

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 03/28/2016
NAME OF PROVIDER OR SUPPLIER CENTRAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 139 APEX LANE MOUNT AIRY, NC 27030		
(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 This report is of a Followup Survey done by Bob Getchell on March 28, 2016. The followup revealed that all deficiencies have not been corrected, therefore a new plan of correction is required..	{C 000}		
{C 189}	Building Equipment Maintained Safe, Operating SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. (k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities. This Rule is not met as evidenced by: 3. Based on observation the required one-hour fire rated walls and/or ceilings were compromised in several locations. Followup Findings on March 28, 2016 include: a. Holes in ceiling of closet off the laundry, b. Hole in ceiling of laundry next to hinge on disappearing stairway, c. Hole in ceiling of community bath next to hinge on disappearing stairway,	{C 189}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE