AND PLAN OF CORRECTION IDENTIFI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>		(X3) DATE SURVEY COMPLETED	
		HAL043027	B. WING	B. WING		10/17/2019
NAME OF F	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
GREEN L	EAF CARE CENTER		210 NORTH	_		
		LILLING	TON, NC 2754			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
C 000	Initial Comments		C 000			
		on Biennial Survey report by Id Suzanna Fay conducted on				
	currently licensed for facility was surveyed 1991 Rules for Lice Seven or More Bed licensure, the 2005 Care Homes of Sev applicable portions	ensed on 07/01/1992 and is or 105 Beds. Therefore, this d for conformance with the ensing of Adult Care Homes of is in effect at the time of initial Rules for Licensing of Adult ven or More Beds and of the 1991 (1992 Revision) Carolina Building Code, ancy.				
	Deficiencies have b Correction is requir	een cited and a Plan of ed.				
C 164	Housekeeping and	Furnishings-Clean, Repaired	C 164			
	<ul><li>coverings kept clea</li><li>(2) have no chronic</li><li>(3) have furniture of</li></ul>	06 HOUSEKEEPING AND				
		et as evidenced by: ation, this facility has failed to construction in good repair.				
	Findings on 10/17/2 There is a 4" hole in Laundry Room/"C" ealth Service Regulation	n the ceiling located in the				

Division	of Health Service Re	gulation				APPROVE
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b> B. WING		(X3) DATE SURVEY COMPLETED 10/17/2019	
		HAL043027				
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GREEN L	EAF CARE CENTER		210 NORTH	<b>^</b>		
		LILLING TEMENT OF DEFICIENCIES	TON, NC 2754	PROVIDER'S PLAN OF CC	PRECTION	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
C 164	Continued From pa	ge 1	C 164			
		ation, this facility has failed to construction in good repair.				
	Findings on 10/17/2 There is a 2" hole ir Clean Linen Closet	n the ceiling located in the				
		ation, this facility has failed to construction in good repair.				
		2019: wall penetrations that are not Sprinkler Riser Room.				
		ation, this facility has failed to rings clean in good repair.				
	Findings on 10/17/2 All of the resident ro and require cleanin	oom floor coverings are dirty				
		ation, this facility has failed to rings clean in good repair.				
	Findings on 10/17/2 The floor coverings Community Bath/"D	are dirty and disrepair in the				
C 166	Housekeeping-Mair	ntained Free of Hazards	C 166			
		06 HOUSEKEEPING AND				
		apply to new and existing				

STATE FORM

STATEMEN	of Health Service Re	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI F	CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING: <b>01</b>		COMPLETED	
		HAL043027	B. WING		10/	17/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	TATE, ZIP CODE		
GREEN I	LEAF CARE CENTER		C 210 NORTH STON, NC 2754	6		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 166	Continued From pa	ige 2	C 166			
	facilities.					
	be maintained order Findings on 10/17/2 There are doors that drag on the floor at (a) Room A6 (b) Community Bath 2-Based on observat maintained in a safe storing oxygen cylin expose staff and re Findings on 10/17/2 There are oxygen b	ation, this facility has failed to orly and in good repair. 2019: at are out of adjustment and the following locations: h/"D" HALL ation, this facility has not beer e manner by improperly nders that could potentionally sidents to a ruptured cylinder. 2019: pottles that are not secured in racks located at the following	1			
C 189	Building Equipment	t Maintained Safe, Operating	C 189			
	10A NCAC 13F .03 REQUIREMENTS					
	mechanical, and plu care home shall be operating condition (k) This Rule shall	umbing equipment in an adult maintained in a safe and apply to new and existing ception of Paragraph (e)				

Division	of Health Service Re	egulation			FORM	APPROVED	
STATEMEN						X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING	: 01	COWF	LETED	
		HAL043027	B. WING		10/1	7/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
GREEN	LEAF CARE CENTER		210 NORTH ON, NC 27	546			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTI	ON	(X5)	
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRC DEFICIENCY)		COMPLETE DATE	
C 189	Continued From pa	ge 3	C 189				
		et as evidenced by: ation, this facility has failed to ng's fire safety construction in					
		2019: astic pipe penetration through all in the "A" HALL that is not					
		ation, this facility has failed to g's fire safety construction in					
		ectrical conduit penetrations ry fire wall in the "B" HALL that					
		ation, the fire safety equipment in a safe and operating					
	Findings on 10/17/2 The emergency ligh tested at the followi (a) PT/"A" HALL (b) Dining/"b" HALL (c) Room C9 (d) Room D9	nt units did not illuminate when ng locations:					
		ation, the HVAC equipment in an operating condition.					
	and the condensate	2019: not located in the drain pan e piping is not secured into the Mechanical Room/"C" HALL.\					
		ation, this facility has failed to					
Division of H	ealth Service Regulation		6899	22/0/21	If continue	tion sheet 1 of f	

Division of Health Service Regulation           STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING: <b>01</b>		COMPLETED	
		HAL043027	B. WING		10/	17/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GREEN	LEAF CARE CENTER		210 NORTH	•		
		TEMENT OF DEFICIENCIES	TON, NC 2754	PROVIDER'S PLAN OF	CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
C 189	Continued From pa	ge 4	C 189			
	maintain the plumb operating condition	ing fixtures in a safe and				
	Findings on 08/28/2 The toilets are not s following locations: (a) Room A20 (b) Community Bath	secured to the floor at the				
		ation, this facility has failed to g's fire resistant components ting condition.				
	construction that me requirementsbut are angle iron around the support the access panels are supported	ss panels are composite eets DHSR Construction e not support on 1"x1"x1/8" ne perimeter opening to panels. Currently the access ed by 2" wide 20 GA. metal ng the fire resistance of the				
C 199	Exhaust Ventilation		C 199			
	provided with exhau two cubic feet per n requirement does n	11 OTHER 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; toilet rooms;				

STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUP IDENTIFICATION HAL043027		IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		HAL043027	B. WING		10/	17/2019
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE	10/	1772013
REEN L	EAF CARE CENTER		210 NORTH TON, NC 2754	6		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
C 199	Continued From pa	ge 5	C 199			
	facilities with the ex	apply to new and existing ception of Paragraph (e) ly to existing facilities.				
		et as evidenced by: ation, this facility has failed to anical exhaust system in good				
	Findings on 10/17/2 Mechanical exhaus the following locatio (a) Room A6 (b) Room A10 (c) Room A11 (d) Room A12 (e) Men's Spa Bath (f) Room B4 (g) Room B4 (g) Room B4 (h) Room B10 (i) Room B13 (j) Room B14 (k) Community Bath (l) Room C14 (m) Room C16	t fans are not operational at ns: /"A" HALL				
	provide a mechanic Findings on 10/17/2	2019:				
		loes not have a mechanical vents to the exterior.				

3YQV21

If continuation sheet 6 of 6