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
	HAL029004	A. BUILDING: 01 B. WING _____	03/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THOMASVILLE	915 WEST COOKSEY DRIVE THOMASVILLE, NC 27360

(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 Construction Section Biennial Survey by Ed Miller, conducted on March 13, 2017. Records indicates this facility was first licensed on June 19, 1991 for Sixty-Two (62) Beds with includes a 14 bed Special Care Unit. Based on this information, the facility is required to meet the 1991 Homes for the Aged- Minimum and Desired Standards and Regulations; applicable portions of the 2005 Licensing of Adult Care Homes of Seven or More Beds; and the 1991 North Carolina State Building Code, Section 409.1- Institutional (I) Occupancy. Deficiencies were cited that require a Plan of Correction.	C 000	It is the community's standard practice to comply with the referenced regulations	
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. Based on interview with Executive Director and Maintenance Staff, the facility failed to maintain in the facility, the current (completed within the last twelve months) annual inspection report(s) required by this Rule. This deficiency affects all by preventing any deficiency that may be discovered with annual inspections from being corrected. Findings on March 13, 2017: a. The current annual Building Sanitation Inspection Report was not available for review.	C 111	Plan of Correction: a) The annual Building Sanitation Inspection was last completed by the County 12/2015. Report is available in emergency crisis binder. ED contacted county to request new survey; county will schedule ASAP.	3/17/2017

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Audrey M. Howell
TITLE: Executive Director
(X6) DATE: 4/13/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029004	A. BUILDING: 01 B. WING _____	03/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THOMASVILLE	915 WEST COOKSEY DRIVE THOMASVILLE, NC 27360

(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 111	Continued From page 1 b. Facility Manager indicated that the Annual Fire Alarm System Inspection and Testing Report in accordance with NFPA 72, was not available for review.	C 111	Plan of Correction: b) The Annual Fire Alarm System Inspection was completed 03/21/17 by Fire Marshal and filed in community emergency crisis binder. Copy of report submitted to DHSR.	4/14/2017
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 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 Building was not maintained free of hazards, because the portable medical oxygen cylinders were not being properly handled/stored. This could affect all residents, staff and visitors if cylinders fall, breaking their	C 166		

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
	HAL029004	A. BUILDING: 01 B. WING _____	03/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THOMASVILLE	915 WEST COOKSEY DRIVE THOMASVILLE, NC 27360

(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 166	Continued From page 2 valves, propelling the cylinder and turning it into a dangerous projectile. Findings on March 13, 2017: a. Bedroom 110 - a portable medical oxygen cylinders were stored standing up and not secured to the structure. b. SCU Soiled Linen - three portable medical oxygen cylinders were stored standing up and not secured to the structure. 2. Based on Observation, the facility failed to maintain the building in an clean manner. Findings on March 13, 2017: a. Kitchen - the HVAC return grille and its radiation damper had an excessive accumulation of dust/lint and grease.	C 166	Plan of Correction: 1) All oxygen bottles were placed in approved containers or returned to equipment company a) Bedroom 110 - oxygen bottles were returned to equipment company b) SCU Soiled Linen - oxygen bottles were returned to equipment company 2) Kitchen HVAC return grille was cleaned to remove dust, lint and grease Prevention of Re-occurrence: 1) Routine monitoring to ensure proper storage of oxygen bottles, including monitoring of third party vendors providing oxygen to our community 2) Maintenace Director will routinely check and monitor to prevent any accumulation of dust, lint or grease.	3/14/2017 3/15/2017
C 183	Fire Extinguishers SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0308 FIRE EXTINGUISHERS (a) At least one five pound or larger (net charge) A-B-C type fire extinguisher is required for each 2,500 square feet of floor area or fraction thereof. (b) One five pound or larger (net charge) A-B-C or CO/2 type is required in the kitchen and, where applicable, in the maintenance shop. This Rule is not met as evidenced by: 1. Based on observation, the facility failed to properly maintain the fire extinguishers and associated equipment. This could hamper staffs ability to extinguish a small fire and permit it to grow larger. This would affect all residents, staff and visitors by not identifying emergency equipment not in proper working order. Findings on March 13, 2017: a. Exterior Mech Room Behind SCU - since the annual maintenance, performed in December	C 183	Plan of Correction: 1. a) Exterior Mech Room behind SCU: Monthly inspections were properly documented: inspection tag on extinguisher was signed and replaced 1. b) SCU Laundry - Annual Maintenance Extinguisher in Laundry was inspected by Simplex Prevention of Re-occurrence: Mainteance Director and Executive Director will monitor monthly	3/15/2017 4/6/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029004	A. BUILDING: 01 B. WING _____	03/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THOMASVILLE	915 WEST COOKSEY DRIVE THOMASVILLE, NC 27360

