THE HAVEN
VILLAGE AT CAROLINA PLACE

FIVESTAR SENIOR LIVING™

October 27, 2015

Edward R. Miller
NC Department of Health and Human Services
Architect, Construction Section
Division of Health Service Regulation
2705 Mail Service Center
Raleigh, NC 27699-2705

VIA U.S. MAIL, Facsimile (919-733-6592) and Email (Ed.Miller@dhhs.nc.gov)

RE: Facility: The Haven at Carolina Place
License Number: HAL-060-107 FID #971417
Survey Conducted: September 24, 2015
Statement of Deficiencies Report Printed 10/6/15
(Postmarked October 12, 2015. Received October 16, 2015)
Plan of Correction

Dear Mr. Miller:

Enclosed, as per your request, is our completed plan of correction for our survey conducted September 24, 2015. This plan of correction meets the criteria as specified by DHSR, for each deficiency noted on the statement of deficiencies. We appreciate your extension to submit this Plan of Correction, given the unfortunate circumstances in regards to the time this report was received.

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

The Haven at Carolina Place values our reputation and relationship with your agency. We appreciate any assistance you provide to us, as it relates to licensure rules and regulations.

Sincerely,

Jason T. Fisher
Executive Director

Enclosures: Statement of Deficiencies and Plan of Correction, 23 Pages

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060107	A. BUILDING: 01 B. WING _____	09/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HAVEN IN THE VILLAGE AT CAROLINA P	13150 DORMAN ROAD PINEVILLE, NC 28134

(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 Construction Survey by Ed Miller on September 24, 2015. Records indicates that this facility was first licensed on January 1, 1997. Therefore, we are requiring this facility to meet the 1996 Rules for the Licensing of Adult Care Homes and the applicable portions of the 2005 Licensing Rules and the 1996 edition of the North Carolina State Building Code Volume I - General Construction - Section 409 Institutional Occupancy (Group I). Currently licensed as a SIXTY BED SPECIAL CARE UNIT Facility. Physical plant deficiencies were noted which require a plan of correction.	C 000	See attached POC 12 pages	
C 101	Existing Licensed Fac- No less than '71 Rules SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0301 APPLICATION OF PHYSICAL PLANT REQUIREMENTS The physical plant requirements for each adult care home shall be applied as follows: (2) Except where otherwise specified, existing licensed facilities or portions of existing licensed facilities shall meet licensure and code requirements in effect at the time of construction, change in service or bed count, addition, renovation, or alteration; however in no case shall the requirements for any licensed facility where no addition or renovation has been made, be less than those requirements found in the 1971 "Minimum and Desired Standards and Regulations" for "Homes for the Aged and Infirm", copies of which are available at the Division of Health Service Regulation, 701 Barbour Drive, Raleigh, North Carolina, 27603 at no cost;	C 101		

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C 101	Continued From page 1 This Rule is not met as evidenced by: 1. Based on observation, the facility failed to meet the Code requirements in effect at the time of construction by not having all of the required components for doors equipped with Special Locking Arrangements. This could affect all occupants who would need to evacuate through the door(s) if the exit were obstructed. Findings on September 24, 2015: a. The exit doors are equipped with magnetic locks and the emergency release switches requireing a key to operate. Interview with staff in the area revealed that they did not have keys to operate the emergency release. This is not in accordance with the NC State Building Code requirement that if emergency release switches are of the keyed type, all staff responsible for evacuation of the locked unit must carry keys at all times.	C 101		
C 111	Must Have Current San. & Fire Safety Reports SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0302 DESIGN AND CONSTRUCTION(f) The facility shall have current sanitation and fire and building safety inspection reports which shall be maintained in the home and available for review. This Rule is not met as evidenced by: 1. Based on record review, interview with Executive Director, and Maintenance Contractor, the facility failed to maintain, a current (completed within the last twelve months) annual inspection report(s) required. This deficiency affects all residents, staff and visitors by not preventing any systems deficiency that may be discovered with annual inspections.	C 111		

