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
	HAL092209	A. BUILDING: 01 B. WING _____	08/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF CARY	1206 WEST CHATHAM STREET CARY, NC 27513

(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 a Construction Section Biennial Survey by Suzanna Fay and Ed Miller conducted on August 30, 2018. This facility was first licensed on July 23, 2009 as a Home for the Aged serving 85 residents including a 35 bed Special Care Unit. Therefore the facility must meet the 2006 North Carolina State Building Code(s) for Institutional Occupancy, and, the 2005 Rules for the Licensing of Adult Care Homes of Seven or More Beds. Deficiencies were noted which require a Plan of Corrections.	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		

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C 101	Continued From page 1 1. Observations revealed that the facility did not meet the code requirements in effect a the time of construction. Findings on August 30, 2018: a. Third Floor - the exit door that enters the SCU from the elevator lobby is a delayed egress door. The code requires a sign on the door with instructions to push until alarm sounds and the door will release in 30 seconds.	C 101	See attached	
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 walls were not kept in clean and in good repair. Findings on August 30, 2018: a. Room 313 - there is a small ding behind the door where the door handle hit the wall. There is a small ding in the wall to the right of the door. b. Small Med Room across from Room 314 - the med cart has damaged the back wall along the base. c. SCU Laundry - there is an 8"x15" hole cut out of the wall behind the dryer. d. Third Floor Bathtique - there are mildew stains on the wall above the door and a few mildew	C 164	See attached	

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C 164	Continued From page 2 spots on the supply vent and on the ceiling around the supply vent. 2. Observations revealed that the furnishings were not kept in good repair. Findings on August 30, 2018: a. Third Floor Restroom by Bathtique - the cover plate for the door spring has fallen off and the door is splintered at the edge of the opening. b. Room 202 - the corridor door drags on the frame making it difficult to open. This was repaired on site. c. Room 109 - the door drags on the frame making it difficult to open and close. This was corrected at the time of survey. d. Room 112 - the door is dragging making it hard to close. e. Private Dining - one of the dining table chairs was damaged. This was repaired at the time of survey.	C 164	See attached	
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. Findings on August 30, 2018:	C 166	See attached	

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C 166	Continued From page 3 a. Second Floor - the astragal was bent at the bottom of one of the fire doors by the wellness office posing a possible trip hazard. 2. Based on observation the facility was not maintained free from hazards. Oxygen bottles that are improperly stored may present a danger to the occupants of the facility. Findings on August 30, 2018: a. Room 104 - there were four unsecured oxygen bottles in a wicker basket.	C 166	See attached	
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 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 August 30, 2018: a. SCU Electrical Room, A Side - a blue cable was run between the walls at conduit penetrations. The wall was damaged and the	C 189	See attached	

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C 189	Continued From page 4 caulking was knocked out when the cable was run leaving small gaps in the rated walls. b. SCU Electrical Closet by Baby Room - the fire caulk was removed from a penetration on the corridor wall to run a cable bundle. The penetration was not resealed. c. Third Floor Landing at Stairwell on A side - there are holes in the ceiling where the sprinkler pipe penetrates. d. Electrical Closet across from Room 225 - a small square hole was cut into the corridor wall to run cable. One 2" conduit penetrating the ceiling is not sealed on the back side of the conduit. e. Second Floor, Activity Room Office Closet - the access panel in the ceiling was open. This was corrected at the time of survey. f. First Floor Electrical Closet by Room 101 - there is an open sleeve penetrating the ceiling. g. Main Laundry Room - the flange for the dryer duct is falling off creating a gap in the ceiling. 2. 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 corridor doors must not have holes or gaps in the door nor between the door or the door frame stops. Findings on August 30, 2018: a. Third Floor REM Office - the door to the elevator lobby is a Dutch door with a 1/2" gap between the panels. 3. 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 quickly closed so as to limit the spread	C 189	See attached See attached	

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C 189	Continued From page 5 of smoke and/or fire to the area of origin. Findings on August 30, 2018: a. Second Floor ALC Office - the door was held open using a wedged device. The wedge was removed at the time of survey. b. Second Floor - the door to the Activity Center was held open with a flower vase. The was corrected on site. 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 August 30, 2018: a. Second Floor PT Room - the door hardware was a deadbolt latch and did not latch automatically. b. Room 210 - the corridor door did not latch when closed. This was repaired at the time of survey. c. Copy Room - the door was wedged open and did not close and latch easily. d. Dining Room - the doors separating the lobby from the dining area did not latch automatically and they were held open using kickdowns. 5. Based on observation the facility's fire safety equipment is not maintained in operating condition. Failure to maintain fire safety equipment in operating condition due to sprinkler heads being obstructed could effect occupants in the fire compartment if the sprinkler head could not suppress a fire. Findings on August 30, 2018:	C 189	See attached See attached	

