STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b> B. WING			(X3) DATE SURVEY COMPLETED 07/21/2016	
	HAL081051		07/					
NAME OF PROVIDER OR SUPPLIER STREET ADD				DRESS, CITY, STATE, ZIP CODE				
	SSISTED LIVING FA	CILITY # 2		LAND ROAD				
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
C 000	Initial Comments		C 000					
	Report of Complaint Survey by Dennis Harrell on 7-21-2016.							
	Records indicate that this facility was first licensed on 6-1-1968, for 44 residents. Based on this information, we are requiring the facility to meet the 1967 Edition of the North Carolina State Building Code, the 1971 Rules for the Licensing of Adult Care Homes, and the applicable portions of the 2005 Regulations for Adult Care Homes of Seven or More Beds. The complaint alleged that bed bugs were							
	The complaint was were cited that will	s. substantiated	and deficiencies					
C 164	Housekeeping and	Furnishings-C	lean, Repaired	C 164				
	SECTION .0300 - F 10A NCAC 13F .03 FURNISHINGS (a) Adult care home (1) have walls, ceil coverings kept clea (2) have no chroni (3) have furniture of (e) This Rule shall facilities.	06 HOUSEK es shall: lings, and floor an and in good c unpleasant o clean and in go	EEPING AND s or floor repair; dors; od repair;					
	This Rule is not m Based on interview maintained clean d bugs. Findings include: a. Bed bugs had b bedrooms. b. The facility either	with staff, the ue to the prese een seen in 15	facility was not ence of bed resident					

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## PRINTED: 08/22/2016 FORM APPROVED

Division of Health Service Regulation           STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLI           AND PLAN OF CORRECTION         IDENTIFICATION NU				(X3) DATE SURVEY COMPLETED		
				07/	07/21/2016	
	2270 🕰					
SSISTED LIVING FA						
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
Continued From pa	age 1	C 164				
introduced in bags immediately distribution Note: A Plan of Pro	of donated clothing that were uted to the same 15 rooms. tection to help prevent					
	OF CORRECTION ROVIDER OR SUPPLIER SSISTED LIVING FA SUMMARY STA (EACH DEFICIENC' REGULATORY OR L Continued From pa their bed bug proto introduced in bags immediately distribution Note: A Plan of Processor	OF CORRECTION IDENTIFICATION NUMBER: HAL081051 ROVIDER OR SUPPLIER STREET A 2270 OA	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING: C         HAL081051       B. WING       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, S'         SSISTED LIVING FACILITY # 2       STREET CITY, NC 2800         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 1       C 164         their bed bug protocol in that the bugs first were introduced in bags of donated clothing that were immediately distributed to the same 15 rooms. Note: A Plan of Protection to help prevent       C 164	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING: 01         HAL081051       B. WING       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         SSISTED LIVING FACILITY # 2       2270 OAKLAND ROAD FOREST CITY, NC 28043         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC         Continued From page 1       C 164       C 164         their bed bug protocol in that the bugs first were introduced in bags of donated clothing that were immediately distributed to the same 15 rooms. Note: A Plan of Protection to help prevent       C 164	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING: 01       COM         HAL081051       B. WING       07/         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         SSISTED LIVING FACILITY # 2       2270 OAKLAND ROAD FOREST CITY, NC 28043       PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         Continued From page 1       C 164       C 164	

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