THE LAURELS & THE HAVEN
IN THE
VILLAGE AT CAROLINA PLACE

FIVE STAR
SENIOR LIVING

October 22, 2019

Dennis Harrell
Biennial Institutional Engineering Surveyor
DHSR – Construction Section

Re: The Haven in the Village at Carolina Place – HA Follow-Up Biennial Survey
13150 Dorman Rd.
Pineville, NC 28134
Mecklenburg County
FID# 971417 License #: HAL-060-104

Enclosed is the response from The Haven in the Village at Carolina Place for each rule violation/deficiency cited during the Follow-Up Biennial Construction Survey completed on October 1, 2019.

Respectfully,

Shay Lingerfelt
Executive Director

Enclosures

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
	HAL060107	A. BUILDING: 01 B. WING _____	R 10/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HAVEN IN THE VILLAGE AT CAROLINA P	13150 DORMAN ROAD PINEVILLE, NC 28134

(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 10-1-2019. Several 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: 3. Based on observation and interview, at least one staff was unaware of the location or the use or even the existence of the required central emergency 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. 4. Based on observation, the facility failed to	{C 101}	See Attached.	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 10/22/19

Division of Health Service Regulation

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{C 101}	Continued From page 1 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 central emergency release switch must be labeled as such. Finding on 10-1-2019: The central emergency release switch on the Special Care side was labeled wrong as "Fire". 6. Based on observation, the Building did not meet the code requirements in effect at the time of initial Licensing or alteration, by not providing all required exits or exit access doors with exit signs. This could affect residents, staff, and visitors by not providing egress directions for a prompt evacuation of the building. Finding on 10-1-2019: There are 2 corridor exits and 2 other doors leading into the large entrance foyer at the front door. The exit leads through an interior door into a vestibule and then through an exterior door. The exit path is a required exit. No exit sign is provided over the interior door and the exit sign over the exterior door is not visible from most of the foyer.	{C 101}	See Attached.	
{C 184}	Fire Safety-Evacuation plan SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0309 PLAN FOR EVACUATION (a) A written fire evacuation plan (including a diagrammed drawing) which has the written approval of the local Code Enforcement Official shall be prepared in large print and posted in a central location on each floor of an adult care home. The plan shall be reviewed with each resident on admission and shall be a part of the orientation for all new staff.	{C 184}		

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{C 184}	Continued From page 2 (f) This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: 1. Based on observation and interview, the exterior evacuation paths were not clearly defined or communicated. Findings on 10-1-2019; a. The exits from Asheville, Charlotte and Wilmington lead to angular courtyards. There were no exit signs in the courtyards to clarify the intended exit path. It was not clear from observation or interview with staff if the gates are intended to be used during evacuation. The gates were not easily visible or located. It took a few minutes to find the gates in the day light. In the confusion of an evacuation at night, finding the gates would be very difficult. c. The exit gates from the courtyards were secured with padlocks. Staff did not carry keys to the locks	{C 184}	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: 2. Based on observation, many corridor doors are prevented from closing quickly and latching to	{C 189}		

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{C 189}	Continued From page 3 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 10-1-2019; a. The closer is disconnected on the 3/4 hour fire door to the laundry. h. Two doors to activity closets on the Charlotte Community were disabled from latching with tape over the strike.	{C 189}	See Attached.	

The Haven in the Village at Carolina Place
HA Biennial Follow Up Construction Survey
Plan of Correction
Facility License # HAL-060-107

1) 10A NCAC 13F .0301 Application of Physical Plant Requirements – Based on observation and interview, at least one staff was unaware of the location or the use or even the existence of the required central emergency 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.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

All SCU staff were in-serviced by 9/11/19 on the use of the central emergency release switch for the Special Locking on all the exit doors. Additional in-services have been completed to further cement the purpose and use of the Central Emergency Release Switch.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All SCU residents could potentially be affected.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Maintenance Director or designee will conduct random verbal surveys of the SCU staff to ensure compliance. Additionally, the community will conduct training for all new staff upon hire during orientation.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will conduct random verbal surveys of the SCU staff to ensure compliance. Additionally, the community will conduct training for all new staff upon hire during orientation.

2) 10A NCAC 13F .0301 Application of Physical Plant Requirements – 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 central emergency release switch must be labeled as such. Finding on 8-14-2019: The central emergency release switch on the Special Care side was labeled wrong as "Fire".

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

The central emergency release switch on the Special Care side was correctly labeled on 9/11/19 but removed. A more permanent label was affixed on 10/2/19.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All SCU residents could potentially be affected.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Maintenance Director or designee will conduct random visual inspections to ensure compliance.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will conduct random visual inspections to ensure compliance.

3) 10A NCAC 13F .0301 Application of Physical Plant Requirements – Based on observation, the Building did not meet the code requirements in effect at the time of initial Licensing or alteration, by not providing all required exits or exit access doors with exit signs. This could affect residents, staff, and visitors by not providing egress directions for a prompt evacuation of the building. Finding on 8-14-2019: There are 2 corridor exits and 2 other doors leading into the large entrance foyer at the front door. The exit leads through an interior door into a vestibule and then through an exterior door. The exit path is a required exit. No exit sign is provided over the interior door and the exit sign over the exterior door is not visible from most of the foyer.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

An exit sign over the Interior Door will be installed by 10/16/19.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All SCU residents could potentially be affected.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Maintenance Director or designee will ensure an exit sign is installed over the interior door.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will ensure an exit sign is installed over the interior door.

4) 10A NCAC 13F .0309 Plan for Evacuation – Based on observation and interview, the exterior evacuation paths were not clearly defined or communicated. Findings on 8-14-2019;

a. The exits from Asheville, Charlotte and Wilmington lead to angular courtyards. There were not exit signs in the courtyards to clarify the intended exit path. It was not clear from observation or interview with staff if the gates are intended to be used during evacuation. The gates were not easily visible or located. It took a few minutes to find the gates in the day light. In the confusion of an evacuation at night, finding the gates would be very difficult.

c. The exit gates from the courtyards were secured with padlocks. Staff did not carry keys to the locks.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

a. The exits from Asheville, Charlotte and Wilmington courtyards. Exit signs will be installed on the courtyard gates upon completion of the magnetic locking system installation. Additionally, all SCU staff will be trained on the proper egress route in the courtyards to exit.

c. The exit gates from the courtyards were secured with padlocks – a magnetic locking system with a keypad will be installed on each courtyard gate by 11/8/19. Delay of install is due to vendor scheduling/availability. All SCU staff will be trained on how to use the new locking system after installed.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All SCU residents could potentially be affected.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Maintenance Director or designee will conduct routine operational checks/inspections of the SCU courtyards to ensure compliance.

D) The facility will monitor the corrective actions as follows:

The Executive Director or designee will conduct routine operational checks/inspections of the SCU courtyards to ensure compliance.

5) 10A NCAC 13F .0311 Other Requirements – 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 8-14-2019;

a. The closer is disconnected on the 3/4 hour fire door to the laundry.
h. Two doors to activity closets on the Charlotte Community were disabled from latching with tape over the strike.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

a. The closer is disconnected on the 3/4 hour fire door to the laundry – will be repaired by 10/17/19.
h. Two doors to activity closets on the Charlotte Community – the tape was removed and a new lockset was installed to allow the door to latch properly on 10/18/19.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All SCU residents could potentially be affected.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Maintenance Director or designee will conduct a community wide inspection of all corridor doors by 10/18/19 to ensure compliance.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will conduct routine operational checks/inspections of corridor doors to ensure compliance.

Respectfully,

Shay Lingerfelt
Executive Director