McNeil, Jennifer

From: Godwin, Alison M <mercedez.godwin@dhhs.nc.gov>
Sent: Tuesday, November 19, 2019 10:00 AM
To: McNeil, Jennifer; 'jeffery.johnson@townofcary.org'; Catherine Goldman
Cc: Fay, Suzanna E; Sluder, Chris
Subject: [EXTERNAL] DHSR- HeartFields at Cary
Attachments: 20191119-Heartfields at Cary-letter.pdf; 20191119-Heartfields at Cary-sod.pdf

Importance: High

Attached is the Statement of Deficiencies and letter for the **DHSR-Construction Section Biennial Survey** conducted on October 24, 2019 by Suzanna Fay.

Write the date that the work will be completed, and how it will be completed on the right hand side of your Plan of Correction. The work does not have to be completed before you submit this form. You also need to sign and date the Plan of Correction at the bottom. The POC is due back by December 04, 2019.

The Plan of Correction can be:

Mail to: DHSR Construction Section
2705 Mail Service Center
Raleigh NC 27699-2705

Fax to: (919)-733-6592

Email to: DHSR.Construction.Admin@dhhs.nc.gov

Thank you

Mercedez Godwin
Administrative Specialist I
Division of Health Service Regulation, Construction Section
NC Department of Health and Human Services

Office: 919-855-3871
Fax: 919-733-6592
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2705 Mail Service Center
Raleigh, NC 24699-2705

NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

November 19, 2019
Jennifer McNeil (via e-mail only)
1050 Crescent Green Drive
Cary, NC 27511

RE: Heartfields At Cary - HA Biennial Survey
1050 Crescent Green Drive
Cary Wake County
FID #970161 Hal092156

Dear Ms. McNeil:

Thank you for the cooperation and courtesies extended during the recent Division of Health Service Regulation (DHSR) – Construction Section Biennial survey of your facility on October 24, 2019. As a result of the survey, deficiencies were cited which will require an acceptable Plan of Correction. The deficiencies cited are listed on the enclosed Statement of Deficiency. Your Plan of Correction should indicate the following:

- What corrective action(s) will be accomplished in those areas of the facility found to have been affected by the deficient practice;
- How you will identify other areas of the facility having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.
- Include dates when corrective action will be completed. The corrective action dates must be acceptable to the State.

    1. Corrective action must begin immediately.
    2. Any completion date greater than 45 days from date of survey requires a written waiver from DHSR-Construction Section.

Please type or print clearly your correction action on the enclosed Statement of Deficiencies. You will need to

SIGN, DATE AND RETURN the Plan of Correction to DHSR-Construction by December 4, 2019. Failure to return the signed Plan of Correction within this time period could jeopardize the status of your license. The PROVIDER may copy form(s) to be retained for your files.

Your Plan of Correction can be:

Mail to: DHSR Construction Section
2705 Mail Service Center
Raleigh NC 27699-2705

Fax to: (919)-733-6592

Email to: DHSR.Construction.Admin@dhhs.nc.gov

Prior to making any changes to your facility you will need to verify with the local Building Official whether or not a permit is needed to make the changes on the enclosed Statement of Deficiencies. The North Carolina State Building Code requires that "No person, firm or corporation shall erect, construct, enlarge, install, alter, repair, move, improve, convert or demolish any building, structure, or service system without first obtaining a permit for such from the Inspection Department having jurisdiction".

Informal Dispute Resolution

In accordance with G.S. § 131D-2.11(a2), you have one opportunity to question cited deficiencies through an informal dispute resolution (IDR) process. You may also contest the severity of noncompliance that resulted in a violation determination. To be given such an opportunity, you are required to send your written request identifying the specific deficiencies being disputed postmarked by December 4, 2019. An explanation of why you are disputing those deficiencies (or why you are disputing the severity of noncompliance that resulted in a violation determination) along with any supporting documentation must be sent and postmarked by December 4, 2019. You must submit 2 copies of material and highlight or use some other means to identify written information pertinent to the disputed deficiency(ies). Additional written material that does not meet these requirements will not be reviewed. This information should be sent to: Steven C. Lewis, Construction Section Chief, 2705 Mail Service Center, Raleigh NC 27699-2705. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action. IDR Procedures can be accessed at: https://info.ncdhhs.gov/dhsr/.

Please do not hesitate to call us if you have questions concerning the deficiencies or if we can be of other assistance.