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C 111	Continued From page 2 Findings on September 24, 2015: a. Records indicate that the last Annual Fire Alarm System Inspection and Testing Report in accordance with NFPA 72 was performed on July 8, 2015. The report listed several deficiencies that must be addressed.	C 111		
C 150	Corridors-Free of equipment and Obstructions SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0305 PHYSICAL ENVIRONMENT (g) The requirements for corridors are: (4) Corridors shall be free of all equipment and other obstructions. This Rule is not met as evidenced by: 1. Based on observation, the Building was not maintained in a safe manner by not maintaining a clear unobstructed exit path from the residents' rooms to the outside. This would affect all residents, staff and visitors by obstructing egress during an emergency. Findings on September 24, 2015: a. Between Willington wing and front Building an exit to the courtyard was blocked with a piano stool. b. The six-foot wide corridor was being used for storage of a resident bed near Bedroom 310, c. In Service hall near kitchen, wall mounted mail boxes and other equipment obstructed the six foot wide corridor.	C 150		
C 164	Housekeeping and Furnishings-Clean, Repaired SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0306 HOUSEKEEPING AND FURNISHINGS (a) Adult care homes shall:	C 164		

10/23/15

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C 164	Continued From page 3 (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; (2) have no chronic unpleasant odors; (3) have furniture clean and in good repair; (e) This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: 1. Based on Observation, the facility failed to have furniture kept clean and in good repair. Findings on September 24, 2015: a. In the Activity Room, the built-in counter was missing one of its drawers.	C 164		
C 166	Housekeeping-Maintained Free of Hazards SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0306 HOUSEKEEPING AND FURNISHINGS (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; (e) This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: 1. Based on Observation, the facility failed to provide an environment in accordance with this Rule, by not maintaining the HVAC/ventilation, grilles and their associated dampers free of hazards. This could affect all residents, staff and visitors if in the event of a fire the dampers do not close completely to contain the fire within the room of origin. Findings on September 24, 2015: a. The return HVAC and ventilation grilles and their radiation dampers have an excessive accumulation of dust/lint. Locations of specific	C 166		

10/22/15

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C 166	Continued From page 4 examples include but are not limited to: i. Pair of Visitor's Toilet Rooms, near Actively Room, ii. Janitor's Closet near Kitchen, iii. Staff Toilet Room near Kitchen, iv. Therapy	C 166		
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, the Building was not maintained in a safe and operating condition, by failing to ensure that egress from all areas can be done without the use of keys, tools or, special knowledge or effort. This could affect some staff and visitors if someone becomes trapped inside. Findings on September 24, 2015: a. The Activity Room's occupant load excesses 49 persons but there was only one marked exit door. The room also has two pairs of double doors that open onto a courtyard (no exit signs) that had a locked gate. The gate was locked with a breakaway pad lock. 2. Based on observation, the Building was not maintained in a safe and operating condition, because the exit signs did not work or relay	C 189		

10/07/15

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C 189	Continued From page 5 directional information properly. This would affect all residents, staff and visitors if they could not promptly find their way to an exit during an emergency. Findings on September 24, 2015: a. The exit sign did not work on backup power when tested. Locations of specific examples include but are not limited to: i. Corridor near Bedroom 407, ii. Corridor near Bedroom 410. b. The front door's exit sign had inappropriate chevrons graphics that misrepresent the way to egress from the building during an emergency. c. The exit sign did not work on normal power or backup power when tested in the Therapy Room. 3. Based on observation, the Building was not maintained in a safe and operating condition, because the commercial kitchen hood's fire extinguishing system lacked the inspections, maintenance and documented required to ensure a properly working system. This could affect all residents, staff and visitors if the commercial kitchen hood's suppression system fails to operate properly when needed. Findings on September 24, 2015: a. Per the semi-annual maintenance tag, the commercial kitchen hood's fire extinguishing system was last maintained in July of 2014. b. Since the semi-annual maintenance of the commercial kitchen hood's fire extinguishing system in July 2014, there has been no record keeping of the monthly inspections. 4. Based on observation, the Building was not maintained in a safe and operating condition, because the electrical power system was not being operated or maintained safely. This would affect all staff, by allowing unsafe conditions to	C 189		