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C 189	Continued From page 6 a. Biohazard Room, Second Floor- there was one cardboard box stored within a few inches of the ceiling. The box was removed at the time of survey. b. Second Floor, Activity Room Office Closet - diapers were stored within 18" of the ceiling. This was corrected at the time of survey. c. Dry Storage - items were stored within 4" of the ceiling. 6. Based on observation 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 August 30, 2018: a. The fire alarm panel was in trouble mode and an alarm was sounding every few minutes. Interview with staff revealed that he believed the battery was depleted in the NAC [Notification Appliance Circuit] Extender. The fire alarm vendor was notified of the problem and were scheduled to come to the facility that day. 7. Observations revealed that the electrical equipment was not maintained in a safe and operating condition. Findings on August 30, 2018: a. Outside Electrical Room - Panel EL-P has an open breaker. b. Room 118 - there were two multi-plug adaptors in use. c. Administrator's Office - there was an extension cord in use.	C 189	 	

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C 195	Continued From page 7	C 195		
C 195	Hot Water System SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). (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 hot water temperature was not maintained between 100 and 116 degrees Fahrenheit in areas used by residents. Findings on August 30, 2018: a. Beauty Shop - the water temperature at the hair washing sink was 135 degrees and there was not a mixing valve for the sink. Interview with staff revealed that the sink must be on the kitchen water heater and that the salon was always supervised. However, the area is in use by residents and the temperature is such that it could cause injury.	C 195		
C 199	Exhaust Ventilation SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS	C 199		

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C 199	Continued From page 8 (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: 1. Observations revealed that the facility does not have working exhaust ventilation in required areas. Findings on August 30, 2018: a. Room 112 Bath - the exhaust fan is not working.	C 199	See attached	

X _____, ED

Sunrise Senior Living
Plan of Correction Template

Name of Community: Sunrise of Cary
Address: 1206 W. Chatham Street
License number: HAL 092209
Inspection date(s): 8-30-18
Name and Title of Sunrise Representative Signing the Plan of Correction: **Jennifer Earp, Executive Director**

Signature of Sunrise Representative:
Date of Submission: **9-21-18**

Regulation	Target Date by Which Correction will be completed	Plan of Correction
C 101 Section.0300 – Physical Plant 10A NCAC 13F. 0301 a. Third Floor – exit door that enters SCU from elevator lobby is a delayed egress door. Code requires a sign on door with instructions to push until alarm sounds and door will release in 30 seconds	9-25-18	**A. With respect to the specific resident/situation cited:** Two signs will be ordered and installed by the Maintenance Coordinator (MC) that will read "Push until alarm sounds. Door will open in 30 seconds".

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
		B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:
	8-31-18	The MC conducted walking rounds of the community to confirm required signs are in place. No issues were identified.
		C. With respect to what systemic measures have been put into place to address the stated concern:
	9/21/18	Maintenance Coordinator or designee will inspect the required signs on a monthly basis for 3 months. Issues identified will be addressed and resolved.
	9/26/18	In order to confirm that the processes outlined above are sustained: The MC will report the results of the sign inspections to the Quality Assurance and Performance Improvement (QAPI) committee for 3 months. The QAPI committee will re-evaluate and initiate necessary action or extend the review period.
		D. With respect to how the plan of correction will be monitored:
	8/31/18	The Executive Director is responsible for confirming the implementation and ongoing compliance with the components of this Plan of Correction and for addressing and resolving variances that may occur

