Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING: <b>01</b>		(X3) DATE SURVEY COMPLETED				
			D W/N/O		F			
		HAL092027	B. WING		02/1	0/2016		
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE				
BROOKI	BROOKDALE MACARTHUR PARK  111 MACARTHUR DRIVE							
	I	CARY, NO	27513					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE		
{C 000}	Initial Comments		{C 000}					
	Report of Follow Up Cates on 02/10/201	Survey Billy Bryant and Greg 6.						
	Deficiencies from the Inspection remain to	ne 09/24/2016 Biennial o be completed.						
{C 189}	Building Equipment	Maintained Safe, Operating	{C 189}					
	mechanical, and plu care home shall be operating condition. (k) This Rule shall facilities with the ex	11 OTHER d all fire safety, electrical, umbing equipment in an adult maintained in a safe and						
	maintain one pair of cross-corridor doors Cross-corridor door and latch present the begins in one space	vation, the facility failed to						
		2015: s loose on the doors and passage of fire or smoke.						
		s would not completely close assed by activation of the fire						
		ation the facility's fire safety t being maintained in a safe						

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

(X6) DATE TITLE

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING: <b>01</b>		(X3) DATE SURVEY COMPLETED		
		HAL092027	B. WING		F 02/1	尺 0/2016	
NAME OF F	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 02/1	0/2010	
BROOKDALE MACARTHUR PARK  111 MACARTHUR DRIVE							
BROOKL	DALE WACARTHUR P	CARY, NO	27513				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
{C 189}	Continued From pa	ge 1	{C 189}				
	blocked open or he devices or methods facility could be effe	Doors were permitted to be all open by unapproved and the occupants in the exted if doors cannot be closed as to limit the spread of the area of origin.					
	resistant rated door	o16: s of opposite swinging fire s separating the kitchen from m. Both doors were found					
	not closing and/or fi resist the passage of doors that do not cl present the possibil	ation, many corridor doors are itting well and/or latching to of fire and smoke. Corridor ose completely and latch ity that a fire that begins in kly spread to the corridor and e facility.					
	the door frame whe b. The door to roor c. The door to roor closed.	n 101 had a large at the top of					
{C 199}	Exhaust Ventilation		{C 199}				
	provided with exhautwo cubic feet per n						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING: <b>01</b>		(X3) DATE SURVEY COMPLETED		
		B. WING		R		
	HAL092027			02/1	0/2016	
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE			
BROOKDALE MACARTHUR PARK 111 MACARTHUR DRIVE CARY, NC 27513						
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
these specified space (1) soiled linen stora (2) soil utility room; (3) bathrooms and to (4) housekeeping clo (5) laundry area. (k) This Rule shall approximate facilities with the excessibilities	with natural ventilation in es: ge; ge; collet rooms; cosets; and pply to new and existing eption of Paragraph (e) to existing facilities.  as evidenced by: tion the facility failed to haust in a working condition. The facility failed to haust in a working condition. The facility failed to haust in a working condition. The facility failed to haust in a working condition. The facility failed to haust in a working condition. The facility failed to haust in a working condition. The facility failed to have a working condition. The facility failed to have a working condition to the facility failed to have a working condition. The facility failed to have a working condition to the facility failed to have a working condition to the facility failed to have a working condition. The facility failed to have a working condition to the facility failed to have a working condition to the facility failed to have a working condition.	{C 199}				

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