

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL079092	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/10/2016
NAME OF PROVIDER OR SUPPLIER MOYER'S REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5767 HWY 135 STONEVILLE, NC 27048		
(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 Ed Miller on August 10, 2016. Records indicate this facility was first licensed or submitted for licensure as a Home for the Aged serving 18 residents on or about 3-1-1971. Therefore the facility must meet the 1971 Minimum and Desired Standards for Homes for the Aged and Infirm, the applicable portions of the 2005 Rules for the Licensing of Adult Care Homes of Seven or More Beds, and the 1967 North Carolina State Building Code Section 407.1, Group D-2 -Institutional Occupancy Deficiencies were noted which require a Plan of Correction.	C 000		
C 148	Corridors-Handrails SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0305 PHYSICAL ENVIRONMENT (g) The requirements for corridors are: (2) Handrails shall be provided on both sides of corridors at 36 inches above the floor and be capable of supporting a 250 pound concentrated load; This Rule is not met as evidenced by: 1. Based on observation, the building was not providing handrails in the corridor that could support 250 pounds. This deficiency affects residents, staff and visitors who use unstable handrails by not providing increase safety, stability/balance, and maneuverability provide by these devices. Findings on August 10, 2016: a. Corridor across for Housekeeping - two large bedspread were blocking access to the corridor	C 148		

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 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL079092	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/10/2016
NAME OF PROVIDER OR SUPPLIER MOYER'S REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5767 HWY 135 STONEVILLE, NC 27048		
(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 148	Continued From page 1 handrails.	C 148		
C 150	Corridors-Free of equipment and Obstructions SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0305 PHYSICAL ENVIRONMENT (g) The requirements for corridors are: (4) Corridors shall be free of all equipment and other obstructions. This Rule is not met as evidenced by: 1. Based on observation, corridors were not free of all equipment and other obstructions. This would affect residents, staff and visitors by slowing or obstructing egress during an emergency. Findings on August 10, 2016: a. Back Left Exit - the exit door was blocked with multiple boxes and a wheelchair.	C 150		
C 152	Entrances-Steps, Porches with Handrails SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0305 PHYSICAL ENVIRONMENT (h) The requirements for outside entrances and exits are: (2) All steps, porches, stoops and ramps shall be provided with handrails and guardrails; This Rule is not met as evidenced by: 1. Based on observation, the building was not equipped with stable handrails and guardrails at steps, porches, stoops and ramps. This would affect all residents, staff and visitors who use these unstable handrail/guardrails by not providing increasing safety, stability/balance, and maneuverability required of these devices.	C 152		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL079092	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/10/2016
NAME OF PROVIDER OR SUPPLIER MOYER'S REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5767 HWY 135 STONEVILLE, NC 27048		
(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 152	Continued From page 2 Findings on August 10, 2016: a. Porch near Kitchen - a section of guardrail was loose. b. Central Back Exit - the handrail down the steps was loose. c. Front Porch Right Side - a section of guardrail was loose. d. Front Porch Left Side - a section of guardrail was loose.	C 152		
C 160	Outside Premises-Clean, Safe SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0305 PHYSICAL ENVIRONMENT (m) The requirements for outside premises are: (1) The outside grounds of new and existing facilities shall be maintained in a clean and safe condition; This Rule is not met as evidenced by: 1. Based on observation, the outside grounds were not maintained in a clean and safe condition. Findings on August 10, 2016: a. Front Left Yard - there was a 6 feet by 8 feet by 5 inches deep area where water was standing. Standing water can breed insect. b. Back yard - there were two wet mattress, a broken bench and an old fire extinguisher situated in the yard.	C 160		
C 164	Housekeeping and Furnishings-Clean, Repaired SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0306 HOUSEKEEPING AND FURNISHINGS (a) Adult care homes shall:	C 164		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL079092	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/10/2016
NAME OF PROVIDER OR SUPPLIER MOYER'S REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5767 HWY 135 STONEVILLE, NC 27048		
(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 3 (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; (e) This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: 1. Based on Observation, and interview with Manager, the facility failed to keep plumbing devices in clean and in good repair. Findings on August 10, 2016: a. Bathroom near Bedroom 19 - the toilet bowl was filled with paper towels. 2. Based on Observation, the facility failed to keep walls, ceilings, floors or floor coverings and furniture clean and in good repair. Findings on August 10, 2016: a. Bedroom near Bedroom 19 - the wall above the sink was marred up. b. Bedroom near Bedroom 19 - the wall above the commode was marred up. c. Bedroom near Bedroom 19 - the gypsum wall finish was rough and need to be sanded and finished. d. Right Back Exit - the paint on exterior side of the door was peeling off.	C 164		
