STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060082	A. BUILDING: 01 B. WING _____	07/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF LITTLE AVENUE	7745 LITTLE AVENUE CHARLOTTE, NC 28226

(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 Biennial Construction Survey by Dennis Harrell on 7-11-2018. Records indicate this facility was first licensed on 10-29-1997, for 62 beds with 27 of those in a Special Care Unit. Based on this information, we are requiring the facility to meet the 1996 Rules for Homes for the Aged and Disabled - Minimum Standards and Regulations, the applicable portions of the 2005 Rules for Adult Care Homes for Seven or More Beds, and the 1996 w/'99 rev Edition of the North Carolina State Building Code; Section 409 Institutional Occupancy - Group I.	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: 1. Based on observation, the exits from Special Care are equipped with a combination of Special	C 101		

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C 101	Continued From page 1 (magnetic) Locking and Delayed Egress Locking. One of the exit doors in Special Care failed to meet the NC Building Code requirements for Delayed Egress Locking. The Code requires Delayed egress doors to initiate an irreversible process to open when a force of not more than 15 pounds is applied for not more than 15 seconds. Finding on 7-11-2018; The Delayed Egress Locking at the main exit from Special Care into the AL side failed to activate and open when a force in excess of 100 pounds was applied. 2. Based on observation, the facility fails to meet the NC Building Code requirements for storage rooms in excess of 100 square feet. Finding on 7-11-2018; Former bedroom 230 is now being used for storage and is full of combustible items. The room is approximately 260 square feet and the door and frame are only 20 minute rated. 3. Based on observation, the facility fails to meet the NC Building Code requirements for access to electrical panels. The Code requires a clear space of at least 3 feet deep by 2.5 feet wide in front of all electric panels. Finding on 7-11-2018; There were many items stored directly in front of the electric panels in Special Care.	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	C 111		

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C 111	Continued From page 2 shall be maintained in the home and available for review. This Rule is not met as evidenced by: Based on a review of documents, the most recent Fire Marshal building safety inspection report was not available for review. Buildings must be inspected and approved annually as required to ensure all systems can operate properly in an actual emergency.	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: Based on observation, the corridor was not maintained free of obstructions. At least 6 feet of clear width must be maintained in exit corridors. Findings include: a. There was a scales chair stored in the corridor reducing the clear width to about 3.5 feet. b. There was a bench provided in the corridor reducing the clear width to about 4 feet. c. There were 2 med carts stored in the corridor reducing the clear width to about 3.5 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	C 166		

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C 166	Continued From page 3 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 exterior exit paths were not maintained free of obstructions. Findings on 7-11-2018; a. There is a fence and gate just outside each exit from Special Care. The fence and gate are almost 5 feet high and the gates are latched closed by a barrel bolt latch on the outside of the gate, out of sight and probably out of reach for some staff. Opening the gate requires special knowledge of the latch and enough height to reach the latch. b. One of the barrel bolt latches was broken making it even more difficult to open. 2. Based on observation, the exterior exit paths were not maintained uncluttered and free of obstructions. Finding on 7-11-2018; There was a hose across the sidewalk directly outside the exit near the laundry. The hose presented a significant trip and fall hazard. 3. Based on observation, there was no documentation of the required in house/owner's monthly inspections since April provided on the inspection tag at the range hood fire suppression system. Range hood fire suppression systems must be inspected monthly and the inspections must be documented somewhere such as on the tag provided at the system pull. 4. Based on observation, a deep fryer in the kitchen had been moved backward so that the range hood fire suppression nozzle was now	C 166		

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C 166	Continued From page 4 pointed at the floor rather than at the oil reservoir. With the fryer miss-positioned, the range hood fire suppression system may not be capable of suppressing a fryer fire as designed. 5. Based on observation, the ice machine drain line was in direct contact with the floor drain. Ice machine drain lines that are not maintained at least 2 inches above the floor or floor drain, as required 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: 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 2nd or 3rd shifts.	C 185		

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C 185	Continued From page 5 b. In the 2nd quarter of this year, there was no rehearsal done during the 3rd shift. c. In the 3rd quarter of last year, there were no rehearsals done during the 1st or 3rd shifts. d. In the 4th quarter of last year, there were no rehearsals done during the 1st or 2nd shifts.	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, the required one-hour fire rated walls and/or ceilings were compromised in several 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. Gypsum patch, only 1/2 inch thick, on ceiling of mechanical room across from main office. Gypsum wallboard must be at least 5/8 inch thick to be one-hour fire rated. b. Another gypsum patch not sealed at the edges in the mechanical room across from main office. c. Unrated orange foam used to seal gaps where the wall meets the ceiling in the mechanical room across from main office.	C 189		

