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
	HAL060104	A. BUILDING: 01 - MAIN B. WING _____	11/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS IN THE VILLAGE AT CAROLINA	13180 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 Biennial Construction Survey by Dennis Harrell and Ed Miller on 11-5-2015. Records indicate this facility was first licensed on 12-17-1997, for 104 beds. Based on this information, we are requiring the facility to meet the 1996 Homes for the Aged and Disabled - Minimum Standards and Regulations, the applicable portions of the 2005 Rules for Adult Care Homes of Seven or More Beds, and the 1996 Edition of the North Carolina State Building Code (1997 Rev), Section 409.1, Group I Unrestrained Occupancy.	C 000	See attached POC.	
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 at no cost; This Rule is not met as evidenced by: Based on observation the facility did not meet the 1996 NC State Building Code as relates to	C 101	ED 1/1/16	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

1/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 101	Continued From page 1 storage and fire separations. Improper storage could allow a fire to grow beyond the sprinkler system's capacity to extinguish it. Findings include: The C up Parlor, which is much larger than 100 sq. feet, is now being used for combustible storage. The room is sprinkler protected but is separated from the corridor by only an unrated door. Section 409.1.6.1 of the 1991 NC State Building Code requires storage rooms larger than 100 sq. feet to be protected by sprinklers and to be separated from the remainder of the facility with one-hour fire rated construction and a ¾ hour fire rated self-closing or automatic closing door.	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: Based on review of documents, the most recent Fire Marshal inspection report, dated 7-22-2015, listed deficiencies. There was no supporting documentation to indicate the deficiencies had been corrected. Findings include: a. Fire extinguishers need required service/inspection. b. Fire door blocked/inoperable/improperly modified.	C 111		

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C 150	Continued From page 2	C 150		
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: Based on observation, there are 2 exits from "Rehab," both of which are designated with lighted exit signs. One exit was completely obstructed with chairs and equipment. An obstructed exit could delay evacuation in an emergency.	C 150		
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 be maintained free of hazards because of exits signs directing exiting in the wrong directions. Exit signs that lead in the wrong direction could delay an evacuation in an emergency. Findings include: a. The required exit sign near room A201 has the exit arrows pointing in the wrong directions for exiting.	C 166		

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C 166	Continued From page 3 b. The required exit sign near room 201 has the exit arrows pointing in the wrong directions for exiting. c. The required exit sign near room D201 has the exit arrows pointing in the wrong directions for exiting. 2. Based on observation, a waste trap had been allowed to become dry. Dry waste traps allow noxious, combustible odors and possibly harmful bacteria to enter the facility. Findings include: The hopper trap was dry in the soiled utility room. 3. Based on observation, the vacuum breakers had been removed from the plumbing fixtures at mop sinks. Removing vacuum breakers from water fixtures that are desiged for hose connections present the possibility of siphoning contaminated water into the water system. Findings include: There was hose bib above the mop sink in the D up laundry and at the mop sink near the hair salon with no vacuum breaker provided.	C 166		
C 185	Fire Safety-Rehearsals on Each Shift SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0309 PLAN FOR EVACUATION (b) There shall be rehearsals of the fire plan quarterly on each shift in accordance with the requirement of the local Fire Prevention Code Enforcement Official. (c) Records of rehearsals shall be maintained and copies furnished to the county department of social services annually. The records shall include the date and time of the rehearsals, the shift, staff members present, and a short	C 185		

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C 185	Continued From page 4 description of what the rehearsal involved. (f) This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on review of documents, the records of fire drill rehearsals did not include any description of what the rehearsal involved.	C 185		
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 review of documents, the most recent sprinkler inspection report, dated 1-28-2015, listed deficiencies. There was no supporting documentation to indicate the deficiencies had been corrected. A deficient fire sprinkler system could endanger all occupants of the building. Findings include: a. The OS&Y tamper switch did not activate on closing of the valve to the dry sprinkler system. b. The OS&Y tamper switch did not activate on closing of the valve to the wet sprinkler system. 2. Based on observation, many corridor doors are prevented from closing quickly and latching to	C 189		

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C 189	Continued From page 5 resist the passage of fire and smoke. Corridor doors that do not close completely and latch present the possibility that a fire that begins in one space can quickly spread to the corridor and the remainder of the facility. Findings include; a. One of the smoke barrier doors near room C201 was dragging the floor and would not automatically close. b. The receptionist office door was wedged open. c. The door to the laundry near 201 would not latch. d. The door to the soiled utility room in B up would not latch. e. The ¾ hour door to the storage room in B/E up would not latch. f. The latch bolt was missing on the door to the Spa. g. The ¾ hour door to the storage room in E/C up was severely damaged and the closer was disconnected. h. The ¾ hour door to the storage room in C up would not automatically latch. i. One of the smoke barrier doors near D201 would not latch when closed. j. The rated door to the elevator equipment room would not automatically latch. k. The pair of doors from the kitchen to the dining room would not close or latch. l. The ¾ hour door from the kitchen to the service corridor would not automatically latch. m. The smoke barrier doors near the staff rest room on the service corridor are not closing well. n. There is a 3/8 inch gap between the smoke barrier doors near the staff rest room on the service corridor. o. The door to the soiled linen room in the service corridor would not latch. p. One pair of doors to the dining room would not close and latch.	C 189		