10/27/15

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C 189	Continued From page 6 persist. Findings on September 24, 2015: a. The electrical panels had open slots were breakers was removed or a blanks fail out at the following locations to include but not limited to: i. Panel Room-Panel LF ii. Service Hall between Wilmington and Charlotte Wing-Panel MA b. In the Freezer the refrigeration equip was missing it cover plate. c. An electrical power receptacle in the Hopper Room between Wilmington and Charlotte was missing a cover plate. 5. Based on observation, the Building was not maintained in a safe and operating condition, because the fire sprinkler escutcheon plates were impaired, exposing openings through the ceiling that could allow the passage of smoke and heat. This would affect all residents, staff and visitors, if the fire suppression system does not operate in a timely manner and cannot contained fire in the Room of origin. Findings on September 24, 2015: a. The fire sprinkler escutcheon plate had dropped down from the ceiling. Locations of specific examples include but are not limited to: i. Front Corridor of "B" wing. ii. Housekeeping Room in Service Hall between Ashville and Charlotte wings iii. b. The fire sprinkler escutcheon plate did not cover the complete hole through the ceiling. Locations of specific examples include but are not limited to: i. Porch near Bedroom 310. c. The fire sprinkler escutcheon plate was missing. Locations of specific examples include but are not limited to: i. Third Storage Room from the front in the	C 189		

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C 189	Continued From page 7 Activity Room. ii. Freezer iii. Housekeeping Room in Service Hall between Wilmington and Charlotte wings. d. The fire sprinkler escutcheon plate and piping had dropped down from the ceiling in the Laundry in Service Hall between Wilmington and Charlotte wings. e. The fire sprinkler head in the kitchen walk-in cooler had orange foam sealing in the parts around the internal escutcheon plate. 6. Based on observations, the Building was not maintained in a safe and operating condition, because breaches through the fire-resistance-rated construction invalidated its integrity. This could affect all residents, staff and visitors if smoke/fire is not contained in Room or compartment of origin. Findings on September 24, 2015: a. The ceiling had an unprotected cable penetration through the ceiling assembly right of the Double doors to the Staff Only Area. b. The ceiling had unprotected gap around 1 ½ inch conduits penetration in the Fire Panel Room. c. The fire-resistance-rated ceiling assembly had a 1 ½ inch hole in the First Storage Room from the front in the Activity Room, d. In the Second Storage Room from the front in the Activity Room the attic access door was open at the time of Survey. This is not in conformance with the NC State Building Code, which requires the fire-resistance-rating of the ceiling must be maintained. Deficiency corrected before Construction Surveyors departed Site. e. Most of the new exit light did not completely cover the hole through the fire-resistance-rated ceiling assembly throughout the building. 7. Based on observation, the Building was not	C 189		

10/23/15

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C 189	Continued From page 8 maintained in a safe and operating condition, by not maintaining the fire and smoke resistance of doors the NC State Building Code defines as "Hazardous Area". This could affect all residents, staff and visitors if smoke/fire is not contained in Room or fire compartment of origin. Findings on September 24, 2015: a. The Janitor door near Kitchen had duct tape covering strike plate not allowing door to latch. b. The Riser Room had duct tape covering strike plate not allowing door to latch. c. The Kitchen door near Hood suppression Pull, did not close on its own power, 8. Based on observation, the Building was not maintained in a safe and operating condition, because the corridor doors did not resist the passage of smoke due to door leafs not fitting into their fames with acceptable gaps under normal closing force. This could affect all residents, staff and visitors if the doors did not contain smoke/fire in the room of origin. Findings on September 24, 2015: a. The double doors to the Activity Room do not have astragals to provide a smoke tight seal between the meeting edges of the doors. b. The Nurse Station Dutch door had an open gap between the leaves allowing smoke to pass through. c. The top leave of the Nurse Station Dutch door, did not automatically latch into the bottom leaf 9. Based on Observation, the Building was not maintained in a safe and operating condition, because some corridor doors were held open by devices that do not release with a push or pull of the door, preventing the doors from being closed and latched rapidly. This could affect all residents, staff and visitors by not containing	C 189		

10/2/15

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C 189	Continued From page 9 smoke and fire in the room of origin. Findings on September 24, 2015: a. Corridor door to the Kitchen was blocked open with a heavy table, b. The Laundry Room door in service hall between Wilmington and Charlotte Wing had a wedge holding the door open. 10. Based on Observation, the Building was not maintained in a safe and operating condition, because the portable medical oxygen cylinders were not being properly handled/stored. This could affect all residents, staff and visitors if cylinders fall, breaking their valves, propelling the cylinder and turning it into a dangerous projectile. Findings on September 24, 2015: a. Several portable medical oxygen cylinders were stored standing up in beverage crates not secured to the structure in service area between Ashville and Charlotte Wings.	C 189		
C 199	Exhaust Ventilation SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (g) The spaces listed in this Paragraph shall be provided with exhaust ventilation at the rate of two cubic feet per minute per square foot. This requirement does not apply to facilities licensed before April 1, 1984, with natural ventilation in these specified spaces: (1) soiled linen storage; (2) soil utility room; (3) bathrooms and toilet rooms; (4) housekeeping closets; and (5) laundry area. (k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e)	C 199		

