STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: 01 B. WING _____	11/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

(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 11-6-2019. Records indicate this facility was first licensed on 10-11-1996. The facility is currently licensed for 60 Beds. Therefore the facility was surveyed for conformance with the 2005 Rules for Licensing of Adult Care Homes of Seven or More Beds and applicable portions of the 1996 Edition of the North Carolina Building Code(s), Institutional Occupancy, and the 1996 Rules for Licensing of Adult Care Homes of Seven or More Beds in effect at the time of initial licensure.	C 000	**Disclaimer** The provider submits this Plan of Action (POA) in accordance with specific regulatory requirements. The Provider does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that the stated deficiencies are accurate. The Provider submits this POA with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings if at any time the Provider determines that the findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the State of North Carolina or any other entity; or (2) serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider's policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis.	
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, 3 out of 3 staff were not aware of the location, the use or	C 101	**Action Plan** The provider strives to ensure all staff is aware of central emergency relief switch for the magnetic locking door system and how to use. Training, audits, meetings, and various Quality Assurance measures are examples of the many components utilized to ensure preparedness. **Corrective Action** Training was conducted on 11/06/19 with 1st & 2nd shift staff to ensure awareness of location and use of the central emergency relief switch for the magnetic locking door system. Training for remaining facility staff and contract employees were conducted from 11/06/19 through 11-12-19. **ID of Other Areas** N/A. No other central emergency relief switches exist. **Measures** Facility added topic regarding purpose, switch location and use to employee training & orientation check sheet. **Monitor** The Administrator, Maintenance and Resident Care Director will quiz at least 4-6 employees monthly for the next 6 months to ensure staff and contract employees retain where the central emergency relief switch is and it's use in case of an emergency.	11/12/19

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C 101	Continued From page 1 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.			
C 111	Must Have Current San. & Fire Safety Reports SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0302 DESIGN AND CONSTRUCTION(f) The facility shall have current sanitation and fire and building safety inspection reports which shall be maintained in the home and available for review. This Rule is not met as evidenced by: Based on a review of documents, the required annual fire alarm system inspection report could not be located. Fire alarm systems that are not inspected and approved as required could result in the fire alarm system not operating properly in the event of an actual fire.	C 111	**Action Plan** The provider strives to ensure sanitation, fire and building safety inspection reports are maintained and available for review. Consultant audits, facility reviews, DSS inspections, and various other Quality Assurance measures are examples of the many components utilized to ensure compliance. The vendor inadvertently passed the fire system inspection date. **Corrective Action** Vendor contacted on 11/06/19 regarding inspection. Vendor conducted annual fire system inspection on 11/20/19. **ID of Other Areas** As evidenced by findings all other inspections were current and available for review. **Measures** Administrator developed a tickler schedule to track when fire, sprinkler, kitchen hood, fire extinguisher and other system equipment inspections need to be conducted and completed. Maintenance has a copy of the schedule. Maintenance will be responsible going forward to ensure all inspections are conducted timely. **Monitor** Office Manager will contact all inspectors or vendors with a courtesy reminder one month prior to a due date.	11/20/19
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, a pathway to an exit was not maintained free of obstructions. Findings on 11-6-2019: a. The pathway to one of the exits from the Activity room was blocked with chairs stored	C 150	**Action Plan** The facility strives to ensure the facility is being maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards. The facility has policies and procedures designed to maintain these goals. Quality Assurance audits and various other quality assurance measures are examples of the components utilized. **Corrective Action** a.Maintenance and Administrator moved the chairs and table that were too close to the door to allow egress during the survey.	11/12/19

