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
	HAL049015	A. BUILDING: 01 B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

(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 on 11-20-2015. Records indicate this facility was first licensed on 10-11-1996, for 60 residents. Based on this information, we are requiring the facility to meet the 1996 Edition of the North Carolina State Building Code, the 1996 Rules for the Licensing of Adult Care Homes and the applicable portions of the current Rules for Adult Care Homes of Seven or More Beds.	C 000	**Disclaimer** The provider submits this Plan of Action (POA) in accordance with specific regulatory requirements. The Provider does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that the stated deficiencies are accurate. The Provider submits this POA with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings if at any time the Provider determines that the findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the State of North Carolina or any other entity; or (2) serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider's policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis.	
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 a review of documents, a current copy of a fire alarm system inspection was not available in the home for review.	C 111	**Action Plan** The provider strives to ensure compliance with maintaining records of current sanitation, fire and building safety, sprinkler system, and fire alarm system inspection reports. The provider has policies and procedures designed to maintain current availability of these records. QAA audits and various quality assurance measures are examples of the components utilized. **Corrective Action-** The annual fire alarm system inspection (NFPA-72) was completed by the licensed vendor on 12/02/15. (See Attachment #1) **Id of Other Areas-** Other required inspection reports were reviewed for applicable timeframes. All were in compliance. **Measures & Monitor-** The Administrator added the annual fire alarm system inspection to the already established tickler file used to contact all inspectors or contractors with a courtesy reminder one month prior to their due date(s).	12/02/15
C 116	Plans Submittals and Approvals SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0304 PLANS AND SPECIFICATIONS (a) When construction or remodeling of an adult care home is planned, two copies of Construction Documents and specifications shall be submitted by the applicant or appointed representative to the Division for review and approval. As a preliminary step to avoid last minute difficulty with			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: 01 B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

(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 116	Continued From page 1 final plan approval, Schematic Design Drawings and Design Development Drawings may be submitted for approval prior to the required submission of Construction Documents. (b) Approval of Construction Documents and specifications shall be obtained from the Division prior to licensure. Approval of Construction Documents shall expire after one year unless a building permit for the construction has been obtained. (c) If an approval expires, renewed approval shall be issued by the Division, provided revised Construction Documents meeting all current regulations, codes and standards are submitted by the applicant or appointed representative and reviewed by the Division. (d) Any changes made during construction shall require the approval of the Division to assure that licensing requirements are maintained. (e) Completed construction or remodeling shall conform to the requirements of this Section including the operation of all building systems and shall be approved in writing by the Division prior to licensure or occupancy. Within 90 days following licensure, the owner or licensee shall submit documentation to the Division that "as built" drawings have been received from the builder. (f) The applicant or designated agent shall notify the Division when actual construction or remodeling starts and at points when construction is 50 percent, 75 percent and 90 percent complete and upon final completion. This Rule is not met as evidenced by: Based on observation, Special(magnetic) Locking is being installed on the exits throughout the facility. A check of Construction Section records indicates no documents have been	C 116	**Action Plan** The provider believed it was in compliance with a project plan submittal. The licensed vendor installing the wander management system had obtained local permits prior to starting their installation process and believed they had submitted plans and required drawings to DHSR prior to starting their installation process. The vendor had not completed installation or activated the system at the time of the survey. Vendor was awaiting DHSR fee letter and local and state inspections. **Corrective Action-** The licensed vendor contracted to provide/install the wander management system equipment obtained permit(s) on 11/9/15 (Attachment #2 and #3) and believed they had submitted plans to DHSR on10/21/15 (Attachment #4). Vendor checked their records and discovered ommission. (Attachment #4). Vendor submitted information 11/30/15. Project received and number (HA-3127) assigned. (Attachment #5) **Id of Other Areas-** No other construction or remodeling projects are being conducted or planned. **Measures/Monitor-** On projects, where applicable, provider will ensure vendor has ensured DHSR has received plans and drawings prior to beginning a project.	12/03/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: 01 B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

(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 116	Continued From page 2 submitted regarding the modification. Note: On the day of the survey, the locking system could not be inspected because it had not been completed and was not energized.	C 185	**Action Plan** The provider always strives to be in compliance with fire safety rehearsal recordkeeping. The provider has policies and procedures designed to maintain current availability of these records. QAA audits and various quality assurance measures are examples of the components utilized. **Corrective Action/Id of Other Areas-** Individuals conducting the 2015 drills added an addendum to include a short description of what each rehearsal had involved. **Measures-** The Administrator re-educated on 11/20/15 the record keeping guidelines with the facility staff members involved in conducting monthly drills (Maintenance Technician & Resident Care Director). (Attachment #6) December fire drill was conducted on 12/7/15 with both 2nd shift and 3rd shift employees. The report for the drill included a description of what the drill involved. (Attachment #7) **Monitor-** Facility Administrator will review reports prior to filing to ensure required guidelines are included on each report.	12/08/15
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 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 a review of documents, the records of fire plan rehearsals did not include any description of what the rehearsal involved.			
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)	C 189	**Action Plan** The provider strives to ensure that the building, along with all fire safety, electrical, mechanical and plumbing equipment is maintained in a safe and operational condition. The facility has policies and procedures designed to maintain these goals. Maintenance work orders, routine maintenance checks, safety committee audits and meetings, and various quality assurance measures are examples of the many components utilized. Fire barrier penetrations, doors that positively latch, emergency lighting and equipment inspections are evaluated at least quarterly as part of the Quality Assessment & Assurance (QAA) and safety audits.	12/10/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: 01 B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

