

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL045110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B WING: _____	(X3) DATE SURVEY COMPLETED 03/09/2016
--	---	--	--

NAME OF PROVIDER OR SUPPLIER JUST IN TIME FCH UNIT 1	STREET ADDRESS, CITY, STATE, ZIP CODE 226 KENDRICK COURT FLAT ROCK, NC 28731
---	--

(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 Paul Dixon DHSR Construction Section conducted a Biennial Survey on March 9, 2016 from 10:15 AM to 11:35 AM at the above referenced facility. DHSR records indicate the home was first licensed on July 25, 1997 as a Family Care Home for six (6) Residents with to three (3) of whom may be non-ambulatory (un-able to evacuate and respond without any physical or verbal assistance during a fire or other emergency). Based on this information we are requiring the home to maintain compliance with the following: the 1992 "Rules for Family Care Homes Minimum and Desired Standards and Regulations", the applicable portions of the 2005 Rules 10A NCAC 13G for Family Care Homes, the 1996 North Carolina State Building Code - Section 419.3 - Residential Care Facilities. At the time of our visit, we cited deficiencies that require an acceptable plan of correction. They are as follows:	C 000		
C 123	Outside Premises-Clean, Safe SECTION .0300 - THE BUILDING 10A NCAC 13G .0318 OUTSIDE PREMISES (a) The outside grounds of new and existing family care homes shall be maintained in a clean and safe condition. This Rule is not met as evidenced by: Observations during the survey showed that the side window screen frame for the Manager's Bedroom is damaged. Have the screen repaired or replaced. Provide the DHSR Construction section with copies of all invoices, receipts, photographs and any other supporting	C 123		

Division of Health Service Regulation

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

TITLE

(X6) DATE

STATE FORM

4855

LD5721

If continuation sheet 1 of 2

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL045110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING: _____		(X3) DATE SURVEY COMPLETED 03/09/2016
NAME OF PROVIDER OR SUPPLIER JUST IN TIME FCH UNIT 1		STREET ADDRESS, CITY, STATE, ZIP CODE 226 KENDRICK COURT FLAT ROCK, NC 28731			
(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 183	Continued From page 1 documentation concerning this repair.		C 183		



LOUIS WILLIAMS & SONS
300 WEST KING ST
EAST FLAT ROCK, NC 28726
www.louiswilliams.com
PHONE: (828) 692-8216

PAGE NO 1

CUSTOMER NO 5 JOB NO 000 PURCHASE ORDER: REFERENCE
SOLD TO ***** CASH ***** SHIP TO FCH

TERMS CASH/CHECK/BANKCARD CLERK DLW

DATE / TIME 3/18/16 10:46
555

TAX 006 STATE SALES TAX

INVOICE: D99115

SHIPPED	ORDERED	UM	SKU	DESCRIPTION	SUGG	UNITS	PRICE /PER	EXTENSION
3	3	EA	SCREEN	SCREEN REPAIR AND MANUFACTURING	43.17	3	43.17 /EA	129.51
3	3	EA	SCREEN	SPREADER	2.50	3	2.50 /EA	7.50
** PAID IN FULL **					146.26	TAXABLE		137.01
						NON-TAXABLE		0.00
						SUB-TOTAL		137.01
BANKCARD PAYMENT BKCRD#					146.26	TAX AMOUNT		
						TOTAL AMOUNT		146.26

X
Received By _____