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C 199	Continued From page 10 which shall not apply to existing facilities. This Rule is not met as evidenced by: 1. Based on Observation and testing the facility failed to maintain the ventilation system in proper working order. This could affect all residents, staff and visitors by subjecting them to odors. Findings on September 24, 2015: a. The exhaust ventilation was not working. Locations of specific examples include but are not limited to: i. Hopper Room between Wilmington and Charlotte Wings ii. Housekeeping between Wilmington and Charlotte Wings iii. Housekeeping between Ashville and Charlotte Wings	C 199		

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(Postmarked October 12, 2015. Received October 16, 2015)
Plan of Correction

ID PREFIX TAG C101: Section .0300 – PHYSICAL PLANT 10A NCAC 13F .0301 APPLICATION OF PHYSICAL PLANT REQUIREMENTS

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

A. **With respect to the corrective action accomplished in those areas of the facility found to have been affected by the deficient practice.** No residents were injured nor had any adverse effects as a result of this deficiency. Upon this deficiency being brought to our attention, the community immediately ordered keys for all staff to have. Additionally, in the event of an emergency, when the fire alarm sounds, the mag-locks are de-energized, thus releasing the mag-locks.

B. **With respect to how to identify other areas of the facility having the potential to be affected by the same deficient practice and what corrective action will be taken for the same deficient practice.** The Environmental Services Director/Designee will conduct an in-service with staff to insure all staff has a key and knows how to operate the key lock, in the event of an emergency. Staff will be directed to obtain a key if they need a replacement key.

C. **With respect to what measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** Employees will be issued a key upon being hired and trained on how to use the key in the event of an emergency.

D. **With respect to how the corrective action will be monitored to ensure the deficient practice will not reoccur.** Environmental Service Director/Designee will make random inspections to insure all staff have their keys and can demonstrate how to use them.

E. **Date when corrective action will be completed.** Corrective action will be completed within forty-five (45) days of survey date, on or before November 7, 2015.

ID PREFIX TAG C111: Section .0300 – PHYSICAL PLANT 10A NCAC 13F .0302 DESIGN AND CONSTRUCTION

Per conversation with surveyor on October 22, 2015, this deficiency was found to be in compliance. No further action required.

2/12

ID PREFIX TAG C150: Section .0300 – PHYSICAL PLANT 10A NCAC 13F .0305 PHYSICAL ENVIRONMENT

A. **With respect to the corrective action accomplished in those areas of the facility found to have been affected by the deficient practice.** No residents were injured nor had any adverse effects as a result of this deficiency. Upon this deficiency being brought to our attention, the community immediately removed any obstructions from exit path.

B. **With respect to how to identify other areas of the facility having the potential to be affected by the same deficient practice and what corrective action will be taken for the same deficient practice.** The Environmental Services Director/Designee will conduct an in-service with staff to insure all staff understands the importance of maintaining unobstructed exit paths and what action to take should they see this.

C. **With respect to what measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** The Environmental Services Director/Designee will make routine safety rounds to insure that exit paths are unobstructed.

D. **With respect to how the corrective action will be monitored to ensure the deficient practice will not reoccur.** Environmental Service Director/Designee will make random inspections to insure all exit paths are in compliance.

E. **Date when corrective action will be completed.** Corrective action will be completed within forty-five (45) days of survey date, on or before November 7, 2015.

3/12

ID PREFIX TAG C164: Section .0300 – PHYSICAL PLANT 10A NCAC 13F .0306 HOUSEKEEPING AND FURNISHINGS

A. **With respect to the corrective action accomplished in those areas of the facility found to have been affected by the deficient practice.** No residents were injured nor had any adverse effects as a result of this deficiency. This item was in repair during the survey. It has since been repaired/replaced.

