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
	HAL060019	A. BUILDING: 01 B. WING _____	06/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF CHARLOTTE	6000 PARK SOUTH DRIVE CHARLOTTE, NC 28210

(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 conducted by Suzanna Fay and Frank Strickland on June 21, 2018. Records indicate that this facility was first licensed for licensure on March 0, 1997 and is currently licensed for 125 Beds with a 25 Bed SCU. Based on this information we are requiring the facility to meet the 1996 "Homes for the Aged and Disabled - Minimum Standards and Regulations," applicable portions of the 2005 Rules for Adult Care Homes, and the 1996 Edition of the North Carolina State Building Code; Section 409.1 Group I, Unrestrained Occupancy. Deficiencies were 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;	C 101		

Division of Health Service Regulation

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C 101	Continued From page 1 This Rule is not met as evidenced by: 1. Observations revealed that the facility does not meet licensure and code requirements in effect at the time of construction, renovation or alteration. Findings on June 21, 2018: a. Residential Laundry (2nd and 3rd Floors) - thru-wall exhaust vents were installed in the corridor walls. Building Code requires corridors to resist the passage of smoke. Transfer grilles are not permitted. b. The Memory Care Unity has a magnetic locking system with keyed override switches. Three of three staff interviewed did not carry the override key on their person. All staff responsible for evacuation shall carry a key for the manual override with them at all times. c. Memory Care Courtyard - the gate had a keypad and a keyed manual override switch. The key maintained with staff did not release the manual override. d. AL Courtyard by dining - the key for the manual override at the locked gate is maintained in a lockbox at the gate. Two of two staff interviewed knew the code to open the lockbox. e. Service Corridor - no exits were visible in the service corridor and there were no exit signs directing people toward the exits.	C 101		
C 111	Must Have Current San. & Fire Safety Reports SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0302 DESIGN AND CONSTRUCTION(f) The facility shall have current sanitation and fire and building safety inspection reports which shall be maintained in the home and available for	C 111		

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C 111	Continued From page 2 review. This Rule is not met as evidenced by: 1. Review of records revealed that the facility did not have an approved fire inspection report. Findings on June 21, 2018: a. A Fire Inspection at the facility on June 11, 2018 cited 22 deficiencies to be corrected. b. A copy of the current Fire Alarm Inspection report was not available for review.	C 111		
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. Observations revealed that the corridors were not free of all equipment and other obstructions. Findings on June 21, 2018: a. The exit corridor by Maintenance had shelving and activity equipment stored in the corridor reducing the width to less than 6'.	C 150		
C 160	Outside Premises-Clean, Safe SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0305 PHYSICAL ENVIRONMENT (m) The requirements for outside premises are: (1) The outside grounds of new and existing facilities shall be maintained in a clean and safe condition;	C 160		

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C 160	Continued From page 3 This Rule is not met as evidenced by: 1. Observations revealed that the outside premises were not maintained in a clean and safe manner. Findings on June 21, 2018: a. AL Courtyard by the Beauty Salon - a roof drain grille was off and laying on the ground near dining. b. AL Courtyard - the exterior light over the dining doors is broken and dangling from its' wires.	C 160		
C 164	Housekeeping and Furnishings-Clean, Repaired SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0306 HOUSEKEEPING AND FURNISHINGS (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; (2) have no chronic unpleasant odors; (3) have furniture clean and in good repair; (e) This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: 1. Observations revealed that the floors were not kept clean and in good repair. Findings on June 21, 2018: a. Wellness Office (3rd Floor) - there was a large, 12" tear in the floor near the right desk. There was a section of floor near the left desk, approximately 24 inches in diameter where the floor was torn and worn down into the concrete slab. b. Kitchen - the kitchen floors were dirty. There	C 164		

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C 164	Continued From page 4 was debris under the shelving in the pantry. 2. Observations revealed that the walls and furnishings were not kept clean and in good repair. Findings on June 21, 2018: a. Third Floor Bathtique - there was an excessive build up of lint or dust on the door frame. b. Room 361 - the bathroom door trim had been torn off the walls. There were holes in the wall on either side of the bathroom door. The walls of the room were gouged and scuffed from wheelchair damage. The base was pulled loose and the walls were damaged at the closet alcove. The wall at the AC vent was heavily gouged and scuffed from wheelchair use. c. Room 361 bath - there is a large hole, approximately 12" x 6" at the base of the wall between the shower and sink. The wallpaper is torn along the same wall. The interior door trim has been removed. d. Corridor outside of 361 - the corner wall is scuffed and gouged. There are black scuff marks on the door to the room. e. Care Manager's Office (Second Floor) - there is a 4" x 6" hole in the wall where a junction box was removed. Some type of equipment was removed from the wall and the wall has not been repaired. f. Care Manager's Office (Second Floor) - there is an open junction box in the corridor wall by the sprinkler head. g. Memory Care Utility Room - the corner wall by the door is heavily scuffed and the sheetrock has been damaged. The base has pulled away from the wall. h. SCU Manager's Office bath - the wallpaper is peeling off and hanging in sheets along the wall. i. Kitchen - the back exit door is damaged around	C 164		

