PRINTED: 12/08/2016
FORM APPROVED

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
	HAL010007	A. BUILDING: 01 B. WING _____	11/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LELAND HOUSE	1935 LINCOLN ROAD LELAND, NC 28451

(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 11-23-2016. Records indicate this facility was first licensed on 6-25-1996, as an HA. The facility is currently licensed for 78 Beds with a 24 Bed Special Care Unit. Therefore the facility was surveyed for conformance with the applicable portions of 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 Minimum Standards and Regulations for Homes for the Aged in effect at time of initial licensure.	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: 1. Based on observation, the facility failed to	C 101		

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C 101	Continued From page 1 meet the NC State Building Code in effect at the time of construction as relates to the required emergency release switches at the Special (magnetically) locked exits. The switches provided were of the locking type requiring a key to operate. The Code requires, if any required emergency release switch is of the locking type, all staff responsible for evacuation of the residents must carry emergency release switch keys. Findings include: a. Most staff did not carry release switch keys. b. Some staff that had a key on the ring provided, were not aware they had a key to operate the locked emergency release switch. 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 include: a. There was no central emergency release switch provided in the Special Care Unit. b. There was no wiring diagram or systems components location map posted under glass at the fire alarm panel.	C 101	C-101 Kill Switches Responses to the cited deficiencies do not constitute admission or agreement by the facility of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action report; the Plan of Correction is solely prepared as a matter of compliance with state law. Corrective Action * First Fire Protection has been contracted to replace existing locking kill switches at each memory care door with non-locking kill switches and to install a master kill switch in the memory care nurse station. * The wiring diagram was posted under glass at the fire alarm panel Identify Potential: We have checked the other required locations for master kill switches, and they are functional. Systemic Changes: We will monitor the kill switches as described below to assure they function properly. Monitor: We have a program where our fire alarm contractor checks these installations on a regular basis	1-7-2017 12-23-2016
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.	C 111		

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C 111	Continued From page 2 This Rule is not met as evidenced by: Based on review of documents, required reports were not available in the home for review. Findings include the following missing reports: a. Fire and building safety inspection report, b. Fire alarm inspection, c. Sprinkler inspection.	C 111	C-111 Inspection Reports Responses to the cited deficiences to not constitute an admission or agreement by the facility of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action report; the Plan of Correction is solely prepared as a matter of compliance with state law. Corrective Action * Fire and building safety inspection: see attached report from the Fire Marshal dated 4-29-2016 * Fire alarm inspection completed and current, see attached report dated 9-12-2016 * Sprinkler inspection will be completed by a licensed sprinkler inspection company Identify Potential: We have checked our inspection records, and these three inspections are complete or will be complete by 1-7-2017 Systemic Changes: We will monitor the inspection reports as described below to assure they are current. Monitor: We have a program where our fire alarm contractor, sprinkler contractor, and building maintenance contractor (BMS) check these installations on a regular basis.	1-7-2017 12-23-2016 1-7-2017
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 operation, a portion of the hardware was missing from the panic release bar on a smoke barrier door near the Kitchen/100 Hall. The missing part exposed sharp edges that could be a laceration hazard. 2. Based on observation, the warning device, "screamer," protecting the emergency release switch was found switched off at the exit in the Activity room. Warning devices that do not operate could allow resident elopement.	C 166	C-166, Safety Maintenance Responses to the cited deficiences do not constitute an admission or agreement by the facility of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action report; the Plan of Correction is solely prepared as a matter of compliance with state law. Corrective Action * Panic release bar hardware will be repaired by BMS * Screamer cover switch was resolved on 11-23-2016. During the inspection, the switch was found in the off position. We immediately turned it on. Identify Potential: We have checked all other screamer covers, and they are all switched in the on position Systemic Changes: We will monitor the screamer covers as described below to assure they are switched on. Monitor: We have a program where our building maintenance contractor BMS checks these installations on a regular basis.	1-7-2017 11-23-2016
C 185	Fire Safety-Rehearsals on Each Shift SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0309 PLAN FOR EVACUATION	C 185		

