

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL097014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 02/10/2016
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NAME OF PROVIDER OR SUPPLIER WILKES COUNTY ADULT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 176 REST HOME ROAD WILKESBORO, NC 28697
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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
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{C 189}	Continued From page 1 Finding includes: There were open holes around the air conditioner installed in the main dining room.	{C 189}		4/30/16
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