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
	HAL049033	A. BUILDING: 01 B. WING _____	05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL CREEK MANOR	1902 ORA 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 a Biennial Construction Survey by Suzanna Fay conducted on May 10, 2023. Records indicate this facility was first licensed on April 2, 1990 as a HA and an addition of a Special Care Unit was licensed on May 12, 1994. This facility is currently licensed for 80 Beds including a 28 Bed Special Care Unit. Therefore, this facility was surveyed for conformance with the 1987 Rules for Adult Care Homes, the applicable portions of the 2005 Rules for Licensing of Adult Care Homes of Seven or More Beds, and the 1978 and the 1991 Edition, of the North Carolina Building Code(s), Institutional Occupancy. Deficiencies were cited that require a Plan of Correction.	C 000	In accordance with Section .0300 10A NCAC 13F.0302, the Administrator will contact Iredell County Health Department/Sanitation since no inspection has been completed in the facility since April 2021.	
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: 1. Review of records revealed that the facility did not have current sanitation reports maintained in the home and available for review. Findings on May 10, 2023: a. The most current Kitchen Sanitation inspection report was dated April 15, 2021.	C 111		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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C 154	Continued From page 1	C 154		
C 154	Entrances/Exits-Wanderer Alarms SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0305 PHYSICAL ENVIRONMENT (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: 1. Observations revealed that the facility has residents known to be disoriented or a wanderer that required that each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. Findings on May 10, 2023: a. Exit by Room 8 - the screamer box did not alarm when opened. b. Exit by Room 11 - the screamer box did not alarm when opened. c. The screamer box to the Courtyard on the AL side did not alarm when opened.	C 154	In accordance with 10 A NCAC 13 F.0305 Administrator will Purchase alarm/Sounding device that will activate/Sound upon entering or exiting the facility and can be heard by staff. This will be monitored by maintenace monthly to ensure device is working properly a)+B) batteries were replaced in Rooms 8 and 11. C) The Screamer box was replace since the hinge was broken	6/13/2023
C 160	Outside Premises-Clean, Safe SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0305 PHYSICAL	C 160		

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C 160	Continued From page 2 ENVIRONMENT (m) The requirements for outside premises are: (1) The outside grounds of new and existing facilities shall be maintained in a clean and safe condition; This Rule is not met as evidenced by: 1. Observations revealed that the outside premises were not maintained in a clean and safe condition. Findings on May 10, 2023: a. Exit by Room 11 - a section of the exterior siding in the gable to the left of the door is pulling loose. b. Exit by Room 11 - the exterior soffit at the end of the gable on the right is pulling loose and leaving an opening for pests to enter. c. There is a large pothole approximately 6' in diameter at the entrance to the facility. d. The dumpster vehicle has created large ruts in the pavement outside of the kitchen.	C 160	Exit by room 11 was repaired and siding Snapped back into place B) The exterior soffit was repair and closed the openings so that nothing can enter	5/24/23
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:	C 164	C and D Waiting on Corporate office to approve two(2) Bids one of $65,000 the other $50,000 to repair pavement	

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C 164	Continued From page 3 1. Observations revealed that the walls, ceilings and floors were not kept clean and in good repair. Findings on May 10, 2023: a. There was a pattern of exhaust fan grilles with heavy accumulations of dust. b. Room 2 - there is a 1" hole in the surface of the door leaving rough edges that could cause an injury. c. B Hall Community Bath - the ceiling is spalling over the shower around the curtain tracks. d. Room 25 - the door veneer is damaged and broken off leaving rough edges at the latch side of the door and along the top and bottom of the door. e. Room 33 Bath - there are dark brown and gray stains on the floor around the base of the toilet and toward the walls. f. Kitchen - there are 6 to 8 broken floor tiles at the drain between the stove and the sinks. g. Room 25 - a section of the base on the left wall has fallen off exposing a hole at the base of the wall approximately 4" high and 18" long.	C 164	A) Exhaust fan grilles were cleaned by maintenace B) 1" hole was filled with wood filler and edges cleaned C) Maintenance removed flaking paint and primed the area. D) Door was repaired rough edges removed E) Housekeeping is placing rust remover on stain daily F) The broken tiles were replaced with new tile G) Hole at base of wall was repaired	5/16/23 5/16/23 5/22/23
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	C 166		

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C 166	Continued From page 4 maintained free from hazards. Oxygen bottles were improperly stored. 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 May 10, 2023: a. Room 5 - there are 15-16 oxygen bottles stored in shallow plastic crates without a means of securing them. There are at least three bottles of oxygen unsecured on the floor in the closet. b. Basement, first room - there are seven oxygen bottles sitting unsecured on the floor and 12 oxygen bottles sitting unsecured on a table. c. Basement, Storage Room - there is one unsecured oxygen bottle on the floor of the room and 8 oxygen bottles in a shallow Pepsi crate, unsecured.	C 166	Received metal racks from oxygen supplier to secure oxygen bottles from floor and remove from plastic crates All oxygen bottles remved from floor and from Pepsi crate	5/25/23
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. Review of records revealed that the facility did	C 185	In accordance with Section 0300 10A NCAC 13F.0309 Fire drills will be completed quarterly on each shift by maintenace	

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C 185	Continued From page 5 not have records of rehearsals of the fire plan quarterly on each shift. 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. Findings on May 10, 2023: a. Records of the fire rehearsals for 2023 and 2022 were not available for review. Interview with staff revealed that he was not aware of any fire drills being conducted since the previous staff member who conducted the drills left approximately six months ago.	C 185		
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 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 May 10, 2023: a. Reception Area - there is a small unsealed penetration through the corridor wall where the	C 189	In accordance to Section .0300 10A NCAC 13F.0311 all hole have been filled in the ceilings and walls with 3M Fire Berrier Sealant	5/22/23

