

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001159	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 07/16/2024
NAME OF PROVIDER OR SUPPLIER MEBANE RIDGE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1999 SOUTH NC HWY 119 MEBANE, NC 27302		
(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 Construction Section Biennial Follow Up Survey by Tod Hancock conducted on July 16, 2024. This facility was licensed on December 8, 2014, for One Hundred (100) Resident Beds including a Thirty-two (32) Beds Special Care Unit. Based on the above information, this facility is required to meet the 2005 Rules for Adult Care Homes of Seven or More Beds and the 2012 North Carolina State Building Code Section 409, Group I-2 Unrestrained Occupancy. Cited deficiencies have not been corrected and a Plan of Correction 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: 2. Based on observation there is a failure to maintain the facility's fire safety equipment in a safe operating condition. The occupants in the smoke compartment could be affected if doors do not completely close and latch to help limit the spread of smoke or fire to the area of origin. Findings July 16, 2024:	{C 189}		

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

TITLE

(X6) DATE

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STATE FORM