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C 189	Continued From page 6 d. Holes in the wall in the maintenance office, e. Hole in the wall and ceiling of the 2nd floor housekeeping closet, f. Gypsum compound and tape falling off the ceiling in the 2nd floor electrical room, g. Hole in ceiling at the exit sign outside the Dining room on the AL side. h. Hole in ceiling at the WiFi device in the Dining room on the AL side. 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 smoke barrier door near room 201 did not close when activated by the fire alarm system. b. The 1.5 hr fire rated door from the kitchen to the rear exit corridor was propped open. c. The door to the storage room off the exit corridor behind the kitchen would not latch when closed. d. The strike was missing on the 1.5 hr fire rated door to the water heater room. e. The 1.5 hr fire rated door to the 2nd floor electrical room would not latch when closed. f. One of the hinges was missing on the 20 minute door to bedroom 216. g. The 1.5 hr fire rated door to the 2nd floor stairs near the kitchen storage does not fit the opening properly to be resistant to the passage of smoke. h. The 1.5 hr fire rated corridor door to the water heater room does not fit the opening properly to be resistant to the passage of smoke. i. The door to the biohazard room does not fit the opening properly to be resistant to the passage of	C 189		

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C 189	Continued From page 7 smoke. j. The door to the library does not fit the opening properly to be resistant to the passage of smoke. 3. Based on observation, the facility failed to be maintained in a safe condition because of exit signs not working properly. Exit signs that will not work properly for at least 90 minutes after loss of power could endanger the residents and staff. Finding on 7-11-2018: At least one exit sign in Special Care was not battery backed up for loss of power.	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 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: Based on observation the facility failed to maintain required exhaust in a working condition. Findings on 7-11-2018; a. The exhaust provided was not working in the bathroom off room 204.	C 199		

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C 199	Continued From page 8 b. The exhaust fan was removed from the housing in the bathroom off the Resident Services Director's office. c. The exhaust fan was removed from the housing in the bathroom off the Weston Group Therapy Department.	C 199		

Tina Benson 8.6.18

The following is the Plan of Correction for Community name Elmcroft of Little Avenue. This Plan of Correction is in regards to the Statement of Deficiency from the Biennial Construction Survey completed on July 11th 2018. This Plan of Correction is not to be construed as an admission of our agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is 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.

Section 0300- Physical Plant 10A NCAC 13F .0301 Application of Physical Plant requirements:

1.Findings on 7-11-2018; The Delayed Egress Locking at the main exit from Special Care into the AL side failed to activate and open when a force in excess of 100 lbs was applied.

Effective-- The delayed Egress locking at the main exit from special care into AL activates and opens when a force in excess of 15lbs for more than 15 seconds. Weekly inspection of exit doors that have delayed egress locking mechanism to ensure that they activate and open within the parameters of NC regulation to be performed by MD or designee and monthly inspection of exit doors that have delayed egress locking mechanism to be performed by ED or designee.

2.Findings on 7-11-2018- Former bedroom 230 is now being used for storage and is full of combustible items.

Effective- on 8/14/18 scheduled clean- up of room and removal of certain items to be placed in outside storage unit. Weekly inspection of room 230 performed by MD or designee. Monthly inspection of room 230 performed by ED or designee.

3. Findings on 7-11-2018; There were many items stored directly in front of the electric panels in Special Care.

Effective--items directly in front of electric panels in Special Care Unit relocated. Weekly inspections of electrical panels to ensure there is access weekly by MD and or designee and Monthly inspections of electrical panels to ensure there is access.

SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0302 DESIGN AND CONSTRUCTION

4.Findings-The most recent Fire Marshal building safety inspection report was not available for review.

Effective-- We received Fire Marshall building safety inspection report and it is available in the community for review.

SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0305 PHYSICAL ENVIRONMENT

Findings on 7/11/2018-.Findings include: a. There was a scales chair stored in the corridor reducing the clear width to about 3.5 feet. b. There was a bench provided in the corridor reducing the clear width to about 4 feet. c. There were 2 med carts stored in the corridor reducing the clear width to about 3.5 feet..

Effective – Removal of scales chair with the exception of during use. Removal and of both med carts from corridor when not in use. Weekly inspections of corridors to be performed by MD and or designee. Monthly inspections of corridors performed by ED and or designee.

SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0306 HOUSEKEEPING

1. Findings on 7-11-2018; a. There is a fence and gate just outside each exit from Special Care. The gates are latched closed by a barrel bolt latch on the outside of the gate. b. One of the barrel bolt latches was broken making it even more difficult to open.

Effective-Removed barrel bolt latches outside of gate.

2. Findings on 7-11-2018; There was a hose across the sidewalk directly outside the exit near the laundry.

Effective-hose removed across the sidewalk directly outside the exit door near the laundry. Weekly inspections of walkways to be performed by MD and or designee. Monthly inspections of walkways performed by ED and or designee.

