

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING: _____	(X3) DATE SURVEY COMPLETED 05/18/2016
---	---	---	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

OAK HAVEN ASSISTED LIVING

**506 MATTOX ROAD
GREENVILLE, NC 27834**

(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 Biennial Construction Survey by Frank Strickland on 05/18/2016: Records indicate that this facility was first licensed on 08/01/1989 as a HA. The facility is currently licensed for 54 Beds, with a 22 Bed Special Care Unit. Therefore the facility was surveyed for conformance with the applicable portions of the 2005 Rules for Licensing of Adult Care Homes of Seven or More Beds, and applicable portions of the 1978(with amendments thru 1991) Edition, of the North Carolina Building Code(s), Institutional Occupancy, and the 1987 Minimum Standards and Regulations for Homes for the Aged in effect at time of initial licensure. Deficiencies have been cited and a Plan of Correction is required.	C 000		
C 101	Existing Licensed Fac- No less than 71 Rules SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0301 APPLICATION OF PHYSICAL PLANT REQUIREMENTS The physical plant requirements for each adult care home shall be applied as follows: (2) Except where otherwise specified, existing licensed facilities or portions of existing licensed facilities shall meet licensure and code requirements in effect at the time of construction, change in service or bed count, addition, renovation, or alteration; however in no case shall the requirements for any licensed facility where no addition or renovation has been made, be less than those requirements found in the 1971 "Minimum and Desired Standards and Regulations" for "Homes for the Aged and Infirm", copies of which are available at the Division of Health Service Regulation at no cost;	C 101		

Division of Health Service Regulation

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

TITLE

(X6) DATE

Douglas Frances

Administrator

06/28/2016

STATE FORM

5509

550Y21

If continuation sheet 1 of 6

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING: _____	(X3) DATE SURVEY COMPLETED 05/18/2016
NAME OF PROVIDER OR SUPPLIER OAK HAVEN ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 506 MATTOX ROAD GREENVILLE, NC 27834		
(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 101	Continued From page 1 This Rule is not met as evidenced by: 1-Based on observations, this facility has not maintained the measures for the Special Locking (magnetic locks) on the exit doors. Findings on 05/18/2016: No wiring diagram and system components location map has been provided nor mounted at the FACP.	C 101	<i>Done</i>	<i>6/24/16</i>
C 133	Bathrooms-Hand Grips SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0305 PHYSICAL ENVIRONMENT (a) The requirements for bathrooms and toilet rooms are: (b) Hand grips shall be installed at all commodes, tubs and showers used by or accessible to residents; This Rule is not met as evidenced by: 1- Based on observation, the facility has failed to provide hand grips in walk-in showers. This could result in falls due to unaccessibility to residents. Findings on 05/18/2016: The following resident rooms that have walk-in showers, do not have hand grips. (a) Room 101 (b) Room 102 (c) Room 115 (d) Room 116 (e) Room 201 (f) Room 202	C 133	<i>Hand grips will be purchased and installed on or before 7/22/16</i>	

Division of Health Service Regulation
STATE FORM

6000

550Y21

If continuation sheet 2 of 5

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING: _____	(X3) DATE SURVEY COMPLETED 05/18/2016
NAME OF PROVIDER OR SUPPLIER OAK HAVEN ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 506 MATTOX ROAD GREENVILLE, NC 27834		
(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 164	Continued From page 2	C 164		
C 164	Housekeeping and Furnishings-Clean, Repaired SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0306 HOUSEKEEPING AND FURNISHINGS (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; (2) have no chronic unpleasant odors; (3) have furniture clean and in good repair; (c) This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: 1-Based on observation, the facility has not maintained the plumbing fixtures in good repair. Findings on 05/18/2016: There is a loose toilet that is located in the Tub Room 2. 2-Based on observation, the facility has not maintained the exterior wood finishes of the interior doors in good repair. Findings on 05/18/2016: Some of the resident entry room doors are either scratched, marked and have damaged edges due wheel chair interaction. 3-Based on observation, the facility has not maintained the room wall finishes in habitable rooms in good repair. Findings on 05/18/2016: The wall by the window has damaged paint finishes in Room 214.	C 164 C 164	Done Painter contacted and doors scheduled to be repaired and painted by 7/20/16 Scheduled same time as doors 7/20/16	6/23/16

Division of Health Service Regulation
STATE FORM

6889

580Y21

If continuation sheet 3 of 5

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING: _____	(X3) DATE SURVEY COMPLETED 05/18/2016
NAME OF PROVIDER OR SUPPLIER OAK HAVEN ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 506 MATTOX ROAD GREENVILLE, NC 27834		
(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)	(X6) COMPLETE DATE
C 189	Continued From page 3	C 189		
C 189	Building Equipment Maintained Safe, Operating SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. (k) This Rule shall apply to new and existing facilities with the exception of Paragraph (a) which shall not apply to existing facilities. This Rule is not met as evidenced by: 1-Based on observations, the facility has failed to maintain the egress hardware on required exit doors in a safe and operating condition. This condition will eventually delay opening the doors in an event of an emergency for all residents and staff to exit the facility. Findings on 05/18/2016: The following locations have exit doors that have panic bars that are broken at the ends which makes operating the door's latching mechanism difficult: (a) SCU and of corridor exit door, (b) Exit door adjacent to Main Laundry (c) Kitchen exit door (d) Dining Hall	C 189		
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		

Panic Bars ordered and to be installed on or before 7/28/16

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING: _____		(X3) DATE SURVEY COMPLETED 05/18/2016
NAME OF PROVIDER OR SUPPLIER OAK HAVEN ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 506 MATTOX ROAD GREENVILLE, NC 27834		
(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 4 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 (a) which shall not apply to existing facilities. This Rule is not met as evidenced by: 1-Based on observation, this facility failed to provide an environment in accordance with this Rule by not providing ventilation where odors are generated. This could affect residents and staff by subjecting them to house-keeping odors. Findings on 05/18/2016: The mechanical exhaust fans are not exhausting interior air in the following locations: (a) All of the Resident Bathrooms in the Special Care Unit. (b) Room 202	C 199	Parts order, to be completed by 7/11/16		

Division of Health Service Regulation
STATE FORM

6000

580Y21

If continuation sheet 5 of 5