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C 164	Continued From page 5 the hinges and the door drags on the floor. 3. Observations revealed that the ceilings were not maintained in good repair. Findings on June 21, 2018: a. Room 260 - there is a 12" x 24" yellow stain on the ceiling. The ceiling material is soft to the touch and the moisture has caused the ceiling finish to pucker. b. SCU Manager's Office - there is an old leak and the ceiling of the office is stained. Some of the sheetrock tape is pulling away from the ceiling and sections of the finish have flaked off. c. SCU Manager's Office bath - water damage from an old leak has caused the ceiling to split and crack and some of the finish is peeling off. d. Sitting area outside of the Bistro - there is one ceiling tile that has a star shaped water stain. The tile was damp to the touch. e. Kitchen - there is a small hole, 2" x 4" in a ceiling tile near the icemaker.	C 164		
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. Observations revealed that the facility was not maintained free of hazards.	C 166		

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C 166	Continued From page 6 Findings on June 21, 2018: a. Stairwell 3 by Room 351 - there is a 1 1/2" height difference in the floor at the stair door threshold where the carpet edge is turned up creating a trip hazard. b. Room 347 - three oxygen bottles were found unsecured on the floor. c. Med Tech's Office (Second Level) - there were seven unsecured oxygen bottles on the floor and there were seven oxygen bottles bottles stored in a Pepsi crate.	C 166		
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 and testing there is failure to maintain the facility's emergency fire alarm system devices and equipment in a safe operating condition. All the occupants of the facility could be effected if the equipment failed to alert the occupants in case of a fire. Findings on June 21, 2018: a. At the time of survey, the fire alarm panel was indicating trouble. A service representative was on site. The fire alarm did sound when tested.	C 189		

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C 189	Continued From page 7 2. Based on observation there is a failure to maintain the building's fire safety systems in a safe condition. Holes or gaps at penetrations through fire resistant rated ceilings or walls could allow fire and smoke to spread beyond the area of origin. Findings on June 21, 2018: a. Electrical Closet by Bathtique (Third Floor) - there was an unsealed cable bundle penetrating the ceiling. b. Stairwell 3 by Room 351 - the sprinkler escutcheon plate is recessed in the ceiling and there is a hole in the ceiling at the smoke detector. c. 2nd Floor, Stairwell 4 - there is a hole in the rated wall above the sprinkler pipe penetration. d. Room 260 bath - the fan does not sit squarely in the opening leaving a gap around the fan. e. Janitor Closet (Second Floor) - the seal around one of the HVAC ducts has come loose leaving a small hole in the ceiling. f. Janitor Closet (Second Floor) - the fire caulk around the 1 1/2" copper pipe has pulled away from the ceiling leaving an opening in the fire rated assembly. g. Mechanical Closet off of Care Manager (Second Floor) - there are 2 unsealed copper pipes penetrating the concrete ceiling. h. Memory Care Utility Room - there is a 12" x 18" hole in the ceiling. i. Electrical Room by SCU - there is a hole in the corridor wall where cables penetrate the wall. j. Dining Room Storage - there are gaps around the plumbing pipes where they penetrate the corridor wall. k. Chemical Storage - the sprinkler head is missing its escutcheon plate. l. Large Maintenance Storage - there is a 6" x 12" hole in the wall at the back corner of the room.	C 189		

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C 189	Continued From page 8 m. Exit corridor by Maintenance Storage - one of the sprinkler heads is missing the escutcheon plate. Staff stated that this head was in the process of being replaced as they could no longer obtain the rings for it. n. Janitor closet by Maintenance - the sprinkler head is missing the escutcheon plate. Staff stated that this head was in the process of being replaced as they could no longer obtain the rings for it. o. Activity Room (First Floor) - three escutcheon plates are missing from the sprinkler heads. Staff stated that these heads were in the process of being replaced as they could no longer obtain the rings for them. 3. Based on observation the facility's fire safety equipment is not maintained in operating condition. Obstructing fire safety equipment may not allow it to operate properly in the event of a fire or other emergency. Findings on June 21, 2018: a. Room 361 - blankets were stuffed in the closet up to the ceiling and did not provide the 18" clearance below the sprinkler head. b. Room 268 - items in the front closet were stored less than 18" below the sprinkler head. c. Kitchen Pantry - items are stored within 18" of the sprinkler heads. 4. Based on observation there is a failure to maintain the facility's fire safety equipment in a safe operating condition. Occupants in the smoke compartment could be exposed to smoke or fire if doors do not completely close and latch to help limit the spread of smoke or fire to the area of origin. Findings on June 21, 2018:	C 189		

