

Division of Health Service Regulation

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

TITLE

1-89-24

(X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013047	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING: _____	(X3) DATE SURVEY COMPLETED R 11/21/2023
NAME OF PROVIDER OR SUPPLIER MORNINGSIDE OF CONCORD		STREET ADDRESS, CITY, STATE, ZIP CODE 500 PENNY LANE, NE CONCORD, NC 28025		
(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 101}	Continued From page 1 that does not have sprinkler protection. c. Elevator Equipment Room - There is not a sprinkler head located in the room.	{C 101}	quote received for (3) → new Tyco pendent style sprinklers to the following locations 1. 1st floor outside mechanical boiler room 2. 2nd floor 313 nurses station 3. 2nd floor 313 nurses station Rq - 04096970 PO - 01177333 Rtl 59306 5700 50016 projected date by end of 2/24	