Regulation	Target Date by Which Correction will be completed	Plan of Correction
C 164 Housekeeping and Furnishings – Clean, Repaired Section .0300 – Physical Plant 10A NCAC 13 F .0306 Housekeeping and Furnishings 1: a. Room 313 – there is a small ding behind the door where the door handle hit the wall. There is a small ding in the wall to the right of the door. b. Small Med Room across from Room 314 – med cart has damaged the back wall along the base c. SCU Laundry – there is 8" x 15" hole cut out of the wall behind dryer d. Third Floor Bathtique – mildew stains on wall above the door and a few spots on supply vent and on ceiling around supply vent.	9-25-18 9/25/18 8/31/18	**A. With respect to the specific resident/situation cited:** **(a, b, c)** The holes in the walls are in the process of being be patched and painted by the Maintenance Coordinator. The MC will also conduct refresher training with team members regarding the process for and importance of completing and submitting work orders when repair or sanitation issues are observed. (**d**) Mildew observed in the bathing area was cleaned by the maintenance and housekeeping team.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
	8-31-18	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The MC conducted walking round inspections of the community to check the status of walls and bathing areas. No issues were identified.
	9/21/18 9/26/18	**C. With respect to what systemic measures have been put into place to address the stated concern:** Maintenance Coordinator or designee will inspect walls and bathing areas to confirm the walls and bathing areas are in good repair, are clean, and are free of mildew. The inspections will occur on a monthly basis for 3 months Issues identified will be addressed and resolved. In order to confirm that the processes outlined above are sustained: The MC will report the results of the inspections to the Quality Assurance and Performance Improvement (QAPI) committee for 3 months. The QAPI committee will re-evaluate and initiate necessary action or extend the review period.
	8/31/18	**D. With respect to how the plan of correction will be monitored:** The Executive Director is responsible for confirming the implementation and ongoing compliance with the components of this Plan of Correction and for addressing and resolving variances that may occur.
C164 2a. Third floor restroom by		**A. With respect to the specific resident/situation cited:**

Regulation	Target Date by Which Correction will be completed	Plan of Correction
bathtique – the cover plate for the door spring has fallen off an the door is splintered at the edge of the opening. 2b. Room 202 – corridor door drags on the frame making it difficult to open. This was repaired on site. 2c. Room 109 – door drags on the frame making it difficult to open and close. This was corrected at the time of survey. 2d. Room 112 – the door is dragging making it hard to close. 2e. Private dining – one of the dining table chairs was damaged. This was repaired at the time of survey.	9/30/18 8/30/18 8/30/18 10/14/18 8/30/18	2a – Maintenance Coordinator will order new plate to cover edge of door and will install upon the arrival of the part. 2b – MC repaired the door on room 202 that was dragging on the frame at the time of the survey. 2c – MC repaired the door on room 109 that was dragging on the frame at the time of the survey. 2d – MC will repair or replace the door on room 112. 2e – The damaged dining room chair was repaired during the survey.
		B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:
	8/31/18	The MC conducted walking inspections of check the status of doors. No issues were identified.
		C. With respect to what systemic measures have been put into place to address the stated concern:
	9/21/18	Maintenance Coordinator or designee will inspect doors to confirm they are functional. The inspections will occur on a monthly basis for 3 months Issues identified will be addressed and resolved.
	9/26/18	In order to confirm that the processes outlined above are sustained: The MC will report the results of the inspections

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		to the Quality Assurance and Performance Improvement (QAPI) committee for 3 months. The QAPI committee will re-evaluate and initiate necessary action or extend the review period.
	8/31/18	**D. With respect to how the plan of correction will be monitored:** The Executive Director is responsible for confirming the implementation and ongoing compliance with the
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: 1. Observations revealed that the facility was not maintained free of hazards. a. Second Floor – astragal was bent at the bottom of one of the fire	8/30/18 8/31/18 9/21/18	**A. With respect to the specific resident/situation cited:** Resident Care Coordinator contacted the oxygen company and discussed and confirmed their understanding regarding storage of oxygen requirements. Empty Cylinders were removed on 8/30/18 (from room 104) and racks were delivered to store the active oxygen cylinders on 8/31/18. The MC will repair or replace astragal upon delivery of supplies.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
doors by the wellness office posing a possible trip hazard. 2. Based on observation the facility was not maintained free from hazards. Oxygen bottles that are improperly stored may present a danger to the occupants of the facility. a. Room 104 – there were four unsecured oxygen bottles in wicker basket.		
		B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:
	8/31/18	The MC conducted walking round inspections of the resident rooms where oxygen is in use and the rooms where oxygen is being stored. No issues were identified.
	8/31/18	The MC conducted walking rounds of the other fire doors and there were no issues noted with the astragals.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		C. With respect to what systemic measures have been put into place to address the stated concern:
	9/21/18	Resident Care Director or designee will conduct walking rounds to confirm proper storage of Oxygen on a weekly basis for 3 months. Issues identified will be addressed and resolved.
	9/21/18	The MC will conduct walking rounds on a weekly basis for 3 months to confirm that the bottom of the fire doors, including the astragals, are not presenting a potential trip hazard.
	9/26/18	In order to confirm that the processes outlined above are sustained: The RCD and the MC will report the results of their walking rounds to the Quality Assurance and Performance Improvement (QAPI) committee for 3 months. The QAPI committee will re-evaluate and initiate necessary action or extend the review period.
		D. With respect to how the plan of correction will be monitored:
	8/31/18	The Executive Director is responsible for confirming the implementation and ongoing compliance with the components of this Plan of Correction and for addressing and resolving variances that may occur.
C 189 – Building Equipment Maintained Safe, Operating Section .0300 Physical Plant 10A NCAC 13F .0311 Other Requirements:		**A. With respect to the specific resident/situation cited:**
	10-2-18	(Items 1. a - f) The Maintenance Coordinator is in the process of fire caulking the penetrations.
	10-14-18	(Item 1. g) The Maintenance Coordinator will have flange for the dryer duct repaired or replaced. The vendor has already inspected the work that is required.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
1: a. SCU Electrical Room, a Side – blue cable was run between walls at conduit penetrations. Wall was damaged and caulking was knocked out when the cable was run leaving small gaps in rated walls. b. SCU Electrical Closet by Baby Room – fire caulk was removed from a penetration on the corridor wall to run a cable bundle. The penetration was not resealed. c. Third Floor Landing at Stairwell on A side – there are holes in ceiling where the sprinkler pipe penetrates d. Electrical Closet across from Room 225 – a small square hole	9/21/18	(Item 2a) The Maintenance Coordinator will close gap with weather stripping to seal the gap in the Dutch door

