

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL088015	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING: _____	(X3) DATE SURVEY COMPLETED 02/22/2017
NAME OF PROVIDER OR SUPPLIER KINGSBRIDGE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 10 SUGAR LOAF ROAD BREVARD, NC 28712		
(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 Construction Section Biennial Survey report by Frank Strickland on 02/22/2017: This facility was first licensed 07/25/1997 for 60 beds. Based on this information, we are requiring that this facility meet the 1996 "Homes for the Aged and Disabled - Minimum Standards and Regulations", the applicable portions of the 2005 Rules for Adult Care Homes of Seven or More Beds, and the 1996 Edition of the North Carolina State Building Code; Section 409.1 Group I, Unrestrained Occupancy. Deficiencies have been cited and a Plan of Correction is required.	C 000		
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; (e) This Rule shall apply to new and 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 02/22/2017: The mechanical exhaust fans are not exhausting interior air in the following locations:	C 164		

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

TITLE

(X6) DATE

STATE FORM

6800

C1RY21

If continuation sheet 1 of 2

Dorena Stallings

Administrator

3/17/17

If continuation sheet 2 of 2