Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED						
AND PLAN OF CORRECTION			A. BUILDING: 01								
		HAL019018	B. WING		R 05/15/2019						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
COVENTRY HOUSE OF SILER CITY 260 VILLAGE LAKE ROAD SILER CITY, NC 27344											
(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 APPROPRIED TO THE	(X5) COMPLETE DATE						
{C 000}	Initial Comments		{C 000}								
	Report of a Biennial Follow Up Construction Survey by Suzanna Fay conducted on May 15, 2019.										
		ies cited in the Biennial y that remain to be corrected.									
{C 164}	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	06 HOUSEKEEPING AND									
	This Rule is not me 1. Observations re not kept in good rep	vealed that the ceilings were									
	the joints. The sea	5, 2019: ng finishes were separating at ms have been patched and ess of finishing them for paint.									
{C 189}	Building Equipment	Maintained Safe, Operating	{C 189}								
	mechanical, and plu										

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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED					
		HAL019018	B. WING			₹ 1 5/2019				
NAME OF PROVIDER OR SUPPLIER COVENTRY HOUSE OF SILER CITY STREET ADDRESS, CITY, STATE, ZIP CODE 260 VILLAGE LAKE ROAD SILER CITY, NC 27344										
(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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE				
{C 189}	operating condition (k) This Rule shall facilities with the ex which shall not app This Rule is not me 3. Based on observation and safe condition. Hole through fire resistar fire and smoke to sorigin. Findings on May 15 a. Room 9 - the es from the front sprint ceiling around the h has been notified a them to come and of	apply to new and existing ception of Paragraph (e) ly to existing facilities. et as evidenced by: vation there is a failure to g's fire safety systems in a es or gaps at penetrations at rated ceilings could allow pread beyond the area of	{C 189}	DEFICIENCY)						
	equipment was not operating condition Findings on May 15 a. There was a pat in the mechanical e accumulation of dustrians and the mechanical experiences.	maintained in a safe and								

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