Sincerely,

Suzanna Fay

Suzanna Fay
Biennial Institutional Engineering Surveyor
DHSR - Construction Section

cc: Adult Care Licensure Section-with attachment
City Building Inspection Department - with attachment-(via e-mail only)
Wake County DSS - with attachment-(via e-mail only)

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
	HAL092156	A. BUILDING: 01 B. WING _____	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT CARY	1050 CRESCENT GREEN DRIVE CARY, NC 27511

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C 000	Initial Comments Report of a Construction Section Biennial Survey by Suzanna Fay and Frank Strickland conducted on October 24, 2019. The facility was first licensed on February 3, 1997 for Ninety-Seven (97) residents, including a Sixteen (16) bed Special Care unit. Based on this information, we are requiring that this facility meet the 1996 Rules for the Licensing of Domiciliary Homes and the 1996 North Carolina State Building Code, Section 419- Institutional Occupancy; and the applicable portions of the 2005 Rules for Adult care Home of Seven or More Beds. Deficiencies have been cited and a Plan of Correction 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;	C 101	SECTION .0300-Physical Plant 10A NCAC 13F .0301 Application of physical plan Requirements a. Emergency Exit switch was repaired on 11/26 by electrical company. Switch tested multiple times and now releases all five (5) exit doors as intended. b. Screamer box battery was replaced 11/26 and tested multiple times and found in working order as intended. c. MCU staff and Maintenance were trained on 11/26 on the functions of the switch and how to properly operate.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Executive Director | 12/02/19

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C 101	Continued From page 1 This Rule is not met as evidenced by: 1. Observations revealed that the facility does not meet building code requirements in effect at the time of construction. Findings on October 24, 2019: a. A switch was observed in the elevator lobby of the MCU labeled, 'Emergency Exit.' When the override switch was activated, none of the exit doors released. Although Delayed egress doors do not require a central on\off release switch, it was not clear whether this installed switch is required for other reasons. b. Additionally, the screamer box did not sound when opened. c. Staff were not familiar with the locking system and did not know how to reactivate the switch. The override switch required a special tool which was eventually located.	C 101	All findings were corrected 11/26. Remainder of alarms in building were tested and found to be in working order by 11/26. Emergency switch will be tested on a quarterly basis to ensure compliance and in working order. Quarterly tests to be conducted by Maintenance Director or designee. Maintenance Director or designee to provide ongoing staff training on switch operation with all new employees' initial orientation and with quarterly testing of switch.	11/26/19
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: 1. Observations revealed that the corridors were not free of obstructions. A six foot wide path of egress must be maintained at all times. Findings on October 24, 2019: a. MCU - a garden bench in the corridor narrows the path of egress to less than 6'-0". The bench was relocated at the time of survey.	C 150	SECTION .0300-Physical Plant 10A NCAC 13F .0305 Physical Environment **1) a.** Garden bench was moved 10/24 during survey. Remainder of building was checked by Maintenance 10/24 to ensure compliance with 6ft path. No other areas of non-compliance. Ongoing building compliance will be monitored through Monthly Safety Committee meetings by Safety Committee, chaired by Maintenance Director.	10/24/19

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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; (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: 1. Observations revealed that the ceilings were not kept clean and in good repair. Findings on October 24, 2019: a. MCU Janitor's closet - the exhaust fan has a heavy accumulation of dust. b. Staff Break Room Toilet - there is 6" diameter damp spot on the corner of one ceiling tile. The area is black with mildew. c. General note - most of the exhaust fans throughout the facility had heavy accumulations of dust. d. First Floor Small Dining - there is a large discolored area on the ceiling in the corner and the finish is cracking and flaking. 2. Observations revealed that the walls and furnishings were not kept clean and in good repair. Findings on October 24, 2019: a. Room 103 - one of the door handles on the back closet is missing a knob. b. Room 105 - the door to the shared bathroom does not close and latch for privacy. c. Kitchen - the doors between kitchen and	C 164	SECTION .0300-Physical Plant 10A NCAC 13F .0306 Housekeeping and Furnishings **1) a.** MCU Janitor's closet fan cleaned by 11/14. **b.** Staff Break Room Bathroom ceiling tile was replaced 11/14 **c.** Exhaust fans throughout building were cleaned by 11/14. **d.** 1st Floor Dining room ceiling repair in progress as of 11/14 and will be complete by 12/5. To ensure ongoing compliance exhaust fans will be cleaned by housekeeping and ceilings checked for leaks during weekly deep cleans. Maintenance Director or designee to review weekly deep clean sheets for completion. Maintenance to complete weekly spot checks of fans and ceilings throughout building to ensure ongoing compliance. **2) a.** Rm 103 knob replaced 11/5 **b.** Rm 105 door fixed 11/5 **c.** Kitchen doors repaint started 11/5 and will be completed 12/5 **d.** Dining room door handles ordered by 11/5 and replaced by 12/5.	11/14/19

