| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|---|--|---------------------|---|-------------------------------|--------------------------|
| AND I LAW OF CONTROL | | | A. BUILDING: | UT | | |
| | | HAL051061 | B. WING | <u> </u> | 01/1 | 6/2020 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| PROVIDI | ENCE ASSISTED LIVI | NG 4302 NC 2 SMITHFIE | 210 ELD, NC 275 | 77 | | |
| (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 CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| C 000 | Initial Comments | | C 000 | | | |
| | | Construction Section Biennial by Suzanna Fay on January | | | | |
| | This facility originally operated as a County Home and was built prior to the 1967 Building Code. DHSR records indicate that this facility was converted to a Home for the Aged on September 1, 1986. The facility is currently licensed for 20 residents. Therefore the facility was surveyed for conformance with the applicable portions of the 2005 Rules for Adult Care Homes of Seven or More Beds. | | | | | |
| | The following defici | iencies were cited. | | | | |
| C 164 | Housekeeping and | Furnishings-Clean, Repaired | C 164 | | | |
| | FURNISHINGS (a) Adult care home (1) have walls, ceil coverings kept clea (2) have no chroni (3) have furniture of | 06 HOUSEKEEPING AND | | | | |
| | 1. Observations re | et as evidenced by: vealed that the walls and ot kept clean and in good | | | | |
| | damaged and does | se cabinet near the hood is | | | | |

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE | | SURVEY | | |
|---|--|---|---------------------|--|------|--------------------------|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING: 01 | | COMPLETED | | |
| | | | | | | |
| | | HAL051061 | B. WING | | 01/1 | 6/2020 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| PROVIDI | ENCE ASSISTED LIVI | NG 4302 NC 2 | | | | |
| | | | LD, NC 275 | | | |
| (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 APPROINT DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| C 164 | Continued From pa | ge 1 | C 164 | | | |
| | vented. The holes and will allow for per c. The exterior door not secure and most there are gaps bettexterior wall for pest the facility. d. A piece of the tild corner of the opening Mechanical Room. 2. Observations remot kept clean and in the proof of the period of the proof of the period water clean and in the proof of the pr | y 16, 2020: rd Bedroom - the ceiling has a roof leak and the ceiling large chunks. The ceiling tain in the middle of the room. | | | | |
| C 166 | SECTION .0300 - F 10A NCAC 13F .03 FURNISHINGS (a) Adult care home (5) be maintained i orderly manner, free hazards; (e) This Rule shall facilities. | es shall: n an uncluttered, clean and e of all obstructions and apply to new and existing et as evidenced by: vealed that the facility was not nazards. | C 166 | | | |

Division of Health Service Regulation STATE FORM

J7NW21 If continuation sheet 2 of 6

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION 01 | (X3) DATE SURVEY COMPLETED | |
|--|--|---|------------------------------|---|-------------------------------|--------------------------|
| | HAL051061 | | B. WING | | 01/16/2020 | |
| NAME OF F | PROVIDER OR SUPPLIER | | DRESS, CITY, S | STATE, ZIP CODE | 1 0171 | 0/2020 |
| PROVIDE | ENCE ASSISTED LIVI | NG 4302 NC 2 | | | | |
| | 0111414151/074 | | LD, NC 275 | | 211 | |
| (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 2 | C 166 | | | |
| | a. Kitchen - the metal kickplate on the exterior door from the kitchen was bent creating a hazard. | | | | | |
| C 185 | Fire Safety-Rehear | sals on Each Shift | C 185 | | | |
| | SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0309 PLAN FOR EVACUATION (b) There shall be rehearsals of the fire plan quarterly on each shift in accordance with the requirement of the local Fire Prevention Code Enforcement Official. (c) Records of rehearsals shall be maintained and copies furnished to the county department of social services annually. The records shall include the date and time of the rehearsals, the shift, staff members present, and a short description of what the rehearsal involved. (f) This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: 1. Review of records revealed that the facility was not conducting fire rehearsals each shift for each quarter. | | | | | |
| | Findings on Januar a. There was not a the first or third shif 2019. b. There was not a | y 16, 2020: record of a fire rehearsal for t during the second quarter of record of a fire rehearsal for t during the fourth quarter of | | | | |
| C 189 | Building Equipment | Maintained Safe, Operating | C 189 | | | |
| | SECTION .0300 - F 10A NCAC 13F .03 REQUIREMENTS | | | | | |

