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
	HAL011338	A. BUILDING: 01 B. WING _____	11/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TERRACE OF ASHEVILLE	3199 SWEETEN CREEK ROAD ASHEVILLE, NC 28803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments Report of Construction Section Biennial Survey by Dennis Harrell on 2-16-2017. Records indicate this facility was first licensed on 7-22-1997, for 70 residents. Based on this information we are requiring the facility to meet the 1996 "Homes for the Aged and Disabled - Minimum Standards and Regulations", the 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.	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: Based on observation and interview some staff were not aware of the location or the use, or even the existence of the required central emergency	C 101 C 101	11/29/18 meeting for employees to discuss the existence and location of the required central emergency release switch for the Special (magnetic) locking on all exit doors. Meeting also held with dept heads. Ongoing daily training of this and during orientation with new staff	11/28/18 11/29/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011338	A. BUILDING: 01 B. WING _____	11/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TERRACE OF ASHEVILLE	3199 SWEETEN CREEK ROAD ASHEVILLE, NC 28803

(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 101	Continued From page 1 release switch for the Special (magnetic) Locking on all the exit doors. All staff responsible for evacuation in an emergency must be properly trained in evacuation procedures and equipment.	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: 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 on 11-28-2018: a. There were 3 chairs stored in the exit corridor by the maintenance room reducing the clear width to 2.5 feet. b. There was a table/desk in the corridor near room 220 obstructing the access to the stairway door to 3.5 feet. c. There were 2 wheel chairs and a med cart stored in the corridor near room 101 reducing the clear width to 3.75 feet.	C 150	A Chairs were removed B.Desk moved C.wheel chairs moved , discussed with staff having Correct clearance around med cart.	11/29/18 12/20/18 11/29/18
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	C 166		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011338	A. BUILDING: 01 B. WING _____	11/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TERRACE OF ASHEVILLE	3199 SWEETEN CREEK ROAD ASHEVILLE, NC 28803

(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 166	Continued From page 2 facilities. This Rule is not met as evidenced by: 1. Based on observation, exterior exit paths were not maintained uncluttered and free of obstructions. Findings on 11-28-2018; a. The exterior exit path from the Evergreen Hall near room 6 was completely blocked with items that had been removed the day before from an adjacent exterior storage room. b. The exterior exit path from the stairway exit beside the Evergreen Hall exit near room 6 was completely blocked with items that had been removed the day before from an adjacent exterior storage room. 2. Based on observation, there was no documentation of the required in house/owner's monthly inspections for the fire extinguishers since June. Fire extinguishers must be inspected monthly and the inspections must be documented somewhere such as on the tag provided on the extinguisher. 3. Based on observation, the facility was not maintained free of hazard because of damaged or missing fire extinguishers. Fire extinguishers must be inspected monthly and if not in proper working condition they must be repaired or replaced. Findings on 11-28-2018; a. The fire extinguisher in the Dining room was low in pressure. b. The fire extinguisher was missing in the elevator room. 4. Based on observation, there was no documentation of monthly inspections provided	C 166	Exterior paths were cleared that afternoon by maintenance director. We had pulled out our Christmas decorations that day out of storage. Path s cleared that afternoon as requested. Above is the correction for 1.A and 1.B 2.Fire extinguishers have been ckd and documented on individual tags. inspections will continue on a monthly basis. 3.Monthly inspections now in place. And monthly checks documented on tag. 3.A. Fire extinguisher in dining room has been recharged. 3.B. Fire Extinguisher has been recharged and placed in elevator room 4. Monthly documentation will be provided	11/28/18 12/5/18 12/5/18 12/5/18 12/5/18 12/5/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011338	A. BUILDING: 01 B. WING	11/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TERRACE OF ASHEVILLE	3199 SWEETEN CREEK ROAD ASHEVILLE, NC 28803

