Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL046004	A. BUILDING: **01** B. WING _____	R **03/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELOATCH'S REST VILLA I	**104 E LEWISTOWN ROAD** **MURFREESBORO, NC 27855**

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	Initial Comments Report by Jonathan Gamsey DHSR Construction Section conducted a Biennial Follow-up Survey on March 13, 2024 from 01:45 PM to 02:25 PM at the above referenced facility. At the time of the survey not all deficiencies were corrected therefore further action is required. Additional deficiencies were also observed. NOTES: 1.) At the time of our visit, we cited deficiencies that require an acceptable plan of correction. All deficiencies listed were discussed with onsite staff during the exit interview. There were previous deficiencies that were not closed out from an open biennial survey, these deficiencies were brought forward from previous survey. 2.) Take actions to correct all listed deficiencies, once completed provide verification in the form of photos, receipts, invoices, etc. for all work performed. The cited deficiencies are as follows:	{C 000}		
{C 174}	Building Equipment Maintained Safe, Operating SECTION .0300 - THE BUILDING 10A NCAC 13G .0317 BUILDING SERVICE EQUIPMENT (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in a family care home shall be maintained in a safe and operating condition. (j) This Rule shall apply to new and existing family care homes. This Rule is not met as evidenced by: 1.) At the time of the survey, it was observed that	{C 174}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Adminstrator /Owner | 4/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL046004	A. BUILDING: **01** B. WING _____	R **03/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELOATCH'S REST VILLA I	**104 E LEWISTOWN ROAD MURFREESBORO, NC 27855**

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 174}	Continued From page 1 the residential smoke alarm in the 2nd story was not working as intended and is not interconnected with the downstairs hallway smoke detector. This is not compliant with the rule. Take the necessary steps to troubleshoot the smoke detector to ensure it is audible and interconnected with the residential smoke detector on the first floor.	{C 174}	Electrician has been out to assess smoke alarm system x's 2 and states that he is unable to connect wire from 2nd floor to hallway on 1st floor d/t construction of home. Fire Marshall will be out on 4/22 to reassess as well new opinion of another electrician to seeif complaint stated in report is doable. Expected date of completion cannot be determined as of now.	4/15/24