B. **With respect to how to identify other areas of the facility having the potential to be affected by the same deficient practice and what corrective action will be taken for the same deficient practice.** The Environmental Services Director/Designee will repair/replace furnishings accordingly, upon finding such items not in compliance.

C. **With respect to what measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** The Environmental Services Director/Designee will make routine rounds to insure that all furnishings are in compliance.

D. **With respect to how the corrective action will be monitored to ensure the deficient practice will not reoccur.** Environmental Service Director/Designee will make random inspections to insure furnishings are in compliance and repaired/replaced accordingly.

E. **Date when corrective action will be completed.** Corrective action will be completed within forty-five (45) days of survey date, on or before November 7, 2015.

4/12

ID PREFIX TAG C166: Section .0300 – PHYSICAL PLANT 10A NCAC 13F .0306 HOUSEKEEPING AND FURNISHINGS

A. **With respect to the corrective action accomplished in those areas of the facility found to have been affected by the deficient practice.** No residents were injured nor had any adverse effects as a result of this deficiency. Upon this deficiency being brought to our attention, the community immediately removed dust/lint from dampers.

B. **With respect to how to identify other areas of the facility having the potential to be affected by the same deficient practice and what corrective action will be taken for the same deficient practice.** The Environmental Services Director/Designee will conduct an in-service with staff to insure all housekeeping staff understands the importance of keeping dampers free of dust/lint.

C. **With respect to what measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** The Environmental Services Director/Designee will make routine rounds to insure all dampers are maintained properly. This will be maintained on a monthly cleaning schedule.

D. **With respect to how the corrective action will be monitored to ensure the deficient practice will not reoccur.** Environmental Service Director/Designee will make random inspections to insure all dampers are kept in compliance.

E. **Date when corrective action will be completed.** Corrective action will be completed within forty-five (45) days of survey date, on or before November 7, 2015.

ID PREFIX TAG C189: Section .0300 – PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS

1)

A. **With respect to the corrective action accomplished in those areas of the facility found to have been affected by the deficient practice.** No residents were injured nor had any adverse effects as a result of this deficiency. An exit sign has been installed and the breakaway padlock has been removed (Based upon clarification from surveyor on 10/22/15).

B. **With respect to how to identify other areas of the facility having the potential to be affected by the same deficient practice and what corrective action will be taken for the same deficient practice.** The Environmental Services Director/Designee will conduct an in-service with staff to insure everyone understands the importance of keeping this breakaway lock off the gate.

C. **With respect to what measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** The Environmental Services Director/Designee will make routine rounds to insure the gate doesn't have a lock installed.

D. **With respect to how the corrective action will be monitored to ensure the deficient practice will not reoccur.** Environmental Service Director/Designee will make random inspections to insure the lock and gate are kept in compliance.

E. **Date when corrective action will be completed.** Corrective action will be completed within forty-five (45) days of survey date, on or before November 7, 2015.

2)

A. **With respect to the corrective action accomplished in those areas of the facility found to have been affected by the deficient practice.** No residents were injured nor had any adverse effects as a result of this deficiency. The exit sign(s) of concern have been fixed accordingly.

B. **With respect to how to identify other areas of the facility having the potential to be affected by the same deficient practice and what corrective action will be taken for the same deficient practice.** The Environmental Services Director/Designee will conduct an in-service with staff to insure everyone understands the importance of making sure exit signs are functional and check them for emergency operation.

C. **With respect to what measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** The Environmental Services Director/Designee will make routine rounds to insure exit sign are operating correctly and that directional tabs reflect appropriate egress direction.

D. **With respect to how the corrective action will be monitored to ensure the deficient practice will not reoccur.** Environmental Service Director/Designee will make random inspections to insure all exits sign meet the requirement.

E. **Date when corrective action will be completed.** Corrective action will be completed within forty-five (45) days of survey date, on or before November 7, 2015.

3)

A. **With respect to the corrective action accomplished in those areas of the facility found to have been affected by the deficient practice.** No residents were injured nor had any adverse effects as a result of this deficiency. The commercial kitchen hood had the appropriate inspection completed. The inspection tag is in place and current.

B. **With respect to how to identify other areas of the facility having the potential to be affected by the same deficient practice and what corrective action will be taken for the same deficient practice.** The Environmental Services Director/Designee will conduct an in-service with staff to insure everyone understands the importance of making sure inspection tags reflect the correct/current dates.