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C 150	Continued From page 2 against the wall and with a table and chairs. b. One of the exits from the Activity room was completely blocked with an easel. Note; These deficiencies were corrected during the survey.	C 150	Continued from Page 2 b.Maintenance and Administrator moved the easel that was too close to the door to allow egress during the survey. **ID of Other Areas** Maintenance inspected on 11/06/19 all other corridors and exits for obstructions. No other obstructions were found. **Measures** Corridor and exit check was added to the Safety Check Sheet. Staff was reminded during training conducted from 11/06/19 through 11/12/19 to be observant to ensure exits and pathways are not obstructed and what to do if not. **Monitor** Maintenance will monitor all means of egress on at least a monthly basis to ensure pathways are not obstructed and exits are clear. Results will be reported to the Administrator. Corrective action will be taken if needed.	
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, there was a dust pan on the sidewalk immediately outside one of the exits from the Activity room. The dust pan was a trip and fall hazard. Note; This deficiency was corrected during the survey. 2. Based on observation, 2 electrical outlet expanders were in use in the laundry. Electrical outlet expanders are not approved for use in Institutional Occupancies.	C 166	**Action Plan** The facility strives to ensure the facility is being maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards. The facility has policies and procedures designed to maintain these goals. Inspections, Quality Assurance audits and various other QA measures are examples of the components utilized. **Corrective Action** 1. As noted in findings corrected during survey. 2. The electrical outlet expanders were removed from the laundry room. **ID of Other Areas** Maintenance inspected remaining portions of the facility and found no other rooms/offices with outlet expanders. **Measures** Expanders were replaced on 11/18/19 with new wall outlets. All washers are now plugged into regular wall outlets. Maintenance added monitoring for outlet expanders to the monthly safety inspection checklist. **Monitor** Maintenance will monitor on a monthly basis that no items are plugged into an outlet expander. Findings will be reported to the Administrator. Corrective action will be taken if needed.	11/18/19
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	C 185	**Action Plan** The provider strives to ensure fire plan rehearsals are conducted at least monthly with each shift practicing at least quarterly. The facility has policies and procedures	12/20/19

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C 185	Continued From page 3 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 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 11-6-2019: a. In the 2nd quarter of this year, there was no rehearsal done during the 2nd shift. b. In the 3rd quarter of this year, there were no rehearsals done. c. In the 4th quarter of last year, there were no rehearsals done. 2. Based on a review of documents, the records available onsite included no description of what the rehearsal involved.	C 185	Continued from Page 3 designed to maintain these goals. Consultant audits, DSS surveys, Fire Marshal inspections, routine record reviews, QA/Safety committee audits and meetings, and various other quality assurance measures are examples of the many components utilized. **Corrective Action** Unable to correct, after the fact, rehearsal records that are unavailable. However, Administrator met on 11/06/19 with Maintenance to review fire rehearsal policies & procedures. **ID of Other Areas** N/A. Findings identify all rehearsals where records were not available. **Measures** Maintenance developed a tickler file to monitor that at least one fire rehearsal is conducted per shift per quarter. Maintenance or their designee will ensure each rehearsal record includes- date/time of rehearsal; participants; location; type/nature of rehearsal; response time & results. **Monitor** Administrator will review records monthly to ensure fire rehearsals are being conducted, documented and filed.	
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)	C 189	**Action Plan** The provider strives to ensure that the building, along with all fire safety, electrical, mechanical and plumbing equipment is maintained in a safe and operational condition. The facility has policies and procedures designed to maintain these goals. Maintenance work orders, routine maintenance checks, safety committee audits and meetings, and various quality assurance measures are examples of the many components utilized. **Corrective Action** 1) a. Closing mechanism was replaced on 11-8-19 for the 3\4 hour fire door in kitchen. (See attached). b. Obstacle removed during survey.	12/20/19

