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
	HAL023042	A. BUILDING: 01 B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT PLACE OF KINGS MOUNTAIN	1001 PHIFER ROAD KINGS MOUNTAIN, NC 28086

(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 and Ed Miller on 9-18-2019. Records indicate this facility was first licensed on 2-4-1998, for 65 residents. There was an addition of the 100 Hall in 2006 but the capacity remained the same. 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 of Seven or More Beds, the 1996 w/ ' 97 rev Edition of the North Carolina State Building Code; Institutional Occupancy - Group I(U), and the 2002 Edition of the North Carolina State Building Code; Institutional Occupancy, - Group I-2. Defiecienciea were cited which require a plan of correction.	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	C 101		

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C 101	Continued From page 1 Health Service Regulation at no cost; This Rule is not met as evidenced by: 1. Based on observation, the facility failed to meet the NC State Building Code in effect at the time of construction by not having all of the required components for doors with Special Locking System. The required emergency release switch at each locked exit must be an on-off type switch. This could affect all occupants who would need to evacuate through the door(s) if the exit were obstructed. Finding on 9-18-2019; The gate in the courtyard in Special Care is a required exit. The emergency release switch at the gate is a momentary push button switch that unlocks only while the button is pushed. 2. Based on observation, the facility failed to meet the NC State Building Code in effect at the time of construction by not having all of the required components for doors with Special Locking System. This could affect all occupants who would need to evacuate through the door(s) if the exit were obstructed. Findings on 9-18-2019: There was no wiring diagram or systems components location map posted under glass at the fire alarm panel.	C 101	1. Parts have been ordered to switch to an on-off switch. Will be completed by 10/25/19. 2. Completed 10/4/19. Wiring diagram has been placed by the main fire alarm panel. (See attached Diagram A)	
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;	C 164		

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C 164	Continued From page 2 (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: Based on observation, the building mechanical systems are not kept clean and in good repair. Finding on 9-18-2019: The HVAC exhaust grill and radiation damper in the beauty parlor had an excessive accumulation of dust/lint.	C 164	Completed on 10/2/19. HVAC exhaust grill and radiation damper in beauty parlor were cleaned. (See attached Photo B)	
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. Based on observation, the building was not maintained in a safe manner by not properly handling portable medical oxygen cylinders. This could affect all residents, staff and visitors if cylinders fall, breaking their valves, propelling the cylinder and turning it into a dangerous projectile. Findings on 9-18-2019 a. Several (3 large and 2 small) portable medical oxygen cylinders were stored in no container or rack and 9 small portable medical oxygen cylinders were stored in a cardboard box in the	C 166	1. Completed 10/26/19. All oxygen cylinders are now maintained in steel racks/containers. All cardboard and plastic milk crates have been removed. (See attached Photo C)	

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C 166	Continued From page 3 oxygen room on 200 Wing. b, Several (6) portable medical oxygen cylinders were stored in no container or rack and 5 were stored in an unapproved plastic crate and 1 freestanding on a table in room 206. 2. Based on observation, a cleanout plug was missing on a 3 inch cleanout in the driveway toward the parking area. The missing cleanout plug presented a trip and fall hazard. 3. Based on observation, there were wrinkles in the carpet in the corridor in BTR. The wrinkles presented a trip and fall hazard. 4. Based on observation, there were sand bags and a 4 inch drain pipe in the walkway from the exit door near the Marketing Director's office. The bags and pipe present a trip and fall hazard. 5. Based on observation, an electrical outlet cover was broken in the 200 Wing main bathroom. The broken cover could expose energized wires and parts. 6. Based on observation, an outside corner wall tile was broken in the 200 Wing main bathroom. The broken tile presents a laceration hazard. 7. Based on observation a toilet was loosely mounted to the floor. Loose toilets can cause leaking and/or fall hazards. Finding on 9-18-2019: The toilet was loose in the bathroom off the Resident Care Director's office. 8. Based on observation, an electrical outlet expander was in use in room 221. Electrical outlet expanders are not approved for use in Institutional Occupancies.	C 166	2. Completed 9/26/19; Installed 3 inch plug in clean out in driveway. (See attached Photo D) 3. Received quote and approval to replace flooring in BTR. Flooring will be replaced by 11/1/19. 4. Completed 9/24/19. Sandbags were removed and drain pipe was moved 4 inches from door to clear exit. (See attached Photos E and F) 5. Completed 10/2/19. Replaced with new cover. (See attached Photo G) 6. Completed 10/2/19. Replaced with new tile. (See attached Photo H) 7. Currently working to mount toilet to floor. Will be completed by 10/11/19. 8. Completed 10/2/19. Removed expander and placed surge protector. (See attached Photos I and J)	

