THE HAVEN
VILLAGE AT CAROLINA PLACE

FIVE STAR SENIOR LIVING

October 17, 2017

Frank Strickland
NC Department of Health and Human Services
Architect, Construction Section
Division of Health Service Regulation
2705 Mail Service Center
Raleigh, NC 27699-2705

VIA U.S. MAIL, Facsimile (919-733-6592) and Email (Frank.Strickland@dhhs.nc.gov and DHSR.Construction.Admin@dhhs.nc.gov)

RE: Facility: The Haven at Carolina Place
License Number: HAL-060-107 FID #971417
Survey Conducted: September 24, 2017
Statement of Deficiencies Report Printed 10/3/17
(Received via Email October 3, 2017)
Plan of Correction

CONSTRUCTION SECTION
OCT 20 2017
RECEIVED

Dear Mr. Strickland:

Enclosed, as per your request, is our completed plan of correction for our survey conducted September 24, 2017. This plan of correction meets the criteria as specified by DHSR, for each deficiency noted on the statement of deficiencies. However, please note we have requested an extension to complete the emergency override switch in the nurse station. This request is in a separate letter enclosed for all intents and purposes.

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.

The Haven at Carolina Place values our reputation and relationship with your agency. We appreciate any assistance you provide to us, as it relates to licensure rules and regulations.

Sincerely,

Jason T. Fisher
Executive Director

Enclosures: 1) Statement of Deficiencies with Plan of Correction 2) Request for a written waiver, from DHSR – Construction Section, to extend completion date.
7 pages

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
	HAL060107	A. BUILDING: 01 B. WING _____	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HAVEN IN THE VILLAGE AT CAROLINA P	13150 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 Construction Section Biennial Survey report by Frank Strickland on 08/24/2017: This facility was first licensed on 01/01/1997. Therefore, we are requiring that this facility to meet the 1996 Rules for the Licensing of Adult Care Homes and the applicable portions of the 2005 Licensing Rules and the 1996 edition of the North Carolina State Building Code Volume I - General Construction - Section 409 Institutional Occupancy (Group I). Currently licensed as a SIXTY BED SPECIAL CARE UNIT Facility. Deficiencies have been cited and a Plan of Correction is required.	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:	C 101	See SOD POC, page 1/3 and waiver request enclosed. CONSTRUCTION SECTION OCT 20 2017 RECEIVED	11/16/17

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

Dawn T. Brisk — Administrator/ED — 10/17/17

Division of Health Service Regulation

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C 101	Continued From page 1 1-Based on observations, this facility has not provided measures indicate in the 1996 NC Building Code for the Special Locking (magnetic locks) regarding emergency release. Findings on 08/24/2017 The required main over-ride emergency release switch is currently located at the Front Entry Vestibule and there is not a central release switch at the Nurse Station within the locked unit.	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 observations, this facility has failed to store gas cylinders in a orderly manner to be free of hazards. Findings on 08/24/2017: There is a helium gas cyclinder that is located in the Soiled Linen/Utility Closet (Wilmington Community) that is standing upright not in a storage rack nor secured by a chain adjacent to a wall.	C 166	See SOD POC, page 2/3 enclosed.	8/24/17
C 189	Building Equipment Maintained Safe, Operating SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER	C 189	See SOD POC, page 3/3 enclosed.	8/24/17

10/11/17

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C 189	Continued From page 2 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, this facility has not maintained the building and all fire safety equipment in a safe condition. This could allow the spread of fire and/or smoke beyond the room of origin. Findings on 08/24/2017: The kitchen door adjacent to the Service Hall is out of adjustment and does not close all the way to the door frame to prevent the passage of smoke or fire.	C 189		

10/13/17

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License Number: HAL-060-107 FID #971417
Survey Conducted: September 24, 2017
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ID PREFIX TAG C101: Section .0301 – 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. Upon this deficiency being brought to our attention, the community immediately sought resolution, contacting an approved vendor to have a centralized override switch installed, at the nurses station. For additional reference, in the event of an emergency, when the fire alarm sounds, the mag-locks are de-energized, thus releasing the mag-locks.

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 is aware of the new centralized emergency switch and knows how to operate the switch, in the event of an emergency.

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.** Employees will be trained on how to use the override switch, in the event of an emergency, upon being hired.

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 monthly inspections to insure the switch is operable and check to see if staff can demonstrate how to use it, in the event of an emergency.

E. **Date when corrective action will be completed.** Corrective action will be completed within forty-five (45) days of receipt of the Statement of Deficiencies (October 3, 2017), on or before November 16, 2017. (*Please see enclosed request for a written waiver, from DHSR – Construction Section, to extend completion date.)*

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

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. Upon this deficiency being brought to our attention, the community immediately secured the helium gas tank, with a chain, to the wall.

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 is aware of the regulation in regards to compressed gas storage and the importance of securing these items at all times. If a gas cylinder is moved from one location to another, it must be secured upon being moved.

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.** Employees will be trained how to secure all compressed gas cylinders, to include but not limited to; the use of storage racks and wall chains.

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 monthly inspections to insure the all compressed gas cylinders are properly secured and check to see if staff can demonstrate how to secure them alike.

E. **Date when corrective action will be completed.** Corrective action was completed on August 24, 2017.

10/17/17

ID PREFIX TAG C189: Section .0300 – PHYSICAL PLANT 10A NCAC 13F .0311 OTHER 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. Upon this deficiency being brought to our attention, the fire resistant door was adjusted. Upon correction, the door closed properly, to prevent the passage of smoke or fire.

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 any doors with any discrepancies, which would compromise safety standards 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 monthly 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 monthly 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 was completed on August 24, 2017.

10/17/17

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Frank Strickland
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RE: Request for a written waiver, from DHSR – Construction Section, to extend completion date.
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Dear Mr. Strickland,

Please accept this letter of request, for an extension to complete the items noted in your statement of deficiencies. This is in specific regards to *ID PREFIX TAG C101: Section .0301 – PHYSICAL PLANT 10A NCAC 13F .0301 APPLICATION OF PHYSICAL PLANT REQUIREMENTS – The centralized override emergency switch, located at the nurse station.* We anticipate having corrections completed within forty-five (45) days of receipt of the Statement of Deficiencies (October 3, 2017), on or before November 16, 2017. The two other deficiencies have been corrected.

For reference, this inspection was conducted on Thursday, August 24, 2017. As you know, I contacted you a few times via email after the inspection, to request the SOD (Statement of Deficiencies). We finally received the SOD on October 3, 2017, via email, from one of your peers. However, to date, we have not received a hardcopy. *(It may have been sent to our home office, in Newton, MA)*

We fully intend to complete any corrections, as required. However, due to multiple variables regarding this, to include having an appropriate amount of time to write an adequate plan of correction, we find it reasonable to request this extension.

As always, we appreciate your guidance and thank you in advance for your consideration.

Sincerely,

Jason T. Fisher
Executive Director

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