Division of Health Service Regulation

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED		
		HAL092182	B. WING		04/0	4/2017
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4230 WENDELL BOULEVARD WENDELL, NC 27591					
(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			
	Survey by Dennis H The Complaint alleg in portions of the far Records indicate th licensed or submitte for the Aged. The fa 100 beds including Therefore the facilit conformance with th 2005 Rules for Lice Seven or More Bed the 1978 (Revision Building Code(s), S	ged the heat was not working cility. at the Facility was first ed on 2-12-1987, as a Home acility is currently licensed for a a 31-bed special care unit.				
	Aged (1984) in effective The Complaint was	ct at time of initial licensure. substantiated.				
C 189	SECTION .0300 - F 10A NCAC 13F .03 REQUIREMENTS (a) The building an 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	C 189			
		et as evidenced by: vation and interview, the as not maintained in a safe or				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
			A. DOILDING.	~.		
		HAL092182	B. WING		04/0	4/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
OLIVER	HOUSE		IDELL BOUL _, NC 27591			
(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 SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
C 189			C 189			
C 190	Heating System	social during the ourvey.	C 190			
	maintain 75 degree					

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED		
		HAL092182	B. WING		04/0	4/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DDRESS, CITY, STATE, ZIP CODE				
OLIVER	HOUSE		NDELL BOULEVARD .L, NC 27591				
(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 SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	CTION SHOULD BE O THE APPROPRIATE		
C 190	Continued From page 2		C 190				
	following shall apply appliances. (1) Built-in electric installed or protecte to residents and roc (k) This Rule shall facilities with the ex which shall not app This Rule is not me Based on observati not maintained in a Finding includes:	y to heaters and cooking heaters, if used, shall be ed so as to avoid burn hazards om furnishings. apply to new and existing ception of Paragraph (e) ly to existing facilities. et as evidenced by: on, the heating system was working condition. eat/ac unit in the TV room was					

6899

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