

Division of Health Service Regulation

|                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                   |                                                                                                                          |                                                        |
|----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>HAL017004</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: <b>01</b><br><br>B. WING _____                                                | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/20/2016</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>JEFFERSON CARE HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>111 STALEY BOSWELL ROAD<br/>YANCEYVILLE, NC 27379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| C 000                                                          | Initial Comments<br><br>Report of a Biennial Construction Survey by<br>Frank Strickland on 10/20/2016:<br><br>This facility was licensed on 12/01/1985 for<br>licensure as a Home for the Aged, serving<br>TWELVE CLIENTS on December 1, 1985.<br>Therefore, this facility must meet the 1984 and<br>applicable portions of the 2005 Rules for the<br>Licensing of Adult Care Homes, and, the 1978<br>North Carolina State Building Code with 1984<br>revision section 409.1(c) Institutional (I)<br>Occupancy- Unrestrained.<br><br>Deficiencies have been cited and a Plan of<br>Correction is required.                                                                                                                              | C 000                                                                                             |                                                                                                                          |                                                        |
| C 160                                                          | Outside Premises-Clean, Safe<br><br>SECTION .0300 - PHYSICAL PLANT<br>10A NCAC 13F .0305 PHYSICAL<br>ENVIRONMENT<br>(m) The requirements for outside premises are:<br>(1) The outside grounds of new and existing<br>facilities shall be maintained in a clean and safe<br>condition;<br><br>This Rule is not met as evidenced by:<br>1-Based on observations, this facility has failed to<br>maintain the facility and the grounds in a safe<br>manner. This could affect the residents while<br>walking the grounds.<br><br>Findings on 10/20/2016:<br>The following items present a hazard to residents<br>and staff:<br>(a) There are old bed mattresses at the back of<br>the facility at the dumpster that need to be<br>removed. | C 160                                                                                             |                                                                                                                          |                                                        |

Division of Health Service Regulation

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

TITLE

(X6) DATE

Division of Health Service Regulation

|                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                   |                                                                                                                          |                                                        |
|----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>HAL017004</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: <b>01</b><br><br>B. WING _____                                                | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/20/2016</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>JEFFERSON CARE HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>111 STALEY BOSWELL ROAD<br/>YANCEYVILLE, NC 27379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| C 160                                                          | Continued From page 1<br><br>(b) The pickets are missing at the front handrails<br>leaving the rail system unstable.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | C 160                                                                                             |                                                                                                                          |                                                        |
| C 164                                                          | Housekeeping and Furnishings-Clean, Repaired<br><br>SECTION .0300 - PHYSICAL PLANT<br>10A NCAC 13F .0306 HOUSEKEEPING AND<br>FURNISHINGS<br>(a) Adult care homes shall:<br>(1) have walls, ceilings, and floors or floor<br>coverings kept clean and in good repair;<br>(2) have no chronic unpleasant odors;<br>(3) have furniture clean and in good repair;<br>(e) This Rule shall apply to new and existing<br>facilities.<br><br>This Rule is not met as evidenced by:<br>1-Based on observations, this facility has failed to<br>maintain the interior wall construction in the<br>bathing facilities. This condition is harmful to the<br>occupants during the use of these facilities.<br><br>Findings on 10/20/2016:<br>The following locations have damaged ceramic<br>tile walls and floors:<br>(a) Rest Room #1 tub surrounding walls are<br>ungROUTED at the bases.<br>(b) Rest Room #2 has hole in the ceramic tile<br>surrounding wall at the tub/shower.<br><br>2-Based on observation, the facility has not<br>maintained the wood finishes of the interior doors<br>in good repair.<br><br>Findings on 10/20/2016:<br>Some of the resident entry room doors are<br>scratched, marked and have damaged edges due<br>wheel chair interaction at the following locations:<br>(a) Bedroom #2 | C 164                                                                                             |                                                                                                                          |                                                        |

