

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL030009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 10/02/2019
NAME OF PROVIDER OR SUPPLIER MOCKSVILLE SENIOR LIVING & MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 337 HOSPITAL STREET MOCKSVILLE, NC 27028		
(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 a Complaint Follow Up Construction Survey by Ed Miller, conducted on October 2, 2019. 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: 3. Based on observation, interview with Executive Director, Fire Marshal and Fire Sprinkler Maintenance Company Manager, the Building was not maintained in a safe and operating condition; because maintenance was not performed in a timely manner leaving the facility without proper fire sprinkler protection. This would affect all residents, staff and visitors, by not providing the protection fire sprinklers provide. Finding on October 2, 2019: a.. The trip time on the annual inspection report was 138 seconds. There is no documentation of a revised trip time.	{C 189}		

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

TITLE

(X6) DATE