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C 189	Continued From page 6 MiFi cable was run. b. RCC Office - there are small holes in the ceiling in both the front and back corners of the right side of the room. c. Pantry - there is an unsealed penetration at the back wall. d. Kitchen - the caulk for the hood suppression system piping has fallen out leaving gaps around the conduit penetrations in the ceiling. e. The escutcheon ring on the sprinkler head outside of Room 30 has dropped leaving a gap in the fire resistant rated ceiling. f. Basement Riser Room - the ceiling has water damage near the door running the length of the room. There are yellow water stains around the sheetrock joints. The finishing tape and paint is peeling off leaving the sheetrock joints exposed. g. SCU enclosed Porch - the sprinkler head and escutcheon are not secure to the ceiling. 2. 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 May 10, 2023: a. A Hall - the emergency lights did not illuminate when the battery pack was tested. b. SCU Dining - the emergency light over the entry doors did not illuminate on test. c. SCU - the emergency light outside of the Living area did not illuminate on test. d. SCU Living Area - the emergency light did not illuminate on test. 3. 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	C 189	All batteries were replaced in fixtures that were not working Properly or new fixture were installed.	5/31/23

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C 189	Continued From page 7 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 May 10, 2023: a. Dining - a serving cart prevented the door to the kitchen from closing quickly an a walk-off mat in front of the courtyard door prevented the door from closing. 4. 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 May 10, 2023: a. A Hall Snack Room - the door rubs on the frame and does not close and latch. 5. Based on observation fire safety equipment has not been inspected to assure it has been maintained in a safe and operable condition. Occupants of the facility could be effected if fire safety equipment in the smoke compartment did not operate when needed to provide fire protection. Kitchen hood suppression systems require 6 month inspections. Findings on May 10, 2023: a. The tag on the kitchen hood suppression system indicated that the hood was last inspected in November of 2021. 6. Based on observation the electrical equipment has not been maintained in a safe manner. This is a potential shock hazard if receptacles near	C 189	The serving cart was moved to a different location away from the door. So that it would not prevent the door from closing The door was adjusted so that it closes Both kitchen hood suppression system and fire system have been inspected	5/10/23 5/15/23

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C 189	Continued From page 8 water sources do not function to provide shock protection. Findings on May 10, 2023: a. Community Bath - the GFCI outlet does not have power and the reset button is damage. 7. Observations revealed that the electrical equipment was not maintained in a safe condition. Open sockets can cause a shock injury if a resident touched the exposed elements. Findings on May 10, 2023: a. B Hall Community Bath - the light fixture over the sink has one open socket. 8. Based on observation there is a failure to maintain the facility's fire safety equipment in a safe condition. In order to resist the passage of smoke resident room doors must not have gaps between the door and the door frame stops. Findings on May 10, 2023: a. Room 25 - there is a 1/2 inch gap between the top of the door and the door frame stop. 9. Based on observation fire safety equipment has not been inspected to assure it has been maintained in a safe and operable condition. Occupants of the facility could be effected if fire safety equipment in the smoke compartment did not operate when needed to provide fire protection. Findings on May 10, 2023: a. Basement - the fire extinguisher has not been serviced since November of 2021. 10. Based on observation and testing there is failure to maintain the facility's emergency fire	C 189	GFCI outlet was replaced with new GFCI Bulbs placed in open socket Basement fire extinguisher has been replaced	5/22/23 5/10/23 5/11/23

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C 189	Continued From page 9 alarm system devices and equipment in a safe operating condition. All the occupants of the facility could be effected if the equipment failed to alert the occupants in case of a fire. Findings on May 10, 2023: a. Basement first room - the smoke detector was removed from its base and was sitting on a table.	C 189	Smoke Detector batteries replaced and mounted to the base	5/10/23
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 (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 exhaust ventilation in specified spaces. Lack of ventilation allows for the build up humidity that can cause mildew and slick areas and prevents the dissipation of odors. Findings on May 10, 2023: a. Room 2 Bath - the exhaust fan is not working. b. Room 5 Bath - the exhaust fan is not working.	C 199	Exhaust fans in bath 2 and 5 are now working properly	

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C 199	Continued From page 10 c. B Hall Housekeeping - the exhaust fan is not working. d. Room 26 Bath - the exhaust fan is not working. 2. Based on observation the facility failed to provide exhaust ventilation in specified spaces. This could effect occupants of the facility if odors were to permeate the facility's occupied areas beyond the Housekeeping Room. Findings on May 10, 2023: a. Housekeeping/Storage Closet at the end of the SCU Hall - a floor sink indicates this room was used for housekeeping and is currently used for storage. There is not an exhaust fan in this room.	C 199		

NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

June 6, 2023
Blondie Harris, Assisted Living Administrator (via email only)
1902 Ora Drive
Statesville, NC 28625

RE: Mill Creek Manor – ACH Biennial Survey
1902 Ora Drive
Statesville (Iredell County)
FID #941148

Dear Ms. Harris:

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 May 10, 2023. 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 June 21, 2023. 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:

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

Faxed to: (919) 733-6592

Emailed 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 June 21, 2023. 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 June 21, 2023. 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: Jeff Hams, Acting 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: DHSR – Adult Care Licensure Section
County Building Inspection Department – with attachment (via email only)
Iredell County DSS – with attachment (via email only)