


Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HAL045092	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01  B. WING: _____	(X3) DATE SURVEY COMPLETED  R 05/14/2015
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NAME OF PROVIDER OR SUPPLIER  
SPRING ARBOR WEST

STREET ADDRESS, CITY, STATE, ZIP CODE  
1825 PISGAH DRIVE  
HENDERSONVILLE, NC 28791

(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 Follow-up Survey by Dennis Harrell on 5-14-2015.  Some deficiencies were not corrected. Further action 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 required one-hour fire rated walls and/or ceilings were compromised in several locations. Holes, sleeves and penetrations that are not sealed with materials approved for use in one-hour fire rated construction present the possibility that a fire that begins in one space can quickly spread to other areas of the facility. Findings include: c. Hole in the attic smoke barrier wall above 200 Hall, e. The sprinkler escutcheons were missing or not tightly fitted to the ceiling complete the one-hour protection in the following locations; l. Sunroom,	(C 189)	  <i>Sealed hole in the attic smoke barrier wall above 200 hall with fire caulking sprinkler escutcheons were tightened to the ceiling in the sunroom.</i>	<i>5/11/2015</i>  <i>5/18/15</i>

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

*Jammy Lopez*

TITLE *Business Office* (X5) DATE

*05/14/2015* *7/31/15*