

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 06/19/2019
NAME OF PROVIDER OR SUPPLIER CARILLON ASSISTED LIVING OF MOORESVIL		STREET ADDRESS, CITY, STATE, ZIP CODE 198 E WATERLYNN RD MOORESVILLE, NC 28117		
(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 a Biennial Follow Up Construction Survey Up by Ed Miller, conducted on June 19, 2019. Deficiencies were cited that will require a new Plan of Correction.	{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: 1-Based on observation, this facility has not maintained the fire safety components in a safe and operating condition. Findings on 06/19/2019: The emergency lights at the following locations do not illuminate when tested: (a) "C" HALL-Courtyard exit gate	{C 189}	The exit light on the C Hall Courtyard gate has been replaced.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

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If continuation sheet 1 of 1