

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001025	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 09/08/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SPRINGVIEW - CROUSE BUILDING	STREET ADDRESS, CITY, STATE, ZIP CODE 613 W WHITSETT STREET GRAHAM, NC 27253
---	--

(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 This report is of a Followup Survey done by Bob Getchell on September 8, 2015. The followup survey revealed that all deficiencies were not completed, therefore a new 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, the building was not maintained in a safe manner by not maintaining the fire-resistance rating of building components. Followup Findings on 9-8-15 include: a. The Dining Room ceiling has an unprotected penetration b. The back left exterior storage room has an unprotected penetration in the ceiling by wires. 2. Based on observation, the facility components were not maintained operable by having doors that did not close completely and latch. Followup Findings on 9-8-15 include: The following doors have issues: b) Dining Room doors on the corridor will not	{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: HAL001025	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 09/08/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SPRINGVIEW - CROUSE BUILDING	STREET ADDRESS, CITY, STATE, ZIP CODE 613 W WHITSETT STREET GRAHAM, NC 27253
---	--

(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 close and latch, d) Office door to the corridor will not close and latch when released e) Bedroom 6 door won't close and latch .	{C 189}		