

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002007	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING: _____	(X3) DATE SURVEY COMPLETED 12/30/2014
NAME OF PROVIDER OR SUPPLIER A NEW OUTLOOK OF TAYLORSVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681		
(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 166	Continued From page 1 damage in the room. c. The ceiling radiation dampers in the supply and return ducts had activated and closed. This room must not be used as a bedroom until the window is replaced, the damage repaired and the radiaion dampers are reset using manufacturer's approved fuse links.	C 166	<i>be repaired or replaced by 1.31.15 using manufacturer's approved fuse links.</i>	<i>1.31.15</i>