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C 164	Continued From page 3 dining are very dirty. d. Dining - the door handle on the left side exterior door is broken and the door will not open. (Note: This is not an exit and there are two other exterior doors in the room.) 3. Observations revealed that the facility was not maintained free of offensive odors. Findings on October 24, 2019: a. Room 124 - the room has a strong urine odor.	C 164	Monthly checks for Maintenance Director or designee has been added to ensure doors and handles are in working order going forward. **3) a.** Rm 124 odor was addressed same day 10/24 and deodorized by housekeeping. Housekeeping to continue to address and urine or odor issues immediately upon finding them. Managers will ensure ongoing Compliance through already established Manager Building Walkthroughs conducted weekly.	11/5/19
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 facility was not maintained free from hazards. Oxygen bottles without any means of restraint to prevent them from falling or being knocked over may present a danger to the occupants of the facility. Findings on October 24, 2019: a. Room 216 - four oxygen bottles were stored in a plastic rack without any means of restraint. b. Room 307 - four oxygen bottles were stored in a plastic rack without any means of restraint and one bottle was sitting on the floor without any	C 166	SECTION .0300-Physical Plant 10A NCAC 13F .0306 Housekeeping and furnishings Rms 216; 307; 309; 312; 316 oxygen bottles outside of plastic racks removed day of survey 10/24. These are all of oxygen rooms currently in building. Metal racks for oxygen bottles have been ordered through vendor since 11/14 and awaiting arrival. All Oxygen bottles to be switched From plastic holders to metal holders per survey.	

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C 166	Continued From page 4 means of restraint. c. Room 309 - twenty-two oxygen bottles were stored in a plastic racks without any means of restraint. d. Room 312 - three oxygen bottles were sitting on the floor without any means of restraint. e. Room 316 - three oxygen bottles were sitting on the floor without any means of restraint.	C 166	Director of Resident Care/LPN or designee to ensure ongoing compliance by conducting weekly checks of rooms where oxygen is in use.	11/14/19
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 there is a failure to maintain the facility's fire safety equipment in a safe operating condition. Occupants in the smoke compartment could be exposed to smoke or fire if doors do not completely close and latch to help limit the spread of smoke or fire to the area of origin. Findings on October 24, 2019: a. Third Floor Tea Room - the doors are on magnetic hold open devices. The right leaf did not close completely when the fire alarm was activated. b. Second Floor Game Room - the doors are on magnetic hold open devices. The left leaf drags	C 189	SECTION .0300-Physical Plant 10A NCAC 13F .0311 Other Requirements 1) a. 3rd floor tea room door repaired 11/8. b. 2nd floor game room door repaired 11/8 c. 2nd floor magnetic hold open device will be re-secured by 12/6 All other fire doors in building checked for proper operation and in compliance. Ongoing fire door checks to be conducted by Maintenance Director or designee and will occur monthly along with monthly building fire drills.	12/6/19

