

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL051052	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/02/2018
NAME OF PROVIDER OR SUPPLIER PROGRESSIVE CARE OF PRINCETON		STREET ADDRESS, CITY, STATE, ZIP CODE 160 HAVEN LANE PRINCETON, NC 27569		
(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 Construction Section Biennial Survey report by Frank Strickland on 08/02/2018: This facility was first licensed as a Home for the Aged serving 12 residents on 05/01/1991. Therefore, this facility must meet the 1993 and the applicable portions of the 2005 Rules for the Licensing of Adult Care Homes, and, the 1991 North Carolina State Building Code(s), Institutional Occupancy. Deficiencies have been cited and a 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: 1-Based on observation, this facility has failed to maintain the fire safety components in a safe and operating condition. Findings on 08/02/2018: The noted corridor doors have damaged closure arms preventing latching that are located at the following locations: (a) Living Room adjacent to Bedroom 1 (b) Living Room adjacent to Med Room	C 189		

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: HAL051052	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/02/2018
NAME OF PROVIDER OR SUPPLIER PROGRESSIVE CARE OF PRINCETON		STREET ADDRESS, CITY, STATE, ZIP CODE 160 HAVEN LANE PRINCETON, NC 27569		
(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 (c) Bathroom #2	C 189		