3. Findings on 7/11/18- there was no documentation of the required in-house/owner's monthly inspections since April provided on the inspection tag at the range hood fire suppression system. Range hood fire suppression systems must be inspected monthly and the inspections must be documented somewhere such as on the tag provided at the system pull.

Effective - contacted responsible vendor and requested documentation of monthly inspection of range hood suppression systems. Inspection report is in community available for review. Monthly inspection reports of range suppression system will be performed by MD and or designee.

4. Findings on 7/11/18- a deep fryer in the kitchen had been moved backward so that the range hood fire suppression nozzle was now pointed at the floor rather than at the oil reservoir. With the fryer miss-positioned, the range hood fire suppression system may not be capable of suppressing a fryer fire as designed.

Effective 7/11/18- positioning of deep fryer in the kitchen repositioned. Weekly inspections of positioning of deep fryer to be performed by MD and or designee. Monthly inspections of positioning of deep fryer will be performed by ED and or designee.

5. Findings on 7/11/2018-the ice machine drain line was in direct contact with the floor drain.

Effective - The ice machine drain line is corrected. Monthly inspections of ice machine drain line will be performed by ED and or designee.

SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0309 PLAN FOR

Findings include; a. In the 1st quarter of this year, there was no rehearsal done during the 2nd or 3rd shifts. In the 2nd quarter of this year, there was no rehearsal done during the 3rd shift. c. In the 3rd quarter of last year, there were no rehearsals done during the 1st or 3rd shifts. d. In the 4th quarter of last year, there were no rehearsals done during the 1st or 2nd shifts.

Effective 7/11/18- Rehearsals of the fire plan quarterly on each shift and records will be maintained and copies will be furnished to the county department of social services annually. Monthly inspections of rehearsals of fire plan and records will be audited by ED and or designee.

SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS

Findings on 7/11/2018- a. Gypsum patch, only 1/2 inch thick, on ceiling of mechanical room across from main office.b. Another gypsum patch not sealed at the edges in the mechanical room across from main office, c. Unrated orange foam used to seal gaps where the wall meets the ceiling in the mechanical room across from main office. d. Holes in the wall in the maintenance office, e. Hole in the wall and ceiling of the 2nd floor housekeeping closet, f. Gypsum compound and tape falling off the ceiling in the 2nd floor electrical room, g. Hole in ceiling at the exit sign outside the Dining room on the AL side. h. Hole in ceiling at the WIFI device in the Dining room on the AL side.

Effective- The identified areas will be corrected prior to 8/26/18. Monthly inspection of ceiling and walls in community common areas, office spaces and resident rooms to be performed by MD and or designee.

Findings on 7/11/18-include a. The smoke barrier door near room 201 did not close when activated by the fire alarm system. b. The 1.5 hr fire rated door from the kitchen to the rear exit corridor was propped open. c. The door to the storage room off the exit corridor behind the kitchen would not latch when closed. d. The strike was missing on the 1.5 hr fire rated door to the water heater room. e. The 1.5 hr fire rated door to the 2nd floor electrical room would not latch when closed. f. One of the hinges was missing on the 20 minute door to bedroom 216. g. The 1.5 hr fire rated door to the 2nd floor stairs near the kitchen storage does not fit the opening properly to be resistant to the passage of smoke. h. The 1.5 hr fire rated corridor door to the water heater room does not fit the opening properly to be resistant to the passage of smoke. The door to the biohazard room does not fit the opening properly. The door to the library does not fit the opening properly to be resistant to the passage of smoke.3. Based on observation, the facility failed to be maintained in a safe condition because of exit signs not working properly. Exit signs that will not work properly for at least 90 minutes after loss of power could endanger the residents and staff.

Effective - repairs began and will be corrected prior to 8/26/18. Weekly inspection of the 1.5 hr fire rated doors to ensure that they are within the parameters of NC regulation to be performed weekly by MD and or designee and monthly inspection of the 1.5 hr fire rated doors to ensure that they are within the parameters of NC regulation to be performed by ED and or designee.

Finding on 7-11-2018: At least one exit sign in Special Care was not battery backed up for loss of power.

Effective- will ensure that each exit sign is properly functioning prior to 8/26/18. Weekly inspection of exit sign functioning will be performed by MD and or designee. Monthly inspection of exit signs will be performed by designee and or designee.

SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER

Findings on 7-11-2018; a. The exhaust provided was not working in the bathroom off room 204.b. The exhaust fan was removed from the housing in the bathroom off the Resident Services Director's office. c. The exhaust fan was removed from the housing in the bathroom off the Weston Group Therapy Department.

Effective- The areas identified will be repaired prior to 8/26/18. Weekly inspections of exhaust fans to be performed by MD and or designee. Monthly inspections of exhaust fans to be performed by ED and or designee.

Signature of Executive Director/Date: Tara Benson 8.3-16

Name of Executive Director and title. Tara BENSON 8-3-16

Tara Benson

Executive Director