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C 185	Continued From page 3 (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: Based on a review of documents, records were not available onsite for the rehearsals of the fire plan. Records must be maintained and available for review.	C 185	C-185 Fire Drills Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the facts alleged or conclusions set forth in the Statement of Deficiencies or Correction Action report; the Plan of Correction is solely prepared as a matter of compliance with state law. Corrective Action. * On 12-21-2016, a representative from First Fire Protection (our fire panel inspection company) provided inservice to the administrator on the operation of the fire panel during a fire drill. He also provided inservice training for our staff, and we conducted a fire drill. We have completed all fire drills for the current quarter as of 12-23-2016. Identify Potential: On 12-21-2016, a representative from First Fire Protection checked all fire panels, and they were functioning properly. Systemic Changes: We will conduct the required fire drills each quarter. Monitor: Monthly for three months, the administrator or designee will spot check the fire drill reports to assure they are current and will report the results to the QA Meeting. If there are issues after that time, monthly reports will be given to the QA Committee until any concerns are resolved.	12-23-2016
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 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	C 189		

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C 189	Continued From page 4 possibility that a fire that begins in one space can quickly spread to other areas of the facility. Findings include: a. Hole in the ceiling of the Memory Care office, b. Hole in the ceiling of the electrical room, c. Gap where the wall meets the ceiling in the electrical room, d. Unsealed sleeve through ceiling of the electrical room, e. Sleeve sealed with combustible foam through ceiling of the electrical room, f. Hole in the ceiling of the kitchen storage room, g. Holes in the ceiling of the RN office, h. Sprinkler escutcheons were missing or not tightly fitted to the ceiling in the main office, pantry, laundry, boiler room and the corridor near room 206. 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 include; a. One of the ¾ hour fire rated doors from the kitchen to the dining room was wedged open. b. The ¾ hour fire rated door to the shop does not fit the opening properly to be resistant to the passage of smoke and does not latch when closed. c. One of the smoke barrier doors on 100 Hall does not close completely or latch. d. One of the smoke barrier doors on 300 hall does not close completely or latch. e. One of the smoke barrier doors near the lobby bathrooms does not close completely or latch. f. The door to bedroom 209 does not fit the opening properly to be resistant to the passage of	C 189	C-189 Penetrations, doors, exit signs, and screamer cover Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action report; the Plan of Correction is solely prepared as a matter of compliance with state law. Corrective Action * Our building maintenance company BMS is repairing all penetrations through fire walls or ceilings, applying fire caulk as needed to fill holes or gaps * Our sprinkler contractor will correct any escutcheons that are not tightly fitted to the ceiling * Any wedges to hold doors open have been removed, and BMS is adjusting doors throughout the building to assure that they close and latch to provide protection from fire and smoke * BMS is repairing the exit sign * BMS is repairing the screamer cover in the lobby * BMS is repairing the latch sets in three doors with holes adjacent to the door handle hardware Identify Potential: We have checked throughout the building and have not found any additional penetrations in fire walls and ceilings. We have also not located doors that fail to close and latch. Systemic Changes: We will monitor the building for penetrations, doors, exit signs, or screamer covers, etc. as described below to assure they are properly maintained for fire safety. Monitor: We have a program where our building maintenance contractor BMS checks these installations on a regular basis	1-7-2017 1-7-2017 1-72017 1-7-2017 1-7-2017 1-7-2017

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C 189	Continued From page 5 smoke and does not latch when closed. g. The doors to bedrooms 104, 204, 205, 207, 208 and 306 do not fit the openings properly to be resistant to the passage of smoke. h. The doors to the Sweet Shoppe and bedrooms 108 and 110 will not latch when closed. i. The door to bedroom 202 could not close because of decorations hung on the door. j. There were holes beside the latchsets through the doors to the Activity room and the Women's and Men's bathrooms in the Lobby. The holes caused the doors to fail to be resistant to the passage of smoke. 3. Based on observation, the exit sign in the corridor near the RN office did not illuminate on normal power or battery back-up. Exit signs that do not illuminate as required could endanger the residents and staff. 4. Based on observation, the warning device, "screamer," protecting the emergency release switch was not working at the exit from the Lobby. Malfunctioning warning devices could allow resident elopement.	C 189		