AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01			(X3) DATE SURVEY COMPLETED		
		FCL098036		B. WING		01/	10/2024
NAME OF F	PROVIDER OR SUPPLIER		REET ADI	DRESS CITY S	STATE ZIP CODE	<u> </u>	
2413 FOXCROFT RD							
COMPAS	SIONATE CARE HON	ME AT FOXCROFT WI	LSON,	NC 27893			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULI SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
C 000 Initial Comments		C 000					
	Report by Jonathan	n Gamsey					
	Survey on January 01:10 PM at the aborecords indicate the August 24, 2021 as (3) non-ambulatory and evacuate witho assistance during a Based on this we all compliance with the 10A NCAC 13G for applicable portions	n Section conducted a Bin 10, 2023 from 11:35 AM ove referenced facility. De home was first licensed a Family Care Home for Residents (unable to result any physical or verball fire or other emergency re requiring the home to be following: the 2005 Rul Family Care Homes the of the 2018 North Carolication 428.2 - Residential	to DHSR d on r six spond l '). be in es e				
	NOTES:						
	that require an acce	ur visit, we cited deficience eptable plan of correction vere discussed with on-s interview.	n. All				
	once completed pro	correct all listed deficient ovide verification in the fo voices, etc. for all work					
		e survey, it was identified rved any residents in the					
	The cited deficienci	es are as follows:					
C 105	Initial Licensure-Me	eet NCSBC		C 105			
	SECTION .0300 - T 10A NCAC 13G .03						

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01			(X3) DATE SURVEY COMPLETED		
		FCL098036		B. WING		01/	10/2024
NAME OF	PROVIDER OR SUPPLIER	ST	REET ADD	RESS, CITY, S	TATE, ZIP CODE		
COMPAS	SSIONATE CARE HOM	ME AT FOXCROFT		ROFT RD IC 27893			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 105	CONSTRUCTION (a) Any building lider family care home is requirements of the Code. All new contrenovations to exist requirements of the Code for One and Residential Care Frapplicable volumes Building Code, while reference, including may be purchased Insurance Enginee Chapanoke Road, Carolina 27603 at a dollars (\$380.00). (b) Each home shared	censed for the first time a hall meet the applicable of North Carolina State Bristruction, additions and ting buildings shall meet of North Carolina State Bristruction of Two Family Dwellings are acilities if applicable. All of The North Carolina State by gall subsequent amendrating Division located at 3 Suite 200, Raleigh, North a cost of three hundred of the planned, construction of the provide the serior of the provide the serior applicable.	the uilding ad State ments, 322 heighty ted,	C 105			
	1.) At the time of the laundry room of 210.8(A) states " D single-phase, 15- a installed in the local through (10) shall he circuit-interrupter p is not compliant with steps to reach out the install a GFCI in the 2.) At the time of the staff bathroom 210.8(A) states " D single-phase, 15- a	et as evidenced by: ne survey, it was observe oes not have a GFCI. Pe welling Units. All 125-vo and 20-ampere receptach tions specified in 210.8(have ground-fault rotection for personnel. ' the rule. Take the nece to a certified professional e laundry room for the welling units. All 125-vo and 20-ampere receptach tions specified in 210.8(er It, les A)(1) 'This essary It to asher. ed that Per It, les				

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED			
		FCL098036	B. WING		01/1	0/2024	
NAME OF PROVIDER OR SUPPLIER COMPASSIONATE CARE HOME AT FOXCROF1 STREET ADDRESS, CITY, STATE, ZIP CODE 2413 FOXCROFT RD WILSON, NC 27893							
(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 SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
C 105	is not compliant with steps to reach out to install a GFCI in the current receptacle. 3.) At the time of the DHSR does not have facility. This is not of the necessary steps.		C 105				
C 115	SECTION .0300 - T 10A NCAC 13G .03 CONSTRUCTION (I) The local code consulted before st renovations for info and construction re This Rule is not me 1.) At the time of the the garage in the fa without approval fro section. This is not the necessary steps	enforcement official shall be arting any construction or rmation on required permits quirements. et as evidenced by: e survey, it was observed that cility had had alterations om the DHSR construction compliant with the rule. Take is to follow up with the local or provide a permit to DHSR of needed provide	C 115				
C 147	SECTION .0300 - T	Exits-Single Hand Motion THE BUILDING 112 OUTSIDE ENTRANCE	C 147				

6899

Division of Health Service Regulation STATE FORM

LGV621 If continuation sheet 3 of 5

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		COMPLETED			
FCL098036			B. WING		01/10/2024		
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COMPASSIONATE CARE HOME AT FOXCROF1 2413 FOXCROFT RD WILSON, NC 27893							
(X4) ID	SUMMARY STA		WILSON,	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
C 147	Continued From pa	ge 3		C 147			
	by a single hand mo times without keys.	cks shall be easily operation, from the inside a Existing deadbolts of the of exit doors shall but.	at all turn				
	the front and rear strule above. This is i	et as evidenced by: e survey, it was obser torm doors do not me not compliant with the steps to alter the doo	et the rule.				
C 174	Building Equipment	Maintained Safe, Ope	erating	C 174			
	EQUIPMENT (a) The building ar mechanical, and plucare home shall be operating condition.	nd all fire safety, electrumbing equipment in a maintained in a safe	rical, a family and				
	the hallway bathroo loose toilet at the bate leaks to happen and injured when using compliant with the r	et as evidenced by: ne survey it was obser m near the rear exit h ase causing a potentia d also for residents to the facilities. This is n rule. Take the necessa to prevent any leaks	ad a al for be ot ary steps				
	bedroom #4 had an	e survey, it was obser extension cord. This ule. Take the necessa	is not				

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE COMI	(X3) DATE SURVEY COMPLETED	
		FCL098036	B. WING		01/	10/2024
NAME OF PROVIDER OR SUPPLIER COMPASSIONATE CARE HOME AT FOXCROF1 STREET ADDRESS, CITY, STATE, ZIP CODE 2413 FOXCROFT RD WILSON, NC 27893						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
C 174	to remove the exter utilize a surge prote 3.) At the time of the the rear ramp leading the grading built balead to a tripping harmonic to the surgery of th	nsion cord from the facility and ector if needed. e survey, it was observed that ng to the gate sidewalk needs ck up. This could potentially azard. This is not compliant the necessary steps to build	C 174			

6899

Division of Health Service Regulation STATE FORM