STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED	
			A. BUILDING: 01		R		
		HAL060077	B. WING			0/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
EAST TO	WNE		TH SHARON TTE, NC 282	NAMITY ROAD 05			
(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 SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE	
{C 000}	Initial Comments		{C 000}				
		I Follow Up Construction Fay conducted on May 30,					
		ies cited in the Biennial y that remain to be corrected.					
{C 160}	Outside Premises-0	Clean, Safe	{C 160}				
	(1) The outside gro						
	maintain outside of Findings on 05/30/2 The soffit is rotten lelocations: (a) The wood fascia Smoking Area Patio the wood is decayin adhering. (b) The wood fascia	ation, this facility has failed to the facility in a safe condition. 2018: ocated at the following a for "B" HALL adjacent to b. The fascia was painted but any and the paint is not a for the covered roof at the e damaged portion of trim was					
{C 189}	Building Equipment SECTION .0300 - F 10A NCAC 13F .03 REQUIREMENTS		{C 189}				

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED			
	HAL060077	B. WING		05/3	₹ 6 0/2018		
NAME OF PROVIDER OR SUPPLIE	R STREET AL	DRESS, CITY, S	TATE, ZIP CODE	•			
EAST TOWNE	EAST TOWNE 4815 NORTH SHARON AMITY ROAD CHARLOTTE, NC 28205						
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC 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		
mechanical, and care home shall operating condition (k) This Rule shall reconstruction in the emergency of following location in the emergency lights 2-Based on obsermaintain the fire operating condition in the emergency lights 2-Based on obsermaintain the fire operating conditions in the fire operating conditions in the emergency lights 2-Based on obsermaintain the fire operating conditions in the operating conditions in the emergency lights 2-Based on obsermaintain the fire operating conditions in the emergency lights in the operating conditions in the emergency lights in the e	and all fire safety, electrical, plumbing equipment in an adult be maintained in a safe and on. all apply to new and existing exception of Paragraph (e) oply to existing facilities. met as evidenced by: rvation, this facility has failed to safety equipment in a safe and on. 0/2018: vall lights that are located at the s did not illuminate when tested or mode: Room outside Porch (two of two did not illuminate) rvation, this facility has failed to safety equipment in a safe and on. 0/2018: ations have doors that are en position: entry doors w/closures into the e wedges were removed and added to the doors to prop them is act in the same manor as ars from the Dining Hall into the or was found propped open with a safety equipment in a safe and or safety equipment in a safe and or safety equipment in a safe and or safety equipment in a safe and	{C 189}					

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Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING: 01			X3) DATE SURVEY COMPLETED	
					R		
		HAL060077	B. WING		05/3	0/2018	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
EAST TO	OWNE		TH SHAROI TTE, NC 282	N AMITY ROAD 205			
(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 APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
{C 189}	Continued From pa	ge 2	{C 189}				
	latching action at th (a) Kitchen door ad deadbolt mechanist prevents the door for stated that the door but it is the door by not get corrected.	is damaged preventing e following locations: jacent to dishwashing. The m slides in the door and rom opening. The report was by the hand wash sink dishwashing; so this item did eation, this facility has failed to fety equipment in a safe and					
	operating condition Findings on 05/30/2 The door(s) located not prevent the passissues:	2018: I at the following locations do sage of smoke due to sealing					
	Weatherstripping for	ding into the Dining Hall. or the door has been ordered ot come in. Door will be nardware arrives.					
		ation, this facility has failed to ing equipment in a safe and					
	following locations: (a) "B" HALL-Room	2018: secured to the floor at the 43/Bathroom. This toilet was spairs were being conducted.					
	New Deficiency:						
	maintain the mecha	ation, this facility has failed to nical equipment and ife and operating condition.					

Division of Health Service Regulation

STATE FORM 933822 If continuation sheet 3 of 4

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 01	R				
HAL060077 B. WING	05/30/2018				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
EAST TOWNE 4815 NORTH SHARON AMITY ROAD CHARLOTTE, NC 28205					
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORR	CS PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE				
{C 189} Continued From page 3 {C 189}					
Findings on 05/30/2018: a. There is a leak at the mechanical vent on the porch outside of the TV Room at the corner. The leak has damaged the exterior porch ceiling and has caused a green stain down the brick wall and onto the concrete walkway.					

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Division of Health Service Regulation STATE FORM