

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-C 07/20/2016
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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
{C 000}	Initial Comments Report of Follow-up Survey by Dennis Harrell on 7-20-2016. A deficiency was not corrected. Further action is required.	{C 000}		
{C 189}	Building Equipment Maintained Safe, Operating SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. (k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities. This Rule is not met as evidenced by: 3. Based on observation, the facility was not maintained in a safe manner by having fire rated doors not close completely in order to contain smoke and fire. This could affect all residents and staff by not containing smoke and fire in the fire compartment of origin. Findings on February 10, 2016: a. The cross-corridor fire door on the 100 hall did not close completely when activated by the fire alarm system because a chair was propping it open,	{C 189}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____