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
	HAL011035	A. BUILDING: 01 B. WING _____	07/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ASHEVILLE WALDEN RIDGE	4 WALDEN RIDGE DRIVE ASHEVILLE, NC 28803

(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 on 7-5-2017. Records indicate this facility was first licensed on 7-30-1998, for the licensed capacity of 38 residents. Based on this information, the facility is required to meet the 1996 Rules for Homes for the Aged and Disabled - Minimum Standards and Regulations, applicable portions of the 2005 Rules for Adult Care Homes of Seven or More Beds, and the applicable portions of the 1996 North Carolina State Building Code, Volume I General Construction, Section 409.1, Group I - Unrestrained.	C 000	Please see attached POC. Dee Brooks, Executive Director	
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 Delayed Egress exit at	C 101		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: DeLotha C Brooks RN, TITLE: Executive Director, (X6) DATE: 7/28/17

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C 101	Continued From page 1 the front door failed to comply with Section the NC State Building Code requirement for a sign on each Delayed Egress door that reads "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS."	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 facility was not maintained in a safe condition because of improper storage too close to a fire sprinkler head. Storage that is not kept at least 18 inches below the sprinkler head could negate the ability of the fire sprinkler system to extinguish a fire. Findings include; a. Items had been stacked to within 9 inches of the ceiling in a closet off the laundry room. b. Items had been stacked to the ceiling in the outside storage off C Hall. c. Items had been stacked to within 6 inches of the ceiling in soiled linen on the service hall. d. Items had been stacked to within 5 inches of the ceiling in a closet in the A-B Living room. 2. Based on observation, the ice machine drain line extends into the floor drain. Ice machine drain lines that are not maintained at least 2 inches above the floor or floor drain, as required	C 166		

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C 166	Continued From page 2 by Code, could cause the ice to become contaminated.	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 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 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 1st quarter of this year, there was no rehearsal done during the 1st shift. b. In the 2nd quarter of this year, there was no rehearsal done during the 2nd shift. c. In the 3rd quarter of last year, there were no rehearsals done during the 2nd or 3rd shifts. d. In the 4th quarter of last year, there was no rehearsal done during the 3rd shift. 2. Based on a review of documents, the records available onsite included little to no description of	C 185		

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C 185	Continued From page 3 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 observation, many 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. Findings include; a. The cross-corridor smoke barrier doors on A Hall did not close completely when activated by the fire alarm system. b. The door to the exit corridor on B Hall was hard to open. c. The latchset was missing on the door to the mop room on the service hall. d. The door to Private Dining was hard to close and latch. e. The door to bedroom A7 does not fit the opening properly on the side and top to be resistant to the passage of smoke. f. The doors to bedrooms C3 and C7 do not fit the opening properly at the top to be resistant to	C 189		

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C 189	Continued From page 4 the passage of smoke. g. The doors to bedrooms C2 and C6 do not fit the opening properly on the side to be resistant to the passage of smoke. h. There is a hole at the latchset through the door to housekeeping on D Hall. i. There is a hole at the latchset through the door to the RCC office. j. The strike was missing at the door to the community bathroom. 2. 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. Hole in the wall in the medroom, b. Attic access door in the service hall was not closed completely. Note: This deficiency was corrected during the survey. 3. Based on observation, the light switch and plate was missing in the storage room outside C Hall. The missing components exposed energized wires. 4. A closet door in the Beauty Salon was badly damaged and in danger of falling.	C 189		

The following is the Plan of Correction for **Brookdale Asheville Walden Ridge** regarding the Statement of Deficiencies dated **July 14, 2017, related to the Biennial Construction Survey completed on July 5, 2017**. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.

Deficiency C 101: Physical Plant 10A NCAC 13F. 0301

A Delayed Egress signage was added to the front Lobby Door on 7/20/2017. It reads as follows: **Keep Pushing. This door will open in 15 seconds. Alarm will sound.**

Deficiency C 166: Physical Plant 10A NCAC 13F. 0306 Housekeeping and Furnishings

1) All items were removed from the storage closets, to leave the required 18 inches below the sprinkler heads, on 7/17/17. The Maintenance Director or designee will check storage areas on a weekly basis to ensure on-going compliance. Re-training for all associates utilizing storage areas was completed by 7/20/17.
2) The ice machine drain was repaired on 7/12/17 with a bracket to hold the overflow line 2 inches above floor drain.

Deficiency C 185: Physical Plant 10A NCAC 13F. 0309 Plan for Evacuation

Quarterly calendars for scheduled Fire Drills have been developed, with a fire drill scheduled for each shift, each quarter. The Executive Director will be provided with a copy of the calendar and with a copy of the fire drill report once completed. Details of the scenarios used in the fire drill will be added to the drill report. The Executive Director will conduct monthly audits of the fire drill reports to ensure compliance with completion of the drills.

Deficiency C 189: Physical Plant 10A NCAC 13F. 0311 Other Requirements

1) Repairs to all of the identified doors, latch sets, door frame fittings and strike plate were repaired or replaced on 7/10/17.
2) Repairs were completed to the identified area on 7/17/17.
3) The light switch and plate were replaced on 7/10/17
4) The closet door in the Beauty Salon was replaced on 7/10/17.

The Maintenance Director will perform weekly preventive maintenance audits and repair or replace any items/areas identified as non-compliant or hazardous and provide a copy of the audit report and repairs to the Executive Director.

Respectfully Submitted,
Dee Brocks
Dee Brocks-6 RN, Executive Director
Brocksdale Asheville Walden Ridge
HAL 011035