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
	HAL085009	A. BUILDING: 01 B. WING _____	05/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIDDY MANOR ASSISTED LIVING	1294 PRIDDY ROAD KING, NC 27021

(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 Construction Section Biennial Survey by Dennis Harrell March 5-2-2017. Records indicate this facility was first licensed on 4-29-2003, as an Adult Care Facility with a total capacity of 70 residents, including 24 Special Care Residents. Based on this information, we are requiring the facility to meet the 1996 Rules for the Licensing of Adult Care Homes, the applicable components of the current 2005 Licensing of Adult Care Homes of Seven or More Beds, and the 1996 (w/revisions) North Carolina State Building Code(s) for Group I - Institutional Unrestrained Occupancy.	C 000		
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 failed to meet	C 101	10A NCAC 13F .0301 System Components location map has been constructed for your review. This drawing is posted at the FACP.	5/19/17

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C 101	Continued From page 1 the Code requirements in effect at the time of construction by not having all of the required components forSpecial Locking Arrangements. Finding includes: The special locking system does not have a system components location map posted at the FACP.	C 101		
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 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. Finding includes A portable medical oxygen cylinder was stored on a table in no container at all in room A-01. 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. Finding includes: The hopper in the Horizon Wellness Director's office was hidden behind a curtain and had been allowed to become almost completely dry.	C 166	10A NCAC 13F .0306(a) (1)All portable medical oxygen cylinders are now stored in designated areas in proper containment. (2)The hopper in the HZ Wellness Directors office was flushed. The director was instructed to check the hopper weekly for dryness.	5/03/17 5/03/17

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C 166	Continued From page 2 3. Based on observation, there was no documentation of monthly inspections provided on the inspection tag at the range hood fire suppression system. Range hood fire suppression systems must be inspected monthly and the inspections must be documented on a tag provided at the system pull.	C 166	(3)Range hood fire suppression system was inspected 5/15/17 and was documented on the tag.	5/15/17
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: 1. Based on a review of documents, most of the records available onsite included no description of what the rehearsal involved. 2. Based on review of documents, fire drill rehearsals are not being done regularly with at least one per shift each quarter. Failure to rehearse the fire plan could lead to confusion and delay in an actual emergency. Findings include: a. In the 2nd quarter of this year, there was no	C 185	10A NCAC 13F .0309 (1)Fire rehearsal completed for 2nd Shift on 5/16/17 was done with a complete description documented. (2) (a) (b) DHSR documented failure to rehearse the fire plan for 2nd and 3rd quarter of 2016. On 10/17/16 this error was discovered in a routine Internal Quality Assurance and Compliance site review. At that time, an Internal Corrective Action was put into place. Fire drills were monitored form Oct. 2016-March 2017 by the Administrator. Since that time proper protocol has been followed and documented. Please see attached Internal Corrective Action Plan and Plan Review Log.	5/16/17 5/03/17

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C 185	Continued From page 3 rehearsal done during the 2nd shift. b. In the 3rd quarter of this year, there were no rehearsals done during the 3rd shift.	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 observation, the facility failed to be maintained in a safe condition because of exit signs not working properly. Malfunctioning exit signs could delay or prevent an evacuation in an emergency. Findings include: a. The exit sign at the left front entrance was not illuminated. b. The exit sign near room C-04 did not work on battery when tested. c. There was no exit sign visible on the back corridor at room C-11 looking toward the nurse station. The sign was turned to be visible from the front corridor and will not be visible from that direction if turned toward the back corridor. 2. Based on observation. the facility failed to be maintained in a safe condition because of an impaired sprinkler system. The sprinkler system consists of 2 separate dry pipe systems, each	C 189	10A NCAC 13F .0311 (1)a The exit sign at the left front entrance was replaced. It now illuminates. (1)b The exit sign near C-04 has been replaced and is working. (1)c The Exit sign near C11 was Replaced with a double sided Exit sign. It is now visible from both directions. It is visible from the back corridor now.	5/03/17 5/03/17 5/03/17