C. **With respect to what measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** The Environmental Services Director/Designee will make routine rounds to insure all inspection tags reflect correct/current dates.

D. **With respect to how the corrective action will be monitored to ensure the deficient practice will not reoccur.** Environmental Service Director/Designee will make random inspections to insure all inspection tags are in compliance.

E. **Date when corrective action will be completed.** Corrective action will be completed within forty-five (45) days of survey date, on or before November 7, 2015.

4)

A. **With respect to the corrective action accomplished in those areas of the facility found to have been affected by the deficient practice.** No residents were injured nor had any adverse effects as a result of this deficiency. The breaker box, switches and receptacles of concern have been addressed accordingly. Cover plates have been installed.

B. **With respect to how to identify other areas of the facility having the potential to be affected by the same deficient practice and what corrective action will be taken for the same deficient practice.** The Environmental Services Director/Designee will conduct an in-service with staff to insure everyone understands the importance of making sure cover plates are installed and in good repair, for all electrical components/fixtures.

7/12

C. **With respect to what measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** The Environmental Services Director/Designee will make routine rounds to insure all electrical components/fixtures are in compliance.

D. **With respect to how the corrective action will be monitored to ensure the deficient practice will not reoccur.** Environmental Service Director/Designee will make random inspections to insure all electrical components/fixtures are in compliance.

E. **Date when corrective action will be completed.** Corrective action will be completed within forty-five (45) days of survey date, on or before November 7, 2015.

5)

A. **With respect to the corrective action accomplished in those areas of the facility found to have been affected by the deficient practice.** No residents were injured nor had any adverse effects as a result of this deficiency. The escutcheon plates of concern have been addressed accordingly. Escutcheon plates have been installed.

B. **With respect to how to identify other areas of the facility having the potential to be affected by the same deficient practice and what corrective action will be taken for the same deficient practice.** The Environmental Services Director/Designee will conduct an in-service with staff to insure everyone understands the importance of making sure escutcheon plates are installed and in good repair.

C. **With respect to what measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** The Environmental Services Director/Designee will make routine rounds to insure all escutcheon plates are installed and in good repair.

D. **With respect to how the corrective action will be monitored to ensure the deficient practice will not reoccur.** Environmental Service Director/Designee will make random inspections to insure all escutcheon plates are installed, in good repair and are in compliance.

E. **Date when corrective action will be completed.** Corrective action will be completed within forty-five (45) days of survey date, on or before November 7, 2015.

6)

A. **With respect to the corrective action accomplished in those areas of the facility found to have been affected by the deficient practice.** No residents were injured nor had any adverse effects as a result of this deficiency. Areas of concern for breached fire resistance will be sealed accordingly, using approved material(s).

B. **With respect to how to identify other areas of the facility having the potential to be affected by the same deficient practice and what corrective action will be taken for**

the same deficient practice. The Environmental Services Director/Designee will conduct an in-service with staff to insure everyone understands what to look for in regards to breach protected areas and how to address it.

C. **With respect to what measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** The Environmental Services Director/Designee will make routine rounds to insure all fire resistance standards are maintained and repaired accordingly.

D. **With respect to how the corrective action will be monitored to ensure the deficient practice will not reoccur.** Environmental Service Director/Designee will make random inspections to insure all fire resistance standards are maintained and repaired accordingly.

E. **Date when corrective action will be completed.** Corrective action will be completed within forty-five (45) days of survey date, on or before November 7, 2015.

7)

A. **With respect to the corrective action accomplished in those areas of the facility found to have been affected by the deficient practice.** No residents were injured nor had any adverse effects as a result of this deficiency. The fire and smoke resistant doors of concern have been addressed and fixed accordingly.

B. **With respect to how to identify other areas of the facility having the potential to be affected by the same deficient practice and what corrective action will be taken for the same deficient practice.** The Environmental Services Director/Designee will conduct an in-service with staff to insure everyone understands the importance to maintain the integrity and purpose of a fire/smoke rated door.

C. **With respect to what measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** The Environmental Services Director/Designee will make routine rounds to insure all fire and smoke resistant door standards are maintained and repaired accordingly.

D. **With respect to how the corrective action will be monitored to ensure the deficient practice will not reoccur.** Environmental Service Director/Designee will make random inspections to insure all fire and smoke resistant door standards are maintained and repaired accordingly.

