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
	HAL014004	A. BUILDING: 01 B. WING _____	07/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SHAIRE CENTER	1450 SHAIRE CENTER DRIVE LENOIR, NC 28645

(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 and Ed Miller on 7-18-2018. Records indicate this facility was first licensed on 7-1-1985, for 70 beds. There was a 12 bed addition in 1991, that brought the total number of beds to 82. Based on this information, we are requiring the facility to meet the 1984 rules for Homes for the Aged and Disabled - Minimum Standards and Regulations, the applicable portions of the 2005 Rules for Adult Care Homes of Seven or More Beds, and the 1978 Edition of the North Carolina State Building Code; Volume I - General Construction.	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 meet	C 101	This Plan of Correction is submitted to address deficiencies cited under Tag# C101. This is to state that we do not concur with this recommendation as stated for deficient practice. Upon finding stated deficiencies. 1. On July 20, 2018 A wiring diagram denoting the locations of all of the required components for doors with Special Locking Systems was posted under glass at the fire alarm panel. 2. On August 15, 2018, the special locking (magnetically locked) exit doors at the ends of A hall and D hall were	7/20/18 8/15/18

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 8/23/18

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C 101	Continued From page 1 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. Finding on 7-18-2018: There was no wiring diagram posted under glass at the fire alarm panel. 2. Based on observation, the facility is equipped with Special (magnetic) Locking at the exits. Some of the exits did not unlock properly which could delay and evacuation in an exit. Finding on 7-18-2018; a. The exit on A Hall did not unlock when the central emergency release switch was activated. b. The exit on D Hall did not unlock when the central emergency release switch was activated.	C 101	repaired by Unifour Fire and Safety to release and open upon the activation of the fire alarm system as well as by an adjacent emergency release switch, or the central/master emergency release switch located at the nurses station.	
C 133	Bathrooms-Hand Grips SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0305 PHYSICAL ENVIRONMENT (e) The requirements for bathrooms and toilet rooms are: (6) Hand grips shall be installed at all commodes, tubs and showers used by or accessible to residents; This Rule is not met as evidenced by: Based on observation, there were no hand grips provided at the toilet in the women's and men's bathrooms near the front door.	C 133	This Plan of Correction is submitted to address deficiencies cite under Tag# C133 This is to state that we do not concur with this recommendation as stated for deficient practice. Upon finding stated deficiencies. On July 31, 2018 hand grips/grab bars were installed in the commode area in the women's and men's bathrooms located near the front door.	7/31/18
C 150	Corridors-Free of equipment and Obstructions SECTION .0300 - PHYSICAL PLANT	C 150		

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C 150	Continued From page 2 10A NCAC 13F .0305 PHYSICAL ENVIRONMENT (g) The requirements for corridors are: (4) Corridors shall be free of all equipment and other obstructions. This Rule is not met as evidenced by: Based on observation, the corridor was not maintained free of obstructions. At least 6 feet of clear width must be maintained in exit corridors. Finding on 7-18-2018: There was a walker and a fan in the corridor reducing the clear width to less than 4 feet. Note; This deficiency was corrected during the survey.	C 150	This Plan of Correction is submitted to address deficiencies cited under Tag# C150 This is to state that we do not concur with this recommendation as stated for deficient practice. Upon finding stated deficiencies. On July 18, 2018 a walker and a fan were removed from corridor to allow for at least 6 feet of clear width for exiting. The nursing, environmental service and maintenance departments were re-educated as to the importance of keeping all corridors free of all equipment and other obstructions. At least 6 feet of clear width must be maintained in exit corridors.	7/18/18
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 in a safe manner by not properly handling portable medical oxygen cylinders. This could affect all residents, staff and visitors if cylinders fall, breaking their valves, propelling the cylinder and turning it into a dangerous projectile. Findings on 7-18-2018: a. Two portable medical oxygen cylinders were stored in no rack or container in room 37. b. A portable medical oxygen cylinder was stored	C 166	This Plan of Correction is submitted to address deficiencies cited under Tag# C166 This is to state that we do not concur with this recommendation as stated for deficient practice. Upon finding stated deficiencies. 1. On July 18, 2018 all medical oxygen cylinders were placed in an approved portable oxygen storage container. On July 19-	7/18/18