Division of Health Service Regulation

|                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                   |                                                                                                                          |                                                        |
|----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>HAL017004</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: <b>01</b><br><br>B. WING _____                                                | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/20/2016</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>JEFFERSON CARE HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>111 STALEY BOSWELL ROAD<br/>YANCEYVILLE, NC 27379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| C 164                                                          | Continued From page 2<br><br>(b) Dining Room                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | C 164                                                                                             |                                                                                                                          |                                                        |
| C 189                                                          | Building Equipment Maintained Safe, Operating<br><br>SECTION .0300 - PHYSICAL PLANT<br>10A NCAC 13F .0311 OTHER<br>REQUIREMENTS<br>(a) The building and all fire safety, electrical,<br>mechanical, and plumbing equipment in an adult<br>care home shall be maintained in a safe and<br>operating condition.<br>(k) This Rule shall apply to new and existing<br>facilities with the exception of Paragraph (e)<br>which shall not apply to existing facilities.<br><br>This Rule is not met as evidenced by:<br>1-Based on observations, this facility has failed to<br>maintain the installation of the fire detection<br>devices. This could present a hazard regarding<br>the detection of smoke or fire to the residents,<br>guests and staff.<br><br>Findings on 10/20/2016:<br>The heat detector has been removed from ceiling<br>mount housing located in the Linen Closet.<br><br>2-Based on observations, this facility has failed to<br>maintain and service all the lighting fixtures in<br>occupied spaces. This is a hazard in the evening<br>use of such spaces by the residents and staff.<br><br>Findings on 10/20/2016:<br>All of the light bulbs have been removed in the<br>Day Room. | C 189                                                                                             |                                                                                                                          |                                                        |
| C 199                                                          | Exhaust Ventilation<br><br>SECTION .0300 - PHYSICAL PLANT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | C 199                                                                                             |                                                                                                                          |                                                        |

Division of Health Service Regulation

|                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                   |                                                                                                                          |                                                        |
|----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>HAL017004</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: <b>01</b><br><br>B. WING _____                                                | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/20/2016</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>JEFFERSON CARE HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>111 STALEY BOSWELL ROAD<br/>YANCEYVILLE, NC 27379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| C 199                                                          | Continued From page 3<br><br>10A NCAC 13F .0311 OTHER<br>REQUIREMENTS<br>(g) The spaces listed in this Paragraph shall be<br>provided with exhaust ventilation at the rate of<br>two cubic feet per minute per square foot. This<br>requirement does not apply to facilities licensed<br>before April 1, 1984, with natural ventilation in<br>these specified spaces:<br>(1) soiled linen storage;<br>(2) soil utility room;<br>(3) bathrooms and toilet rooms;<br>(4) housekeeping closets; and<br>(5) laundry area.<br>(k) This Rule shall apply to new and existing<br>facilities with the exception of Paragraph (e)<br>which shall not apply to existing facilities.<br><br>This Rule is not met as evidenced by:<br>1-Based on Observation, the facility failed to<br>provide an environment in accordance with this<br>Rule by not providing ventilation where odors are<br>generated. This could affect residents and staff<br>by subjecting them to house-keeping odors.<br><br>Findings on 10/20/2016:<br>The following rooms and spaces do not have<br>mechanical ventilation to remove odors:<br>(a) Laundry Room<br>(b) Janitor's Room<br>(c) Men's Bathroom accross the Hall from Staff<br>Quarters<br>(d) Bathroom #2 | C 199                                                                                             |                                                                                                                          |                                                        |
| C 200                                                          | Facilities for 7-12 Res.-Call System<br><br>SECTION .0300 - PHYSICAL PLANT<br>10A NCAC 13F .0311 OTHER<br>REQUIREMENTS<br>(h) In facilities licensed for 7-12 residents, an                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | C 200                                                                                             |                                                                                                                          |                                                        |

Division of Health Service Regulation

|                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                   |                                                                                                                          |                                                        |
|----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>HAL017004</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: <b>01</b><br><br>B. WING _____                                                | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/20/2016</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>JEFFERSON CARE HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>111 STALEY BOSWELL ROAD<br/>YANCEYVILLE, NC 27379</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| C 200                                                          | <p>Continued From page 4</p> <p>electrically operated call system shall be provided connecting each resident bedroom to the live-in staff bedroom. The resident call system activator shall be such that they can be activated with a single action and remain on until deactivated by staff at the point of origin. The call system activator shall be within reach of the resident lying on the bed.</p> <p>(k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities.</p> <p>This Rule is not met as evidenced by:<br/>1-Based on observations, this has failed to maintain the electrical call system for each resident bedroom. This conditon could cause harm to a resident in the event of assistance.</p> <p>Findings on 10/20/2016:<br/>The installed electrically operated call system failed to operate in each Resident Bedroom when tested.</p> | C 200                                                                                             |                                                                                                                          |                                                        |