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 _____	R 09/07/2018

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 Biennial Follow Up Construction Survey by Dennis Harrell on 9-7-2018. Some deficiencies were not corrected. Further action is required.	{C 000}		
{C 101}	Existing Licensed Fac- No less than '71 Rules SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0301 APPLICATION OF PHYSICAL PLANT REQUIREMENTS The physical plant requirements for each adult care home shall be applied as follows: (2) Except where otherwise specified, existing licensed facilities or portions of existing licensed facilities shall meet licensure and code requirements in effect at the time of construction, change in service or bed count, addition, renovation, or alteration; however in no case shall the requirements for any licensed facility where no addition or renovation has been made, be less than those requirements found in the 1971 "Minimum and Desired Standards and Regulations" for "Homes for the Aged and Infirm", copies of which are available at the Division of Health Service Regulation at no cost; This Rule is not met as evidenced by: 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	{C 101}		

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

Amy Blalock Executive Director 10/22/18

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{C 101}	Continued From page 1 are not permitted. Finding on 9-7-2018; The facility had installed fire dampers in the openings. Fire dampers are not capable of resisting the passage the smoke. Findings on June 21, 2018: 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. Finding on 9-7-2018; Some staff interviewed did not know the code to open the lockbox and did not know the purpose of the lockbox.	{C 101}		
{C 150}	Corridors-Free of equipment and Obstructions SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0305 PHYSICAL ENVIRONMENT (g) The requirements for corridors are: (4) Corridors shall be free of all equipment and other obstructions. This Rule is not met as evidenced by: 1. Observations revealed that the corridors were not free of all equipment and other obstructions. At least 6 feet of clear space shall be maintained at all times. Findings on June 21, 2018: a. The exit corridor by Maintenance had a large ride-on vacuum cleaner stored in it. b. The service corridor had many things stored in it reducing the clear width down to 3 feet 3 inches.	{C 150}		
{C 189}	Building Equipment Maintained Safe, Operating	{C 189}		

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{C 189}	Continued From page 2 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: 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 9-7- 2018: e. Janitor Closet (Second Floor) - the seal around one of the HVAC ducts has come loose leaving a small hole in the ceiling. l. Large Maintenance Storage - there is a 6" x 12" hole in the wall at the back corner of the room. New finding on 9-7-2018: The bottom 6 inches had been removed from all the walls on the lower floor at the right end on the facility due to a recent roof drain leak. 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.	{C 189}		

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{C 189}	Continued From page 3 Findings on 9-7- 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. 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 9-7- 2018: a. Third Floor, right door of fire doors by Room 310 did not latch when released by the fire alarm.	{C 189}		

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): September 7, 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: 10/22/18

Regulation	Target Date by Which Correction will be completed	Plan of Correction
C101 Section .0300 Physical Plant 10A NCC 13F .0301 (2) 1(a) Residential Laundry (2nd & 3rd Floors) – thru-wall exhaust vents were installed in the corridor walls. Building Code requires corridors to resist the passage of smoke. 1(d) AL Courtyard by dining – the key for the manual override at the locked gate is maintained in a lockbox at the gate. Two or two staff knew the code to open the lockbox. Some staff interviewed did not know the code to open the lockbox or the purpose of the lockbox.	10/09/2018 10/15/2018 09/08/2018 09/07/2018	**1. Corrective Action for the Affected Residents/Specific Situation cited:** 1 (a) Maintenance Coordinator removed the fire dampers and repaired the walls utilizing sheetrock, which resists the passage of smoke. 1 (d) Maintenance Coordinator made additional keys and provided a key to individual team members responsible for evacuation to carry with them when they are on duty. The Maintenance Coordinator provided training to team members on the proper use of the manual key override switch. **2. Corrective Action for Other Residents/Specific Situation cited:** 1 (a) (d): No additional area identified specific to the situation cited observed upon completion of a building walk through. **3. Systemic Correction to Prevent Recurrence:** The Maintenance Coordinator or designee will provide initial training to new team members upon hire on the operation of the manual override switch located in the Assisted Living Courtyard, including the purpose of the lockbox and the code. The Maintenance Coordinator or designee will routinely walk the building weekly for 3 months to confirm key code compliance and resolve issues that may be identified. In additional, the Executive Director will conduct joint rounds with the Maintenance Coordinator on a periodic basis to confirm key code understanding and compliance. **4. Monitoring Plan:** The Executive Director or designee is responsible for confirming implementation and ongoing compliance with the components of this plan of correction, and addressing and resolving variances that may occur. The Executive Director is responsible for confirming the status of this Plan of Correction is reviewed and discussed at Quality Assurance