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C 166	Continued From page 3 in a plastic bin in room 40. Note; These deficiencies were corrected during the survey. 2. Based on observation, there was no documentation of the required in house/owner's monthly inspections for May and June provided on the inspection tag at the range hood fire suppression system. Range hood fire suppression systems must be inspected monthly and the inspections must be documented somewhere such as on the tag provided at the system pull. 3. Based on observation, there was no documentation of the required in house/owner's monthly inspections for May and June provided on the inspection tag at the fire extinguishers. Fire extinguishers must be inspected monthly and the inspections must be documented somewhere such as on the tag provided on the extinguisher. 4. Based on observation a toilet was loosely mounted to the floor. Loose toilets can cause leaking and/or fall hazards. Finding on 7-18-2018: The toilet was loosely mounted to the floor in the shower room by room 4. 5. Based on observation, a towel bar was missing in the bathroom off room 38. The towel bar mounting devices were still on the wall and presented sharp edges.	C 166	20, 2018, all staff was notified of the importance of keeping all portable oxygen stored properly to ensure the safety of all residents, staff and visitors. The rationale was discussed relating to oxygen tanks that fall, breaking their valves, propelling the tank and turning them into a dangerous projectile. 2. On July 23, 2018 the required in house/owner's monthly inspection of the range hood fire suppression system was completed and documented on the tag at the system pull. In addition, maintenance and dietary staff were notified of the importance of completing this monthly inspection with documentation to be completed on the tag provided at the system pull. 3. On July 23, 2018 the required in house/owner's monthly inspection of the fire extinguishers was completed and documented on the tag provided on the extinguisher. In addition, maintenance staff was notified of the importance of completing this monthly inspection with documentation to be completed on the tag provided on the extinguisher.	7/23/18 7/23/18
C 184	Fire Safety-Evacuation plan SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0309 PLAN FOR EVACUATION	C 184	4. On July 25, 2018, the toilet was repaired and re-installed in the shower room next to room #4. The toilet was repaired to allow	7/25/18

for security and lessen fall hazards.

5. On July 25, 2018, a towel bar was replaced in room #38. On July 25-27, 2018, nursing, environmental service and maintenance staff was re-educated of the importance of notifying the maintenance department of any issues that may need addressing by maintenance regardless of the nature. 7/25/18

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C 184	Continued From page 4 (a) A written fire evacuation plan (including a diagrammed drawing) which has the written approval of the local Code Enforcement Official shall be prepared in large print and posted in a central location on each floor of an adult care home. The plan shall be reviewed with each resident on admission and shall be a part of the orientation for all new staff. (f) This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on a review of documents, the evacuation plan posted in the corridor near room 3 was not oriented correctly to the structure. Note; This deficiency was corrected during the survey.	C 184	This Plan of Correction is submitted to address deficiencies cited under Tag# C184 This is to state that we do not concur with this recommendation as stated for deficient practice. Upon finding stated deficiencies. On July 18 2018, the correct evacuation plan was posted in the corridor near room #3 that had the correct orientation.	7/18/18
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. Based on a review of documents, fire drill rehearsals are not being done regularly with at	C 185	This Plan of Correction is submitted to address deficiencies cited under Tag# C185 This is to state that we do not concur with this recommendation as stated for deficient practice. Upon finding stated deficiencies. On August 8, 2018 a fire drill was conducted on first and second shifts. A walk through with third shift staff was conducted on August 9,2018, The fire drill was documented appropriately and placed in the fire safety folder. The maintenance department was re-educated as to the importance of keeping all fire drill records current, up-to-date, together and immediately available for	8/08/18

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C 185	Continued From page 5 least one per shift each quarter. Failure to rehearse the fire plan could lead to confusion and delay in an actual emergency. Findings on 7-18-2018: a. Two of the records available did not indicate on which shift they were done. b. All of the remaining records available were for the 1st shift. 2. Based on a review of documents, the records available onsite included no description of what the rehearsal involved.	C 185	review. The requirement of rehearsals being done regularly with at least one per shift each quarter was reviewed. In addition a description of what the rehearsal involved needs be documented on the record was discussed with maintenance acknowledging understanding.	
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: 2. Based on observation, battery powered emergency lights would not work when tested. Battery powered emergency lights that will not work properly for at least 90 minutes could endanger the residents and staff. Mal-functioning lights include the following areas: a. Corridor near room 9, b. A Hall dining, c. The emergency light in the corridor near D Hall Dining was falling apart.	C 189	This Plan of Correction is submitted to address deficiencies cited under Tag# C189 This is to state that we do not concur with this recommendation as stated for deficient practice. Upon finding stated deficiencies. 2. On July 23, 2018, all emergency lights were tested and repaired as needed. Battery powered emergency lights were replaced to provide for proper function in the corridor near room #9, A Hall dining area, and the corridor near D Hall dining. 3. On July 23, 2018, all exit signs were tested and repaired as needed. Battery powered exit signs were replaced to provide for proper function in the corridor near the mechanical room.	7/23/18 7/23/18

