(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: 01 B. WING \_ HAL081052 09/18/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2270 OAKLAND ROAD **CEDAR CREEK LIVING LLC** FOREST CITY, NC 28043 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) C 000 C 000 Initial Comments Construction Section Biennial Survey report by Frank Strickland and Suzanna Fay conducted on 09/18/2019: This facility was first licensed on 06/01/1968 for 44 residents. Based on this information, we are requiring that this facility to meet the 1967 Edition of the North Carolina State Building Code, the 1971 Rules for the Licensing of Adult Care Homes, and the applicable portions of the 2005 Regulations for Adult Care Homes of Seven or More Beds. Deficiencies have been ciate and a Plan of Correction is required. C 111 C 111 Must Have Current San. & Fire Safety Reports SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0302 DESIGN AND CONSTRUCTION( f) The facility shall have current sanitation and fire and building safety inspection reports which shall be maintained in the home and available for review. This Rule is not met as evidenced by: 1-Based on observation, this facility does not have current inspection reports on site for review. Findings on 09/18/2019: List below are required safety reports that were not on site for review: (a) Fire Inspection Report (b) Fire Alarm Inspection Report per NFPA 72 (c) Current Building Sanitation Report (d) Current Kitchen Sanitation Report

Division of Health Service Regulation

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

TITLE (X6) DATE

DIVISION	of Health Service Re	guiation			1	
	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	
		HAL081052	B. WING		09/1	8/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
CEDAR (	CREEK LIVING LLC		LAND ROAL CITY, NC 28			
		FOREST	JIII, NC 20	043		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 141	Continued From pa	ge 1	C 141			
C 141	Food Storage-Com	ply with Sanitation	C 141			
	closets are: (3) Food Storage. dry, refrigerated and with sanitation rules  This Rule is not me 1-Based on observa provided space for of food.  Findings on 09/18/2 At the time of surve equipped. There we	ts for storage rooms and Space shall be provided for d frozen food items to comply s; et as evidenced by: ation, this facility has not dry, refrigerated and frozen 2019: y, the Kitchen was not ere no shelves for storing dry not a functioning refrigerator or				
C 153	Exit Door Locks-Sir	ngle Hand Motion	C 153			
	exits are: (3) All exit door loc					

Division of Health Service Regulation STATE FORM

This Rule is not met as evidenced by: 1-Based on observation, this facility has failed to be maintained in a safe and operating condition.

KVEI21 If continuation sheet 2 of 9

Division	of Health Service Re	egulation				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>		(X3) DATE COMP	SURVEY PLETED
		HAL081052	B. WING		09/18/2019	
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET AD			STATE, ZIP CODE		
CEDAR CREEK LIVING LLC			KLAND ROAI CITY, NC 28			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 153	Continued From pa	ge 2	C 153			
	Findings on 09/18/2 The front entry door motion.	2019: r does not have single hand				
C 160	Outside Premises-0	Clean, Safe	C 160			
	(1) The outside gro					
		et as evidenced by: ation, this facility has not erior and the grounds.				
	Findings on 09/18/2 There is an abando of the front drive-wa	n vehicle at the left-hand side				
		ion, this facility has not rior and the grounds.				
	disrepair on the ent	as rooten wood siding and is ire outside construction. Also, penings that are not protected				
		ation, this facility has not rior and the grounds.				

following issues:

Findings on 09/18/2019: The gable end of HALL #1 and HALL #3 have the

(a) Peeling paint on the wood siding

<u> </u>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION <b>01</b>	(X3) DATE SURVEY COMPLETED	
		HAL081052	B. WING		09/1	8/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CEDAR (	CREEK LIVING LLC		LAND ROAL			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D BE	(X5) COMPLETE DATE
C 160	Continued From pa	ge 3	C 160			
	(b) Rooten wood sid (c) Wood soffit mat attic and not secure	erial that has opening into the				
		ation, this facility has not erior and the grounds.				
	Findings on 09/18/2019: There is a steel pipe column that supported the concrete walk-way outside Room 28 that has been hit and not longer providing support to the walk-way at the corner of the porch.					
		ation, this facility has not erior and the grounds.				
	Findings on 09/18/2 The basement wind 25 & 28.	2019: dows are broken below Rooms				
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	es shall: ings, and floors or floor n and in good repair;				
		et as evidenced by: ealed that the facility did not and floors kept clean and in				