C 166	Housekeeping-Maintained Free of Hazards SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0306 HOUSEKEEPING AND FURNISHINGS (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards;	C 166		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL079092	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/10/2016
NAME OF PROVIDER OR SUPPLIER MOYER'S REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5767 HWY 135 STONEVILLE, NC 27048		
(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 166	Continued From page 4 (e) This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: 1.1. Based on observation, the Building equipment was not maintained in a safe manner by not have properly working or installed parts. This could affect all residents, staff and visitors by not protecting them from falls or injury due to broken or missing parts. Findings on August 10, 2016: a. Bathroom near Bedroom 19 - the commode's tank top was broken, producing sharp edges. b. Left Back Exit - the storm door's Plexiglas panel was broken, producing sharp edges. 2. Based on Observation, a hazard was present due to the possibility of the backflow of contaminated water into the domestic water supply. Findings on August 10, 2016: a. Bathroom across from Bedroom 15 - the tub had a shower wand with hose long enough to reach gray water which was not equipped with a vacuum breaker to prevent backsiphonage of gray water back into the potable water plumbing lines. b. Staff Bathroom - the tub had a shower wand with hose long enough to reach gray water which was not equipped with a vacuum breaker to prevent backsiphonage of gray water back into the potable water plumbing lines. c. Bathroom near Staff Bedroom - the tub had a shower wand with hose long enough to reach gray water which was not equipped with a vacuum breaker to prevent backsiphonage of gray water back into the potable water plumbing lines. 3. Based on observation, the building was not	C 166		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL079092	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/10/2016
NAME OF PROVIDER OR SUPPLIER MOYER'S REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5767 HWY 135 STONEVILLE, NC 27048		
(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 166	Continued From page 5 maintained in a safe manner by failing to ensure that clothes dryer duct can exhaust freely to an open free area. This could affect all residents, staff and visitors by allowing lint to accumulate (fuel for a fire) Findings on August 10, 2016: a. Back Right Wing - the clothes dryer exhaust duct and vent were clogged.	C 166		
C 167	Housekeeping- Supply Soap, Clean Towels SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0306 HOUSEKEEPING AND FURNISHINGS (a) Adult care homes shall: (6) have a supply of bath soap, clean towels, washcloths, sheets, pillow cases, blankets, and additional coverings adequate for resident use on hand at all times; (e) This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: 1. Based on observation, the facility failed to maintain adequate supplies for resident use on hand at all times Findings on August 10, 2016: a. Group Bathroom near Bedroom 19 - there was no paper towels at the sink do dry your hands.	C 167		
C 174	Bedroom Furnishings-Table, Mirror, Chairs SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0306 HOUSEKEEPING AND FURNISHINGS (b) Each bedroom shall have the following	C 174		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL079092	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/10/2016
NAME OF PROVIDER OR SUPPLIER MOYER'S REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5767 HWY 135 STONEVILLE, NC 27048		
(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 6 furnishings in good repair and clean for each resident: (2) a bedside type table; (3) chest of drawers or bureau when not provided as built-ins, or a double chest of drawers or double dresser for two residents; (4) a wall or dresser mirror that can be used by each resident; (5) a minimum of one comfortable chair (rocker or straight, arm or without arms, as preferred by resident), high enough from floor for easy rising; (6) additional chairs available, as needed, for use by visitors; (e) This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: 1. Based on observation, the facility has failed to provide resident rooms with the required furnishings and furniture for the number of residents. Findings on August 10, 2016: a. Bedroom 14 - the room accommodates two residents but had no bedside table, no comfortable chair.	C 174		
C 176	Bedroom Furnishings-Light Overhead or Lamp SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0306 HOUSEKEEPING AND FURNISHINGS (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (8) a light overhead of bed with a switch within reach of person lying on bed; or a lamp. The light shall provide a minimum of 30 foot-candle power of illumination for reading. (e) This Rule shall apply to new and existing	C 176		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL079092	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/10/2016
NAME OF PROVIDER OR SUPPLIER MOYER'S REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5767 HWY 135 STONEVILLE, NC 27048		
(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 176	Continued From page 7 facilities. This Rule is not met as evidenced by: 1. Based on observation, the facility failed to provide the required lighting for a bedroom. Findings on August 10, 2016: a. Bedroom 14 - the room accommodates two resident but had no bedside lamp or light controlled from the bed.	C 176		
