STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL059-033	A. BUILDING: **01** B. WING _____	**08/13/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW FAMILY CARE HOME	**3341 OLD HWY #10 E NEBO, NC 28761**

(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 Kelly Myers DHSR Construction Section conducted a Biennial Survey on August 13, 2025, from 12:05 PM to 12:55 PM at the above referenced facility. DHSR records indicate the home was first licensed on March 11, 1991 as a Family Care Home with a capacity of Six (6) all-ambulatory residents (able to respond and evacuate without any physical or verbal assistance during a fire or other emergency). Based on this information we are requiring the home to maintain compliance with the following: the 1991 "Rules for Family Care Homes Minimum Standards and Regulations", the applicable portions of the 2005 Rules 10A NCAC 13G for Family Care Homes, and the 1991 North Carolina State Building Code - Section-513.1 - Exception #1-Residential Care facilities. 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 exit interview. 2.) Take actions to correct all listed deficiencies, once complete provide verification in the form of photos, receipts, invoices, etc. for all work performed. 3.) The cited deficiencies are as follows.	C 000		
C 021	10A NCAC 13G .0302 (a) Building Code and 60 day Termination 10A NCAC 13G .0302 Design And Construction	C 021		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL059-033	A. BUILDING: **01** B. WING _____	**08/13/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW FAMILY CARE HOME	**3341 OLD HWY #10 E NEBO, NC 28761**

(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 021	Continued From page 1 (a) A building licensed for the first time as a family care home, or a licensed family care home relicensed after the license is terminated for more than 60 days, shall meet the requirements of the North Carolina State Building Code: Residential Code in effect at the time of licensure or relicensure. Additionally, facilities requesting licensure or relicensure for four to six residents shall meet the North Carolina State Building Code: Building Code, Licensed Residential Care Facilities Section in effect at the time of licensure or relicensure. The North Carolina State Building Codes, which are hereby incorporated by reference, including all subsequent amendments and editions, may be purchased from the International Code Council online at https://shop.iccsafe.org/ at a cost of eight hundred fifty-eight dollars ($858.00) or accessed electronically free of charge at https://codes.iccsafe.org/codes/north-carolina. This Rule is not met as evidenced by: 1. At the time of the survey it was observed that DHSR Construction does not have a copy of the floor plan for the finished basement. This is not compliant with the rule. Take the necessary steps to provide DHSR Construction a copy of the floor plan for the basement with the plan of correction. 2.	C 021		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL059-033	A. BUILDING: **01** B. WING _____	**08/13/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW FAMILY CARE HOME	**3341 OLD HWY #10 E NEBO, NC 28761**

(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 102	Continued From page 2	C 102		
C 102	10A NCAC 13G .0317 (a) Maintenance Building Service Equipment 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. This Rule is not met as evidenced by: 1. At the time of the survey it was observed that the fire extinguishers were not monitored monthly. This is not compliant with the rule. Take the necessary steps to. Monitor the fire extinguishers monthly to ensure they are ready for use in the event of a fire emergency. 2. At the time of the survey it was observed that both the resident bathroom exhaust fans were very dusty. This is not compliant with the rule. Take the necessary steps to routinely clean the bath exhaust fans. 3. At the time of the survey it was observed that the lower level back left bedroom window could not be opened. This is not compliant with the rule. Take the necessary steps to ensure that at least one window in each sleeping room can be opened for emergency egress.	C 102		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL059-033	A. BUILDING: **01** B. WING _____	**08/13/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW FAMILY CARE HOME	**3341 OLD HWY #10 E NEBO, NC 28761**

(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 118	Continued From page 3	C 118		
C 118	10A NCAC 13G .0316 (d) Requirements Fire Safety 10A NCAC 13G .0316 Fire Safety and Emergency Preparedness Plan (d) The facility shall meet all fire safety requirements required by city ordinances or county building inspectors. Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: 1. At the time of the survey it was observed that the master bedroom on the lower level did not have an emergency egress window or door that opens directly to the exterior. This is not compliant with the rule. Take the necessary steps to ensure that there is an emergency egress window or door or change the use of the room to something other than a sleeping room.	C 118		
C 120	10A NCAC 13G .0316 (f) Fire drills Fire Safety 10A NCAC 13G .0316 Fire Safety and Emergency Preparedness Plan (f) There shall be at least four unannounced fire drills of the fire evacuation plan every year on each shift. For the purpose of this Rule, a fire drill is the method of practicing how occupants of the facility shall evacuate in the event of a fire or	C 120		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL059-033	A. BUILDING: **01** B. WING _____	**08/13/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW FAMILY CARE HOME	**3341 OLD HWY #10 E NEBO, NC 28761**

(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 120	Continued From page 4 other emergency. Documentation of the fire drills shall be maintained by the administrator or their designee in the facility and be made available upon request to the Division of Health Service Regulation, county department of social services, and the local fire code enforcement official. The documentation shall include the date and time of the fire drill, the shift, the names of staff members present, and a short description of drill. Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: 1. At the time of the survey it was observed that fire drills were not being conducted on each shift quarterly. This is not compliant with the rule. Take the necessary steps to ensure that fire drills are conducted on first, second, and third shift and the smoke alarms are activated every time without verbalizing or assisting the residents. The third shift fire drill should be conducted while the residents are sleeping.	C 120		