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C 189	Continued From page 9 a. Care Manager's Office (Second Floor) - the door latch was taped over so that it no longer latched. The tape was removed at the time of survey. 5. Based on observation electrical equipment has not been maintained in a safe and operating manner. Findings on June 21, 2018: a. SCU Manager's Office - the cover plate is missing from the electrical outlet at the scale. b. SCU Manager's Office - the night light is missing leaving a hole in the wall at the housing. 6. Based on observation there is a failure to maintain the facility's fire safety equipment in a safe condition. In order to resist the passage of smoke resident room doors must not have holes or damage to the doors compromising their fire resistant rating. Findings on June 21, 2018: a. SCU Manager's Office - there are three holes in the door above the inside face door hardware. b. Kitchen - the "in" door had holes in the side where the hinges had been removed. 7. Based on observation there is a failure to maintain the buildings's fire safety components in a safe operating condition. Any unapproved device used to keep a door open is an impediment to quickly closing the door. The occupants in the facility could be effected if doors cannot be closed as required so as to limit the spread of smoke and/or fire to the area of origin. Findings on June 21, 2018: a. Bistro - the doors were propped open using an unapproved device. Further investigation	C 189		

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C 189	Continued From page 10 revealed that these doors have magnetic hold open devices that release on activation of the fire alarm. The magnets were missing from the doors so that they no longer operated as intended. b. The kitchen door was being held open with a kickdown device attached to the door. 8. Observations revealed that the plumbing equipment was not maintained in a safe and operating condition. Findings on June 21, 2018: a. Dining Room Storage - a utility sink has been removed leaving the drain and drain pan, creating a trip hazard from the hole in the floor. 9. Based on observation there is a failure to maintain the facility's fire safety equipment in a safe operating condition. The occupants in the smoke compartment could be effected if doors do not completely close and latch to help limit the spread of smoke or fire to the area of origin. Findings on June 21, 2018: a. Third Floor, right door of fire doors by Room 310 did not latch when released by the fire alarm. b. Second Floor, left door of fire doors by Biohazard/Electrical Room did not latch when released by the fire alarm.	C 189		
C 199	Exhaust Ventilation SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (g) The spaces listed in this Paragraph shall be provided with exhaust ventilation at the rate of two cubic feet per minute per square foot. This	C 199		

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C 199	Continued From page 11 requirement does not apply to facilities licensed before April 1, 1984, with natural ventilation in these specified spaces: (1) soiled linen storage; (2) soil utility room; (3) bathrooms and toilet rooms; (4) housekeeping closets; and (5) laundry area. (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. Observations revealed that the facility did not provide exhaust ventilation in required areas. Findings on June 21, 2018: a. Third floor visitors' bath - the exhaust fan is not working. b. SCU Manager's Offic Bath - the exhaust fan is not working.	C 199		

Sunrise Senior Living
Plan of Correction

Name of Community: Brighton Gardens of Charlotte
Address of Community: 6000 Park South Drive Charlotte, NC 28210
License number: HAL – 060-019
Inspection date(s): June 21, 2018
Name/Title of Legal Entity Representative Signing the Plan of Correction:
Amy Blalock, Executive Director

Signature of Sunrise Representative: Amy Blalock
Date of Submission: 8/2/18

Regulation	Target Date by Which Correction will be completed	Plan of Correction
C 101 SECTION .0300 Physical Plant 10A NCAC 13F .0301 (2) Findings on June 21, 2018: a. Residential Laundry (2nd and 3rd Floors) - thru-wall exhaust vents were installed in the corridor walls. Building Code requires corridors to resist the passage of smoke. Transfer grilles are not permitted. b. The Memory Care Unity has a magnetic locking system with keyed override switches. Three of three staff interviewed did not carry the override key on their person. All staff responsible for evacuation shall carry a key for the manual override with them at all times.	08/15/2018 06/22/2018 08/16/2018 07/20/2018 08/30/2018 06/26/2018	**1. Corrective Action for the Affected Residents/Specific Situation cited:** (a) Maintenance Coordinator contacted Sylvester and Cochren (outside contractor) to obtain quote on removing thru-wall exhaust vents and replacing with appropriate part. Quote pending at this time with completion date scheduled. (b) Maintenance Coordinator made additional keys and attached key to team member's key rings working in the memory care unit (Reminiscence Neighborhood). The Reminiscence Coordinator and Maintenance Coordinator provided training to each team member on the proper use of the manual key override switch. Team members will carry the key for the manual override with them at all times. (c) Maintenance Coordinator contacted Philips Healthcare Senior Living Solutions (outside contractor) for a quote for a CYL key switch. Quote received on July 24, 2018 and approved. Parts are ordered and upon arrival, the Phillips technician to be dispatched to install the override key switch on the Reminiscence Courtyard gate. A key lock box placed near the manual override key switch and the code provided to all team members. (d) Maintenance Coordinator replaced current key lock box. Staff provided with code to open the lockbox. (e) Maintenance Coordinator contacted Sylvestor and Cochren (outside contractor) to obtain a quote on placing required visible exit signs (adding 3) in the service corridor. Install will occur once quote received, approved and necessary parts delivered to contractor. **2. Corrective Action for Other Residents/Specific Situation cited:** A building walk through was conducted by the Maintenance Coordinator: (a) No additional areas identified in the community. (b) No additional areas identified in the Reminiscence Neighborhood specific to situation cited.

