STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
				•		
		HAL041054	B. WING		02/1	1/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CLAPP'S	ASSISTED LIVING		ASANT GAR IT GARDEN,			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
C 000	Initial Comments		C 000			
		Biennial Construction Survey lell on February 11, 2015.				
	Home and was first 11/09/2004. The fat 30 residents in a sp facility must meet th 2005 Rules for the Homes, and, the 20 Building Code(s), In	ginally licensed as a Nursing t licensed a Home for the Aged cility is currently licensed for pecial care unit. Therefore the he applicable portions of the Licensing of Adult Care 202 North Carolina State Institutional Occupancy, I-2.				
C 101	Existing Licensed F	ac- No less than '71 Rules	C 101			
	PHYSICAL PLANT The physical plant of care home shall be (2) Except where of licensed facilities of facilities shall meet requirements in effecting in service of renovation, or alterathe requirements for addition or renovation or renovation or requirements for addition or renovation than those requirements for "Minimum and Des Regulations" for "Hopies of which are Health Service Regulations of which are Health Service Regulations of which are Health Service Regulations of which Care This Rule is not me	and APPLICATION OF REQUIREMENTS requirements for each adult applied as follows: otherwise specified, existing reportions of existing licensed licensure and code ect at the time of construction, or bed count, addition, ation; however in no case shall or any licensed facility where vation has been made, be less ments found in the 1971 ired Standards and omes for the Aged and Infirm", available at the Division of gulation, 701 Barbour Drive, olina, 27603 at no cost; et as evidenced by:				
		et as evidenced by: vation, egress from all areas				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING: 01			(X3) DATE SURVEY COMPLETED	
		HAL041054	B. WING		02/1	1/2015	
NAME OF I	PROVIDER OR SUPPLIER		1	STATE, ZIP CODE	02/1	1/2015	
	S ASSISTED LIVING	4558 PLE	ASANT GAR	DEN ROAD			
			IT GARDEN,				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
C 101	Continued From page 1		C 101				
	meeting the Buildin the door locking sys modified. This wou potentially prohibitin emergency.						
	alarm activation and	ked doors released upon fire d the emergency release at ral on/off switch at the Nurse					
	doors has been rep equipment and the required devices fo	ress equipment on the exit placed with wander guard doors equipped with the r 'special locking', the delayed till on the exit doors.					
	grease duct for the meet the Building C was installed. This	rvation, the installation of the kitchen range hood does not code requirements for when it would effect all residents by ke and fire in the room or not of origin.					
		e hood exhaust duct in the thes of combustible material					
C 189	Building Equipment	Maintained Safe, Operating	C 189				
	mechanical, and plu						

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			TE SURVEY MPLETED	
	HAL041054	B. WING		02/1	11/2015	
NAME OF PROVIDER OR SUPPL	IER STREET AL	DRESS, CITY, S	STATE, ZIP CODE			
CLAPP'S ASSISTED LIVIN	G	EASANT GAR NT GARDEN,				
PREFIX (EACH DEFICI	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
This Rule is no 1. Based on observations by Ba	ion. hall apply to new and existing exception of Paragraph (e) apply to existing facilities. If met as evidenced by: servation, the building was not safe manner by not maintaining ce rating of building components. It all residents by not containing in the room or smoke origin. I/2015: wall at room 305 has unprotected cables. wall separating the 300 wing from on building has unprotected wire and conduit. I/2015: wall separating the 300 wing from on building has unprotected wire and conduit. I/2016: I/2015: I/2015: I/2015: I/2016: I/2016: I/2016: I/2017: I/2017: I/2016: I/2017: I/2017: I/2017: I/2018: I/2018: I/2018: I/2018: I/2018: I/2018: I/2018: I/2018: I/2018: I/2019: I/2018: I/2018: I/2018: I/2018: I/2018: I/2018: I/2019: I/2018: I/2018: I/2019: I/2019	C 189	DEFICIENC	·Y)		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY LETED
		HAL041054	B. WING		02/1	1/2015
NAME OF F	PROVIDER OR SUPPLIER	STATE, ZIP CODE				
CLAPP'S ASSISTED LIVING 4558 PLEAS PLEASANT						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 189	Continued From pa	ge 3	C 189			
	Kitchen ceiling at ca	amera cable, and Anusl				
	equipment was not by allowing cross co	vation, the building plumbing maintained in a safe manner onnects. This would effect all ially siphoning waste water ter system.				
	Findings on 2/11/20 The spray hose on vacuum breaker.	115: the Beauty Shop sink has no				
	equipment was not by not cleaning HVA	vation, the building mechanical maintained in a safe manner AC return vents. This would by not clearing dust from the				
		ol15: Iding the radiation dampers in re covered with dust.				

Division of Health Service Regulation STATE FORM