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
	HAL034085	A. BUILDING: 01 B. WING _____	12/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY ELMS	3750 HARPER ROAD CLEMMONS, NC 27012

(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 and Ed Miller on 12-6-2017. Records indicate that this facility was first licensed on 10-8-1997, for 104 beds, including 30 Special Care Beds. Based on this information, the facility is required to meet the 1996 - Rules for the Licensing of Adult Care Homes, applicable portions of the 2005 Rules for Licensing of Adult Care Homes of Seven or More Beds, and the 1996 NC State Building Code(s) for a Group I-Institutional Unrestrained Occupancy.	C 000	C101 The Administrator has contacted an outside contractor to add vision panels of ¼ inch labeled glass mounted in steel frames to all double egress smoke doors. The Maintenance Director is working with an outside contractor on providing a wiring diagram or systems components location map that will be posted under glass at the fire alarm panel. A waiver was requested for these two areas to extend the completion date.	03-09-2018
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: 1. Based on observation, the facility failed to meet the provisions of Section 409.1.2.4 of the 1996 NC State Building Code. Section 409.1.2.4	C 101		

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C 101	Continued From page 1 requires that, "double egress cross corridor [smoke barrier] doors shall have... vision panels of 1/4 inch labeled wire glass mounted in in steel frames..." Additionally, a review of the original building blue prints on-site showed that doors with vision panels were specified at each smoke barrier. Finding includes; Smoke barrier doors throughout the facility were not equipped with vision panels. 2. Based on observation, the facility failed to meet the provisions of Section 1012.6.1.4.C of the 1996 NC State Building Code by not having all of the required components for doors with Special Locking System. Finding includes: There was no wiring diagram or systems components location map posted under glass at the fire alarm panel.	C 101		
C 150	Corridors-Free of equipment and Obstructions SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0305 PHYSICAL ENVIRONMENT (g) The requirements for corridors are: (4) Corridors shall be free of all equipment and other obstructions. This Rule is not met as evidenced by: 1. Based on observation, the exit door near room 707 was dragging on the exterior concrete and was hard to open. Exit doors that do not open easily could delay or prevent an evacuation in an emergency. 2. Based on observation, the corridors were not maintained free of obstructions. At least 6 feet of	C 150	C150 The Maintenance Assistant adjusted the exit door near room 707 on 12/8/2017 to assure it does not drag on the exterior concrete. The Maintenance Assistant cleared items that were stored in both back hall areas to assure corridors are free of obstructions on 12/8/2017. A 100 percent audit was completed on 1/16/2017 by the Maintenance Director to assure that no items were stored in corridors throughout the facility. Any areas identified in this audit were corrected as appropriate. The Maintenance Director inserviced the Maintenance Assistant on not storing items in the back halls and importance of assuring that at least 6 feet of clear width must be maintained in exit corridors on 1/16/2017. The Maintenance Director will audit the back hall areas to assure no items are stored there weekly for four weeks, then monthly for two months utilizing a "Quality Improvement Preventative Maintenance Round" audit tool. The Administrator will review the completed audit tool weekly for four weeks then monthly for two months to assure completion of audits and regulatory compliance in this area. The Quality Improvement Committee will review the audit tools weekly for four weeks then monthly for two months to assure systems for monitoring are effective, make recommendations, and assure continued compliance in this area.	01-19-2018