Responses on the enclosed plan of correction do not constitute an admission or agreement of the truth of the facts alleged or the conclusion set forth in the regulatory report. The responses are prepared solely as a matter of compliance with law.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
c. Memory Care Courtyard - the gate had a keypad and a keyed manual override switch. The key maintained with staff did not release the manual override. d. AL Courtyard by dining - the key for the manual override at the locked gate is maintained in a lockbox at the gate. Two of two staff interviewed knew the code to open the lockbox. e. Service Corridor - no exits were visible in the service corridor and there were no exit signs directing people toward the exits.	07/26/2018 07/26/2018 08/01/2018 08/01/2018 08/01/2018	(c) No additional areas identified specific to the situation cited. (d) No additional gates in Assisted Living community present. (e) No additional areas identified requiring exit signs. **3. Systemic Correction to Prevent Recurrence:** The Maintenance Coordinator will provide initial training to all new team members upon hire on the operation of the override switches in Assisted Living and Reminiscence courtyard gates. The Reminiscence Coordinator will complete random audits to ensure team member keys are present in the neighborhood for the manual key override systems to ensure compliance. The Maintenance Coordinator will routinely walk the building to ensure key code compliance and resolve any findings. Executive Director will conduct joint rounds with the Maintenance Coordinator on a periodic basis. **4. Monitoring Plan:** The Executive Director or designee is responsible for ensuring implementation and compliance with all components of this plan of correction, addressing, and resolving any variance that may occur. The Executive Director is responsible for ensuring the status of this Plan of Correction reviewed and discussed at Quality Assurance Performance improvement Meetings and action initiated as required.
C 111 SECTION .0300-PHYSICAL PLANT 10A NCAC 13F .0302 (f) This Rule is not met as evidenced by: a. Review of records revealed that the facility did not have an approved fire inspection report. Findings on June 21, 2018: a. A Fire Inspection at	06/21/2018 06/21/2018 06/21/2018 06/21/2018	**1. Corrective Action for the Affected Residents/Situation Cited:** (a) Fire inspection report completed on June 11, 2018. Copy of report provided to construction survey team on June 21, 2018. (b) Fire Alarm Inspection report reviewed by Frank Strickland at the time of the construction survey. **2. Corrective Action for Other Residents/Situation Cited:** (a) (b) No additional action required. **3. Systemic Correction to Prevent Recurrence:** The Executive Director and Maintenance Coordinator maintains the current sanitation and fire and building safety inspection reports in binders located in the community. **4. Monitoring Plan:** The Executive Director or designee is responsible for ensuring implementation and compliance with all components of this plan of

Regulation	Target Date by Which Correction will be completed	Plan of Correction
the facility on June 11, 2018 cited 22 deficiencies to be corrected. b. A copy of the current Fire Alarm Inspection report was not available for review.	08/01/2018	correction, addressing, and resolving any variance that may occur. The current sanitation, fire and building safety inspection reports will be presented and discussed at the Leadership Meetings as new inspections and initiate any necessary action to ensure regulatory compliance.
C150 SECTION .0300-PHYSICAL PLANT 10A NCAC 13F .0305 (g)(4) This Rule is not met as evidenced by: 1. Observations revealed that the corridors were not free of all equipment and other obstructions. Findings on June 21, 2018: a. The exit corridor by Maintenance had shelving and activity equipment stored in the corridor reducing the width to less than 6'.	07/18/2018 07/18/2018 07/18/2018 07/18/2018 07/24/2018	**1. Corrective Action for the Affected Residents/Specific Situation:** (a) Shelving utilized for temporary linen storage removed upon initiating of internal commercial laundry start up. Activity equipment removed and maintained in activity room when not in use. **2. Corrective Action for Other Residents/Specific Situation:** (a) Maintenance Coordinator completed walkthrough of exit corridors to ensure corridors were free from obstructions. **3. Systemic Correction to Prevent Recurrence:** Maintenance Coordinator will routinely walk the building to ensure key code compliance and resolve any findings. Executive Director will conduct joint rounds with the Maintenance Coordinator on a periodic basis. **4. Monitoring Plan:** The Executive Director or designee is responsible for ensuring implementation and compliance with all components of this plan of correction, addressing, and resolving any variance that may occur. .
C 160 SECTION .0300-PHYSICAL PLANT 10A NCAC 13F .0305 (m)(1) This Rule is not met as evidenced by: 1. Observations revealed that the outside premises were not maintained in a clean and safe manner. Findings on June 21,	06/27/2018 07/17/2017 07/17/2018 07/17/2018	**1. Corrective Action for the Affected Residents/Specific Situation:** (a) Roof drain grille reattached appropriately. (b) Exterior light at AL Courtyard globe was missing at the time of the inspection. New fixture installed. **2. Corrective Action for Other Residents/Specific Situation:** Maintenance Coordinator completed a walkthrough of the grounds/building and no other areas identified. **3. Systemic Correction to Prevent Recurrence:** The Executive Director, Maintenance Coordinator and Leadership team will routinely complete community walkthroughs and document any areas of concern in the TELS System (computerized maintenance log).