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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: 1. Based on interview with staff, the fire alarm system has not worked for 3 weeks. Staff have been conducting a fire watch since then. However, further interview revealed the fire watch staff do fire watch for 10 to 15 minutes and then do other duties for 15 to 20 minutes, and then repeat. This method of fire watch did not appear to meet the provisions of the Fire Prevention Code. The local Fire Prevention Code Enforcement Official was notified and he visited the facility and instructed them on how the fire watch must be done. 2. 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 on 9-18-2019: a. In the 2nd quarter of this year, there was no rehearsal done during the 2nd shift.	C 185	1. Completed 9/19/19. Retrained staffs on proper fire watch protocol. Also, designated one person to perform the fire walks only without any other duties. 2. a. June 2019 2nd shift fire drill was conducted late on July 2, 2019. Another drill was also done in July for another shift. (See attached Exhibit A b. There was a fire drill done in the 4th quarter of last year. (See attached Exhibit B)	

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C 185	Continued From page 5 b. In the 4th quarter of last year, there was no rehearsal done during the 2nd shift. 3. Based on a review of documents, the records available onsite included no description of what the rehearsal involved.	C 185	3. Starting October 2019 and all on going months, we will give detailed description of what the fire drills involve. Maintenance Director has now been educated on this.	
C 189	Building Equipment Maintained Safe, Operating SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. (k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities. This Rule is not met as evidenced by: 1. Based on observation and interview with staff, the fire alarm system had been struck by lightning 3 weeks ago and had not worked since. The facility staff are conducting a fire watch. 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 on 9-18-2019; a. One of the smoke barrier doors near the Marketing office was wedged open. Note; This deficiency was corrected during the survey. b. There was a mail slot opening in the door to	C 189	1. Fire panel was completely fixed and back working properly on 9/26/19, and fire walks are no longer being conducted. (See attached Photo K) 2. a. Corrected during survey. Will assure that smoke barrier doors are never to be wedged open. b. White seal barrier was placed over slot opening on Business office door. (See attached Photo L)	

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C 189	Continued From page 6 the Business office. The mail slot makes the door unable to resist the passage of smoke. c. The door to the copy room was propped open with a trash can. d. The door to the Marketing Director's office does not fit the opening properly to be resistant to the passage of smoke. e. The door to room 224 does not fit the opening properly to be resistant to the passage of smoke. f. The door to room 209 does not latch when closed. g. The door to room 215 does not latch when closed. h. The door to room 320 does not latch when closed. i. The door to room 324 does not latch when closed. j. The door to beauty parlor was wedged open. k. There was a hole at the latchset through the door to the storage room in BTR. l. There was a wedge found at the door to med room indicating it is sometimes wedged open. m. There was a wedge found at the door to the Resident Care Director's office indicating it is sometimes wedged open. 3. 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 on 9-18-2019; a. Unsealed 2 inch sleeve in the attic smoke barrier wall near private dining, b. Sleeve (4 inch) in the attic smoke barrier wall near private dining sealed with only gypsum compound. c. Unsealed ceiling penetration in soiled linen on	C 189	c. Completed 9/25/19. Installed flip stop on bottom of door. (See attached Photo M) d. and e. Completed 9/27/19. Adjusted doors and installed trim pieces. f. to i. Completed 9/26/19 Fixed/adjusted latches on doors. j. Completed 10/4/19. Installed flip stop at bottom of door. (See attached Photo N) k. Completed 9/25/19. Filled hole in door. l. Completed 9/18/19. Removed wedge. Educated staff on 9/25/19 meeting that medroom door is never to be propped open. m. Completed 9/18/19. Removed wedge and installed flip stop. 3. a. and b. Completed 9/24/19. Filled in 2 inch and 4 inch sleeves with file protectant. (See attached Photo O) c. Completed 9/24/19. Sealed with fire preventive caulk. (See attached Photo P)	