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C 189	Continued From page 6 q. The door to room A107 is hard to close. r. One of the smoke barrier doors near B101 would not latch when closed. s. The 1½ hour door to the stair tower near room B110 would not close and latch. t. The door to the D up laundry, which is larger than 100 sq. feet, was held open by a permanent magnet. Doors on laundries larger than 100 sq. feet must be self-closing or automatic closing on activation of the fire alarm system. u. The door to the clean linen room across from the hopper room had holes through it. 3. Based on observation the required one-hour fire rated walls and/or ceilings were compromised in several locations. Holes and penetrations that are not sealed with materials approved for use in one-hour fire rated construction present the possibility that a fire that begins in one space can quickly spread to other areas of the facility. Findings include: a. The exit sign near the laundry was not tightly mounted to the ceiling. b. Hole in ceiling at a patch in the storage room at B/E up. c. Holes (2) in the ceiling in "Rehab." d. Conduit sleeve (3 inch) from floor through ceiling, not fire protected at the floor or the ceiling. e. Hole in wall in C up pantry. f. Plastic unrated washing machine connection boxes (2) in smoke barrier wall in D up laundry. g. Holes in walls and ceiling in the communication room. h. Hole through the smoke barrier wall at the smoke barrier doors near the staff rest room on the service corridor. i. Unprotected 3 inch PVC penetrations (3) in the maintenance office. j. Hole in ceiling at refrigerant lines in the	C 189		

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C 189	Continued From page 7 maintenance office. k. Ceiling damaged at refrigerant lines in the maintenance office. l. Holes in wall in soiled linen room on service corridor. m. Holes in ceiling in sprinkler riser room. n. Hole above electric box for magnetic hold open at the left dining room doors. 4. Based on observation, the facility was not maintained in a safe manner because of exit signs not working. Malfunctioning exit signs could delay an evacuation in an emergency. Findings include: Both of the lighted exit signs in "Rehab" were not illuminated. 5. Based on Observation, the building was not maintained in a safe manner by not properly handling portable medical oxygen cylinders. 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 include: a. Several (7) portable medical oxygen cylinders were stored in no container in room B108. b. One portable medical oxygen cylinder was stored leaning against the wall in room B202. c. One portable medical oxygen cylinder was stored in no container in room D112. d. Several (3) portable medical oxygen cylinders were stored in no container in room A109. Deficiency d. was corrected onsite. 6. Based on observation, the GFCI type receptacles (2) in the Clinic would not trip when tested. GFCI type receptacles that do not work properly present a shock or electrocution risk.	C 189		

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C 189	Continued From page 8 7. Based on observation, there were component covers missing on the panic hardware latches on one pair of dining room doors. The missing covers exposed sharp edges. 8. Based on observation, there were many items stored directly in front of the electrical panels in the main electrical room. Storage in front of electrical panels is a Building Code violation and could delay access to the electrical disconnects in an emergency. Finding includes; The electric panel in the C up Parlor was obstructed with a sofa. 9. Based on observation, the ice machine drain line was laying directly on the floor. Ice machine drain lines that are not maintained at least 2 inches above the floor or floor drain, as required by Code, could cause the ice to become contaminated.	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	C 199		

Division of Health Service Regulation

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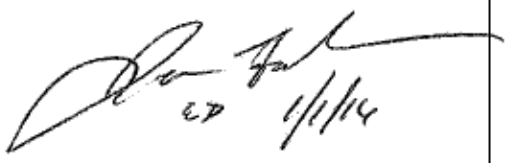
C-199	Continued From page 9 facilities with the exception of Paragraph (e) which shall not apply to existing facilities. This Rule is not met as evidenced by: Based on observation the facility failed to maintain required exhaust in a working condition. Non-functioning exhaust could cause an unhealthy buildup of moisture and possibly bacteria. Findings include; a. The exhaust fan was not working in the laundry near the hair salon. b. There was no exhaust provided in the laundry near room 201.	C-199		

Facility: The Laurels at Carolina Place
License Number: HAL-060-104 FID #971517
Survey Conducted: November 5, 2015
Statement of Deficiencies Report (Received via Email December 18, 2005. Hardcopy – postmarked December 19, 2015. Received December 28, 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. Excess furniture (combustibles) will be reduced to an adequate amount, not to exceed what would be of normal use for its room size.

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 rooms are used appropriately, not to exceed its capacity and/or used for, as properly rated by code.

