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
	HAL023011	A. BUILDING: 01 B. WING _____	06/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SHELBY	1425 E MARION STREET SHELBY, NC 28150

(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 6-21-2017. Records indicate this facility was first licensed on 6-11-1997, for a capacity of 60. Therefore the facility was surveyed for conformance with the 1996 Rules for the Licensing of Adult Care Homes, the applicable portions of the 2005 Rules for Adult Care Homes of Seven or More Beds, and the 1996 North Carolina Building Code for Institutional Unrestrained Occupancies.	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, one of the Delayed Egress exits failed to comply with the NC State Building Code that requires the doors begin the exit process when a force of not more than 15 pounds	C 101	Simplex Grinell contacted to come out and service door. Appointment made for July 24th, 2017 for visit to evaluate issue with door. Door will be serviced to begin the exit process with no more than 15 pounds of pressure as per regulation. Maintenance Director or (cont.)	

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C 101	Continued From page 1 is applied. Finding includes: The Delayed Egress exit at the front door did not initiate the egress process even after a force of approximately 100 pounds was applied.	C 101	(cont.) designee to check all delay egress doors for proper exit process with a force of not more than 15 lbs per regulation monthly. Executive Director/Designee to review monitoring logs to insure compliance.	
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: Based on observation, an exit path was not maintained free of obstructions. Finding includes: The exit to the exterior from the dining room was obstructed with a table and 2 chairs.	C 166	Table and 2 chairs moved away from exit path 6/21/17 immediately following notification of obstruction. All staff inserviced regarding exit paths being free of obstruction. Dietary Manager or designee to monitor daily ongoing to be sure exit path is free from obstruction in dining room. All managers to monitor other exits daily for obstructions. Exit paths to be free of obstructions.	
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 2 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 available onsite included little to no description of what the rehearsal involved.	C 185	Maintenance Director educated regarding proper documentation of fire rehersals. Documentation to include date, time, shift staff attending and a short description of rehearsal scenario. Executive Director or designee to review fire rehearsal records monthly for proper documentation ongoing.	
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 corridor smoke detector near bedroom 801 failed to activate when tested with smoke. Smoke detectors that do not work properly endanger all residents and staff. 2. 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 double doors from the corridor to the	C 189	1. Smoke detector was replaced in corridor near bedroom 801. Maintenance Director to perform monthly checks on smoke detectors in community and record. Executive Director or designee to review records to insure compliance during monthly safety meeting. 2. All doors in community checked by Maint. Director during week of 7/3/17. Seven doors need repairs to facilitate quicker closing and latching. Maintenance Director has completed repairs on 5 of 7 doors. Plans for all doors to be repaired by 7/24/17. Maintenance Director to perform monthly checks on all doors in community for proper closure and latching. Executive Director or designee to review autdit tools monthly for compliance.	

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C 189	Continued From page 3 dining room do not latch when closed. b. There is a gap of 3/16 to 7/16 inch between the double doors from the corridor to the dining room . c. The door to bedroom 705 was hard to latch when closed. d. The door to beauty salon 19 was propped open. 3. Based on observation, the emergency lite on the ceiling of the corridor near room 101 was partially hanging down by the wires. 4. Based on observation the required one-hour fire rated ceiling was compromised. 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. Finding includes: Unsealed penetration for wires in the ceiling of the Administrator's office.	C 189	a.and b. Doors to dining room will be replaced with proper fitting and latching doors. to meet regulation. Please see #2 for follow up moniotoring. Will complete by 8/1/17. c. Corrected on 6/22/17. Door now latches without difficulty. please #2 for follow up monitoring. d. Beautician educated regarding not proping open door with door stop. Maintenance director to put magnetic door holder in beauty shop to facilitate having the door open per regulation. Will be installed by 8/1/17. Door stop removed and thrown away. Managers to monitor all door daily during rounds to ensure that no door stops are being used. 3. Emergency light in ceiling of corridor near room 101 was repaired on 6/22/17. Mainten. Director to perform weekly inspection of emerg. lights throughout community for any issues in need of repair. Executive Director to review audit tool weekly to insure compliance. 4. Maintenance Director sealed area of wire penetration in ceiling of administrators office on 6/23//17. Maintenance Director to perform monthly visual checks on all areas of possible unsealed penetration and repair immediately. Executive Director to review audit tool monthly to ensure compliance.	