

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL051041	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 11/30/2016
NAME OF PROVIDER OR SUPPLIER CLAYTON HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 145 DAIRY ROAD CLAYTON, NC 27520		
(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 Biennial Follow Up Construction Survey by Billy S. Bryant conducted on 11/30/2016. Deficiencies from the 09/30/2016 Construction Section Biennial Survey remain to be corrected.	{C 000}		
{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 observations, this facility has failed to maintain the grounds free of hazards. This could affect residents and staff. Findings on 11/30/2016: The outside grounds are not free from the following hazards: (a) Abandoned station wagon at the front parking lot, (d) Structurally damaged out building at the rear of the facility.	{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: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair;	{C 164}		

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: HAL051041	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 11/30/2016
NAME OF PROVIDER OR SUPPLIER CLAYTON HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 145 DAIRY ROAD CLAYTON, NC 27520		
(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 1 (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 observations, this facility has not maintained the ceiling construction. This could affect residents and staff while occupying spaces with this condition. Findings on 11/30/2016: a. Women's Bath - The ceiling has been repaired but the track for the privacy curtain is still loose and not fastened tight to the ceiling. 5-Based on observations, this facility has not maintained the prevention of water migration through exterior walls. Findings on 11/30/2016: a. The AC unit that is mounted at the base of the exterior wall in the Staff Break Room does not have any preventative measures in place to prevent water migration. Findings on 11/30/2016: The AC unit that is mounted at the base of the exterior wall in the Staff Break Room does not have any preventative measures in place to prevent water migration.	{C 164}		
{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	{C 189}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL051041	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 11/30/2016
NAME OF PROVIDER OR SUPPLIER CLAYTON HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 145 DAIRY ROAD CLAYTON, NC 27520		
(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 2 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 observations, this facility has failed to maintain the active fire protection devices. Findings on 11/30/2016: There was not a fire extinguisher in the cabinet located at the end of the front left-hand side Hall. 2-Based on observation, this facility has failed to maintained in a safe and operating condition the emergency lighting. This would affect all residents, staff and visitors if the egress pathways were not illuminated during a power outage. Findings on 11/30/2016: The corridor emergency wall lights that are located at the following locations did not illuminate when tested in the emergency mode: (d) Rear Exit at HC wood ramp 3-Based on observations, this facility has failed to provide life-safety devices to activate the fire alarm control panel in the event of an emergency. This will affect all residents, staff and guests. Findings on 11/30/2016: a. One of the required exit doors in the Dining Room does not have a manual pull station. 4-Based on observations, this facility has failed to maintain the outbuildings on site in a safe manner. This is a hazard to the residents and staff.	{C 189}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL051041	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 11/30/2016
NAME OF PROVIDER OR SUPPLIER CLAYTON HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 145 DAIRY ROAD CLAYTON, NC 27520		
(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 3 Findings on 11/30/2016: There is a out building at the rear yard of the facility that has 4'x4' hole in the roof and is about to collapse. 5-Based on observations, this facility has failed to maintain the smoke-barrier door hardware. This could affect residents and staff in an event of an emergency to evacuate the facility. Findings on 11/30/2016: The cross-corridor doors that are located adjacent to Room 103 do not latch. 6-Based on observations, this facility has not maintained the wood ramp construction at the rear of the facility. This is a hazard to residents, staff and guests. Findings on 11/30/29/2016: The rear HC wood ramp has the following degrading components: (a) Rotten wood decking (b) Handrails that are spitting leaving obstructions (c) Handrails with exposed nails at gripping surfaces (d) Ramp surfaces that are not anti-slip 7-Based on observation, the facility has not maintained in a safe manner by improper storage of oxygen cylinders. This could affect all residents and staff by potentially exposing them to hazards for a ruptured ruptured cylinder. Findings on 11/30/30/2016: There are oxygen bottles not stored in approved racks in the Med Room.	{C 189}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL051041	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 11/30/2016
NAME OF PROVIDER OR SUPPLIER CLAYTON HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 145 DAIRY ROAD CLAYTON, NC 27520		
(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	{C 199}		
{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 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, 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 11/30/2016: The mechanical exhaust fans are not exhausting interior air in the following locations: (b) Women's Bath/200 Hall.	{C 199}		