Regulation	Target Date by Which Correction will be completed	Plan of Correction
2018: a. AL Courtyard by the Beauty Salon - a roof drain grille was off and laying on the ground near dining. b. AL Courtyard - the exterior light over the dining doors is broken and dangling from its' wires.	07/18/2018 07/18/2018 08/01/2018	The Maintenance Coordinator and/or designee will review the TELS System daily and take action necessary to address concerns noted. **4. Monitoring Plan:** The Executive Director or designee is responsible for ensuring implementation and compliance with all components of this plan of correction, addressing, and resolving any variance that may occur. The Executive Director is responsible for ensuring the status of this Plan of Correction reviewed and discussed at Quality Assurance Performance improvement Meetings and action initiated as required.
C 164 SECTION .0300-PHYSICAL PLANT 10A NCAC 13F .0306 (a)(1)(2)(3)(e) This Rule is not met as evidenced by: 1. Observations revealed that the floors were not kept clean and in good repair. Findings on June 21, 2018: a. Wellness Office (3rd Floor) - there was a large, 12" tear in the floor near the right desk. There was a section of floor near the left desk, approximately 24 inches in diameter where the floor was torn and worn down into the concrete slab. b. Kitchen - the kitchen floors were dirty. Therewas debris under the shelving in the pantry.	08/22/2018 07/11/2018 06/22/2018 07/31/2018 07/20/2018 07/20/2018 08/04/2018 08/10/2018 06/25/2018 08/04/2018 07/30/2018 08/04/2018 06/21/2018 08/04/2018 07/17/2018	**1. Corrective Action for the Affected Residents/Specific Situation cited:** (1) (a) Maintenance Coordinator requested approval to replace floor in Wellness Office. Purchase orders approved and materials ordered. Interior Specialists (outside contractor) to supply community with install date upon receipt of materials. (1)(b)The Senior Dining Service Coordinator cleaned the kitchen Floors. (2) (a) The Housekeeper cleaned the excessive buildup of dust. (2) (b) (c) (d) Resident in 361 was moved to another rom on July 23, 2018. Outside contracted construction services utilized to complete repairs to the room and hallway area outside room. (2) (e) Repairs made to wall in Care Manager office. (2) (f) Repairs made to the open junction box completed. (2) (g) Repairs to Memory Care Utility room to be completed by Maintenance Coordinator. (2) (h) Repairs to the SCU manager's office bath to be completed by Maintenance Coordinator. (2) (i) The Maintenance Coordinator installed a continuous hinge on back exit kitchen door. . (3) (a) The Maintenance Coordinator completed repairs to the ceiling in room 260. (3) (b) SCU Manager's Office: Ceiling repairs completed and ceiling repainted. (3) (c) SCU Manager's office bath – ceiling repairs completed. (3) (d) Ceiling tile replaced at time of construction survey. (3) (e) Maintenance Coordinator will replace the ceiling tile near The icemaker in the kitchen. **2. Corrective Action for Other Residents/Specific Situation Cited:** Maintenance Coordinator and Executive Director completed a walkthrough of the grounds/building and necessary action taken to ensure regulatory compliance.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
2. Observations revealed that the walls and furnishings were not kept clean and in good repair. Findings on June 21, 2018: a. Third Floor Bathtique - there was an excessive build up of lint or dust on the door frame. b. Room 361 - the bathroom door trim had been torn off the walls. There were holes in the wall on either side of the bathroom door. The walls of the room were gouged and scuffed from wheelchair damage. The base was pulled loose and the walls were damaged at the closet alcove. The wall at the AC vent was heavily gouged and scuffed from wheelchair use. c. Room 361 bath - there is a large hole, approximately 12" x 6" at the base of the wall between the shower and sink. The wallpaper is torn along the same wall. The interior door trim has been removed.	07/01/2018 07/01/2018 7/24/2018 08/01/2018	**3. Systemic Correction to Prevent Recurrence:** The Executive Director, Maintenance Coordinator and Leadership team will routinely complete community walkthroughs and document any areas of concern in the TELS System (computerized maintenance log). The Maintenance Coordinator and/or designee will review the TELS System daily and take action necessary to address concerns noted **4. Monitoring Plan:** The Executive Director or designee is responsible for ensuring implementation and compliance with all components of this plan of correction, addressing, and resolving any variance that may occur. The Executive Director is responsible for ensuring the status of this Plan of Correction reviewed and discussed at Quality Assurance Performance improvement Meetings and action initiated as required.

