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
	HAL096029	A. BUILDING: 01 B. WING	R 07/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUTTON'S RETIREMENT CENTER	4258 HWY 13 NORTH GOLDSBORO, NC 27534

(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 of a Follow Up Survey by Billy S. Bryant and Greg Cates conducted on 07/21/2015. Deficiencies noted during the Biennial Survey on 03/27/2015 remain to be corrected.	(C 000)		
(C 111)	Must Have Current San. & Fire Safety Reports SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0302 DESIGN AND CONSTRUCTION(f) The facility shall have current sanitation and fire and building safety inspection reports which shall be maintained in the home and available for review. This Rule is not met as evidenced by: I. Based on interviews the current fire and building safety reports were not available for review at the time of the survey. A.. Finding on 07/21/2015: 1. The following items from the previous biennial survey remain to be corrected. Findings on 03/27/2015 The following reports were not available at the time of the survey: d) Fire Marshals Report e) Fire Alarm Annual Test Report.	(C 111)	Fire Inspection has been completed, 9/4/15 attached copy	
(C 199)	Exhaust Ventilation SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (g) The spaces listed in this Paragraph shall be provided with exhaust ventilation at the rate of	(C 199)		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 9/24/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096029	A. BUILDING: 01 B. WING	R 07/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUTTON'S RETIREMENT CENTER	4258 HWY 13 NORTH GOLDSBORO, NC 27534

(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 199)	Continued From page 1 two cubic feet per minute per square foot. This requirement does not apply to facilities licensed before April 1, 1984, with natural ventilation in these specified spaces: (1) soiled linen storage; (2) soil utility room; (3) bathrooms and toilet rooms; (4) housekeeping closets; and (5) laundry area. (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: I. Based on observation the the requirement of the rule is not met. Spaces with exhaust fans installed fans must be vented to the exterior of the building. A. Finding on 07/21/2015: 1. The following item from the previous biennial survey remains to be corrected: Findings on 03/27/2015: Exhaust fans have issues in the following locations: (b) The exhaust fan next to HVAC unit #2 is venting into the attic.	(C 199)	Maint. man has been out, had emergency surgery, supplies have been purchased, working on finding someone to work, he may be back couple weeks.	10/31/2015

INSPECTION AND TESTING FORM

DATE: _____

TIME: _____

SERVICE ORGANIZATION

Name: D-arom

Address: 1007 11th Street

Representative: Chris Jones

License No.: _____

Telephone: 919-778-2670

PROPERTY NAME (USER)

Name: Sutton Retirement

Address: 4255 Hwy 13 North

Owner Contact: _____

Telephone: 919-759-4695

MONITORING ENTITY

Contact: Security Central

Telephone: _____

Monitoring Account Ref. No.: _____

APPROVING AGENCY

Contact: _____

Telephone: _____

TYPE TRANSMISSION

- ☐ McCulloh
- ☐ Multiplex
- ☑ Digital
- ☐ Reverse Priority
- ☐ RF
- ☐ Other (Specify) _____

SERVICE

- ☐ Weekly
- ☐ Monthly
- ☐ Quarterly
- ☐ Semiannually
- ☑ Annually
- ☐ Other (Specify) _____

Control Unit Manufacturer: Fire-Lite

Model No.: MS 9200 UD

Circuit Styles: Y

Number of Circuits: 10

Software Rev.: _____

Last Date System Had Any Service Performed: _____

Last Date that Any Software or Configuration Was Revised: _____

ALARM-INITIATING DEVICES AND CIRCUIT INFORMATION

Quantity	Circuit Style	
10	B	Manual Fire Alarm Boxes
		Ion Detectors
67	B	Photo Detectors
4	B	Duct Detectors
15	B	Heat Detectors
		Waterflow Switches
		Supervisory Switches
		Other (Specify): _____

Alarm verification feature is disabled _____ enabled _____.

(NFPA Inspection and Testing, 1 of 4)

FIGURE 10.5.2.3 Example of an Inspection and Testing Form.

ALARM NOTIFICATION APPLIANCES AND CIRCUIT INFORMATION

Quantity	Circuit Style	
2	5	Bells
		Horns
37	B	Chimes
		Strobes
		Speakers
		Other (Specify):

No. of alarm notification appliance circuits: _____
Are circuits monitored for integrity? ☐ Yes ☐ No

SUPERVISORY SIGNAL-INITIATING DEVICES AND CIRCUIT INFORMATION

Quantity	Circuit Style	
		Building Temp.
		Site Water Temp.
		Site Water Level
		Fire Pump Power
		Fire Pump Running
		Fire Pump Auto Position
		Fire Pump or Pump Controller Trouble
		Fire Pump Running
		Generator In Auto Position
		Generator or Controller Trouble
		Switch Transfer
		Generator Engine Running
		Other:

SIGNALING LINE CIRCUITS

Quantity and style of signaling line circuits connected to system *(see NFPA 72, Table 6.6.1)*:
Quantity _____ Style(s) _____

SYSTEM POWER SUPPLIES

(a) Primary (Main): Nominal Voltage 120 Amps 70
Overcurrent Protection: Type Circuit Amps 10
Location (of Primary Supply Panelboard): Kitchen
Disconnecting Means Location: Panel D Breaker 16
(b) Secondary (Standby):
2 12 Storage Battery: Amp-Hr. Rating 12
Calculated capacity to operate system, in hours: 24 60
Location of fuel storage: _____ Engine-driven generator dedicated to fire alarm system:

TYPE BATTERY

- ☐ Dry Cell
- ☐ Nickel-Cadmium
- ☑ Sealed Lead-Acid
- ☐ Lead-Acid
- ☐ Other (Specify):

(c) Emergency or standby system used as a backup to primary power supply, instead of using a secondary power supply:
_____ Emergency system described in NFPA 70, Article 700
_____ Legally required standby described in NFPA 70, Article 701
_____ Optional standby system described in NFPA 70, Article 702, which also meets the performance requirements of Article 700 or 701.

(NFPA Inspection and Testing, 2 of 4)

FIGURE 10.6.2.3 *Continued*

PRIOR TO ANY TESTING

NOTIFICATIONS ARE MADE	Yes	No	Who	Time
Monitoring Entity	☑	☐		
Building Occupants	☑	☐		
Building Management	☐	☐		
Other (Specify)	☐	☐		
AHJ Notified of Any Impairments	☐	☐		

SYSTEM TESTS AND INSPECTIONS

TYPE	Visual	Functional	Comments
Control Unit	☑	☑	
Interface Equipment	☑	☑	
Lamps/LEDS	☑	☑	
Fuses	☑	☑	
Primary Power Supply	☑	☑	
Trouble Signals	☑	☑	
Disconnect Switches	☑	☑	
Ground-Fault Monitoring	☐	☑	

SECONDARY POWER

TYPE	Visual	Functional	Comments
Battery Condition	☑		
Load Voltage		☑	
Discharge Test		☑	
Charger Test		☐	
Specific Gravity		☐	
TRANSIENT SUPPRESSORS	☐		
REMOTE ANNUNCIATORS	☐	☐	
NOTIFICATION APPLIANCES			
Audible	☑	☑	
Visible	☑	☑	
Speakers	☐	☐	
Voice Clarity	☑	☐	

INITIATING AND SUPERVISORY DEVICE TESTS AND INSPECTIONS

Loc. & S/N	Device Type	Visual Check	Functional Test	Factory Setting	Measured Setting	Pass	Fail
		☐	☐			☐	☐
		☐	☐			☐	☐
		☐	☐			☐	☐
		☐	☐			☐	☐
		☐	☐			☐	☐
		☐	☐			☐	☐

Comments: _____

(NFPA Inspection and Testing, 3 of 4)

FIGURE 10.6.2.3 *Continued*

EMERGENCY COMMUNICATIONS EQUIPMENT	Visual	Functional	Comments
Phone Set	☐	☐	
Phone Jacks	☐	☐	
Off-Hook Indicator	☐	☐	
Amplifier(s)	☐	☐	
Tone Generator(s)	☐	☐	
Call-in Signal	☐	☐	
System Performance	☐	☐	

INTERFACE EQUIPMENT	Visual	Device Operation	Simulated Operation
(Specify) _____	☐	☐	☐
(Specify) _____	☐	☐	☐
(Specify) _____	☐	☐	☐
SPECIAL HAZARD SYSTEMS			
(Specify) _____	☐	☐	☐
(Specify) _____	☐	☐	☐
(Specify) _____	☐	☐	☐

Special Procedures: _____

Comments: _____

SUPERVISING STATION MONITORING	Yes	No	Time	Comments
Alarm Signal	☑	☐		
Alarm Restoration	☑	☐		
Trouble Signal	☑	☐		
Supervisory Signal	☑	☐		
Supervisory Restoration	☐	☐		

NOTIFICATIONS THAT TESTING IS COMPLETE	Yes	No	Who	Time
Building Management	☑	☐		
Monitoring Agency	☑	☐		
Building Occupants	☑	☐		
Other (Specify)	☐	☐		

The following did not operate correctly: _____

System restored to normal operation: Date: _____ Time: _____

THIS TESTING WAS PERFORMED IN ACCORDANCE WITH APPLICABLE NFPA STANDARDS.

Name of Inspector: Chris Jones Date: 7/21/15 Time: 1200

Signature: _____

Name of Owner or Representative: _____

Date: _____ Time: _____

Signature: _____

(NFPA Inspection and Testing, 4 of 4)

FIGURE 10.6.2.3 *Continued*