(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 189	Continued From page 3 which shall not apply to existing facilities. This Rule is not met as evidenced by: 1. Based on observation, many corridor doors are not closing well and/or latching to 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. The door to the Chapel will not latch when closed, b. The door to the Activity room will not latch when closed, c. The door to room 17 was propped open, d. The door to room 20 will not latch when closed, e. The door to room 21 will not latch when closed, f. The door to room 23 will not latch when closed, g. There is a hole through the 20 minute rated door from the kitchen to the Activity room. 2. Based on observation, the sampling tube for the duct mounted smoke detector in the attic above the dining room was very dirty. Sampling tubes that are not periodically inspected and cleaned can endanger all residents and staff because the duct detector may fail to operate properly. 3. Based on observation, the battery powered emergency light in the Florida room would not work when tested. Battery powered emergency lights that will not work properly for at least 90 minutes could endanger the residents and staff. 4. Based on observation the required one-hour	C 189	Corrective Action- 1. Positive Latching- a. b. d. e. f. The Maintenance Technician adjusted on 11/25/15 the referenced doors to assure a positive latch. c. The Maintenance Technician immediately removed on 11/20/15 the trash can from room #17's door to eliminate closing obstruction. g. The Maintenance Technician sealed the hole in the Kitchen door leading to Activities with a 1-hour rated fire caulk on 12/1/15. 2. Duct Detector- The fire system inspection vendor thoroughly cleaned all sampling tubes during the system inspection on 12/2/15. (Attachment # 1) 3. Emergency Light- The Maintenance Technician tightened the lose connection on Florida Room fixture on 12/2/15. 4. Ceiling Penetrations- a. – f. The Maintenance Technician sealed the penetrations in the referenced wall and ceilings on 12/01/15 with a 1-hour fire rated sealant. g. The Maintenance Director adjusted on 12/1/15 the two referenced escutcheons so they tightly fit to the ceiling to assure the 1-hour protection of the ceiling. 5. Hood System- A semi-annual inspection of the kitchen hood system was conducted on 3/5/15 (Attachment #8) and again on 9/3/15 by the licensed vendor. (Attachment #9) The Maintenance Technician had been inspecting the system monthly and documenting the monthly inspection on a Maintenance sheet. (Attachment #10) The November and December inspections were documented on the hood system's tag. 6. Extinguishers- An annual inspection was conducted by the licensed vendor on 9/3/15. (Attachment #11) The Maintenance Technician had been inspecting and documenting the monthly inspection on a Maintenance sheet. (Attachment #12) The December inspections were also documented on the extinguisher's tag. 7. Ice Machine Drain- The Maintenance Technician on 11/20/15 raised the height of the drain pipe to assure at least a 2 inch gap between pipe and floor drain.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: 01 B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

(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 189	Continued From page 4 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. Hole in the attic smoke barrier wall above room 31, b. Hole in the ceiling of the Activity office at a wire, c. Hole in the ceiling of the kitchen office at a wire, d. Hole in the wall under the fire alarm panel, e. Hole in the ceiling of the employee break room, f. Hole in the ceiling of the Resident Care Director's office, g. The sprinkler escutcheons were missing or not tightly fitted to the ceiling complete the one-hour protection in the Florida Room and the Administrator's office. 5. Based on a review of documents, the range hood fire suppression system in the kitchen is not being inspected monthly as required. Failure to perform monthly inspections could cause the system to fail to work when needed. Finding includes: The fire suppression system had not been inspected this year. 6. Based on a review of documents, the fire extinguishers were not being properly inspected monthly as required. Failure to perform and properly record monthly inspections could cause the extinguishers to fail to work when needed. Finding includes: The fire extingushers were in locked cabinets and had not been physically inspected this year.	C 189	**Continued from Page 4** Id of Other Areas- The Maintenance Director inspected on 12/9-10/15 all doorways for obstructions; doors for correct operation and positive latching; walls and ceilings for penetrations; escutcheon and pipe collars for proper fit and emergency lights for operation. All remaining sampling tubes were inspected and cleaned as part of the 12/2/15 licensed inspection. (Attachment #1) No other concerns were identified. Measures- The Maintenance Technician, Executive Director and Resident Care Director re-trained facility staff, from 11/20/15 to 11/27/15, regarding means of egress for obstructions; fire door closures for correct operation and positive latching; walls and ceilings for penetrations; escutcheon and pipe collars for proper fit; use on other doors not identified for props. (Attachment #13) The Administrator posted a reminder notice in the staff break room for all staff to report any areas of concern immediately to a Department Manager or Shift Supervisor. (Attachment #14) The Maintenance Director reviewed the findings from the DHSR Construction Survey with QAA members during the facility's monthly QAA Meeting on 12/3/15. Monitor- The Maintenance Director will be responsible for monitoring the facility, at least monthly, to assure: • smoke barrier ceilings, walls and doors have no penetrations. • doors close and positively latch; • doors are free and clear of obstructions; • doors throughout the facility are not wedged open with any type of device or item; • inspections of extinguishers and hood system are noted on tags attached to devices; • inspections of sampling tubes and emergency lighting; and • ice machine drain pipe maintains at least a 2 inch clearance. All Department Managers will assist in monitoring the above areas and findings reviewed in the quarterly QAA meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: 01 B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

(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 189	Continued From page 5 7. Based on observation, the ice machine drain line was in direct contact with the floor drain. 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		