STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL079103	A. BUILDING: **01** B. WING _____	R **04/27/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOYER'S ASSISTED LIVING	**5767 HWY 135** **STONEVILLE, NC 27048**

(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 of Biennial Follow Up Construction Survey by Ed Miller, on April 27, 2017. Deficiencies were cited that will require a new Plan of Correction.	{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: 2. Based on observation, the building's emergency equipment was not maintained in a safe and in operating condition. This would affect residents, staff and visitors if they could not promptly find their way to an exit during an emergency. Findings on April 27, 2017: f. Living Room Exit - the exit sign did not illuminate on normal or backup power when tested. Staff stated the sign was repaired and was working. 3. Based on Observation and interview with Manager, the electrically operated call system was not maintained operating. This could affect all residents, and staff if the system fails to notify staff that assistance is requested. Findings on April 27, 2017:	{C 189}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL079103	A. BUILDING: **01** B. WING _____	R **04/27/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOYER'S ASSISTED LIVING	**5767 HWY 135** **STONEVILLE, NC 27048**

(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 189}	Continued From page 1 a. Bedrooms 8 and 9 (new room numbering system) - the electrically operated call system did not functioning as designed. When activated the signal is not received at the Staff Station. These room had not beed completed, wiring had been pulled to the rooms, but no boxes and switches have been installed. 5. Based on observations, the Building was not maintained in a safe and operating condition. This could expose residents, staff and visitors to fire/smoke if not contained in Room or compartment of origin Findings on April 27, 2017: New Findings aa. Gas Furnace Room Basement - there is large hole 15x18 inches not firestopped as it penetrated the fire-resistance-rated ceiling assembly. 6. Based on observation, the Building was not maintained in a safe and operating condition. This could affect all residents, staff and visitors if the doors did not contain smoke/fire in the room of origin. Findings on April 27, 2017: a. Bedroom 19 (new room numbering system 8) - the corridor doorframe was missing its strike plate, therefore to door does not latch to resist the passage of smoke. 9. Based on observation, the foundation drainage system was not maintained in a operating condition. This would affect residents, staff and visitors water to enter the building. Findings on April 27, 2017: a. Left Basement - there was water entering the basement and is allowed to stand. The heavy rains just a few days before has increased the water in the basement. The one-hour	{C 189}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL079103	A. BUILDING: **01** B. WING _____	R **04/27/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOYER'S ASSISTED LIVING	**5767 HWY 135** **STONEVILLE, NC 27048**

(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 189}	Continued From page 2 fire-resistance-rated gypsum ceiling is now bowing, possibly due to the weight of moisture being absorbed. 10. Based on Observation, the Building was not maintained, because general maintenance was not being done or had not been completed. This could affect all residents, staff and visitors if items are broken or partially removed and left where they could injure all. Findings on April 27, 2017: a. Left Basement- a plumbing leak had deteriorated the one-hour fire-resistance-rated gypsum ceiling assembly to a point where the tape and joint compound had disappeared and ceiling was beginning to fall down. The exposed pipes still are not boxed out and covered as well as penetrations are not firestopped. The leak has not been fix and more deterioration continues.	{C 189}		
{C 199}	Exhaust Ventilation SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (g) The spaces listed in this Paragraph shall be provided with exhaust ventilation at the rate of two cubic feet per minute per square foot. This requirement does not apply to facilities licensed before April 1, 1984, with natural ventilation in these specified spaces: (1) soiled linen storage; (2) soil utility room; (3) bathrooms and toilet rooms; (4) housekeeping closets; and (5) laundry area. (k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities.	{C 199}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL079103	A. BUILDING: **01** B. WING _____	R **04/27/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOYER'S ASSISTED LIVING	**5767 HWY 135** **STONEVILLE, NC 27048**

(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 199}	Continued From page 3 This Rule is not met as evidenced by: 1. Based on Observation and testing with a thin plastic sheet, the facility failed to maintain the ventilation system in proper working order. This could affect all residents, staff and visitors by preventing the exhausting of odors. Findings on April 27, 2017: c. Bath near Staff Bathroom - the exhaust fan cover, and vanes have an excessive accumulation of dust/lint. Progress had been made but this unit is still dirty.	{C 199}		