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C 150	Continued From page 2 clear width must be maintained in exit corridors. Findings include: a. There were items stored in one of the back halls reducing the clear width to about 3.5 feet. b. There were items stored in the other back hall reducing the clear width to about 4 feet.	C 150		
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. Findings include: Two portable medical oxygen cylinders were stored in no container in the closet in room 910. Note; This deficiency was corrected during the survey. 2. Based on observation, the hoses on the shower wands in the Beauty Salon were long enough to reach the sink basins and there were no vacuum breakers provided. Hoses on water fixtures that are long enough to reach the flood rim of the fixtures present the possibility of siphoning contaminated water into the water	C 166	C166 The oxygen tanks were removed from the closet in room 910 by the Memory Care Coordinator on 12/6/2017. The Maintenance Director installed a vacuum breaker on the beauty salon sinks on 1/15/2018. A 100 percent audit of all resident rooms and closets was completed on 1/16/2018 by the Shift Supervisor to assure that oxygen cylinders are stored in proper devices to prevent oxygen cylinders from potentially falling. Any areas identified were corrected as appropriate. The Health Service Coordinator inserviced all nursing staff on 01-17-2018 to assure they understand proper locations to store oxygen cylinders and that all cylinders must be stored in a proper device to prevent the cylinder from potentially falling. The Health Services Coordinator and/or Supervisor In Charge will complete a Quality Improvement Audit weekly for four weeks then monthly for two months to check oxygen storage and resident care areas to assure oxygen cylinders are stored in proper devices to prevent falling utilizing a Oxygen Storage Quality Improvement Audit Tool. The Administrator will review the completed audit tool weekly for four weeks then monthly for two months to assure completion of audits and regulatory compliance in this area. The Quality Improvement Committee will review the audit tools weekly for four weeks then monthly for two months to assure systems for monitoring are effective, make recommendations, and assure continued compliance in this area.	01-19-2018

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C 166	Continued From page 3 system unless a vacuum breaker is installed.	C 166		
C 188	Electrical Outlets in Wet Locations SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0310 ELECTRICAL OUTLETS All adult care home electrical outlets in wet locations at sinks, bathrooms and outside of building shall have ground fault interrupters. This Rule is not met as evidenced by: Based on observation, electrical receptacles less than 6 feet from sinks were not GFCI protected. Receptacles in areas close to wet locations that are not GFCI protected present a shock or electrocution risk. Findings include; a. The receptacle in clean utility was less than 4 feet from the sink and was not GFCI protected. b. The receptacle in the staff lounge was less than 4 feet from the sink and was not GFCI protected.	C 188	C188 The Maintenance Assistant corrected the receptacle in the clean utility room to a GFCI outlet on 1/10/2018 and the receptacle in the staff lounge was corrected to a GFCI outlet on 1/16/2018. A audit of all outlets within 6 feet of sinks was conducted on 1/16/2018 by the Maintenance Director to assure that all were GFCI protected. Any outlets identified were corrected to have GFCI protection. The Administrator inserviced the Maintenance Director and Maintenance Assistant on the importance of all electrical outlets that are in wet locations at sinks, bathrooms, and outside of the building shall have ground fault interrupters. The Maintenance Director will review work completed on electrical outlets in the facility to assure that all outlets in wet locations at sinks, bathrooms, and outside continue to have GFCI protection weekly for four weeks, then monthly for two months utilizing a "Quality Improvement Preventative Maintenance Round" audit tool. The Administrator will review the completed audit tool weekly for four weeks then monthly for two months to assure completion of audits and regulatory compliance in this area. The Quality Improvement Committee will review the audit tools weekly for four weeks then monthly for two months to assure systems for monitoring are effective, make recommendations, and assure continued compliance in this area.	01-19-2018
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:	C 189		

