pa	ge 1	{C 189}		
	mechanical, and plu care home shall be operating condition (k) This Rule shall facilities with the ex which shall not app This Rule is not me 1. Based on obse was not maintained condition. This wou early detection and system. Findings on June 20 b. Laundry Water units have duct mor sampling tube are of c. Exterior Mech F on 12/06/2019, the	d all fire safety, electrical, umbing equipment in an adult maintained in a safe and apply to new and existing ception of Paragraph (e) ly to existing facilities. et as evidenced by: rvation, the Fire Alarm system l in a safe and operating ld affect all by not providing activating the fire alarm 6, 2019: Heater Room - the HVAC unted smoke detectors dirty. Room near Kitchen - observed sample tubes for the HVAC	I		
	no key on site to ac employee departed	-			
	safety was not mair condition. This coul not contained in roc Findings on June 2				
	on 12/06/2019, ther firestopped as they fire-resistance-rated	re are two holes not penetrate the d ceiling assembly. There is cess this room, as previous and took key.			

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034104		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		IDENTIFICATION NOMBER.	A. BUILDING: 01				
		HAL034104	B. WING		R 06/26/2019		
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
FRANQU			NSING DRIVE N SALEM, NC	27105			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF			
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
{C 189}	Continued From page 2		{C 189}				
	III. RCC Office Clo not firestopped as fire-resistance-rated						
{C 199}	Exhaust Ventilation		{C 199}				
	provided with exhau two cubic feet per n requirement does n before April 1, 1984 these specified spa (1) soiled linen stor (2) soil utility room; (3) bathrooms and (4) housekeeping o (5) laundry area. (k) This Rule shall facilities with the ex- which shall not app This Rule is not me 1. Based on Obse plastic sheet, the fa- ventilation system in could affect all resid preventing the exha Findings on June 2 b. Bedroom 26 St	11 OTHER ed in this Paragraph shall be ust ventilation at the rate of ninute per square foot. This tot apply to facilities licensed with natural ventilation in ces: rage; toilet rooms; closets; and apply to new and existing teption of Paragraph (e) ly to existing facilities. et as evidenced by: ervation and testing with a thin icility failed to maintain the n proper working order. This dents, staff, and visitors by austing of odors.					

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