C 181	Fac. Licensed Before 1/1/1984, Fire Alarm Sys SECTION .0300 - PHYSICAL PLANT 10a NCAC 13F .0307 FIRE ALARM SYSTEM (c) In a facility licensed before April 1, 1984 and constructed prior to January 1, 1975, the building, in addition to meeting the requirements of the North Carolina State Building Code in effect at the time the building was constructed, shall be provided with the following: (1) A fire alarm system with pull stations within five feet of each exit and sounding devices which are audible throughout the building; (2) Products of combustion (smoke) U/L listed detectors in all corridors. The detectors shall be no more than 60 feet from each other and no more than 30 feet from any end wall; (3) Heat detectors or products of combustion detectors in all storage rooms, kitchens, living rooms, dining rooms and laundries; (4) All detection systems interconnected with the fire alarm system; and (5) Emergency power for the fire alarm system, heat detection system, and products of combustion detection with automatic start generator or trickle charge battery system capable of operating the fire alarm systems for 24 hours and able to sound the alarm for five minutes at the end of that time. Emergency	C 181		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL079092	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/10/2016
NAME OF PROVIDER OR SUPPLIER MOYER'S REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5767 HWY 135 STONEVILLE, NC 27048		
(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 181	Continued From page 8 egress lights and exit signs shall be powered from an automatic start generator or a U/L approved trickle charge battery system capable of operation for 1-1/2 hours when normal power fails. This Rule is not met as evidenced by: 1. Based on observation, the Building did not meet the Rule Findings on August 10, 2016: a. Back Right Exit - there was no manual fire alarm pull with five feet of this location.	C 181		
C 183	Fire Extinguishers SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0308 FIRE EXTINGUISHERS (a) At least one five pound or larger (net charge) A-B-C type fire extinguisher is required for each 2,500 square feet of floor area or fraction thereof. (b) One five pound or larger (net charge) A-B-C or CO/2 type is required in the kitchen and, where applicable, in the maintenance shop. This Rule is not met as evidenced by: 1. Based on observation, the facility failed to properly maintain the fire extinguishers and associated equipment. This could hamper staffs ability to extinguish a small fire and permit it to grow larger. This would affect all residents, staff and visitors by not identifying emergency equipment not in proper working order. Findings on August 10, 2016: a. Corridor near Nurse Station - the annual fire extinguishers maintenance tag was missing from this fire extinguisher. b. Corridor near Right Back Exit - the fire extinguisher was missing from its bracket, leaving	C 183		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL079092	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/10/2016
NAME OF PROVIDER OR SUPPLIER MOYER'S REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5767 HWY 135 STONEVILLE, NC 27048		
(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 9 the back area without fire extinguisher protection.	C 183		
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 (e) which shall not apply to existing facilities. This Rule is not met as evidenced by: 1. Based on observation, the Fire Alarm system was not maintained in a safe and operating condition. This would affect residents, staff and visitors by not providing early detection and activating the fire alarm system. Findings on August 10, 2016: a. Housekeeping - fire alarm system's heat detector was dangling from the ceiling by its power/operational wires. 2. Based on observation, the building's emergency equipment was not maintained in a safe and in operating condition. This would affect residents, staff and visitors if they could not promptly find their way to an exit during an emergency. Findings on August 10, 2016: a. Fire Wall - the fire door was equipped with a locking door handle so when the fire alarm system was activated, the fire door released, closed and latched into its frame, denying residents on the right side an egress pathway.	C 189		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL079092	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/10/2016
NAME OF PROVIDER OR SUPPLIER MOYER'S REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5767 HWY 135 STONEVILLE, NC 27048		
(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 189	Continued From page 10 b. Corridor near Bedroom Right Back Exit - the self-contained emergency light did not work on backup power when tested. Emergency lighting must illuminate the egress pathway during power outages. c. Kitchen - the exit sign was dangling from its base by its operational wires. d. Corridor near Bedroom 15 - the self-contained emergency light did not work on backup power when tested. Emergency lighting must illuminate the egress pathway during power outages. e. Central Back Exit - the exit sign did not illuminate on normal or backup power when tested. f. Living Room Exit - the exit sign did not illuminate on normal or backup power when tested. 3. Based on Observation and interview with Manager, the electrically operated call system was not maintained operating. This could affect all residents, and staff if the system fails to notify staff that assistance is requested. Findings on August 10, 2016: a. Entire Building - the electrically operated call system did not functioning as designed. When activated the signal is not received at the Staff Station. 4. Based on observation, the Building was not maintained in a safe and operating condition, by failing to ensure that egress from all areas can be done without the use of keys, tools or, special knowledge or effort. This could affect some staff and visitors if someone becomes trapped inside. Findings on August 10, 2016: a. Laundry - the corridor door was equipped with hasp hardware and locked with a padlock. This locking system did not provide an override	C 189		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL079092	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/10/2016
