

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL023008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 06/14/2017
NAME OF PROVIDER OR SUPPLIER SHELBY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 1176 WYKE ROAD SHELBY, NC 28150		
(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 Biennial Follow Up Construction Survey by Ed Miller and, on June 14, 2017. Deficiencies were cited that will require a new Plan of Correction.	{C 000}		
{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: 2. 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 April 19, 2017 and on June 14, 2016: a. Public Restroom - the exhaust ventilation system was running, but did not remove the required amount of air to dissipate the odors. b. Biohazards and Soiled Linen - the exhaust ventilation system was running, but did not remove the required amount of air to dissipate	{C 199}		

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: HAL023008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 06/14/2017
NAME OF PROVIDER OR SUPPLIER SHELBY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1176 WYKE ROAD SHELBY, NC 28150		
(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 the odors.	{C 199}			