

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL018016</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/15/2017</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BROOKDALE HICKORY NORTHEAST</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2530 16TH STREET N E HICKORY, NC 28601</b>
--	--

(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 Biennial Follow Up Construction Survey by Ed Miller, conducted on March 15, 2017.  The following deficiencies cited during the previous Biennial Follow Up Construction Survey, have not been satisfactorily corrected and will require a new Plan of Correction.	{C 000}		
{C 101}	Existing Licensed Fac- No less than '71 Rules  SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0301 APPLICATION OF PHYSICAL PLANT REQUIREMENTS The physical plant requirements for each adult care home shall be applied as follows: (2) Except where otherwise specified, existing licensed facilities or portions of existing licensed facilities shall meet licensure and code requirements in effect at the time of construction, change in service or bed count, addition, renovation, or alteration; however in no case shall the requirements for any licensed facility where no addition or renovation has been made, be less than those requirements found in the 1971 "Minimum and Desired Standards and Regulations" for "Homes for the Aged and Infirm", copies of which are available at the Division of Health Service Regulation at no cost;  This Rule is not met as evidenced by: 2. Based on observation, the smoke barrier doors near bedroom 18 failed to comply with Section 409.1.2.4 of the NC State Building Code. Section 409.1.2.4 requires vision panels of wire reinforced or fire rated glass in each door. The smoke barrier doors near bedroom 18 had no vision panels provided.	{C 101}		

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:  <b>HAL018016</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/15/2017</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BROOKDALE HICKORY NORTHEAST</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2530 16TH STREET N E</b> <b>HICKORY, NC 28601</b>
--	--

(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