

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 10/12/2017
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NAME OF PROVIDER OR SUPPLIER BURLINGTON CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2201 BURCH BRIDGE ROAD BURLINGTON, NC 27217
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(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}	<p>Initial Comments</p> <p>Report of a Biennial Follow Up Construction Survey by Ed Miller, conducted on October 12, 2017.</p> <p>Deficiencies were cited that will require a new Plan of Correction.</p>	{C 000}		
{C 189}	<p>Building Equipment Maintained Safe, Operating</p> <p>SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS</p> <p>(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.</p> <p>(k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities.</p> <p>This Rule is not met as evidenced by: 1- Based on observation, the Building was not maintained in a safe and operating condition, because in some spaces the fire protection equipment was missing.</p> <p>Findings on 10/12/2017:</p> <p>There are not audible fire alarm notification devices on the lower level.</p>	{C 189}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____