

Division of Health Service Regulation

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                      |                                                                                                                          |                                                        |
|---------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>FCL036024</b>                        | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: <b>01</b><br><br>B. WING _____                                                | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/29/2018</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ST MARKS ROAD CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1230 ST MARK'S CHURCH ROAD<br/>CHERRYVILLE, NC 28021</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 Luis Padilla</p> <p>DHSR Construction Section conducted a Biennial Survey on November 29, 2018 from 9:05 AM to 10:25 AM at the above referenced facility. DHSR records indicate the home was first licensed on October 27, 1997 as a Family Care Home for five (5) Residents ambulatory residents (able 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 Family Care Homes T10 42C, the applicable portions of the 2005 Rules for Family Care Homes 10A NCAC 13G, and the 1996 North Carolina State Building Code - Section 419.2 - Residential Care Homes.</p> <p>NOTE:</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> <p>The cited deficiencies are as follows:</p> | C 000                                                                                                |                                                                                                                          |                                                        |
| C 105                                                         | <p>Initial Licensure-Meet NCSBC</p> <p>SECTION .0300 - THE BUILDING<br/>10A NCAC 13G .0302 DESIGN AND CONSTRUCTION<br/>(a) Any building licensed for the first time as a family care home shall meet the applicable</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | C 105                                                                                                |                                                                                                                          |                                                        |

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>FCL036024</b>                        | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: <b>01</b><br><br>B. WING _____                                                | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/29/2018</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ST MARKS ROAD CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1230 ST MARK'S CHURCH ROAD<br/>CHERRYVILLE, NC 28021</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 105                                                         | Continued From page 1<br><br>requirements of the North Carolina State Building Code. All new construction, additions and renovations to existing buildings shall meet the requirements of the North Carolina State Building Code for One and Two Family Dwellings and Residential Care Facilities if applicable. All applicable volumes of The North Carolina State Building Code, which is incorporated by reference, including all subsequent amendments, may be purchased from the Department of Insurance Engineering Division located at 322 Chapanoke Road, Suite 200, Raleigh, North Carolina 27603 at a cost of three hundred eighty dollars (\$380.00).<br>(b) Each home shall be planned, constructed, equipped and maintained to provide the services offered in the home.<br><br>This Rule is not met as evidenced by:<br>1. At the time of our visit it was observed that the Staff Bedroom window would not retain an opening of 16 inches for emergency egress without assistance. Replace/repair the window such that it is in compliant with the rule. | C 105                                                                                                |                                                                                                                          |                                                        |
| C 117                                                         | Have Current San. And Fire Safety Approvals<br><br>SECTION .0300 - THE BUILDING<br>10A NCAC 13G .0302 DESIGN AND CONSTRUCTION<br>(n) The home shall have current sanitation and fire and building safety inspection reports which shall be maintained in the home and available for review.<br><br>This Rule is not met as evidenced by:<br>1. At the time of the survey it was observed that on site staff was unable to provide an up to date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | C 117                                                                                                |                                                                                                                          |                                                        |

Division of Health Service Regulation

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                      |                                                                                                                          |                                                        |
|---------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>FCL036024</b>                        | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: <b>01</b><br><br>B. WING _____                                                | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/29/2018</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ST MARKS ROAD CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1230 ST MARK'S CHURCH ROAD<br/>CHERRYVILLE, NC 28021</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 117                                                         | Continued From page 2<br><br>Sanitation Inspection Report. This is not<br>compliant with the rule.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | C 117                                                                                                |                                                                                                                          |                                                        |
| C 174                                                         | Building Equipment Maintained Safe, Operating<br><br>SECTION .0300 - THE BUILDING<br>10A NCAC 13G .0317 BUILDING SERVICE<br>EQUIPMENT<br>(a) The building and all fire safety, electrical,<br>mechanical, and plumbing equipment in a family<br>care home shall be maintained in a safe and<br>operating condition.<br>(j) This Rule shall apply to new and existing<br>family care homes.<br><br>This Rule is not met as evidenced by:<br>1. At the time of our visit it was observed that the<br>Dryer/Washer Unit for the home was not installed.<br>This is not compliant with the rule.<br><br>2. At the time of our visit it was observed that the<br>hallway Bathroom ventilation system was not<br>functional. This is not compliant with the rule.<br><br>3. At the time of our visit it was observed that the<br>Fire Extinguishers for the home were not<br>mounted along the walls of the home. This is not<br>compliant with the rule.<br><br>4. At the time of our visit it was observed that the<br>Hot Water Tank's discharge valve was not<br>properly piped to the outside. This is not<br>compliant with the rule. | C 174                                                                                                |                                                                                                                          |                                                        |
| C 183                                                         | Outside Premises-Clean, Safe<br><br>SECTION .0300 - THE BUILDING<br>10A NCAC 13G .0318 OUTSIDE PREMISES<br>(a) The outside grounds of new and existing                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | C 183                                                                                                |                                                                                                                          |                                                        |

Division of Health Service Regulation

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                      |                                                                                                                          |                                                        |
|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>FCL036024</b>                        | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: <b>01</b><br><br>B. WING _____                                                | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/29/2018</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ST MARKS ROAD CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1230 ST MARK'S CHURCH ROAD<br/>CHERRYVILLE, NC 28021</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 183                                                         | Continued From page 3<br><br>family care homes shall be maintained in a clean<br>and safe condition.<br><br>This Rule is not met as evidenced by:<br>1. At the time of our visit it was observed that the<br>handrails for the back ramp did not extend to the<br>full extent of the ramp, this creates a trip hazard<br>for the area. This is not compliant with the rule.<br><br>2. At the time of our visit it was observed that<br>along the left exterior of the home the window<br>frame for Bedroom #1 was rotting. This is not<br>compliant with the rule.<br><br>3. At the time of our visit it was observed that the<br>there was an opening on the right side of the<br>home where the previous dryer exhaust was<br>located. This is not compliant with the rule. | C 183                                                                                                |                                                                                                                          |                                                        |