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C 189	Continued From page 4 with an accelerator to speed up water delivery. A sprinkler system not working as designed could endanger all occupants of the facility. Findings include: a. One of the accelerators was obviously turned off. b. The other accelerator showed 0 pounds of pressure on the gauge. 3. Based on observation the required one-hour fire rated walls and/or ceilings were compromised in 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. Unsealed penetrations (3) in the ceiling of the corridor at room B-05, b. Unsealed sleeve through the ceiling in Mechanical room C, c. Sprinkler escutcheon not tightly fitted to the ceiling in the closet in room C-08. 4. Based on observation, the sampling tube for one of the duct mounted smoke detectors in the exterior mechanical room was very dirty. Additionally, parts were missing from the detector. Sampling tubes and detectors that are not periodically inspected and cleaned can endanger all residents and staff because the duct detector may fail to operate properly. 5. Based on observation, corridor doors are prevented from closing quickly and 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.	C 189	(2)a The accelerator has been turned back on and inspected by Twin City Sprinkler System. It is now in proper working order. (2)b The other accelerator was also turned back on and no longer shows a reading of 0 lbs. of pressure on the gauge. (3)a Unsealed penetrations in the ceiling of the corridor at room B-05 have been sealed. (3)b Unsealed sleeve through the ceiling in Mechanical room C has been sealed. (3)c Sprinkler escutcheon is now tightly fitted to the ceiling in the closet in Room C-08. (4) All sampling tubes and detectors have been cleaned, inspected and are in proper working order.	5/03/17 5/03/17 5/04/17 5/04/17 5/04/17 5/04/17

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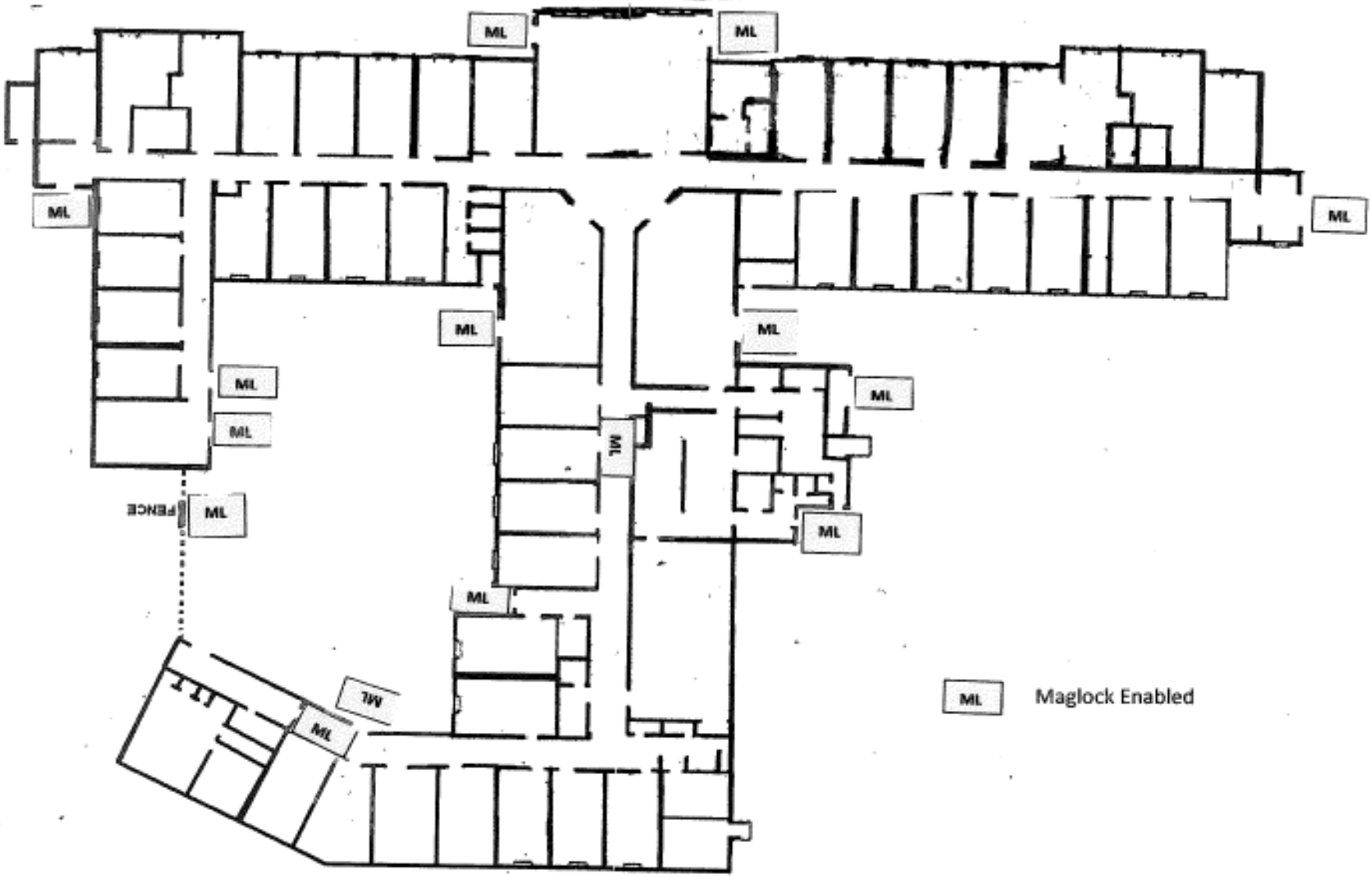
C 189	Continued From page 5 Findings include; a. One of the smoke barrier doors near room B-01 would not latch when closed. b. The door to the Horizon Wellness Director's office was propped and wedged open. 6. Based on observation, the facility failed to be maintained in a safe condition because sprinkler heads had been allowed to accumulate a covering of lint. Lint is insulation that could delay activation of the sprinkler head in an actual fire. Lint covered heads include: a. Bathroom off room A-05, b. Laundry (3). 7. Based on observation, the warning device, "screamer," protecting the emergency release switch was not working at the exit near room C-04. Malfunctioning warning devices could allow resident elopement.	C 189	(5)a The smoke barrier door was adjusted and is now latching properly. (5)b A magnetic door stop has been installed in the HZ Wellness Directors office. (6)a Sprinkler head in bathroom A05 has been cleaned and is clear of lint. (6)b Sprinkler head in the Laundry room (3) has been cleaned and is clear of lint. (7) Warning device (screamer) protecting the emergency release switch has been restored to working condition by new battery installment. Christy Brown, ED	5/04/17 5/04/17 5/04/17 5/04/17 5/04/17 5/19/17

