STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	Hal089002	A. BUILDING: _____ B. WING _____	04/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYRRELL HOUSE	950 HWY 64 EAST COLUMBIA, NC 27925

(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
D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and an annual survey from 04/27/21 to 04/28/21.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 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 hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the facility was free of hazards as evidenced by the storage of four portable oxygen tanks not secured in racks, in a resident's room. The findings are: Observation of Resident #6's room on 04/27/21 at 8:37am revealed: -There were four portable oxygen tanks to the left upon entrance next to a storage closet. -The four portable oxygen tanks were standing upright, with one portable oxygen tank inside of an open portable oxygen tank carrying case. -The four portable oxygen tanks were not secure or in a rack. Interview with a personal care aide (PCA) on 04/27/21 at 9:10am revealed: -She was not sure why the four portable oxygen tanks were in resident #6's room. -She did not know the proper way empty or full	D 079		

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D 079	Continued From page 1 portable oxygen tanks were to be stored. Interview with a Medication Aide (MA) on 04/27/21 at 9:51am revealed: -He was not sure if the four portable oxygen tanks were empty. -The four portable oxygen tanks had been in Resident #6's room since January 2021, when he started working at the facility. -He was aware portable oxygen tanks were to be stored in a rack and not on the floor. Interview with the Care Manager (CM) on 04/27/21 at 9:58am revealed: -She was aware the empty and full portable oxygen tanks were to be stored in racks. -She was not aware the four portable oxygen tanks were sitting on the floor unsecured in Resident #6's room. Interview with the Executive Director (ED) on 04/27/21 at 2:34pm revealed: -The lead MA, CM and she were responsible for "daily walk throughs" in the facility. -The lead MA, CM and she did not notice the four portable oxygen tanks were sitting on the floor. -The empty and full portable oxygen tanks were to be stored in racks. -The four portable oxygen tanks had a potential to explode if they were stored on the floor. Based on interview, observations and review, it was determined Resident #6 was not interviewable. Observation on 04/28/21 at 11:59am revealed the four portable oxygen tanks had been secured in a storage rack in Resident #6's room.	D 079		