Division of Health Service Regulation STATE FORM

6899 XVEI21 If continuation sheet 4 of 9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION  01	(X3) DATE SURVEY COMPLETED	
		HAL081052	B. WING		09/1	8/2019
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CEDAR	CREEK LIVING LLC		(LAND ROAI CITY, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
C 164	Continued From pa	ge 4	C 164			
	frames in the reside are rusting and dete the half baths betwee (b) Room 20 bathre	2019: rn of damaged metal door ent bathrooms. The frames eriorating along the bottom in een rooms at the back hall. oom vinyl floor tiles had been ceptable large joints between				
	2-Based on observation maintained the wall	ations,this facility has not s in good repair.				
	Findings on 09/18/2019: The block wall construction has been deconstructed to access plumbing fixtures on the other side of the closet for Room 28.					
C 166	Housekeeping-Mair	ntained Free of Hazards	C 166			
	orderly manner, fre hazards;	06 HOUSEKEEPING AND				
	This Rule is not me 1-Based on observa all obstructions and	ation, this facility is not free of				
	edges that are bent	2019: anter boxes that have pointed t upward with sharp edges that thata are located at the Dining				

Division of Health 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	
		HAL081052	B. WING	3. WING <b>09/</b> *		8/2019
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 03/1	0/2013
CEDAR CREEK LIVING LLC 2270 OA			LAND ROAL			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
C 166	Continued From pa	ge 5	C 166			
	Room entry betwee	n HALL #1 & HALL #2.				
	2-Based on observa	ation, this facility is not free of hazards.				
		re for a shed roof that covers adjacent to the Kitchen is				
C 170	Housekeeping-Curl	ains, Blinds, Res. Privacy	C 170			
	in resident use area privacy;	06 HOUSEKEEPING AND				
		et as evidenced by: ation, the facility has not w treatments for resident				
		2019: coms do not have any or blinds for privacy.				
C 189	Building Equipment	Maintained Safe, Operating	C 189			
	mechanical, and plu					

Division of Health Service Regulation

STATE FORM 6899 XVEI21 If continuation sheet 6 of 9

Division	Division of Health 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			
	HAL081052		B. WING		09/18/2019			
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE				
CEDAR CREEK LIVING LLC		LAND ROAL						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE		
C 189	operating condition (k) This Rule shall facilities with the ex which shall not app  This Rule is not me 1-Based on observa provided and maint components in a sa  Findings on 09/18/2 Directional exit sign the Dining Room be the exit door at the the Living Room.  2-Based on observa be maintained in a se  Findings on 09/18/2 The corridor doors not prevent the pas (a) Exit door/HALL (b) Rooms 3,4,8,9,  3-Based on observa be maintained in a se  Findings on 09/18/2 The following doors in disrepair: (a) Dining Room sid	apply to new and existing ception of Paragraph (e) ly to existing facilities.  et as evidenced by: ation, the facility has not ained the fire safety afe and operating condition.  2019: It is have been removed outside etween HALLS #1 &2 and at lend of HALL #2 adjacent to safe and operating condition.  2019: It is a total to safe and operating condition.  2019: It is a total to safe and operating condition.  2019: It is a total to safe and operating condition.  2019: It is a total to safe and operating condition.  2019: It is a total to latch and are decorated to latch and are decorated to the Living Room	C 189	DEFICIENCY				
		ation, this facility has failed to safe and operating condition.						

Findings on 09/18/2019:
Division of Health Service Regulation STATE FORM

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION <b>01</b>	(X3) DATE SURVEY COMPLETED	
		HAL081052	B. WING		09/1	8/2019
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CEDAR	CREEK LIVING LLC		LAND ROAL CITY, NC 28			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 189	Continued From pa	ge 7	C 189			
	The electrical conduits and water supply piping in the Kitchen and Basement are not secured to adjacent walls.					
		ation, this facility has failed to safe and operating condition.				
	Findings on 09/18/2019: The attic draft-stopping has been cut above Room 20 and a repair needs to provided.					
		ation, this facility has failed to ng fixtures in a safe and				
	Findings on 09/18/2 The toilets are not s locations: (a) Room 7 (b) Women's Bathro	secured at the following				
		ation, this facility has failed to safe and operating condition.				
	Findings on 09/18/2 All return-air grilles	2019: have excessive particulate.				
C 198	Night Lights		C 198			
	minimum lighting sl (3) 1 foot-candle po at night. (k) This Rule shall facilities with the ex	11 OTHER e required emergency lighting,				

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION 01	(X3) DATE COMP	SURVEY LETED	
		HAL081052	B. WING		00/1	8/2019
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	09/1	0/2019
			LAND ROAI			
CEDAR	CREEK LIVING LLC		CITY, NC 28			
(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 SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
C 198	Continued From pa	ge 8	C 198			
	provided adequate night.	ation, this facility has not lighting of the corridor floor at				
	Findings on 09/18/2 No night lighting ha corridors.	s been provided for the				

Division of Health Service Regulation STATE FORM