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C 189	Continued From page 4 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 smoke barrier doors near the library do not close completely and latch when activated by the fire alarm system. b. The smoke barrier doors near the Spa do not latch when closed by the fire alarm system. c. The closer had been removed from the ¾ hour fire rated door to soiled linen in Memory Care. This fire rated door must be self-closing and must automatically latch when closed. d. The ¾ hour fire rated door to the large laundry would not close completely and automatically latch closed. Note; This deficiency was corrected during the survey. e. The ¾ hour fire rated door to the pantry would not latch when closed. f. The doors to bedrooms 302, 307, 704 and 801 did not latch when closed. g. The door to the dining room in Memory care is damaged. 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 ceiling of the main electrical room, b. Unsealed wire penetration in the ceiling of the IT room,	C 189	C189 The Maintenance Assistant adjusted the smoke barrier doors near the library and near the spa area to assure they close and latch to resist the passage of fire and smoke on 12/06/2017. The closer was re-installed to the ¾ hour fire rated door to the solled linen room in Memory Care on 12/07/2018 by the Maintenance Assistant. The ¾ hour fire rated door to the large laundry was adjusted to close and latch appropriately on 12/06/2017 by the Maintenance Director. The ¾ hour fire rated door to the pantry was adjusted to latch when closed by the Maintenance Assistant on 12/07/2017. The doors to bedrooms 302,307, 704, and 801 were adjusted to latch when closed by the Maintenance Assistant on 12/08/2017. The trim work to the door to the memory care area was repaired by the Maintenance Director on 01/16/2018. The hole in the ceiling of the mechanical room and wire penetration in ceiling of the IT room were repaired/sealed to assure one hour fire ratings by the Maintenance Director on 01/16/2018. The sprinkler escutcheons in the exterior storage and outside water heater room were adjusted to assure they fit tightly to the ceiling by the Maintenance Director on 12/08/2017. The ceiling radiation damper located in the library was cleaned by the Maintenance Assistant on 12/06/2018. A 100 percent audit of all doors was completed on 01-17-2018 to assure that doors latch and close properly and all holes and penetrations are sealed with a material providing one hour fire rating by the Maintenance Director. Any doors identified as needing adjustments or repairs were completed as appropriate. Any holes or penetrations identified were sealed with fire rating material as appropriate. On 01/17/2018 the Administrator inserviced the Maintenance Director and Assistant Director on routinely checking doors for close and latch settings, to assure that fire and smoke barrier doors close and latch appropriately when activated by the fire system, and to check any work done after contractors to assure that any holes or penetrations are sealed with a material for use in one hour rated construction.	01-19-2018

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C 189	Continued From page 5 c. Sprinkler escutcheons not tightly fitted to the ceiling in the exterior storage and the outside water heater room. d. The ceiling radiation damper is very dirty in the return in the library.	C 189	The Maintenance Director will audit all facility doors to assure proper close and latch operations, that doors are in good repair, and any work performed by outside contractors resulting in wall or ceiling penetration has been sealed with fire rated materials weekly for four weeks then monthly for two months utilizing a "Quality Improvement Preventative Maintenance Round" audit tool. The Administrator will review the completed audit tool weekly for four weeks then monthly for two months to assure completion of audits and regulatory compliance in this area. The Quality Improvement Committee will review the audit tools weekly for four weeks then monthly for two months to assure systems for monitoring are effective, make recommendations, and assure continued compliance in this area.	
C 191	Unvented & Portable Elec. Heaters Prohibited SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (b) There shall be a heating system sufficient to maintain 75 degrees F (24 degrees C) under winter design conditions. In addition, the following shall apply to heaters and cooking appliances. (2) Unvented fuel burning room heaters and portable electric heaters are prohibited. (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: Based on observation the facility failed to adhere to the prohibition of portable electric heaters. Portable electric heaters are a potential fire hazard and as such could effect all occupants of the facility. Finding includes: There was a portable electric heater found in the RCD office. Note; This deficiency was corrected during the survey.	C 191	C191 The portable heater was removed from the RCD office and premises by the RCD on 12/06/2017. A audit was completed of the facility to assure that no other portable heaters were present on 01/16/2018 by the Administrator. Are portable heaters identified will be removed from the premises. The Administrator inserviced the RCD and Department Managers that portable heaters were prohibited in assisted livings and are potential fire hazards on 01/17/2018. The Maintenance Director will audit the facility to assure no portable heaters are identified weekly for four weeks then monthly for two months utilizing a "Quality Improvement Preventative Maintenance Round" audit tool. The Administrator will review the completed audit tool weekly for four weeks then monthly for two months to assure completion of audits and regulatory compliance in this area. The Quality Improvement Committee will review the audit tools weekly for four weeks then monthly for two months to assure systems for monitoring are effective, make recommendations, and assure continued compliance in this area.	01-19-2018