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C 189	Continued From page 5 on the floor and caused the doors not to close in sequence. Therefore, the doors did not close and latch when the fire alarm was activated. c. Second Floor - one of the magnetic hold open devices is loose and separating from the wall at the cross corridor fire doors. 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 October 24, 2019: a. Lower Level - Room 3 Bathroom had an escutcheon ring missing from the sprinkler head leaving a hole in the rated ceiling assembly. b. Lower Level Housekeeping - one of the ceiling tiles had been removed and a 1" unprotected PVC pipe was penetrating the one hour wall assembly above the ceiling tile. c. Room 117 - the ceiling finish is failing and there is a hole in the rated ceiling assembly where the finish is cracking. d. Second Floor Electrical Room across from 212 - there is one unsealed conduit penetration through the 1 hour wall assembly. e. Room 303 - the escutcheon plate is missing on the sprinkler head in the bathroom. 3. Based on observation the facility did not maintain electrical emergency/safety lighting equipment in safe operating condition. This could effect occupants of the facility if egress paths and exits were not illuminated during a power outage. Findings on October 24, 2019: a. Stair 2 - the emergency light between the 1st and 2nd floors did not illuminate on battery test.	C 189	**2) a.** Rm 3 escutcheon replaced 11/1 **b.** Lower Level Housekeeping PVC pipe fixed 11/13 **c.** Rm 117 work started 12/3. Final touches complete by 12/06 **d.** 2nd floor Electrical Rm unsealed conduit started 12/3 for final touches by 12/5 **e.** Extra part not on hand and was ordered 11/19 from FLSA, Fire Safety vendor. Awaiting part arrival. Once received it will be installed immediately. A full building review was conducted by 11/13 to ensure all fire safety systems holes or gaps at penetrations were in compliance. Ongoing building compliance checked by Maintenance director or designee through monthly building walkthroughs. **3) a.&b.** Both stairwell emergency lights repaired 12/3. All emergency lights in stairwells	12/6/19

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C 189	Continued From page 6 b. Stair 2 - the emergency light between the 1st and ground floors did not illuminate on battery test. 4. Based on observation the facility's fire safety equipment is not maintained in operating condition. Failure to maintain 18" clearance below the sprinkler heads creates an obstruction which limits the ability of the sprinkler system to suppress a fire. Findings on October 24, 2019: a. Kitchen Pantry - items were stored to the ceiling. The boxes were moved at the time of survey. 5. Based on observation the facility's fire safety equipment is not maintained in operating condition. Failure to maintain fire safety equipment in operating condition could effect occupants of the facility if the equipment did not function during a fire or other emergency. Findings on October 24, 2019: b. First Floor - the smoke detector outside of Room 117 is not secure to the ceiling. 6. 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. Findings on October 24, 2019: a. Maintenance Office - the door to the office was held open using wood blocking.	C 189	checked 12/3 and found to be in compliance. Maintenance Director or designee to ensure ongoing compliance through monthly building checks. **4) a.** Kitchen Pantry stored items removed at time of survey 10/24. Remainder of storage areas were inspected same day and in compliance as of 10/24. Building purchased tape to clearly mark the 18" clearance for all staff going forward. Ongoing compliance of storage areas will be checked by Maintenance Director through monthly building checks. **5) b.** 1st Floor smoke detector By 117 re-secured by 11/12 Smoke detectors security to be Checked for compliance by Maintenance director during Monthly fire alarm building tests **6) a.** Maintenance Office door Was closed date of survey 10/24. A sign was made to display on door To advise staff to keep door closed. Sign was also used for any other fire Staff may prop open. Completed 11/1. Ongoing compliance will be monitored Through Managers Weekly Walkthrough Checklist.	12/3/19 10/24/19 11/12/19 11/1/19

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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: 1. Observations revealed that the facility had unvented portable electric heaters in the building. Findings on October 24, 2019: a. First Floor Physical Therapy - two unplugged portable electric heaters were found under a desk.	C 191	SECTION .0300 – Physical Plant 10A NCAC 13F .0311 Other Requirements a. Physical Therapy removed space heaters as of 10/30 and therapy staff were advised this wasn't allowed. Ongoing compliance to be monitored through Physical Therapist daily checks while in their Office in addition to Maintenance Director monthly building walkthrough	10/30/19
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	SECTION .0300 – Physical Plant 10A NCAC 13F .0311 Other Requirements a-d. Motor and belt ordered and expected to arrive 12/4. Motor and belt will repair all units cited; Kitchen janitor closet, MCU wing 15, 2nd floor spa toilet room, 3rd floor Rm 318 bathroom. Ongoing compliance will be monitored through monthly checks to units on roof conducted by Maintenance Director or designee	12/4/19

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C 199	Continued From page 8 (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: 1. Observations revealed that the facility did not maintain required exhaust ventilation in specified spaces. Findings on October 24, 2019: a. Kitchen Janitor's Closet - the exhaust fan is not working. b. MCU - the exhaust fans in the bathrooms on the wing containing Room 15 are not pulling enough to hold a thin sheet of plastic. c. Second Floor Spa - the exhaust fan in the toilet room is not working. d. Third Floor, Room 318 - the exhaust fan in the bathroom is not working.	C 199		