Regulation	Target Date by Which Correction will be completed	Plan of Correction
was cut into the corridor wall to run cable. One 2' conduit penetrating the ceiling is not sealed on the back side of the conduit. e. Second floor, Activity Room Office Closet – the access panel in ceiling was open. This was corrected at time of survey f. First Floor Electrical Closet by room 101 – there is an open sleeve penetrating the ceiling. g. Main Laundry Room 0 the flange for the dryer duct is falling off creating a gap in ceiling 2: a – Third floor REM office – door to elevator lobby is a Dutch door with a ½" gap between panels.		
		B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:

Regulation	Target Date by Which Correction will be completed	Plan of Correction
	8-31-18	The MC conducted walking round inspections to confirm there were no other penetrations or gaps. No issues were identified.
		C. With respect to what systemic measures have been put into place to address the stated concern:
	9/21/18	Maintenance Coordinator or designee will inspect the community to confirm there are no penetrations or gaps on a monthly basis for 3 months and will confer with vendors as they perform work in the community. Issues identified will be addressed and resolved.
	9/26/18	In order to confirm that the processes outlined above are sustained: The MC will report the results of the inspections to the Quality Assurance and Performance Improvement (QAPI) committee for 3 months. The QAPI committee will re-evaluate and initiate necessary action or extend the review period.
		D. With respect to how the plan of correction will be monitored:
	8/31/18	The Executive Director is responsible for confirming the implementation and ongoing compliance with the components of this Plan of Correction and for addressing and resolving variances that may occur
C 189 - 3: Based on observation there is a failure to maintain the building'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		**A. With respect to the specific resident/situation cited:**
	8/3/1/18	a, b – Maintenance Coordinator removed the wedges from the doors. The flower vase was removed on 8/30/18.
	9/25/18	The MC will provide refresher training to team members regarding the importance of not using wedges and door stops and that they are prohibited.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
in the facility could be effect if doors cannot be quickly closed so as to limit the spread of smoke and/or fire to the area of origin. a. Second Floor ALC Office – the door was held open using a wedged device. The wedge was removed at the time of survey. b. Second Floor – door the activity center was held open with a flower vase. This was corrected on site.		
	8-31-18	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The MC conducted walking round inspections of the corridor doors to confirm wedges were not being utilized. No issues were identified.
	9/21/18 9/26/18	**C. With respect to what systemic measures have been put into place to address the stated concern:** Maintenance Coordinator or designee will inspect doors to confirm that no wedges or door stops are being used on corridor doors - on a monthly basis for 3 months. Issues identified will be addressed and resolved. In order to confirm that the processes outlined above are sustained: The MC will report the results of the inspections

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		to the Quality Assurance and Performance Improvement (QAPI) committee for 3 months. The QAPI committee will re-evaluate and initiate necessary action or extend the review period.
	8/31/18	**D. With respect to how the plan of correction will be monitored:** The Executive Director is responsible for confirming the implementation and ongoing compliance with the components of this Plan of Correction and for addressing and resolving variances that may occur
C 189 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. a. Second Floor PT Room 0 door hardware was a deadbolt latch and did not latch automatically. b. Room 210 – the corridor door did not latch when closed. This was repaired	10-14-18 8-30-18 9-10-18 10-14-18	**A. With respect to the specific resident/situation cited:** (A) Maintenance Coordinator will change door knob to a knob that latches automatically, once the part is received. (B) Maintenance Coordinated corrected the door latch at the time the of survey (C) Maintenance Coordinator removed the wedge and repaired the door to confirm it was closing and latching properly. (D) Maintenance Coordinator will remove the kick downs from the dining rooms.

