Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE SURVEY COMPLETED	
			A. BOILDING.	VI	F	,	
		HAL032091	B. WING			5/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
DURHAM RIDGE ASSISTED LIVING 3420 WAKE FOREST HWY DURHAM, NC 27703							
(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)	D BE	(X5) COMPLETE DATE	
C 000	Initial Comments		C 000				
		I Follow Up Construction Fay conducted on September					
		ies cited in the Biennial y that remain to be corrected.					
C 189	Building Equipment Maintained Safe, Operating		C 189				
	SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. (k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities.						
	maintained in a safe because the door(s firewall did not clos restrict fire and smo residents, staff, and	et as evidenced by: vation, the Building was not e and operating condition,) protecting the opening in the e completely and latch to oke. This could affect all d visitors by not containing the the compartment of origin.					
	the fire alarm was a c. 300 Hall Firewal double-egress cros	all - one leaf did not latch when					

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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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			
			A. BUILDING. VI		R			
		HAL032091	B. WING			5/2019		
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
DURHAM RIDGE ASSISTED LIVING 3420 WAKE FOREST HWY DURHAM, NC 27703								
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE		
C 199	Continued From page 1		C 199					
C 199	Exhaust Ventilation		C 199					
	provided with exhautwo cubic feet per in requirement does in before April 1, 1984 these specified spa (1) soiled linen stor (2) soil utility room; (3) bathrooms and (4) housekeeping (5) laundry area. (k) This Rule shall facilities with the exwhich shall not app This Rule is not me 1. Based on Obser plastic sheet, the faventilation system in	ted in this Paragraph shall be ust ventilation at the rate of minute per square foot. This not apply to facilities licensed 4, with natural ventilation in aces: rage; ; I toilet rooms; closets; and apply to new and existing aception of Paragraph (e) bly to existing facilities. et as evidenced by: rvation and testing with a thin acility failed to maintain the in proper working order. This dents, staff, and visitors by						
	required exhaust vertice creating enough purplastic. c. Bedroom 201 E exhaust ventilation pull to hold a thin st	and 103 Bathroom - the entilation system is not all to hold a thin sheet of Bathroom - the required system is not creating enough	1					
	exhaust ventilation pull to hold a thin sh but this fan is at the	system is not creating enough heet of plastic. Replaced belt e end of the run for this unit. Bathroom - the required						

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STATE FORM FVGC22 If continuation sheet 2 of 3

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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 COMF	(X3) DATE SURVEY COMPLETED		
		HAL032091	B. WING			R 0 5/2019	
NAME OF PROVIDER OR SUPPLIER DURHAM RIDGE ASSISTED LIVING STREET ADDRESS, CITY, STATE, ZIP CODE 3420 WAKE FOREST HWY DURHAM, NC 27703							
(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 ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
C 199	exhaust ventilation pull to hold a thin sh	ge 2 system is not creating enough neet of plastic. Replaced belt end of the run for this unit.	C 199				

6899

Division of Health Service Regulation STATE FORM