NAME OF PROVIDER OR SUPPLIER MOYER'S REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5767 HWY 135 STONEVILLE, NC 27048		
(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 189	Continued From page 11 device allowing exiting from the room. b. Housekeeping - the corridor door was equipped with hasp hardware and locked with a padlock. This locking system did not provide an override device allowing exiting from the room. 5. Based on observations, the Building was not maintained in a safe and operating condition. This could expose residents, staff and visitors to fire/smoke if not contained in Room or compartment of origin Findings on August 10, 2016: a. Bathroom across from Bedroom 15 - there was a gap around call system conduit not firestopped as it penetrate the fire-resistance-rated ceiling assembly. b. Linen Closet near Bedroom 12- there was an open joint between the ceiling assembly and the walls assembly's fire-resistance-rated gypsum wallboard construction. 6. Based on observation, the Building was not maintained in a safe and operating condition. This could affect all residents, staff and visitors if the doors did not contain smoke/fire in the room of origin. Findings on August 10, 2016: a. Bedroom 19 - the corridor doorframe was missing its strike plate, therefore to door does not latch to resist the passage of smoke. b. Bedroom 13 - the corridor doorframe was missing its strike plate, therefore to door does not latch to resist the passage of smoke. c. Bedroom 12 - the corridor doorframe was missing its strike plate, therefore to door does not latch to resist the passage of smoke. d. Bedroom 11 - the corridor door did not latch into its frame as the strike box was filled with a gum like substance.	C 189		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL079092	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/10/2016
NAME OF PROVIDER OR SUPPLIER MOYER'S REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5767 HWY 135 STONEVILLE, NC 27048		
(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 189	Continued From page 12 7. Based on Observation and interview with Administrator, the Building was not maintained accessible for inspection. This will prevent any deficiency that may be discovered with regular inspections from being corrected. Findings on August 10, 2016: a. Furnace Room - there was no key onsite to allow access into this area. 8. Based on observation, the Building electrical system was not maintained in a safe and operating condition. Findings on August 10, 2016: a. Dining Room - the light fixture was missing its globe. b. Porch near kitchen - the ground-fault circuit-interrupter (GFCI) electrical power receptacle was missing its cover plate. c. Bedroom 15 - the call system switch was missing its cover plate. d. Bathroom near Staff Bathroom - the light fixture was missing its globe. 9. Based on observation, the foundation drainage system was not maintained in a operating condition. This would affect residents, staff and visitors water to enter the building. Findings on August 10, 2016: a. Left Basement - there was water entering the basement and allowed to stand.	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 two cubic feet per minute per square foot. This	C 199		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL079092	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/10/2016
NAME OF PROVIDER OR SUPPLIER MOYER'S REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5767 HWY 135 STONEVILLE, NC 27048		
(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 13 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: 1. Based on Observation and testing with a thin plastic sheet, the facility failed to maintain the ventilation system in proper working order. This could affect all residents, staff and visitors by preventing the exhausting of odors. Findings on August 10, 2016: a. Bathroom across from Bedroom 15 - the exhaust fan cover, vanes and radiation damper have an excessive accumulation of dust/lint. b. Staff Bathroom - the exhaust fan cover, vanes and radiation damper have an excessive accumulation of dust/lint. c. Bath near Staff Bathroom - the exhaust fan cover, vanes and radiation damper have an excessive accumulation of dust/lint	C 199		
C 201	Newly Licensed Facilities-Call System SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (i) In newly licensed facilities without live-in staff, an electrically operated call system shall be provided connecting each resident bedroom and bathroom to a staff station. The resident call system activator shall be such that they can be	C 201		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL079092	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/10/2016
NAME OF PROVIDER OR SUPPLIER MOYER'S REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5767 HWY 135 STONEVILLE, NC 27048		
(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 201	Continued From page 14 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. (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: 1.	C 201		