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C 189	Continued From page 7 200 Wing, d. Unsealed ceiling penetration in the breakroom on 200 Wing, e. Hole in the ceiling at the exit sign near room 206, f. Hole in the ceiling at the exit sign near room 213, g. Hole in the ceiling at the exit sign near room 306, h. Hole in the ceiling at the exit sign near room 312, i. Unsealed ceiling penetration in the 300 charting room. j. Unsealed ceiling penetrations (2) in the riser room off the service corridor. k. Hole at the emergency light in the Resident Care Director's office. 4. Based on observation the required one-hour fire rated ceilings were compromised in several locations by improperly fitting or missing sprinkler escutcheons. Improperly fitted sprinkler escutcheons present the possibility that a fire that begins in one space can quickly spread to the attic and could delay activation of the sprinkler system. Improperly fitted sprinkler escutcheons found: a. Corridor at room 220, b. Closet off room 206, c. Kitchen, d. Dining room, e. Enrichment Center (2), f. Maintenance closet, g, Corridor at room 304, h. Corridor at room 318, i. Corridor at room 323, j. Room 309, k. Canwash. 5. Based on observation, the battery powered	C 189	3. d., i., and j. Will complete by 10/18/19 by sealing penetrations with fire preventive caulk. e. to h. and k. Will complete by 10/18/19 by filling holes and then painting. 4. Completed 10/9/19. All Sprinklers were adjusted and tightened. Maintenance Director will be looking at this more throughout the building to assure the sprinklers stay fitting properly. (See attached Photos Q) 5. Batteries have been ordered. Will be completed by 10/18/19 by replacing batteries.	

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C 189	Continued From page 8 emergency light in the Resident Care Director's office would not work when tested. Battery powered emergency lights that will not work properly for at least 90 minutes could endanger the residents and staff. 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. Finding on 9-18-2019; a. Items had been stacked to within 6 inches of the ceiling in the kitchen storage room. b. Items had been stacked to within 6 inches of the ceiling in the Activity storage room. 7. Based on observation, the warning device, "screamer," protecting the emergency release switch at the exit gate from the courtyard would not work. Malfunctioning warning devices could allow resident elopement.	C 189	6. a. Completed 10/3/19. All items were removed. Dietary Manager will assure that items remain stored properly. (See attached Photos R) b. Completed 10/10/19. All items were removed. Activity Director will assure that all items remain stored properly. (See attached Photo S) 7. Have had to order another part to repair warning device. Will replace device once part is in. Will be completed by 10/17/19.	
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	C 199		

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C 199	Continued From page 9 (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 9-18-2019; a. The exhaust provided was not working in the bathroom off the Dining room in BTR. b. The exhaust provided was not working in the housekeeping closet on the 200 Wing.	C 199	a. and b. Had Criswell company come out to service on 10/9/19. They have ordered vent motors and will be installing 3 new rooftop vent motors once parts are in. Will be completed by 10/22/19.	
C 136	Drug Storage-Locked IV. The Building C. Physical Environment (10 NCAC 42D .1503) 6. The requirements for storage rooms and closets are: e. Drug storage requirements are: (2) All drugs (prescription and non-prescription drugs, including topical preparations) must be stored in a well lighted and well ventilated locked cabinet or closet except when under the direct supervision of employees approved to administer drugs. (3) This locked cabinet or closet must be large enough to store all drugs in an orderly manner. Dividers shall be installed or containers provided in the cabinet or closet and drug cart, when used, to separate each resident ' s drugs with proper labeling for each resident. This Rule is not met as evidenced by: Based on observation, the medication storage room on the 200 Wing was found unlocked and unsupervised. The med cart was in the room and was also found unlocked. Many cards of	C 136	Medcart was locked immediately and medroom was shut and locked. More keys have been made for medtechs. Discussed with staff at meeting on 9/25/19 the importance of keeping medroom locked. Was having issues with extra medcart locking but this has been resolved.	

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C 136	Continued From page 10 medication were found accessible in the med cart drawers.	C 136		