Responses on the enclosed plan of correction do not constitute an admission or agreement of the truth of the facts alleged or the conclusion set forth in the regulatory report. The responses are prepared solely as a matter of compliance with law.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
d. Corridor outside of 361 - the corner wall is scuffed and gouged. There are black scuff marks on the door to the room. e. Care Manager's Office (Second Floor) - there is a 4" x 6" hole in the wall where a junction box was removed. Some type of equipment was removed from the wall and the wall has not been repaired. f. Care Manager's Office (Second Floor) - there is an open junction box in the corridor wall by the sprinkler head. g. Memory Care Utility Room - the corner wall by the door is heavily scuffed and the sheetrock has been damaged. The base has pulled away from the wall. h. SCU Manager's Office bath - the wallpaper is peeling off and hanging in sheets along the wall. i. Kitchen - the back exit door is damaged aroundthe hinges and the door drags on the floor. 3. Observations		

Regulation	Target Date by Which Correction will be completed	Plan of Correction
revealed that the ceilings were not maintained in good repair. Findings on June 21, 2018: a. Room 260 - there is a 12" x 24" yellow stain on the ceiling. The ceiling material is soft to the touch and the moisture has caused the ceiling finish to pucker. b. SCU Manager's Office - there is an old leak and the ceiling of the office is stained. Some of the sheetrock tape is pulling away from the ceiling and sections of the finish have flaked off. c. SCU Manager's Office bath - water damage from an old leak has caused the ceiling to split and crack and some of the finish is peeling off. d. Sitting area outside of the Bistro - there is one ceiling tile that has a star shaped water stain. The tile was damp to the touch. e. Kitchen - there is a small hole, 2" x 4" in a ceiling tile near the icemaker.		

Regulation	Target Date by Which Correction will be completed	Plan of Correction
C 166 SECTION .0300-PHYSICAL PLANT 10A NCAC 13F .0306 (a)(5)(e) This Rule is not met as evidenced by: 1. Observations revealed that the facility was not maintained free of hazards. Findings on June 21, 2018: a. Stairwell 3 by Room 351 - there is a 1 1/2" height difference in the floor at the stair door threshold where the carpet edge is turned up creating a trip hazard. b. Room 347 - three oxygen bottles were found unsecured on the floor. c. Med Tech's Office (Second Level) - there were seven unsecured oxygen bottles on the floor and there were seven oxygen bottles bottles stored in a Pepsi crate.	08/06/2018 06/22/2018 06/26/2018 07/10/2018 07/16/2018 07/24/2018 07/24/2018	**1. Corrective Action for the Affected Residents/Specific Situation Cited:** (a) Threshold replacement ordered and to be installed upon delivery. (b) (c) Outside vendors supplying oxygen tanks contacted by the Wellness Department for the resident residing in 347 and the Medication Care Managers Office. Appropriate storage racks provided. **2. Corrective Action for Other Residents/Specific Situation Cited:** Maintenance Coordinator completed inspection of all stairwell entrances to ensure appropriate thresholds were present. Thresholds appropriate at time of inspection with no additional action required. The Wellness Department conducted an inspection of all oxygen containers located in residents rooms identified as utilizing oxygen. Oxygen supply vendors contacted and approved storage racks provided. Unapproved containers removed from the community. **3. Systemic Correction to Prevent Recurrence:** The Resident Care Director, Assisted Living Coordinator, and Reminiscence coordinator will conduct frequent checks to ensure appropriate storage racks utilized. **4. Monitoring Plan:** The Executive Director or designee is responsible for ensuring implementation and compliance with all components of this plan of correction, addressing, and resolving any variance that may occur. The Executive Director or designee is responsible for ensuring implementation and compliance with all components of this plan of correction, addressing, and resolving any variance that may occur
C 189 SECTION .0300-PHYSICAL PLANT 10A NCAC 13F .0311 (a)(k) This Rule is not met as evidenced by: 1. Based on observation and testing there is failure to maintain	07/20/2018 08/15/2018 07/20/2018 07/20/2018 07/20/2018	**1. Corrective Action for the Affected Residents/Specific Situation Cited:** (a) Cable bundle sealed by electrical closet by bathtique. (b) Simplex Grinnell (outside contracted service) to replace sprinkler escutcheon plate in Stairwell 3 by 351 upon arrival of parts delivery. (c) Hold in the rate wall above the sprinkler pipe penetration located in Stairwell 4 on the second floor sealed. (d) Room 260-bathroom bath – repairs made and fan not sits squarely. (e) The seal around the HVAC duct in the janitor closet on the