(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 183	Continued From page 3 2016, there has been no documentation of the portable fire extinguisher's monthly inspections. b. SCU Laundry - the last annual maintenance check of this portable fire extinguisher was last performed in December 2015.	C 183		
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 building's emergency equipment was not maintained in a safe and in operating condition. This would affect residents, staff and visitors if they could not promptly find their way to an exit during an emergency. Findings on March 13, 2017: a. Corridor between AL and SCU Back Exit - the exterior wall-mounted self-contained emergency light did not illuminate on backup power when tested. b. Corridor from SCU to Right Exit - the wall-mounted self-contained emergency light did not illuminate on backup power when tested. c. Corridor near Bedroom 404 - the wall-mounted self-contained emergency light did not illuminate on backup power when tested. d. Corridor near Bedroom 405 - the	C 189	Plan of Correction: 1. a) Exterior emergency light in corridor between AL & SCU was repaired and tested 1. b) Emergency light in corridor from SCU to right exit was repaired and tested 1. c) Emergency light in corridor near bedroom 404 was repaired and tested 1 d) Emergency light in corridor near bedroom 405 was repaired and tested	3/16/2017 3/16/2017 3/16/2017 3/16/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029004	A. BUILDING: 01 B. WING _____	03/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THOMASVILLE	915 WEST COOKSEY DRIVE THOMASVILLE, NC 27360

(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 189	Continued From page 4 wall-mounted self-contained emergency light did not illuminate on backup power when tested. 2. Based on observations, the Building fire safety was not maintained in a safe and operating condition. This could expose residents, all to fire/smoke if not contained in Room or compartment of origin Findings on March 13, 2017: a1. AL Laundry - the listed ceiling radiation damper above the HVAC grill was blocked open with two pieces of wood instead of manufacturer's approved fuse link. a2. Exterior Mechanical Room near Maintenance Office - there was a 2 inches x 3 inches hole with refrigerant piping not firestopped as it penetrates the fire-resistance-rated ceiling assembly. b. Exterior Mechanical Room near Maintenance Office - there was a gap around the flue not firestopped as it penetrates the fire-resistance-rated ceiling assembly. c. 300 Hall Back Attic Access Door - this door remained open during the Survey, which not in conformance with the NC State Building Code, which requires the fire-resistance-rating of the ceiling must be maintained. Interview with Maintenance indicated the attic access doors were open in and attempt to keep the water lines from freezing. Deficiency corrected before Construction Survey departed the site. d. Attic Furnace Room above Bedroom 313 - the fire-resistance-rated gypsum construction was detaching from the wall under the back right ductwork. e. Attic Furnace Room above AL Dining - there was a gap around a cable not firestopped as it penetrates the fire-resistance-rated wall assembly. The cable is located on the attic side of the front wall. f. Break Room's Mech Room - the	C 189	Plan of Correction: 2a1) AL Laundry - wood was removed and fuse link installed per manufacturer guideline 2a2) Exterior Mechanical Room near Maintenance Office - Fire caulk was applied to 2x3 inch hole around refrigerant piping 2b) Exterior Mechanical Room near Maintenance Office - Fire caulk was applied to gap around flue 2c) 300 Hall Back Attic Access Door - deficiency corrected before Survey departed site by closing attic door. 2d) Attic Furnace Room above Bedroom 313- gypsum construction was repaired where detaching from wall under ductwork on back right 2e) Attic Furnance Room above AL Dining - fire caulk was applied to gap around cable on the attic side of front wall Prevention of Re-occurrence: The Maintenance Director and Executive Director will routinely monitor for compliance	3/16/2017 3/16/2017 3/16/2017 3/16/2017 3/16/2017 3/16/2017

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
	HAL029004	A. BUILDING: 01 B. WING _____	03/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THOMASVILLE	915 WEST COOKSEY DRIVE THOMASVILLE, NC 27360

