STATEMEN	of Health Service Re	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		SURVEY	
AND PLAN OF CORRECTION				A. BUILDING: <b>01</b>		(X3) DATE SURVEY COMPLETED	
		FCL054060	B. WING		09/	26/2019	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
A NEW B	EGINNING		T LENOIR AVE I, NC 28501	NUE			
(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 DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
C 000	Initial Comments		C 000				
	Report by Luis Pad	illa					
	records indicate the June 16, 1980 for fi This facility is licens Residents (able to r any physical or vert other emergency) v count was increase 1984. Based on thi the home to mainta following: the 1984 Minimum Standards portions of the 2008 Family Care Homes	ve referenced facility. DHSR e home was first licensed on ve (5) ambulatory Residents. sed for six (6) ambulatory respond and evacuate without oal assistance during a fire or which indicates that the bed d to six sometime after April 1 s information we are requiring in compliance with the "Family Care Homes s and Regulations," applicable 5 Rules 10A NCAC 13G for s and the 1978 North Carolina e - Section 409.1 (g) - acilities.					
	NOTES:						
	that require an acce	r visit, we cited deficiencies eptable plan of correction. All vere discussed with on-site interview.					
	once completed pro	correct all listed deficiencies, ovide verification in the form of voices, etc. for all work					
	The cited deficienci	es are as follows:					
C 149	Outside Entrances/	Exits-Handrails At Porches	C 149				
	SECTION .0300 - T	HE BUILDING 12 OUTSIDE ENTRANCE					

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Division	of Health Service Re	aulation			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION 01	(X3) DATE COMP	SURVEY LETED
		FCL054060	B. WING		09/2	6/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
A NEW E	BEGINNING		LENOIR AV NC 28501	ENUE		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	NC	(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
C 149	Continued From pa	ge 1	C 149			
	AND EXITS (f) All steps, porch provided with handr	es, stoops and ramps shall be ails and guardrails.				
	the the rear exit sta	et as evidenced by: survey it was observed that irs needed a second handrail t compliant with the rule.				
C 152	Floors		C 152			
	smooth, non-skid m to be easily cleanab (b) Scatter or throw	amily care home shall be of aterial and so constructed as				
	the floor of the hom repair. The floor wa	et as evidenced by: survey it was observed that e was not maintained in good as damaged or torn in . These locations include:				
	dining is uneven an b. There is a te room between the t kitchen.	ld between the kitchen and d the floor is ripped and torn. ear in the floor of the dining able and the door to the				
	kitchen, the floor be and spongy and the edge of the tub.	oom between the den and tween the tub and toilet is soft vinyl is pulling away at the bom between dining and				
	Bedroom 3, the floc tub is very soft and floor vent is heavily floor and the corner	r between the sink and the spongy. The floor around the stained. The perimeter of the				
Division of H	ealth Service Regulation					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: <b>0</b>	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		FCL054060	B. WING		09/26/20	19
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	-	
A NEW E	EGINNING		T LENOIR AVE N, NC 28501	NUE		
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE CON THE APPROPRIATE	(X5) MPLET DATE
C 152	Continued From pa	ige 2	C 152			
	<ul> <li>f. In Bedroom</li> <li>corner between the section of the shoe the corner and the g.</li> <li>g. There was a hallway vinyl floor b back of the stairs.</li> <li>This was cited during</li> </ul>	and curling at the edges. #1, the vinyl is torn in the fire place and side wall and a molding is broken between window. an approximately 6" tear in the between the front door and the ng our September 28, 2016 compliant with the rule.				
C 153	Houskeeping And F	Furnishings-Clean, Repaired	C 153			
	FURNISHINGS (a) Each family ca (1) have walls, cei coverings kept clea (2) have no chron (3) have furniture	HOUSEKEEPING AND				
	the upstairs ceiling peeling in the hallw office along the from mold where the dar revealed that the ro point and the dama prior leak. This was	et as evidenced by: e survey it was observed that was bubbled, flaking and ay at the front wall and in the nt wall. There appears to be mages are. Observations oof had been replaced at some ges may have been from a a cited during our September his is not compliant with the				
		e survey it was observed that oom #2, #3, and the Ladies				

Division	of Health Service Re	equiation			FORM APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: <b>0</b>	CONSTRUCTION 1	(X3) DATE SURVEY COMPLETED
		FCL054060	B. WING		09/26/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE	
A NEW B	EGINNING		T LENOIR AVE I, NC 28501	NUE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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 APP DEFICIENCY)	DULD BE COMPLETE
C 153	Continued From pa	ge 3	C 153		
	Bathroom would no compliant with the r	t latch properly. This is not ule.			
C 174	Building Equipment	Maintained Safe, Operating	C 174		
	EQUIPMENT (a) The building ar mechanical, and plu care home shall be operating condition	a17 BUILDING SERVICE and all fire safety, electrical, umbing equipment in a family maintained in a safe and			
	the sink in both bat	et as evidenced by: e survey it was observed that hrooms were deteached from ot compliant with the rule.			
	the toilets in both ba	e survey it was observed that athrooms were loose at its mpliant with the rule.			
		e survey it was observed that Hood light was not functional. ht with the rule.			
C 183	Outside Premises-0	Clean, Safe	C 183		
	(a) The outside gr	00000000000000000000000000000000000000			
		et as evidenced by: e survey it was observed that or the home had a build up of			

Division of Health Service Regulation STATE FORM

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## PRINTED: 10/04/2019 FORM APPROVED

Division of Health Service Regulation           STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	(X3) DATE	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBE		IDENTIFICATION NUMBER:	A. BUILDING: <b>01</b>		COMPLETED	
		FCL054060	B. WING		09/	26/2019
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
NEW B	EGINNING		T LENOIR AVE N, NC 28501	NUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
C 183	Continued From pa	ge 4	C 183			
	lint around it. This is	s not compliant with the rule.				
	the soffit on the rea	e survey it was observed that r right side of the home was ot compliant with the rule.				
	ealth Service Regulation					