Regulation	Target Date by Which Correction will be completed	Plan of Correction
the facility's emergency fire alarm system devices and equipment in a safe operating condition. All the occupants of the facility could be effected if the equipment failed to alert the occupants in case of a fire. Findings on June 21, 2018: a. At the time of survey, the fire alarm panel was indicating trouble. A service representative was on site. The fire alarm did sound when tested. 2. Based on observation there is a failure to maintain the building's fire safety systems in a safe condition. Holes or gaps at penetrations through fire resistant rated ceilings or walls could allow fire and smoke to spread beyond the area of origin. Findings on June 21, 2018: a. Electrical Closet by Bathtique (Third Floor) - there was an unsealed cable bundle penetrating the ceiling. b. Stairwell 3 by	07/20/2018 07/20/2018 08/04/2018 07/20/2018 07/20/2018 08/15/2018 08/15/2018 08/15/2018 06/22/2018 06/21/2018 08/04/2018 08/04/2018 08/06/2018 08/06/2018 08/24/2018 08/24/2018 08/17/2018 07/05/2018 07/17/2018	second floor caulked properly. (f) Fire caulk placed around the copper pipe in the 2nd floor janitor closet closing the opening in the fire rated assembly. (g) Fire caulk applied around the two unsealed copper pipes penetrating the concrete ceiling in the mechanical close in the second floor Care Manager Office. (h) Maintenance Coordinator scheduled to repair the hold in the ceiling in the Memory Care utility room. (i) Appropriate caulking applied around the cables in the electrical room by SCU and no opening is present. (j) Fire caulking applied in the gaps around the plumbing pipes in the dining room storage room. (k) Simplex Grinnell (outside contracted service) to replace sprinkler escutcheon plate upon arrival of parts delivery. (l) Outside contractors to repair wall in the large maintenance storage. (m) (n) (o) Missing sprinkler heads escutcheon plates are obsolete and no longer available. Simplex Grinnell (outside contractor) to install new sprinkler heads upon arrival of parts delivery. (3) (a) (b) (c) Items located in room 361, 268 and kitchen pantry were removed from closet and organized ensuring required 18" of clearance below the sprinkler head was met. (4) (a) Tape immediately removed on the Care Manager's Office door at the time of the survey. (5) (a) The Maintenance Assistant will replace the missing cover plate to the electrical outlet at the scale in the SCU Manager's office. (5) (b) Maintenance Assistant will replace the night light cover in the SCU Manager's office upon arrival of part. (6) (a) Maintenance Coordinator to apply appropriate hardware to cover the holes located in the main door to the SCU Manager's office. (6) (b) Maintenance Coordinator to apply appropriate hardware to the Kitchen "in" door. (7) (a) Simplex (outside contractor) to delivery and apply magnets to ensure doors operate as intended. (7) (b) Simplex (outside contractor) to install appropriate mag lock devices to the kitchen door. (8) (a) Maintenance Coordinator to address/repair the hole in the floor in the dining room storage room. (9) (a)(b) E & S Lock provided services and repairs to fire doors by room 310 and doors located on the 2nd floor near the biohazard/electrical room to ensure both doors latched properly. **2. Corrective Action for Other Residents/Specific Situation Cited:** Maintenance Coordinator completed a walkthrough of the grounds/building and necessary action taken to ensure regulatory

Regulation	Target Date by Which Correction will be completed	Plan of Correction
Room 351 - the sprinkler escutcheon plate is recessed in the ceiling and there is a hole in the ceiling at the smoke detector. c. 2nd Floor, Stairwell 4 - there is a hole in the rated wall above the sprinkler pipe penetration. d. Room 260 bath - the fan does not sit squarely in the opening leaving a gap around the fan. e. Janitor Closet (Second Floor) - the seal around one of the HVAC ducts has come loose leaving a small hole in the ceiling. f. Janitor Closet (Second Floor) - the fire caulk around the 1 1/2" copper pipe has pulled away from the ceiling leaving an opening in the fire rated assembly. g. Mechanical Closet off of Care Manager (Second Floor) - there are 2 unsealed copper pipes penetrating the concrete ceiling. h. Memory Care Utility Room - there is a 12" x 18" hole in the ceiling.	07/0/2018 07/01/2018 07/01/2018 07/24/2018 08/01/2018	compliance. **3. Systemic Correction to Prevent Recurrence:** The Executive Director, Maintenance Coordinator and Leadership team will routinely complete community walkthroughs and document any areas of concern in the TELS System (computerized maintenance log). The Maintenance Coordinator and/or designee will review the TELS System daily and take action necessary to address concerns noted. Maintenance Coordinator and/or designee will ensure fire doors close and latch appropriately during routine fire drills to ensure equipment maintained in a safe operating condition. **4. Monitoring Plan:** The Executive Director or designee is responsible for ensuring implementation and compliance with all components of this plan of correction, addressing, and resolving any variance that may occur. The Executive Director is responsible for ensuring the status of this Plan of Correction reviewed and discussed at Quality Assurance Performance improvement Meetings and action initiated as required.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
i. Electrical Room by SCU - there is a hole in the corridor wall where cables penetrate the wall. j. Dining Room Storage - there are gaps around the plumbing pipes where they penetrate the corridor wall. k. Chemical Storage - the sprinkler head is missing its escutcheon plate. l. Large Maintenance Storage - there is a 6" x 12" hole in the wall at the back corner of the room. m. Exit corridor by Maintenance Storage - one of the sprinkler heads is missing the escutcheon plate. Staff stated that this head was in the process of being replaced as they could no longer obtain the rings for it. n. Janitor closet by Maintenance - the sprinkler head is missing the escutcheon plate. Staff stated that this head was in the process of being replaced as they could no longer obtain the rings for it.		

