

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL043027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 02/24/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GREEN LEAF CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2041 NC 210 NORTH LILLINGTON, NC 27546
---	--

(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 a Follow Up Survey by Billy S. Bryant and Ed Miller conducted on 02/24/2016. Deficiencies noted during the Biennial Survey on 10/30/2015 remain to be corrected.	{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: 2. Based on observation there is a failure to maintain the facility's fire safety equipment in a safe operating condition as evidenced by doors that do not completely close and latch. Doors are required to completely close and latch in the event of a fire in order to resist the passage of smoke or the spread of fire. All the occupants in the facility could be effected if doors do not latch and remain closed so as to limit the spread of smoke or fire to the area of origin. Findings on 02/24/2016: b. "B" Hall, Room B-11 - The door from the room to the corridor did not completely close and latch. c. "A" & "B" Hall - The cross corridor fire resistant rated doors did not completely close and latch when released from their magnetic hold	{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: HAL043027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 02/24/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GREEN LEAF CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2041 NC 210 NORTH LILLINGTON, NC 27546
---	--

(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 open devices. 4. Based on observation there is a failure to install and maintain plumbing piping in a safe condition. Failure to maintain or install plumbing piping in a safe condition could effect all occupants of the facility if because of the unsafe condition the domestic water supply became contaminated. Finding on 02/24/2016: a. The ice maker drain is resting on the floor drain and does not have a minimum 2" gap between the discharge point of the drain pipe and the floor drain.	{C 189}		