(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 166	Continued From page 3 on the range hood fire suppression system inspection tag since June. 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. 5. Based on observation, the cooking equipment associated with the range hood fire suppression system was not properly positioned and maintained free of hazards. With cooking equipment miss-positioned, the range hood fire suppression system may not be capable of suppressing a range fire as designed. Finding on 11-28-2018; The system nozzle for the deep fryer was pointed to the left of the fryer. 6. Based on observation, the facility was not maintained in a safe condition because of improper storage too close to a fire sprinkler head. Storage that is not kept at least 18 inches below the sprinkler head could negate the ability of the fire sprinkler system to extinguish a fire. Findings on 11-28-2018; a. Items had been stacked to within 5 inches of the ceiling in the key room. b. Shelves had been built within 10 inches of the ceiling in the key room. 7. Based on observation, an electrical plate was missing exposing energized wires. Exposed wiring could be a hazard to the residents and staff. Findings on 11-28-2018; A junction box cover was missing on a ground mounted junction box in the courtyard.	C 166	Monthly checks now in place documentation available from maintenance director 5.The nozzle has been properly adjusted. 6.Shelf has been removed 7. Plate has been replaced and secured	12/5/18 12/6/18 12/6/18 12/6/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011338	A. BUILDING: 01 B. WING _____	11/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TERRACE OF ASHEVILLE	3199 SWEETEN CREEK ROAD ASHEVILLE, NC 28803

(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 185	Continued From page 4	C 185		
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 a review of documents, many of the records available onsite included little to no description of what the rehearsal involved.	C 185	Future fire inspections will document what the rehearsal involved in more detail.	12/20/18
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 warning devices,	C 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011338	A. BUILDING: 01 B. WING _____	11/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TERRACE OF ASHEVILLE	3199 SWEETEN CREEK ROAD ASHEVILLE, NC 28803

(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 189	Continued From page 5 "screamers," protecting the emergency release switches were not working at many locations throughout the facility. Malfunctioning warning devices could allow resident elopement. 2. Based on observation, 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 on 11-28-2018; a. The fire rated door to the main laundry could not close and latch because it was blocked by a new washing machine. b. The fire rated door to the main laundry was also blocked from closing by a fan. c. The door to the maintenance room was tied open. d. The door to the mechanical room on the 2nd floor does not fit the opening properly on the side to be resistant to the passage of smoke. e. The door to room 106 will not latch when closed. f. The door to the Special Care Dining room was blocked open. Note; This deficiency was corrected during the survey. g. There were several coats hanging on the door to the Evergreen Wellness Center blocking it from being able to close and latch. Note; This deficiency was corrected during the survey. 3. Based on observation, the required one-hour fire rated walls and/or ceilings were compromised in locations. Holes and penetrations that are not sealed with materials approved for use in one-hour fire rated construction present the possibility that a fire that begins in one space can quickly spread to other areas of the facility.	C 189	All screamers have new 9 volt batteries A. Called Haynes Plumbing Scheduled to be moved 12/24/18 B. Fan has been removed C. Tie on maintenance door removed D. Door to mechanical room adjusted E. Door to 106 has been fixed F. Door stop was removed G. Coats removed and coat rack installed on wall 3. All locations have been caulked with fire rated caulking	12/14/18 12/24/18 12/17/18 12/17/18 12/17/18 1217/18 12/17/18 12/17/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011338	A. BUILDING: 01 B. WING _____	11/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TERRACE OF ASHEVILLE	3199 SWEETEN CREEK ROAD ASHEVILLE, NC 28803

(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 189	Continued From page 6 Findings on 11-28-2018: a. Two unsealed sleeves through the ceiling of the main electrical room, b. Holes at conduits through the ceiling of the main electrical room.	C 189	All areas were sealed with fire block caulking	12/17/18
C 191	Unvented & Portable Elec. Heaters Prohibited SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (b) There shall be a heating system sufficient to maintain 75 degrees F (24 degrees C) under winter design conditions. In addition, the following shall apply to heaters and cooking appliances. (2) Unvented fuel burning room heaters and portable electric heaters are prohibited. (k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities. This Rule is not met as evidenced by: Based on observation the facility failed to adhere to the prohibition of portable electric heaters. Portable electric heaters are a potential fire hazard and as such could affect all occupants of the facility. Finding on 11-28-2018: There were several portable electric heaters found in the exterior storage room near the exit from Evergreen Hall.	C 191	All portable electric heaters have been removed from premise	12/19/18