

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL009008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 09/18/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER OAK GROVE FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 583 SASAFRAS ROAD BLADENBORO, NC 28320
---	--

(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 Suzanna Fay DHSR Construction Section conducted a Biennial Follow-up Survey on September 18, 2015 from 11:04 AM to 11:30 AM at the above referenced facility. Not all of the previously cited deficiencies were corrected. Therefore, further action is required. The remaining 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. (j) This Rule shall apply to new and existing family care homes. This Rule is not met as evidenced by: 2. At the time of this survey, the smoke detector on the Resident hall nearest the living room was not interconnected to the other smoke detectors in the facility. Have a qualified person repair or replace the smoke detector so that when any one detector is activated, all of the detectors sound. Provide documentation of the repairs. 9/18/15: SF-At the time of this survey, the hall smoke detector was not interconnected. Have a qualified technician repair or replace the smoke detector. Provide documentation of the repairs in the form of copies of receipts or work orders. 3. At the time of this survey, the smoke detectors	{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: FCL009008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 09/18/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER OAK GROVE FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 583 SASAFRAS ROAD BLADENBORO, NC 28320
---	--

(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}	<p>Continued From page 1</p> <p>in Bedroom #1 and in Bedroom #4 were not interconnected to the other smoke detectors in the facility. Have a qualified person repair or replace the smoke detector so that when any one detector is activated, all of the detectors sound. Provide documentation of the repairs.</p> <p>9/18/15: SF-At the time of this survey, the smoke detector in Bedroom #1 was working properly. The detector in Bedroom #4 was still not interconnected. Have a qualified technician repair or replace the smoke detector. Provide documentation of the repairs in the form of copies of receipts or work orders.</p>	{C 174}		