

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL001137	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/25/2015
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NAME OF PROVIDER OR SUPPLIER WARREN CARE SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1237 WESTMORELAND DRIVE BURLINGTON, NC 27216
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(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	<p>Initial Comments</p> <p>Report by Greg Williams</p> <p>DHSR Construction Section conducted a Biennial Survey on March 25, 2015 from 1:00 pm to 2:30 pm at the referenced Facility. DHSR records indicate the home was first licensed on February 02, 2011 as a Family Care Home for six (6) ambulatory Residents (able to evacuate and respond 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 and the 2009 North Carolina State Building Code - Section 421.2 - Residential Care Homes.</p> <p>At the time of our visit, we cited deficiencies that require an acceptable plan of correction. They are as follows:</p>	C 000		
C 174	<p>Building Equipment Maintained Safe, Operating</p> <p>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. (j) This Rule shall apply to new and existing family care homes.</p> <p>This Rule is not met as evidenced by: 1. At the time of the survey the GFCI outlet on the right side of the kitchen sink was indicating that the hot and neutral wires were reversed when tested. Have the GFCI wiring corrected and provide documentation to our office when corrected.</p>	C 174		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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C 174	<p>Continued From page 1</p> <p>2. In the Residents Bathroom across from the staff office, the exhaust fan was not working at the time of the survey. Have the exhaust fan repaired or replaced and provide documentation to our office when corrected.</p> <p>3. In the Residents Bathroom across from the staff office, there was a section of floor tile that had come unglued. Have the floor tile reglued to the subflooring and provide documentation to our office when corrected.</p>	C 174		