		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		A. BUILDING: 01		R		
		HAL013044	B. WING			1/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE LIVI	NG CENTER OF CON	CORD	REN C. COLI D, NC 28027	EMAN BLVD. '		
(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 Biennial F by Ed Miller, on July	Follow Up Construction Survey y 11, 2017.				
	Deficiencies were of Plan of Correction.	ited that will require a new				
{C 164}	Housekeeping and	Furnishings-Clean, Repaired	{C 164}			
	FURNISHINGS (a) Adult care home (1) have walls, ceil coverings kept clea (2) have no chronic (3) have furniture of	es shall: ings, and floors or floor n and in good repair;				
		et as evidenced by: ation the facility's floor ept clean and in good repair.				
	corridor carpet that on Observation and the finish floor on the replaced with vinyl the floors are schedule	acility there is a pattern of the is stained and soiled. Based I interview with Administrator he First Floor has been flooring. The second and third d to be replaced within the the meantime, the carpet is				
		ation the facility does not ent to have no chronic				
	Finding on 04/20/20 a. Rooms 108, and	017: 230 - Based on Observation				

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION 01	(X3) DATE COMP	SURVEY LETED
		HAL013044	B. WING		F 07/1	≀ 1/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	0771	1/2017
	NG CENTER OF CON	ICORD 160 WAR	REN C. COLI	EMAN BLVD.		
	OLIMANA DV. OTA		D, NC 28027			
(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 APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
{C 164}	Continued From pa	ge 1	{C 164}			
	continued to have a The Administrator's Doctor's order for a one of the residents	Administrator, Bedroom 230 an odor noticeable in the hall. said they had received the new Bariatric Mattress for s. The mattress should arrive oom 108 continued to have a ceable in the room.				
{C 166}	Housekeeping-Mair	ntained Free of Hazards	{C 166}			
	orderly manner, fre hazards;	06 HOUSEKEEPING AND				
	maintained free froi bottles that are stor restraint to prevent knocked over. Oxyg stored may present the facility.	ration the facility was not m hazards due to oxygen red without any means of them from falling or being gen bottles that are improperly a danger to the occupants of				
		nder was stored standing any means of restraint to				
{C 184}	Fire Safety-Evacua	tion plan	{C 184}			
	SECTION .0300 - F 10A NCAC 13F .03 EVACUATION					

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Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/IDENTIFICATION NUMBER	DED:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION 01	(X3) DATE COMP	SURVEY LETED
						R	
		HAL013044		B. WING		07/1	1/2017
NAME OF I	PROVIDER OR SUPPLIER				TATE, ZIP CODE		
THE LIV	NG CENTER OF CON	ICORD		EN C. COLE , NC 28027	EMAN BLVD.		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
{C 184}	Continued From pa	ige 2	{	{C 184}			
	diagrammed drawing approval of the local shall be prepared in central location on home. The plan sharesident on admissionientation for all net of the plans. This Rule is not medulated in the plans. This Rule is not medulated in the plans. Finding on 04/20/20 a. The fire evacuation of the local shall in the plans.	apply to new and existi et as evidenced by: ration the facility has fa diagrammed fire evac	en official d in a eare ch of the ng iled to uation				
{C 189}	Building Equipment	t Maintained Safe, Ope	erating {	{C 189}			
	mechanical, and plicare home shall be operating condition (k) This Rule shall facilities with the expension of the condition	11 OTHER Ind all fire safety, electric Ind all fire safety, electric Indianal in a safe a Indianal in a safe a	n adult ind ing				
	maintain the facility	et as evidenced by: vation there is a failure 's fire safety systems in etrations or gaps in the	n a safe				

Division of Health Service Regulation STATE FORM

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED		
		HAL013044	B. WING		6 07/1	R 1/2017
NAME OF I	PROVIDER OR SUPPLIER	STATE, ZIP CODE	•			
THE LIV	ING CENTER OF CON	CORD	REN C. COLI D, NC 28027	EMAN BLVD.		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETE DATE	
{C 189}	resistant rated ceiling holes in fire resistant the occupants of the smoke to spread between the fire resistant rate penetrated by piping d. Room 220 - The drooped down leaved between the ceiling New Finding 7. Based on Obsemaintained in a safe all by not containing origin. Findings on July 11 a. Basement Stair	ngs. Penetrations, gaps or not rated ceilings could effect to facility by allowing fire and eyond the area of origin. 2017: Heater Room - There gaps in ed ceiling tiles where they are g. fire resistant ceiling tile has ng gaps in the lay-in ceiling tiles and the support grid. ervation, the Building was not be condition. This could affect g smoke and fire in the room of g. 2017: rwell- the Stairwell door had or open, preventing it from	{C 189}			
{C 199}	provided with exhautwo cubic feet per n requirement does n	ed in this Paragraph shall be ust ventilation at the rate of ninute per square foot. This ot apply to facilities licensed with natural ventilation in ces: rage;	{C 199}			

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED		
		HAL013044	B. WING		6 07/1	R 1/2017
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
THE LIV	ING CENTER OF CON	CORD	REN C. COLI D, NC 28027	EMAN BLVD. 7		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
{C 199}	(5) laundry area. (k) This Rule shall facilities with the ex which shall not app This Rule is not med 1. Based on observe provide the required equipment in space exhausted by rule. Finding on 7/11/201 a. A pattern of exhaunted by the extout of the first 5 resout of 4 of the public on Observation and Director, an exhausted.	apply to new and existing apply to new and existing aception of Paragraph (e) by to existing facilities. Let as evidenced by: Pation the facility failed to dexhaust ventilation are required to be mechanically	{C 199}			

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