Maglock Map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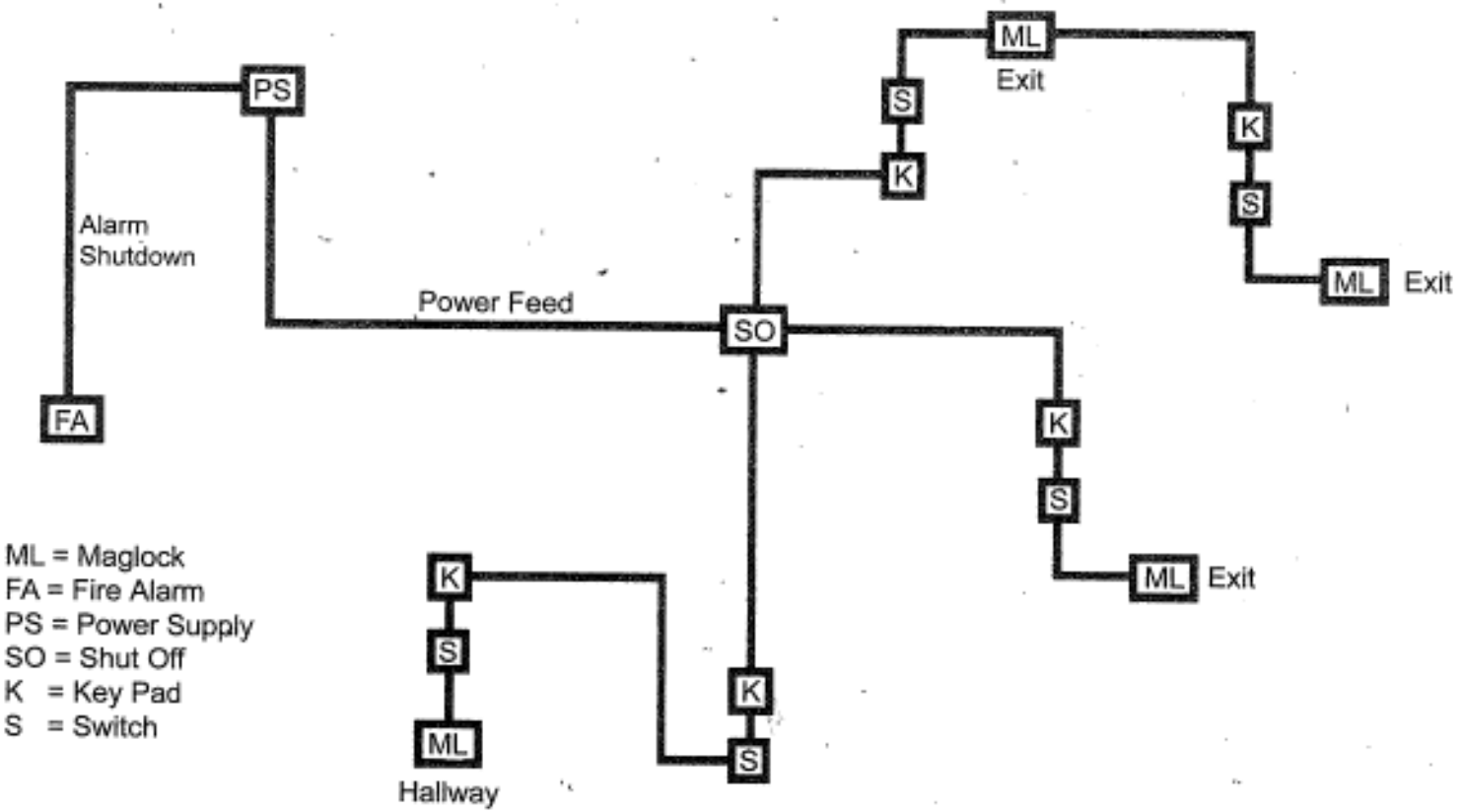

