

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092219	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2024
NAME OF PROVIDER OR SUPPLIER CARY FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 545 FRONT RIDGE DRIVE CARY, NC 27519		
(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 by Jonathan Gamsey DHSR Construction Section conducted a Biennial Survey on May 8, 2024 from 12:00 PM to 01:20 PM at the above referenced facility. DHSR records indicate the home was first licensed on July 07, 2016 as a Family Care Home for three (3) non-ambulatory Residents (Unable to respond and evacuate without any 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 2005 Rules 10A NCAC 13G for Family Care Homes the applicable portions of the 2012 North Carolina Building Code - Residential - Section R103. NOTES: 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. 2.) Take actions to correct all listed deficiencies, once completed provide verification in the form of photos, receipts, invoices, etc. for all work performed. The cited deficiencies are as follows:	C 000		
C 174	Building Equipment Maintained Safe, Operating SECTION .0300 - THE BUILDING 10A NCAC 13G .0317 BUILDING SERVICE EQUIPMENT (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in a family care home shall be maintained in a safe and operating condition.	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 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092219	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2024
NAME OF PROVIDER OR SUPPLIER CARY FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 545 FRONT RIDGE DRIVE CARY, NC 27519		
(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 174	Continued From page 1 (j) This Rule shall apply to new and existing family care homes. This Rule is not met as evidenced by: 1.) At the time of the survey, it was observed that bedroom #2 had a reversed locking mechanism on the door that could potentially lock a resident in a room. This is not compliant with the rule. Take the necessary steps to reverse the door knob to its proper orientation and or install a passage knob. *Fixed at the time of the survey. 2.) At the time of the survey, it was observed that an old monitored smoke alarm was in the facility. This is not compliant with the rule. Take the necessary steps to bring it to working condition and or remove it.	C 174		