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C 189	Continued From page 4 which shall not apply to existing facilities. This Rule is not met as evidenced by: 1. 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 11-6-2019; a. The 3/4 hour fire rated door from the kitchen to the dining room dragged the floor and could not automatically close and latch. b. One of the smoke barrier doors was blocked with a trash can and could not close completely and latch when activated by the fire alarm system. Note; This deficiency was corrected during the survey. c. The door to room 5 was disabled from latching with tape on the strike. Note; This deficiency was corrected during the survey. d. The door to room 6 does not fit the opening properly to be resistant to the passage of smoke. e. The door to room 12 does not fit the opening properly to be resistant to the passage of smoke. f. The door to room 11 was blocked open with a wheelchair. Note; This deficiency was corrected during the survey. g. The door to room 12 was propped open. Note; This deficiency was corrected during the survey. h. The door to room 34 was blocked open. i. The door to room 41 will not latch when closed. j. The doors (2) to the Activity room will not latch when closed. 2. Based on observation, the required one-hour fire rated walls and/or ceilings were compromised	C 189	Continued from Page 4 c. Corrected during survey. d. Outside vendor to fix Room 6 door by. e. Maintenance adjusted Room 12 door on 11/8/19. f. Corrected during survey. g. Corrected during survey. h. Maintenance fixed Room 34 door on 11/8/19. i. Outside vendor to fix Room 41 door by. j. Maintenance fixed the Act. Room doors on 11/8/19. 2) a. Outside contractor is scheduled to fix the fire collars in the water heater room by. b. Maintenance remounted the return register in the beauty shop. 3) New FDC sign will be purchased and re-attached by 12/20/19. 4) Maintenance recorded on 11/6/19 hood suppression system check. 5) a. Maintenance removed on 11/6/19 items above the 18" clearance space. b. Activities removed on 11/6/19 items above the 18" clearance space. c. Clinical staff removed during survey items above the 18" clearance space. 6) Power strip was removed from laundry room and replaced on 11/18/19 with new outlets to power the washing machines. **ID of Other Areas** Maintenance inspected on 11/11/19 and 11/18/19 all doorways for obstructions; doors for correct operation and positive latching; fire rated walls and ceilings for unsealed penetrations; escutcheon and pipe collars for proper fit; required signage; item storage above 18"; power taps; door wedges and equipment inspection tag documentation. No other items found. **Measures** Administrator conducted on 11/6/19 training with Maintenance regarding policies and procedures for documenting monthly hood suppression system and fire extinguisher manual inspections. Maintenance and Administrator re-trained facility staff, from 11/6/19 through 11/13/19, regarding observing means of egress for obstructions and correcting if observed; observing smoke/fire doors for correct operation and positive latching and how to report if not; walls and	

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C 189	Continued From page 5 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. Findings on 11-6-2019: a. Two fire collars were not properly mounted to the ceiling of the water heater room, b. The return register was not properly mounted to the ceiling in the beauty salon. 3. Based on observation, the required Fire Department Connection (FDC) sign had fallen off on the ground and was not legible. Note; This deficiency was cited on the annual sprinkler inspections dated 9-18-2018, and 9-9-2019. 4. Based on observation, there was no documentation of the required in house/owner's monthly inspections since June provided on the inspection tag at the range hood fire suppression system. 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 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 11-6-2019; a. Items had been stacked to within 4 inches of the ceiling in the Maintenance room. b. Items had been stacked to within 9 inches of the ceiling in Activity storage. c. Items had been stacked to within 5 inches of the ceiling in the med room. Note; This deficiency was corrected during the survey.	C 189	Continued from Page 5 ceilings for penetrations; escutcheon and pipe collars for proper fit; not storing items 18" from ceiling; not using electrical power taps; and not using door props, wedges, and/or "kick downs". **Monitor** All Department Managers will assist in monitoring doors for pathway obstructions; check smoke barrier doors for closure and positive latching; and be observant for doors being wedged/propped open with any items. The Maintenance Director will be responsible for monitoring the facility, at least monthly, to assure: • Exits are free and clear of obstructions; • Doors throughout the facility close and positively latch; and are not wedged open with any type of device or item; • Fire rated ceiling and/or doors have no unsealed holes or penetrations; • Items are not stored within 18" of the sprinkler heads. • Hood fire suppression system and all fire extinguisher inspections are documented in the appropriate areas. • Sprinkler signage is visible and attached correctly. • Electrical taps are not being used. Findings will be reported to the Administrator. Corrective action will be taken if needed.	

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C 189	Continued From page 6 6. Based on observation, the electrical system was not maintained in a safe condition. Finding on 11-6-2019; A washing machine is plugged into a power tap in the main laundry. Power taps are not designed for high power loads such as washing machines. Using high power loads on power taps can overload building wiring and cause a fire hazard.	C 189		
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. Findings on 11-6-2019: There was a portable electric heater found in use in the Business office.	C 191	**Action Plan** The provider strives to ensure that prohibited portable electrical heaters are not on premise or being used. The facility has policies and procedures designed to maintain these goals. Visual observance, routine maintenance checks, safety committee audits and meetings, and various other quality assurance measures are examples of the many components utilized. **Corrective Action** On 11/6/19 the Office Manager unplugged and immediately removed from facility the personal portable heater. Office Manager was counseled by administrator regarding portable heaters regulation and prohibited use. **ID of Other Areas** Administrator inspected facility on 11/7/19 to ensure no other heaters were on premises or in use. No others found. **Measures** Staff was reminded during training conducted from 11/6/19 through 11/12/19 regarding regulatory portable heater prohibition. **Monitor** Maintenance will monitor all rooms and offices monthly to ensure that no portable electric heaters are on premise or in use.	11/12/19