

Division of Health Service Regulation

|                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                 |                                                                                                                          |                                                        |
|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>FCL011376</b>                   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: <b>01</b><br><br>B. WING _____                                                | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/25/2018</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>AUTUMN VIEW ASSISTED LIVING # 3</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>232 COUNTRY TIME CIRCLE<br/>LEICESTER, NC 28748</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| C 000                                                                      | <p>Initial Comments</p> <p>Report by Glenn Hoppin</p> <p>DHSR Construction Section conducted a Biennial Survey on October 25, 2018 from 1:30 PM to 3:00 PM at the above referenced facility. DHSR records indicate the home was first licensed on December 16, 1996 as a Family Care Home for six (6) Residents with up to three (3) non ambulatory residents (unable to respond and evacuate without physical or verbal assistance during a fire or other emergency). Based on this we are requiring the home to be in compliance with the following: The 1992 Minimum Standards and Regulations for Family Care Homes, the applicable portions of the 2005 Rules for Family Care Homes 10A NCAC 13G, and the 1996 North Carolina State Building Code - Section 419.3 - Residential Care facilities</p> <p>NOTES:</p> <p>1.) At the time of our visit, we cited deficiencies that require an acceptable plan of correction. All deficiencies listed were discussed with on-site staff during the exit interview.</p> <p>2.) Take actions to correct all listed deficiencies, once completed provide verification in the form of photos, receipts, invoices, etc. for all work performed.</p> | C 000                                                                                           |                                                                                                                          |                                                        |
| C 174                                                                      | <p>Building Equipment Maintained Safe, Operating</p> <p>SECTION .0300 - THE BUILDING<br/>10A NCAC 13G .0317 BUILDING SERVICE EQUIPMENT<br/>(a) The building and all fire safety, electrical, mechanical, and plumbing equipment in a family care home shall be maintained in a safe and</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | C 174                                                                                           |                                                                                                                          |                                                        |

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<br>AND PLAN OF CORRECTION                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>FCL011376</b>                   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: <b>01</b><br><br>B. WING _____                                                | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/25/2018</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>AUTUMN VIEW ASSISTED LIVING # 3</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>232 COUNTRY TIME CIRCLE<br/>LEICESTER, NC 28748</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| C 174                                                                      | Continued From page 1<br><br>operating condition.<br>(j) This Rule shall apply to new and existing family care homes.<br><br>This Rule is not met as evidenced by:<br>At the time of the survey it was observed that a smoke detector in client bedroom #1 was missing the protective screen. This is not compliant with the rule.                                                                                                                                                                                                                                                     | C 174                                                                                           |                                                                                                                          |                                                        |
| C 118                                                                      | Bedrooms-Windows<br><br>T10: 42C<br>.2205 BEDROOMS<br>(g) Each resident bedroom must have one or more operable windows and be lighted to provide 30 foot candles of light at floor level. The window area must be equivalent to at least eight percent of the floor space. The windows must be low enough to see outdoors from the bed and chair, with a maximum 36-inch sill height.<br><br>This Rule is not met as evidenced by:<br>At the time of the survey it was observed that the window in bedroom #2 had a window air conditioning unit. This is not compliant with the rule. | C 118                                                                                           |                                                                                                                          |                                                        |
| C 140                                                                      | Outside Entrances/Exits-Handrails<br><br>T10: 42C<br>.2209 OUTSIDE ENTRANCES AND EXITS<br>(f) All steps, porches, stoops and ramps must be provided with handrails and guardrails.<br><br>This Rule is not met as evidenced by:<br>At the time of the survey it was observed that the sidewalk coming from the kitchen exit and the side door on the right side of the building had a                                                                                                                                                                                                  | C 140                                                                                           |                                                                                                                          |                                                        |

Division of Health Service Regulation

|                                                                            |                                                                                                                              |                                                                                                 |                                                                                                                          |                                                        |
|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                        |                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>FCL011376</b>                   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: <b>01</b><br><br>B. WING _____                                                | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/25/2018</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>AUTUMN VIEW ASSISTED LIVING # 3</b> |                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>232 COUNTRY TIME CIRCLE<br/>LEICESTER, NC 28748</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| C 140                                                                      | Continued From page 2<br><br>drop off which is a trip hazard. This is not<br>compliant with the rule.                        | C 140                                                                                           |                                                                                                                          |                                                        |