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at the time of survey. c. Copy Room – door was wedged open and did not close and latch easily. d. Dining Room – doors separating the lobby from the dining area did not latch automatically and they were held open using kick downs.		
	8-31-18	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The MC conducted walking round inspections of the other doors to confirm they are closing and latching correctly and that no wedges and/or kick down door stops were being used. No issues were identified.
	9/21/18	**C. With respect to what systemic measures have been put into place to address the stated concern:** Maintenance Coordinator or designee will inspect the doors to confirm they are latching and closing correctly, and no wedges or kick downs are being used - on a monthly basis

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		for 3 months. Issues identified will be addressed and resolved. In order to confirm that the processes outlined above are sustained: The MC will report the results of the inspections to the Quality Assurance and Performance Improvement (QAPI) committee for 3 months. The QAPI committee will re-evaluate and initiate necessary action or extend the review period.
	9/26/18 8/31/18	**D. With respect to how the plan of correction will be monitored:** The Executive Director is responsible for confirming the implementation and ongoing compliance with the components of this Plan of Correction and for addressing and resolving variances that may occur
C189 – 5. Based on observation the facility's fire safety equipment is not maintained in operating condition. Failure to maintain fire safety equipment in operating condition due to sprinkler heads being obstructed could affect occupants I the fire compartment if the sprinkler head could not suppress a fire. a. Biohazard Room, Second Floor – there was one cardboard box stored within a few inches of the ceiling. **The box was removed at the time of survey.**	8/30/18 9/19 and 9/25/18	**A. With respect to the specific resident/situation cited:** Items a-c - Maintenance Coordinator removed items less than 18" from ceilings in community rooms The MC will conduct refresher training with the management team and front line team members regarding the requirement that storage must be greater than 18" from the ceilings.

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b. Second Floor, Activity Room Office Closet – diapers were stored within 18" of the ceiling. **This was corrected at the time of survey.** c. Dry Storage – items were stored within 4" of the ceiling.		
	8-31-18	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The MC conducted walking round inspections of the storage areas to confirm compliance with 18 inch requirement No issues were identified.
	9/21/18 9/26/18	**C. With respect to what systemic measures have been put into place to address the stated concern:** Maintenance Coordinator or designee will inspect storage areas to confirm compliance with the 18" requirement - on a monthly basis for 3 months. Issues identified will be addressed and resolved. In order to confirm that the processes outlined above are sustained: The MC will report the results of the storage inspections to the Quality Assurance and Performance Improvement (QAPI) committee for 3 months. The QAPI committee will re-evaluate and initiate necessary action or extend the review period.
	8/31/18	**D. With respect to how the plan of correction will be monitored:** The Executive Director is responsible for confirming the implementation and ongoing compliance with the

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		components of this Plan of Correction and for addressing and resolving variances that may occur
C 189 - 6. Based on observation there is a 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. 6a .The fire alarm panel was in trouble mode and an alarm was sounding every few minutes. Interview with staff revealed that he believed the battery was depleted in the NAC Extender. The fire alarm vendor was notified of the problem and were scheduled to come to the facility that day.	8-31-18	**A. With respect to the specific resident/situation cited:** Maintenance Coordinator arranged for the fire alarm vendor to repair the system on 8/31/18. The repair was successful.
	8-31-18	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The MC conducted walking round inspections of the fire panels with the fire alarm vendor. No issues were identified.