(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 189	Continued From page 5 fire-resistance-rated gypsum construction was detaching from the left side wall up high. g. Break Room's Mech Room - there was a ¾ inch hole through the fire-resistance-rated ceiling assembly not firestopped. h. Business Managers Office Storage Closet - there was a 2 inches x 6 inches hole through the fire-resistance-rated ceiling assembly not firestopped. i. Business Managers Office Storage Closet - there were two open-ended sleeves with cable bundles not firestopped as they penetrate the fire-resistance-rated ceiling assembly. 3. Based on observation, and interview with Executive Director, the facility failed to provide and/or maintain the automatic roll-down fire door. This would affect all residents, staff and visitors by not having emergency equipment in proper working order. Findings on March 13, 2017: a. The automatic roll-down fire door between Kitchen and Dining had not been inspected as required by NFPA 80. 4. Based on observation, the interior doors were not maintained in a safe and operating condition. Findings on March 13, 2017: a. Smoke Barrier Wall near Bedroom 201 - the smoke seal between the two leafs of the cross-corridor doors was falling out of its metal holder, allowing the passage of smoke between the doors. b. Smoke Barrier Wall near Bedroom 101 - the smoke seal between the two leafs of the cross-corridor doors was missing from its metal holder, allowing the passage of smoke between the doors c. Bedroom 209 - the corridor door had a wedge holding the door open, preventing the rapid	C 189	Plan of Correction: 2f) Break Room's Mech Room - gap was fire caulked and detatching gypsum repaired 2g) Break Room's Mech Room - fire caulk was applied to 3/4 inch hole through ceiling assembly 2h) Business Managers Office Storage Closet- 2x6 inch hole in ceiling closed and fire caulked 2i) Business Managers Office Storage Closet - Fire stop applied to to two open-ended sleeves with cable bundles Prevention of Re-occurrence: The Maintenance Director and Executive Director will routinely monitor for compliance Plan of Correction: 3a) SCU Automatic roll-down fire door will be repaired by Custom Overhead doors then inspected Prevention of Re-occurrence: The Maintenance Director and Executive Director will routinely monitor for compliance Plan of Correction: 4a) Smoke seal installed on door near bedroom 201 4b) Smoke seal installed on door near bedroom 101 4c) Wedge was removed from door in bedroom 209, Prevention of Re-occurrence: The Maintenance Director and Executive Director will routinely monitor for compliance	3/16/2017 3/16/2017 3/16/2017 3/16/2017 4/24/2017 3/16/2017 3/16/2017 3/16/2017

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
	HAL029004	A. BUILDING: 01 B. WING _____	03/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THOMASVILLE	915 WEST COOKSEY DRIVE THOMASVILLE, NC 27360

(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 189	Continued From page 6 release of the door with a light push or pull of the door, to close and latch. d. AL Med Room- the corridor door hits its frame, requiring extra force to close and latch the door. e. Library - the right door leaf of the pair of corridor doors, when released by the fire alarm swings and hits a copy machine, preventing the closing and latching of the door. Deficiency corrected before Construction Survey departed the site. f. AL Chart Room - there was a "telephone cable" running in the corridor door opening, interfering with the proper closing and latching of the door. g. 300 Hall Activity Room - the corridor door had a mechanical kick down holding the door open, preventing the rapid release of the door with a light push or pull of the door, to close and latch. h. Bedroom 110 - the corridor door did not latch into its frame when closed. i. SCU Manager Office - the corridor door had a chair holding the door open, preventing the rapid release of the door with a light push or pull of the door, to close and latch 5. Based on observation, the Building Sprinkler System was not maintained in a safe and operating condition. This could affect all residents, staff and visitors if smoke/fire is not contained in the Room or compartment of origin. Findings on March 13, 2017: a. Building -there was a pattern exhibited where many of the concealed fire sprinkler cover plate assemblies had dropped down from the fire-resistance-rated ceiling, exposing an opening that allows the spread of smoke and heat into the attic. Assure that the manufactures preset gap is observed. b. Housekeeping near Bedroom 107 - the	C 189	Plan of Correction: 4d) AL Med Room door was repaired to close and latch properly 4e) Copier was relocated to prevent library doors hitting it when released by fire alarm 4f) Telephone cable was rerouted through wall and removed from door opening 4g) 300 Hall Activity Room - Kick down removed 4h) Bedroom 110- door latch repaired to properly close and latch 4i) SCU Manager Office - Chair was removed from holding door open Prevention of Re-occurrence: The Maintenance Director and Executive Director will routinely monitor for compliance Plan of Correction: 5a) Maintenance Director surveyed entire building and repaired any concealed fire sprinkler cover plate assemblies that had dropped down from ceiling closing openings per manufacturer's presets. 5b) Housekeeping near Bedroom 107 - sprinkler cover plate was repositioned to cover hole through ceiling properly 5c) Bedroom 201 Corridor side closet - sprinkler cover plate was installed.	3/17/2017 3/13/2017 3/17/2017 3/17/2017 3/17/2017 3/17/2017 3/17/2017 3/17/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029004	A. BUILDING: 01 B. WING _____	03/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THOMASVILLE	915 WEST COOKSEY DRIVE THOMASVILLE, NC 27360

