

Division of Health Service Regulation

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                        |                                                                                                                 |                                                     |
|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>FCL051051</b>             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: <b>01</b><br><br>B. WING: _____                                      | (X3) DATE SURVEY COMPLETED<br><br><b>05/09/2017</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HESTER FAMILY CARE HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>154 HAVEN LANE<br/>PRINCETON, NC 27569</b> |                                                                                                                 |                                                     |
| (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                                                              | <p>Initial Comments</p> <p>Report by Paul Dixon</p> <p>DHSR Construction Section conducted a Biennial Survey on May 9, 2017 from 11:30 AM to 12:45 PM at the above referenced facility. DHSR records indicate the home was first licensed on August 21, 1980 as a Family Care Home for five (5) ambulatory Residents (able to evacuate and respond without any physical or verbal assistance during a fire or other emergency). Sometime after 1984 the facility increased their capacity from five to six all ambulatory residents. Based on this information we are requiring the home to maintain compliance with the following: the 1984 "Rules for Family Care Homes minimum and desired standards and regulations" with 1987 revisions, the applicable portions of the 2005 Rules 10A NCAC 13G for Family Care Homes, the 1978 (Rev 2) North Carolina State Building Code - Section 409.1 (g) - Residential Care Facilities.</p> <p>At the time of our visit, we cited deficiencies that require an acceptable plan of correction. They are as follows:</p> | C 000                                                                                  | <p><i>Explanation on 2nd page.</i></p>                                                                          |                                                     |
| C 174                                                              | <p>Building Equipment Maintained Safe, Operating</p> <p>SECTION .0300 - THE BUILDING<br/>10A NCAC 13G .0317 BUILDING SERVICE EQUIPMENT</p> <p>(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.</p> <p>(j) This Rule shall apply to new and existing family care homes.</p> <p>This Rule is not met as evidenced by:</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | C 174                                                                                  |                                                                                                                 |                                                     |

Division of Health Service Regulation

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

TITLE

(X6) DATE

*Shemad W. AIT* 8/1/17

STATE FORM

6899

XHJ221

If continuation sheet 1 of 2

Division of Health Service Regulation

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                        |                                                                                                                 |                                                     |
|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>FCL051051</b>             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: <b>01</b><br><br>B. WING: _____                                      | (X3) DATE SURVEY COMPLETED<br><br><b>05/09/2017</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HESTER FAMILY CARE HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>154 HAVEN LANE<br/>PRINCETON, NC 27569</b> |                                                                                                                 |                                                     |
| (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<br><br>Observations during the survey showed that the Kitchen range hood grease filter is dirty. Clean or replace the grease filter. Provide copies of all photographs and any other supporting documentation concerning this repair.                                                                                                                                                                                                                                                                                                             | C 174                                                                                  | Range hood filter was cleaned and photos are provided                                                           | 5/10/17                                             |
| C 183                                                              | Outside Premises-Clean, Safe<br><br>SECTION .0300 - THE BUILDING<br>10A NCAC 13G .0318 OUTSIDE PREMISES<br>(a) The outside grounds of new and existing family care homes shall be maintained in a clean and safe condition.<br><br>This Rule is not met as evidenced by:<br>Observations during the survey showed that there is a build-up of mildew on the siding of the right side and rear of the the home. Have the siding cleaned to remove the mildew. Provide copies of all invoices, photographs and any other supporting documentation concerning this repair. | C 183                                                                                  | outside of facility was washed and mildew removed and photos are provided.                                      | 5/15/17                                             |