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		C. With respect to what systemic measures have been put into place to address the stated concern:
	9/21/18	Maintenance Coordinator or designee will inspect the fire panels to confirm they are functioning appropriately on a monthly basis for 3 months. Issues identified will be addressed and resolved.
	9/26/18	In order to confirm that the processes outlined above are sustained: The MC will report the results of the fire panel inspections to the Quality Assurance and Performance Improvement (QAPI) committee for 3 months. The QAPI committee will re-evaluate and initiate necessary action or extend the review period.
	8-31-18	**D. With respect to how the plan of correction will be monitored:** The Executive Director is responsible for confirming the implementation and ongoing compliance with the components of this Plan of Correction and for addressing and resolving variances that may occur
C 189 - 7. Observations revealed that the electrical equipment was not maintained in a safe and operating condition. a. Outside electrical Room – Panel EL-P has an open breaker. b. Room 118 – there were two multi-plug adaptors in use c. Administrator's office – there was an extension cord in use.	9/27/18 8-31-18 8-31-18	**A. With respect to the specific resident/situation cited:** a – Maintenance Coordinator will have a breaker or blank plate installed. b – Maintenance Coordinator removed the multi-plug adaptors c – The Administrator removed the extension cord
		B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:

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	8-31-18	The MC conducted walking round inspections of the other areas with electrical equipment and the administrative offices. No issues were identified.
	9/21/18 9/26/18	**C. With respect to what systemic measures have been put into place to address the stated concern:** Maintenance Coordinator or designee will inspect electrical areas and offices to confirm compliance with electrical requirements - on a monthly basis for 3 months. Issues identified will be addressed and resolved. In order to confirm that the processes outlined above are sustained: The MC will report the results of the electrical inspections to the Quality Assurance and Performance Improvement (QAPI) committee for 3 months. The QAPI committee will re-evaluate and initiate necessary action or extend the review period.
	8/3/18	**D. With respect to how the plan of correction will be monitored:** The Executive Director is responsible for confirming the implementation and ongoing compliance with the components of this Plan of Correction and for addressing and resolving variances that may occur
Section .0300 – Physical Plant 10A NCAC 13F. 0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100	9/19/18	**A. With respect to the specific resident/situation cited:** MC installed the new dedicated mixing valve in the beauty salon on 9/19/18 to regulate temperature between 100-116 degrees.

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degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). 1. Observations revealed that the hot water temperature was not maintained between 100-116 degrees F in areas used by residents. a. Beauty Shop – the water temp at the hair washing sink was 135 degrees and there was not a mixing valve for the sink. Interview with staff revealed that the sink must be on the kitchen water heater and that the salon was always supervised. However the area is in use by residents and the temperature is such that if could cause injury.		
	8-31-18	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The MC conducted walking round inspections of common areas and resident plumbing fixtures to confirm that temperatures remained in the required range. No issues were identified.
	8/31/18	**C. With respect to what systemic measures have been put into place to address the stated concern:** Maintenance Coordinator or designee will continue to inspect the water temperatures and confirm proper

Regulation	Target Date by Which Correction will be completed	Plan of Correction
	9/26/18	temperatures on a daily basis for 3 months, including the beauty salon. Issues identified will be addressed and resolved. In order to confirm that the processes outlined above are sustained: The MC will report the results of the water temperatures to the Quality Assurance and Performance Improvement (QAPI) committee for 3 months. The QAPI committee will re-evaluate and initiate necessary action or extend the review period.
	8/31/18	**D. With respect to how the plan of correction will be monitored:** The Executive Director is responsible for confirming the implementation and ongoing compliance with the components of this Plan of Correction and for addressing and resolving variances that may occur
Section .0300 – Physical Plant 10A NCAC 13 F 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. 1. Soiled linen storage 2. Soil Utility room 3. Bathrooms and toilet rooms 4. Housekeeping closets 5. Laundry areas Observations revealed that the facility does not have working exhaust	10-14-18	**A. With respect to the specific resident/situation cited:** Maintenance Coordinator is scheduling the HVAC vendor to repair the exhaust fan, pending receipt of required parts.

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ventilation in required areas: 1. Room 112 Bath – exhaust fan is not working		
	8-31-18	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The MC conducted walking round inspections of the spaces requiring exhaust ventilation No issues were identified.
	9/21/18 9/26/18	**C. With respect to what systemic measures have been put into place to address the stated concern:** Maintenance Coordinator or designee will inspect the spaces and areas requiring exhaust ventilation on a monthly basis for 3 months. Issues identified will be addressed and resolved. In order to confirm that the processes outlined above are sustained: The MC will report the results of the ventilation inspections to the Quality Assurance and Performance Improvement (QAPI) committee for 3 months. The QAPI committee will re-evaluate and initiate necessary action or extend the review period.
	8/3/18	**D. With respect to how the plan of correction will be monitored:** The Executive Director is responsible for confirming the implementation and ongoing compliance with the components of this Plan of Correction and for addressing and resolving variances that may occur