E. **Date when corrective action will be completed.** Corrective action will be completed within forty-five (45) days of survey date, on or before November 7, 2015.

8)

A. **With respect to the corrective action accomplished in those areas of the facility found to have been affected by the deficient practice.** No residents were injured nor

had any adverse effects as a result of this deficiency. The doors of concern, with gaps, have been addressed and fixed accordingly, to contain smoke.

B. **With respect to how to identify other areas of the facility having the potential to be affected by the same deficient practice and what corrective action will be taken for the same deficient practice.** The Environmental Services Director/Designee will conduct an in-service with staff to insure everyone understands the importance of doors, with gaps, and why it's important to identify and correct these, in order to contain smoke.

C. **With respect to what measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** The Environmental Services Director/Designee will make routine rounds to insure all doors are gapped accordingly and have the proper smoke barrier.

D. **With respect to how the corrective action will be monitored to ensure the deficient practice will not reoccur.** Environmental Service Director/Designee will make random inspections to insure all doors are gapped accordingly and have the proper smoke barrier.

E. **Date when corrective action will be completed.** Corrective action will be completed within forty-five (45) days of survey date, on or before November 7, 2015.

9)

A. **With respect to the corrective action accomplished in those areas of the facility found to have been affected by the deficient practice.** No residents were injured nor had any adverse effects as a result of this deficiency. The doors of concern have had their obstruction/wedge removed.

B. **With respect to how to identify other areas of the facility having the potential to be affected by the same deficient practice and what corrective action will be taken for the same deficient practice.** The Environmental Services Director/Designee will conduct an in-service with staff to insure everyone knows why doors should not have any obstruction/wedges placed in front of a door, preventing it to close properly.

C. **With respect to what measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** The Environmental Services Director/Designee will make routine rounds to insure all doors are free of obstruction/wedges.

D. **With respect to how the corrective action will be monitored to ensure the deficient practice will not reoccur.** Environmental Service Director/Designee will make random inspections to insure all doors are free of obstruction/wedges.

E. **Date when corrective action will be completed.** Corrective action will be completed within forty-five (45) days of survey date, on or before November 7, 2015.

10)

A. **With respect to the corrective action accomplished in those areas of the facility found to have been affected by the deficient practice.** No residents were injured nor had any adverse effects as a result of this deficiency. All oxygen tanks have been properly stored and the beverage crates have been removed.

B. **With respect to how to identify other areas of the facility having the potential to be affected by the same deficient practice and what corrective action will be taken for the same deficient practice.** The Environmental Services Director/Designee will conduct an in-service with staff to insure everyone understands the proper storage of oxygen tanks. Further, the community will also speak to oxygen tank suppliers, reiterating the same.

C. **With respect to what measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** The Environmental Services Director/Designee will make routine rounds to insure all oxygen is properly stored and correct any deficiencies.

D. **With respect to how the corrective action will be monitored to ensure the deficient practice will not reoccur.** Environmental Service Director/Designee will make random inspections to insure all oxygen is properly stored and correct any deficiencies.

E. **Date when corrective action will be completed.** Corrective action will be completed within forty-five (45) days of survey date, on or before November 7, 2015.

ID PREFIX TAG C199: Section .0300 – PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS

A. **With respect to the corrective action accomplished in those areas of the facility found to have been affected by the deficient practice.** No residents were injured nor had any adverse effects as a result of this deficiency. All exhaust ventilation areas of concern are in the process of being replaced. It is believed the failure is due to a recent lightning strike, due to the fact they are were inoperable.

B. **With respect to how to identify other areas of the facility having the potential to be affected by the same deficient practice and what corrective action will be taken for the same deficient practice.** The Environmental Services Director/Designee will conduct an in-service with staff to insure they know how to inspect exhaust ventilation failure and to repot it accordingly.

C. **With respect to what measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** The Environmental Services Director/Designee will make routine rounds to insure exhaust ventilation systems are properly functioning.

D. **With respect to how the corrective action will be monitored to ensure the deficient practice will not reoccur.** Environmental Service Director/Designee will make random inspections to insure exhaust ventilation systems are properly functioning.

E. **Date when corrective action will be completed.** Corrective action will be completed within forty-five (45) days of survey date, on or before November 7, 2015.

Jason T. Fiskter
Jason T. Fiskter
Administrator
10/27/15

12/12