

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL081001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/14/2017
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 160 HEALTH CARE DRIVE RUTHERFORDTON, NC 28139		
(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 Construction Section Biennial Survey by Dennis Harrell on 9-14-2017. Records indicate this facility was first licensed on 1-1-1973, for 34 beds. Based on this information, we are requiring the facility to meet the 1971 Minimum and Desired Standards and Regulations for Homes for the Aged and Infirm, the 1967 NC State Building Code and the applicable portions of the 2005 Rules for Adult Care Homes of Seven or More Beds.	C 000		
C 111	Must Have Current San. & Fire Safety Reports SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0302 DESIGN AND CONSTRUCTION(f) The facility shall have current sanitation and fire and building safety inspection reports which shall be maintained in the home and available for review. This Rule is not met as evidenced by: Based on a review of documents, the required annual fire alarm system inspection report could not be located. Fire alarm systems that are not inspected and approved as required could result in the fire alarm system not operating properly in the event of an actual fire.	C 111		
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	C 166		

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: HAL081001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/14/2017
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 160 HEALTH CARE DRIVE RUTHERFORDTON, NC 28139		
(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 1 hazards; (e) This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: 1. Based on observation, there was no documentation of monthly inspections provided on the inspection tag at the range hood fire suppression system. Range hood fire suppression systems must be inspected monthly and the inspections must be documented somewhere such as on the tag provided at the system pull. 2. Based on observation there was a barrel bolt latch on the outside of the door to the walk-in cooler. Latching hardware that can only be operated from one side of the door, such as barrel bolt latches, present the possibility that someone could be trapped in the space.	C 166		
C 185	Fire Safety-Rehearsals on Each Shift SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0309 PLAN FOR EVACUATION (b) There shall be rehearsals of the fire plan quarterly on each shift in accordance with the requirement of the local Fire Prevention Code Enforcement Official. (c) Records of rehearsals shall be maintained and copies furnished to the county department of social services annually. The records shall include the date and time of the rehearsals, the shift, staff members present, and a short description of what the rehearsal involved. (f) This Rule shall apply to new and existing facilities.	C 185		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL081001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/14/2017
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 160 HEALTH CARE DRIVE RUTHERFORDTON, NC 28139		
(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 185	Continued From page 2 This Rule is not met as evidenced by: Based on a review of documents, the records available onsite included no description of what the rehearsal involved.	C 185		
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, battery powered emergency lights would not work when tested. Battery powered emergency lights that will not work properly for at least 90 minutes could endanger the residents and staff. Mal-functioning lights include the following areas: a. Back Hall, b. Dining room. 2. Based on observation, many corridor doors are prevented from closing quickly and latching to resist the passage of fire and smoke. Corridor doors that do not close completely and latch present the possibility that a fire that begins in one space can quickly spread to the corridor and the remainder of the facility. Findings include; a. The door to bedroom 6 will not close and latch.	C 189		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL081001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/14/2017
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 160 HEALTH CARE DRIVE RUTHERFORDTON, NC 28139		
(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 b. The door to bedroom 8 will not close and latch. c. The door to bedroom 15 will not close and latch. d. The door to the A Hall restr room will not close and latch. e. The door to the Administrator's was wedged open. f. There was a hole at the latchset through the kitchen door to the Dining room/corridor. g. The latchset strike is missing on the door from the kitchen to the Dining room/corridor. h. The latchset was loose on the door to bedroom 9.	C 189		
C 191	Unvented & Portable Elec. Heaters Prohibited SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (b) There shall be a heating system sufficient to maintain 75 degrees F (24 degrees C) under winter design conditions. In addition, the following shall apply to heaters and cooking appliances. (2) Unvented fuel burning room heaters and portable electric heaters are prohibited. (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: Based on observation the facility failed to adhere to the prohibition of portable electric heaters. Portable electric heaters are a potential fire hazard and as such could effect all occupants of the facility. Findings include: a. There was a portable electric heater in the	C 191		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL081001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/14/2017
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 160 HEALTH CARE DRIVE RUTHERFORDTON, NC 28139		
(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 191	Continued From page 4 Administrator's office. b. There was a portable electric heater in the foyer.	C 191		