Regulation	Target Date by Which Correction will be completed	Plan of Correction
o. Activity Room (First Floor) - three escutcheon plates are missing from the sprinkler heads. Staff stated that these heads were in the process of being replaced as they could no longer obtain the rings for them. 3. Based on observation the facility's fire safety equipment is not maintained in operating condition. Obstructing fire safety equipment may not allow it to operate properly in the event of a fire or other emergency. Findings on June 21, 2018: a. Room 361 - blankets were stuffed in the closet up to the ceiling and did not provide the 18" clearance below the sprinkler head. b. Room 268 - items in the front closet were stored less than 18" below the sprinkler head. c. Kitchen Pantry - items are stored within 18" of the sprinkler heads. 4. Based on observation there is		

Regulation	Target Date by Which Correction will be completed	Plan of Correction
a failure to maintain the facility's fire safety equipment in a safe operating condition. Occupants in the smoke compartment could be exposed to smoke or fire if doors do not completely close and latch to help limit the spread of smoke or fire to the area of origin. Findings on June 21, 2018: a. Care Manager's Office (Second Floor) - the door latch was taped over so that it no longer latched. The tape was removed at the time of survey. 5. Based on observation electrical equipment has not been maintained in a safe and operating manner. Findings on June 21, 2018: a. SCU Manager's Office - the cover plate is missing from the electrical outlet at the scale. b. SCU Manager's Office - the night light is missing leaving a hole in the wall at the housing. 6. Based on		

Regulation	Target Date by Which Correction will be completed	Plan of Correction
observation there is a failure to maintain the facility's fire safety equipment in a safe condition. In order to resist the passage of smoke resident room doors must not have holes or damage to the doors compromising their fire resistant rating. Findings on June 21, 2018: a. SCU Manager's Office - there are three holes in the door above the inside face door hardware. b. Kitchen - the "in" door had holes in the side where the hinges had been removed. 7. Based on observation there is a failure to maintain the buildings's fire safety components in a safe operating condition. Any unapproved device used to keep a door open is an impediment to quickly closing the door. The occupants in the facility could be effected if doors cannot be closed as required so as to limit the spread of smoke and/or fire to the		

Regulation	Target Date by Which Correction will be completed	Plan of Correction
area of origin. Findings on June 21, 2018: a. Bistro - the doors were propped open using an unapproved device. Further investigation revealed that these doors have magnetic hold open devices that release on activation of the fire alarm. The magnets were missing from the doors so that they no longer operated as intended. b. The kitchen door was being held open with a kickdown device attached to the door. 8. Observations revealed that the plumbing equipment was not maintained in a safe and operating condition. Findings on June 21, 2018: a. Dining Room Storage - a utility sink has been removed leaving the drain and drain pan, creating a trip hazard from the hole in the floor. 9. Based on observation there is a failure to maintain the facility's fire safety equipment in a safe operating condition. The		

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occupants in the smoke compartment could be effected if doors do not completely close and latch to help limit the spread of smoke or fire to the area of origin. Findings on June 21, 2018: a. Third Floor, right door of fire doors by Room 310 did not latch when released by the fire alarm. b. Second Floor, left door of fire doors by Biohazard/Electrical Room did not latch when released by the fire alarm.		
C 199 SECTION .0300-PHYSICAL PLANT 10A NCAC 13F .0311 (g)(1)(2)(3)(4)(5)(k) This Rule is not met as evidenced by: 1. Observations revealed that the facility did not provide exhaust ventilation in required areas. Findings on June 21, 2018: a. Third floor visitors' bath - the exhaust fan is not working. b. SCU Manager's Offic Bath - the exhaust fan is not working.	07/10/2018 0804/2018 0805/2018 07/18/2018	**1. Corrective Action for the Affected Residents/Specific Situation Cited:** (a) (b) Exhaust fans located in the 3rd floor visitors bathroom and SCU Manager's Office Bath were replaced and currently operational. **2. Corrective Action for Other Residents/Specific Situation Cited:** Maintenance Coordinator and Maintenance Assistant to complete walkthrough. Exhaust fans not operational identified. Identified fans repaired and/or replaced. **3. Systemic Correction to Prevent Recurrence:** Housekeepers to text exhaust fans on a weekly basis. Exhaust fans identified as not working logged into TELS (maintenance repair log). The Maintenance Coordinator and/or Maintenance Assistant will take necessary action to ensure identified exhaust fan repairs/replacement is completed. Maintenance Coordinator will routinely walk the building to ensure key code compliance and resolve any findings. Executive Director will conduct joint rounds with the Maintenance Coordinator on a periodic basis.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
	07/24/2018 08/01/2018	**4. Monitoring Plan:** The Executive Director or designee is responsible for ensuring implementation and compliance with all components of this plan of correction, addressing, and resolving any variance that may occur. The Executive Director is responsible for ensuring the status of this Plan of Correction reviewed and discussed at Quality Assurance Performance improvement Meetings and action initiated as required.