

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL053001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/11/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>OAKHAVEN HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 WESTOVER DRIVE SANFORD, NC 27330</b>
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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 of a Biennial Construction Survey by Frank Strickland on 08/11/2016:</p> <p>Records indicate that the Facility was first licensed or submitted for licensure on or about January 1, 1974 for Forty-(40) Beds. Based on the above information, the facility is required to meet the 1971 Minimum and Desired Standards and Regulations for Homes for the Aged and Disabled; the applicable portions of the 2005 Rules for Adult Care Homes of Seven or More Beds; and the 1967 North Carolina State Building Code Section 516- Institutional Buildings.</p> <p>Deficiencies has been cited and a Plan of Correction is required.</p>	C 000		
C 164	<p>Housekeeping and Furnishings-Clean, Repaired</p> <p>SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0306 HOUSEKEEPING AND FURNISHINGS</p> <p>(a) Adult care homes shall:</p> <p>(1) have walls, ceilings, and floors or floor coverings kept clean and in good repair;</p> <p>(2) have no chronic unpleasant odors;</p> <p>(3) have furniture clean and in good repair;</p> <p>(e) This Rule shall apply to new and existing facilities.</p> <p>This Rule is not met as evidenced by:</p> <p>1-Based on observation, the facility has not maintained the wood finishes of the interior doors in good repair.</p> <p>Findings on 08/11/2016:</p> <p>Some of the resident entry room doors are scratched, marked, veneer missing and have damaged edges due wheel chair interaction at</p>	C 164		

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

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C 164	Continued From page 1  the following locations: (a) Resident Room 7 (b) Resident Room 10 (c) Resident Room 18 (d) Resident Room 20 (e) Show Room (Long Hall)	C 164		