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C 189	Continued From page 6 3. Based on observation, the facility failed to be maintained in a safe condition because of an exit sign not working properly. Malfunctioning exit signs could delay or prevent an evacuation in an emergency. Finding on 7-18-2018: The exit sign in the corridor near the mechanical room did not work on battery when tested. 4. Based on observation, the required one-hour fire rated walls and/or ceilings were compromised in locations. Holes and penetrations that are not sealed with materials approved for use in one-hour fire rated construction present the possibility that a fire that begins in one space can quickly spread to other areas of the facility. Findings on 7-18-2018: a. Holes in the walls behind the washers in the main laundry, b. Holes in the walls of the office being renovated, c. Hole in the ceiling at newly installed air conditioning pipes in the pharmacy. 5. Based on observation, many corridor doors are prevented from closing quickly and latching to resist the passage of fire and smoke. Corridor doors that do not close completely and latch present the possibility that a fire that begins in one space can quickly spread to the corridor and the remainder of the facility. Findings on 7-18-2018; a. The door to room 16 would not latch when closed. b. The door to the beauty parlor would not latch when closed. c. The door to room 32 does not fit the opening properly to be resistant to the passage of smoke. d. The door to room 33 does not fit the opening properly to be resistant to the passage of smoke.	C 189	4. On July 27, 2018: a. All penetrations and/or holes in the walls behind the washers in the main laundry were repaired with gypsum board if needed and patched with sheetrock compound and/or fire caulked to provide a one-hour fire rating. b. All penetrations and/or holes in the office being renovated were repaired with gypsum board if needed and patched with sheetrock compound and/or fire caulked to provide a one-hour fire rating. c. All penetrations and/or holes in the pharmacy ceiling were repaired with gypsum board if needed and patched with sheetrock compound and/or fire caulked to provide a one-hour fire rating. 5. On August 1, 2018: a. The door to bedroom 16 was adjusted and repaired to close and latch properly. b. The door to the beauty parlor was adjusted and repaired to close and latch properly. c. The door to bedroom 32 was adjusted and repaired to close and latch properly to be resistant to the passage of smoke. d. The door to bedroom 33 was adjusted and repaired to close and latch properly to be resistant to the passage of smoke.	7/27/18 8/1/18

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C 189	Continued From page 7 e. The door to the shower room on B Hall was wedged open. f. One of the hinges was loose on the door to D Hall Dining. 6. Based on observation, the sampling tube for the duct mounted smoke detector in the mechanical room was very dirty. Sampling tubes that are not periodically inspected and cleaned can endanger all residents and staff because the duct detector may fail to operate properly. 7. Based on observation, the magnetic hold-open device was falling off the smoke barrier door near the pharmacy. The loose device presented sharp edges. 8. Based on observation, an outside receptacle box was falling off the wall near the exit from D Hall. Also, the receptacle provided was not GFCI protected. 9. Based on observation, there was no power at the GFCI type receptacle in the bathroom off room 21. GFCI type receptacles that do not have power cannot be tested to work properly.	C 189	e. On July 18, 2018 the wedge used to prop the door open to the shower room on B hall was removed. f. On July 30, 2018 the door to D Hall dining room was adjusted and repaired to close and latch properly. 6. On August 6, 2018 the sampling tube for the duct mounted smoke detector in the mechanical room was cleaned and inspected to allow the duct detector to operate properly. 7. On August 8, 2018 the magnetic hold-open device was repaired and replaced on the smoke barrier door near the pharmacy. 8. On August 8, 2018 the outside receptacle located near the exit from D hall was replaced with a GFCI protected receptacle and weather proof box. 9. On August 8, 2018 the GFCI receptacle located in the bathroom off room #21 was replaced with a new GFCI protected receptacle and tested for proper function.	7/18/18 7/30/18 8/6/18 8/8/18 8/8/18 8/8/18
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;	C 199	This Plan of Correction is submitted to address deficiencies cited under Tag# C199. This is to state that we do not concur with this recommendation as stated for deficient	

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C 199	Continued From page 8 (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: Based on observation the facility failed to maintain required exhaust in a working condition. Findings on 7-18-2018; a. The exhaust provided was not working in the hopper room. b. The exhaust provided was not working in the nurse restroom.	C 199	practice. Upon finding stated deficiencies. On August 22, 2018, a new exhaust ventilation fan was installed in the hopper room and the nurse restroom to provide exhaust ventilation at the rate of two cubic feet per minute per square feet. The exhaust fans were tested for proper function. The maintenance and environmental services departments will monitor all facility areas for continued compliance.	8/22/18