Division of Health Service Regulation STATE FORM

6899 J7NW21 If continuation sheet 3 of 6

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 | (X3) DATE SURVEY COMPLETED |
|--|-------------------------------|
| HAL051061 B. WING | 01/16/2020 |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | |
| PROVIDENCE ASSISTED LIVING 4302 NC 210 SMITHFIELD, NC 27577 | |
| (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY) | BE COMPLETE |
| C 189 Continued From page 3 (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. This Rule is not met as evidenced by: 1. Based on observation there is a failure to maintain the building's fire safety systems in a safe condition. Holes or gaps at penetrations through fire resistant rated ceilings could allow fire and smoke to spread beyond the area of origin. Findings on January 16, 2020: a. A Hall Women's Bath - there is an unsealed penetration at the ceiling where the conduit for the hand dryer enters the ceiling. b. B Hall Janitor's Closet - there is a large hole in the ceiling around the light fixture. c. Upper Level - there is an unsealed penetration to the right of the stair door at the pull station conduit. d. Upper Level Kitchen - there is a hole in the ceiling over the stove. 2. Based on observation there is a failure to maintain the facility's fire safety equipment in a safe operating condition. Occupants in the smoke compartment could be exposed to smoke or fire if doors do not completely close and latch to help limit the spread of smoke or fire to the area of origin. Findings on January 16, 2020: a. A Hall Diaper Storage - the frame is damaged and the latch plate is missing so that the door | |

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|---|---|---------------------|--|-------------------------------|--------------------------|
| AND PLAN OF CORRECTION | | DERTH TO A HOWDER. | A. BUILDING: | 01 | OCIVII LETED | |
| | | HAL051061 | B. WING | | 01/1 | 6/2020 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| PROVIDI | ENCE ASSISTED LIVI | NG 4302 NC 2 SMITHFIE | 210 ELD, NC 275 | 77 | | |
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| C 189 | Continued From pa | ige 4 | C 189 | | | |
| | does not close and latch. b. Men's Hall Bath - the door does not close completely and there is a gap around the door. | | | | | |
| | maintain the facility safe condition. In o smoke resident roo | vation there is a failure to 's fire safety equipment in a rder to resist the passage of m doors must not have holes e door and the door frame | | | | |
| | from the stair door | y 16, 2020: e door hardware was missing leaving a hole in the door. equired 1 hour fire rated | | | | |
| C 191 | Unvented & Portab | le Elec. Heaters Prohibited | C 191 | | | |
| | maintain 75 degree winter design condifollowing shall appliappliances. (2) Unvented fuel to portable electric he (k) This Rule shall facilities with the exwhich shall not app | a heating system sufficient to as F (24 degrees C) under itions. In addition, the y to heaters and cooking ourning room heaters and aters are prohibited. apply to new and existing acception of Paragraph (e) ly to existing facilities. | | | | |
| | Observations re portable electric he | vealed that the facility had two aters in the building. | | | | |
| 1 | Findings on Januar | ry 16, 2020: ere was a portable electric | | | | |

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SU IDENTIFICATIO | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION 01 | (X3) DATE SURVEY COMPLETED | |
|--|--|---|------------------------------|--|-------------------------------|--------------------------|
| | | HAL051061 | B. WING | | 01/1 | 6/2020 |
| | PROVIDER OR SUPPLIER ENCE ASSISTED LIVI | NG 4302 NC 2 | | STATE, ZIP CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| C 191 | heater in the office. b. Upper Level Bed | | C 191 | | | |

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