(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 189	Continued From page 7 concealed fire sprinkler cover plate assembly did not cover the complete hole through the fire-resistance-rated ceiling that allows the spread of smoke and heat into the attic. c. Bedroom 201 Corridor side Closet - the concealed fire sprinkler cover plate assembly was missing, exposing an opening through the fire-resistance-rated ceiling that allows the spread of smoke and heat into the attic. 6. Based on observation, the Building was not maintained in a safe and operating condition, because the commercial kitchen hood's fire suppression system lacked the inspections, maintenance and documentation required to ensure a properly working system. This could affect residents, staff and visitors if the commercial kitchen hood's suppression system fails to operate properly when needed. Findings on March 13, 2017: a. Kitchen -since the semi-annual maintenance of the commercial kitchen hood's fire suppression system in December 2016, there has been no documentation of the monthly inspections.	C 189	Plan of Correction: 6a) Monthly inspection of the Kitchen's commercial hood fire suppression system implemented and documented Prevention of Re-occurrence: The Maintenance Director and Executive Director will routinely monitor for compliance	3/17/2017 3/17/2017
C 195	Hot Water System SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). (k) This Rule shall apply to new and existing	C 195		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029004	A. BUILDING: 01 B. WING _____	03/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THOMASVILLE	915 WEST COOKSEY DRIVE THOMASVILLE, NC 27360

(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 195	Continued From page 8 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 Building failed to maintain the hot water temperature at a minimum of 100 degrees Fahrenheit and not to exceed 116 degrees Fahrenheit. Findings on March 13, 2017: a. Building - the hot water temperature at plumbing fixtures used by residents throughout the building ranged between 88 degrees Fahrenheit to 90 degrees Fahrenheit.	C 195	Plan of Correction: 1a) Hot water temperature throughout the community was adjusted to be within required range of 100-115 degrees F. Prevention of Re-occurrence: The Maintenance Director and Executive Director will routinely monitor for compliance	

Thomasville Fire Department
712 East Main Street
Thomasville, North Carolina 27360
Telephone 336-475-5527

Office of the Division Chief of Code Enforcement
Rocky A. Watts

Date: March 21, 2017

To: David Adolphus
Spring Arbor

From: Rocky Watts, Fire Marshal
Thomasville Fire Department

Ref: Fire Inspection of "Spring Arbor" located at 915 W. Cooksey

David,

On March 21st, 2017 I performed a fire inspection at "Spring Arbor" located at 915 W. Cooksey, with your assistance. Please review the following comments from this inspection:

- §605.3 – Keep all electrical panels free from obstructions. Electric Panels shall have a minimum of 36" inches clearance in front of all electrical service panels.
    - §605.3.1 – Doors leading to electrical control panels shall be marked ELECTRICAL ROOM
- §509.2 – Remove Chair blocking the use of the manual pull station from being used. Copier blocking FACP at nurse's station.
- §1008.1.9.6- allows special locking arrangements for I-2 facilities including hospitals, child care facilities and nursing homes. The building has to be equipped with an automatic sprinkler system or an automatic fire detection system and in compliance with the following items:
    - Doors shall unlock upon actuation of the sprinkler or fire detection systems.
    - Doors shall unlock on the loss of power – (See Exceptions)
    - A special magnetic locking system shall be utilized when all the following requirements are met.
        - Only used in wards and wings or other portions of the facility that requires security to protect their patients.
        - These systems may be used provided – not more than one system is located in any egress path.
        - A wiring diagram and system components location maps shall be provide under glass adjacent to the fire alarm panel.
        - An on/off emergency switch must be capable of interrupting power to all electromagnetically locked doors in the facility.
            - Shall be located and identified at each nurse's station serving the locked unit and any other control station responsible for the evacuation of the occupants of the locked units which are manned 24 hours.
        - An additional emergency release switch shall be provided for each locked door and shall be located within 3' ft. of the door and shall not depend on relays or other devices to cause the interruption of power.
        - Any required emergency release switch shall interrupt power to the locking devices. If any required emergency locking device is of the locking type, all staff that are

responsible for the evacuation of the occupants shall carry an emergency release switch key. Additional convenience release devices shall be provided.
    - Each special locking installation shall be approved by the appropriate fire and building inspector, prior to installation, after installation and prior to initial use and reviewed periodically thereafter.
    - Emergency Lights shall be provided at the door.