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
		Performance Improvement (QAPI) Meetings. This Plan of Correction will be reviewed for 3 months during the (QAPI) meeting. During and at the conclusion of the three months, the QAPI committee will re-evaluate and initiate necessary action or extend the review period.
C 150 Section .0300 Physical Plant 10A NCAC 13F .0305 Physical Environment 1(a) The exit corridor by Maintenance had a large ride-on vacuum cleaner stored in it. 1(b) The service corridor had many things stored in it reducing the clear width down to 3 feet 3 inches.	09/07/2018 09/09/2018 09/08/2018	**1. Corrective Action for the Affected Residents/Situation Cited:** 1(a) The Maintenance Coordinator removed the large ride-on vacuum cleaner from the hallway. 1(b) The Maintenance Coordinator and Maintenance Assistant cleared the items stored in the service corridor. **2. Corrective Action for Other Residents/Situation Cited:** Maintenance Coordinator completed a walkthrough of exit corridors to confirm corridors were free from obstructions. No issues identified. **3. Systemic Correction to Prevent Recurrence:** Maintenance Coordinator will walk the building weekly for 3 months to confirm that corridors are free of equipment and obstructions. In addition, the Executive Director will conduct joint rounds with the Maintenance Coordinator on a periodic basis to confirm corridor compliance. **4. Monitoring Plan:** The Executive Director or designee is responsible for confirming implementation and ongoing compliance with the components of this plan of correction, and addressing and resolving variances that may occur. The Executive Director is responsible for confirming the status of this Plan of Correction is reviewed and discussed at Quality Assurance Performance Improvement (QAPI) Meetings. This Plan of Correction will be reviewed for 3 months during the (QAPI) meeting. During and at the conclusion of the three months, the QAPI committee will re-evaluate and initiate necessary action or extend the review period.
C 189 Section 0300 – Physical Plant 10A NCAC 13 F .0301 Other Requirements (a)(k) 2 (e) Janitor Closet (2nd Floor) – the seal around one of the HVAC ducts has come loose leaving a small hole in the ceiling.	09/07/2018 09/08/2018 10/07/2018 10/15/2018 10/15/2018	**1. Corrective Action for the Affected Residents/Specific Situation:** 2(e) The seal around the HVAC duct in the janitor closet on the second floor was caulked properly by the Maintenance Coordinator 2(i) The Maintenance Coordinator repaired the hole in the wall in the large storage room. An outside contractor repaired the wall damage on the first floor lower walls and new baseboards were installed. 7(a) Outside contractor, Simplex, applied magnets to the bistro doors allowing the doors to operate as intended. 7(b) Outside contractor, Simplex, applied appropriate devices to the

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Regulation	Target Date by Which Correction will be completed	Plan of Correction
2(i) Large Maintenance Storage – here is a 6 x 12 hole in the wall at the back corner of the room. New finding: the bottom 6 inches had been removed from the walls on the lower floor at the right end on the facility due to a recent roof drain leak. 7(a) Bistro doors propped open using 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 were no longer operational. 7(b) The kitchen door was being held open with a kick down device attached to the door. 9(a) Third floor, right door of the fire doors by Room 310 did not latch when released by the fire alarm.	09/07/2018 09/08/2017	kitchen doors and kick down devices were removed. 9(a) Maintenance Coordinator realigned fire doors on the third floor, and confirmed both doors latched properly. **2. Corrective Action for Other Residents/Specific Situation:** Maintenance Coordinator completed a walkthrough of the grounds/building and necessary action taken to confirm compliance with fire resistant ceilings and walls and appropriate door devices, including magnetic devices. **3. Systemic Correction to Prevent Recurrence:** The Maintenance Coordinator will conduct walking rounds of the community weekly for 3 months to confirm compliance with fire resistant ceilings and walls and appropriate door devices. In addition, the Executive Director, maintenance coordinator and Leadership team will routinely complete community walkthroughs to confirm compliance. Maintenance Coordinator and/or designee will confirm doors and their magnetic devices close and latch appropriately during fire drills. **4. Monitoring Plan:** The Executive Director or designee is responsible for confirming implementation and ongoing compliance with the components of this plan of correction, and addressing and resolving variances that may occur. The Executive Director is responsible for confirming the status of this Plan of Correction is reviewed and discussed at Quality Assurance Performance Improvement (QAPI) Meetings. This Plan of Correction will be reviewed for 3 months during the (QAPI) meeting. During and at the conclusion of the three months, the QAPI committee will re-evaluate and initiate necessary action or extend the review period.

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