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		
		HAL012041	B. WING		04/	02/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
MCALPINE ADULT CARE 3806 KATHY ROAD MORGANTON, NC 28655							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
C 000	Initial Comments		C 000				
	Tod Hancock conduction This facility was lice. Home for the Aged. Based on this inform to meet the 1977 M. Standards and Reg. Aged and Infirm, the Carolina State Build Institutional and the current 2005 Rules. Seven or More Bed. Deficiencies have be Correction is required.	applicable portions of the for Adult Care Homes of s. een cited and a Plan of ed.					
C 166	SECTION .0300 - F 10A NCAC 13F .03 FURNISHINGS (a) Adult care home (5) be maintained i orderly manner, free hazards; (e) This Rule shall facilities. This Rule is not me 1. Based on observation of the second of t	es shall: In an uncluttered, clean and It is of all obstructions and It is apply to new and existing et as evidenced by: It vation the facility was not It is new and existing et as evidenced by: It is of the facility was not It is new and existing et as evidenced by: It is of the facility was not It is new and existing et as evidenced by: It is of the facility was not It is new and existing et as evidenced by: It is of the facility was not It is new and existing et as evidenced by: It is new and existing et as evidenced by: It is new and existing et as evidenced by: It is new and existing et as evidenced by: It is new and existing et as evidenced by: It is new and existing et as evidenced by: It is new and existing	C 166				

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

(X6) DATE TITLE

Division of Health Service Regulation

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING: 01		COMPLETED	
		HAL012041	B. WING		04/0	2/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DDRESS, CITY, STATE, ZIP CODE			
MCAL DIA	NE ADULT CARE					
WICALPII	NE ADULT CARE	MORGAN'	TON, NC 28	655		
(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 SHOUL CROSS-REFERENCED TO THE APPROF	SHOULD BE COMPLETE	
C 166	Continued From page 1		C 166			
	a. Linen Closet- There are several unsecured oxygen bottles on the floor.					
C 188	Electrical Outlets in Wet Locations		C 188			
	SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0310 ELECTRICAL OUTLETS All adult care home electrical outlets in wet locations at sinks, bathrooms and outside of building shall have ground fault interrupters.					
		ation the facility is not ctrical components located e in a safe manner.				
	machine did not trip ground fault protect b. Back Men's Hall- receptacles adjacer	reptacles behind the washing on test indicating the lack of ion. Men's & Women's Bath-The not to the lavatory did not trip on ack of ground fault protection.				
C 189	Building Equipment	Maintained Safe, Operating	C 189			
	mechanical, and plu care home shall be operating condition. (k) This Rule shall facilities with the ex	11 OTHER d all fire safety, electrical, umbing equipment in an adult maintained in a safe and				

Division of Health Service Regulation STATE FORM

6899 1DOH21 If continuation sheet 2 of 3

DIVISION	of Health Service Re		I				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED		
HAL012041		HAL012041	B. WING		04/02/2024		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
MCALPI	MCALPINE ADULT CARE 3806 KAT			655			
(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)	CORRECTIVE ACTION SHOULD BE COMPLÉTE DATE		
C 189	This Rule is not med 1. Based on observe system is not maint Findings on April 2, a. Boiler Room- The water heater is rust components. 2. Based on observe maintaining the electron condition. Findings on April 2, a. Laundry-There is panel allowing read components. b. Front Smoking Himissing. 3. Based on observe was not maintained This could expose a contained in the roof Findings on April 2, a. Room 2 & 4- The	et as evidenced by: ration, the buildings plumbing rained in a safe manner. 2024: e outer metal jacket of the ed through exposing internal ration the facility is not ctrical components in a safe 2024: a breaker missing from the by access to energized lall- The globe on the light is rations, the building fire safety I in a safe operating condition. all to fire/smoke if not om of origin.	C 189				

6899

Division of Health Service Regulation STATE FORM