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 incorporate this material into their safety topics, for their monthly safety committee meeting.

D. **With respect to how the corrective action will be monitored to ensure the deficient practice will not reoccur.** The Environmental Services Director/Designee will make monthly rounds to ensure all rooms are meeting the requirements accordingly.

E. **Date when corrective action will be completed.** Corrective action will be completed on or before January 15, 2016.

1/16

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

This did not require "service". Per the Fire Marshalls report, the fire extinguisher was missing during his inspection and the fire door was opened upon his inspection. Both of these items were in compliance during the HA Biennial Survey. The Fire Marshall deficiencies wouldn't require a fix that produces documentation.

This deficiency was/is in compliance. No further action required.

2/16

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 on or before January 15, 2016.

3/14

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

1) a, b and c

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. Exit sign will be fixed, indicating the proper direction of egress, as applicable.

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 exit signs, 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 exit signs 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 exit signs are in compliance and repaired/replaced accordingly.

E. **Date when corrective action will be completed.** Corrective action will be completed on or before January 15, 2016.

9/16

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

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 waste trap will be filled 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 keep traps wet, 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 waste traps 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 waste traps are in compliance and addressed accordingly.

E. **Date when corrective action will be completed.** Corrective action will be completed on or before January 15, 2016.

5/16
JTR

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

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. Vacuum breakers will be installed 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 repair/replace vacuum breakers, 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 vacuum breakers 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 vacuum breakers are in compliance and repaired/replaced accordingly.

E. **Date when corrective action will be completed.** Corrective action will be completed on or before January 15, 2016.

1/16

ID PREFIX TAG C185: Section .0300 – PHYSICAL PLANT 10A NCAC 13F .0309 PLAN FOR EVACUATION

Fire drill records reflect the following details…

1) The date of which the simulated fire/emergency drill took place.
2) The shift (1st, 2nd & 3rd) of which the simulated fire/emergency drill took place.
3) The time of day the simulated fire/emergency drill took place.
4) The location of which the simulated fire/emergency drill took place.
5) The response time from staff, of which the simulated fire/emergency drill took place.
6) General comments on drill/response (i.e. Number of residents/staff/visitors, any concerns or opportunities, as applicable)

Records were resubmitted for further review. No further action required.

7/16

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

1) a &b

Documentation was provided to surveyors, reflecting deficiencies had been corrected accordingly. No further action required.

2) a through u

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, to include latches, latch bolts, closures, dragging, penetrations, gaps and hardware will be 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. Staff is to report affected doors 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 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 on or before January 15, 2016.

8/26

3) a through n

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 on or before January 15, 2016.

9/16
(FT2)

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. Exit signs will be fixed, to include indicating the proper direction of egress, as applicable.

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 exit signs, 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 exit signs 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 exit signs are in compliance and repaired/replaced accordingly.

E. **Date when corrective action will be completed.** Corrective action will be completed on or before January 15, 2016.

10/16

5) a through d

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 store.

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 on or before January 15, 2016.

11/16

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. The GFCI receptacle will be replaced 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 inspect all GFCI receptacles to insure they work 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 GFCI receptacles 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 GFCI receptacles are maintained and repaired accordingly.

E. **Date when corrective action will be completed.** Corrective action will be completed on or before January 15, 2016.

12/16

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. Hardware latches, on the fire and smoke resistant doors will be 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 having proper hardware in place and how to report discrepancies, for the safety of residents and 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 on or before January 15, 2016.

1/3/16

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. Upon this deficiency being brought to our attention, the community immediately removed the obstruction.

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 areas, in front of electrical panels.

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 electrical panels 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 electrical panels are in compliance.

E. **Date when corrective action will be completed.** Corrective action will be completed on or before January 15, 2016.

14/16

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 ice machine drain line will be raised 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 knows why drain lines need to be raised two (2) inches off the floor.

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 drain lines are raised two (2) inches off the floor.

D. **With respect to how the corrective action will be monitored to ensure the deficient practice will not reoccur.** The Environmental Services Director/Designee will make routine rounds to insure all drain lines are raised two (2) inches off the floor.

E. **Date when corrective action will be completed.** Corrective action will be completed on or before January 15, 2016.

15/16

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 have been 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 conduct an in-service with staff to insure they know how to inspect exhaust ventilation failure and to report 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 on or before January 15, 2016.

1/4/16

TRANSACTION REPORT

JAN/01/2016/FRI 06:24 PM

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#	DATE	START T.	RECEIVER	COM.TIME	PAGE	TYPE/NOTE	FILE
001	JAN/01	06:20PM	919197336592	0:04:36	28	MEMORY OK SG3	2784

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Date:

To: ED Miller	**From:** Jason Fisher
Fax: 919-733-6592	**Pages (including Cover):** 28
Subject: Laurels PAC	
Comments: Please see attached.	

Jason T. Fisher
Executive Director

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Jason T. Fisher
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