RIDGE CARE

Internal Corrective Action Plan

Date: 10/08/16 Team Member Completing Form: Christy Bower

Rule Violation:

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.

Provide a brief description of area of rule violation (include date and time of discovery)

During an internal Quality Assurance & Compliance Site Review on 10/7/16, it was made aware that no 2nd shift drill was completed for the 2nd quarter and no 3rd shift drill was completed for the 3rd quarter causing a North Carolina Rule violation.

Immediate measures put in place:

Maintenance Director was made aware of the issue, and was educated on the proper timing of fire drills according to state regulations.

RIDGE CARE

Internal Corrective Action Plan

Training and Education Plan: (Attach copies of rosters for all trainings performed, and what outside representative will complete training.)

_____

_____

_____

_____

_____

Monitoring Procedures to be put in place to prevent violation from re-occurring: (attach copies of any reports to be completed, who will be responsible for completing, how often they are to be completed, and how long monitoring will be in place)

Executive Director will pull fire drill documentation for 6 months to make sure fire drills are being performed on 1st, 2nd, and 3rd shift each quarter. Once the 6 months is over and the Maintenance Director is in compliance, will discontinue internal audit. See attached audit form.

Department Head: _____

Executive Director: _____

Regional Director of Operations: _____

Date Internal Corrective Action plan is completed: 3/2/17

Fire Drill Internal Correction Plan Log

October 2016

Date of Drill	10/27/16		
Shift of Drill	1st Shift		
Time of Drill	1:30 pm		
Person performing drill	marcel		

November 2016

Date of Drill	11/14/16		
Shift of Drill	2nd Shift		
Time of Drill	3:00 PM		
Person performing drill	marcel		

December 2016

Date of Drill	12/30/16		
Shift of Drill	3rd Shift		
Time of Drill	5:45		
Person performing drill	marcel		

January 2017

Date of Drill	1/25/17		
Shift of Drill	1st Shift		
Time of Drill	1:15 pm		
Person performing drill	marcel		

February 2017

Date of Drill	2/28/17		
Shift of Drill	2nd Shift		
Time of Drill	4:30 pm		
Person performing drill	marcel		

March 2017

Date of Drill	3/2/17		
Shift of Drill	3rd Shift		
Time of Drill	6:40 am		
Person performing drill	Bobby		

Date Completed: March 2, 2017 Signature: Chuy Sr Bar