Note: Please review the items listed above as it pertains to the magnetic locks and confirm all items are addressed. Please call me at 336-475-5527 or email me at rocky.watts@thomasville-nc.gov if you have any questions.

- §906.2 – There was (1) portable fire extinguisher that was not inspected and needs an annual inspection performed. It was dated 2015 and is hanging in the laundry room.
- §807.1 – Curtains, draperies hangings and other decorative materials suspended from the walls or ceilings shall meet the flame propagation performance criteria of NFPA 701 in accordance with §807.2 or be noncombustible.
    - Shall be tested by an approved agency and listed as to meet NFPA 701 and furnished to the fire code official.
- §703.1 – Keep all fire doors closed or placed on approved magnetic closure devices that are tied into the fire alarm system and closes upon activation
    - §703.4 – Automatic fire doors shall be tested and maintained in operable condition. (Fire door was broke during inspection but was being repaired)
- §605.3 – All electrical hazards including unapproved multi-plug adapters and damaged wiring are prohibited.

The building is protected by an automatic sprinkler system that had an NFPA 25 test performed on February 18, 2017. This report showed some minor repairs on the form but was in the process of being corrected. The sprinkler system must have a current 5-year inspection performed or documentation showing this has been completed within the past 5-years.

The Fire Alarm System has had an annual NFPA 72 inspection performed by Tyco Security and records kept on premises.

The automatic fire extinguishing system has been inspected semi-annually and records kept on premises. The hood system was cleaned and a report left on premises.

The emergency lights were tested and maintained and records kept on premises.

Fire drills are being performed quarterly and on each shift and documented. Employee training and response is required per §406 of the NCFC and should be performed by all employees on an annual basis and new employee orientation. Records of this training are required.

Please review this inspection form and call me at 336-475-5527 if you have any questions or email me at rocky.watts@thomasville-nc.gov

Sincerely,

Rocky Watts, Fire Marshal
City of Thomasville

Spring Arbor of Thomasville
March 21, 2107 Fire Inspection Corrective Actions

§605.3 – Items were relocate in mechanical room to provide 36" clearance in front of electrical service panel 3/21/17

§605.3.1 – Mechanical rooms will be labeled "ELECTRICAL ROOM"

§509.2 – Chair in hall blocking manual pull station was relocated; copier blocking FACP at nurse's station was relocated 3/21/17

§1008.1.9.6 – ED & Maintenance Director met with Fire Marshal 4-10-17 to review requirements for special magnetic locking system. It was determined that:

a) a wiring diagram with system components location map should be created and placed under glass adjacent to the fire alarm panel.\
b) a meeting will be held with Fire Marshal, Building Inspector and Maintenance Director to inspect the special locking system for approval to assure system meets all building code requirements. Maintenance Director will schedule meeting with Matt Tow, Building Inspector by 4/24/17.

§906.2 – Portable fire extinguisher missing inspection tag was inspected on 4/6/17 and inspection report provided to Fire Marshal 4/10/17

§807.1 - Fire Marshal states that per Fire Code, curtains and draperies must meet flame propagation performance criteria or be noncombustible. Per meeting with Fire Marshal 4/10/17, he states curtains in patient rooms not made of noncombustible material does not present an imminent danger since the building is fire alarm and sprinkler equipped and he is granting the community 1 year to budget and replace with noncombustible curtains. Community will remove all curtains/valances from patient rooms.

§703.1 - All fire doors will be closed or placed on approved magnetic closure devices tied to the fire alarm system §703.4 – Automatic fore door in cottage was broken upon inspection by Fire Marshal 3/21/17. Door is to be repaired and inspected 04/11/17.

§605.3 – Multi-plug adapter to be removed and damaged wiring repaired 4/10/17

Sprinkler system 5-year inspection was performed 4/3/17 and copy provided to Fire Marshal 4/10/17

New Hire and annual fire safety training documents provided to Fire Marshal with zero deficiencies noted 4/10/17.