SUMMIT PLACE
OF MOORESVILLE

FIVE STAR
SENIOR LIVING

November 14, 2018

NC Department of Health and Human Services
Division of Health Regulation
Construction Section
2705 Mail Service Center
Raleigh, NC 27699-2705

Re: Summit Place of Mooresville - HA Biennial Survey
128 Brawley School Road
Mooresville, NC 28117
Iredell County
License #: HAL-049-030
FID #: 971550

Enclosed is the response of Summit Place of Mooresville for each rule violation/deficiency cited during the Biennial Survey on October 3, 2018.

Respectfully,

Shay Lingerfelt
Executive Director
Email: SLingerfelt@5SSL.com
Office: 704-799-2712

Enclosures

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
	HAL049030	A. BUILDING: 01 B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT PLACE OF MOORESVILLE	128 BRAWLEY SCHOOL ROAD MOORESVILLE, NC 28117

(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 October 3, 2018. Records indicate this facility was first licensed as a Home for the Aged on December 23, 1997. The facility is currently licensed for a total of sixty bed capacity, which includes a twenty bed Special Care Unit. Therefore, we are requiring this facility to meet the 1996 Rules for the Licensing of Adult Care Homes, applicable portions of the 2005 Licensing of Adult Care Homes of Seven or More Beds, and the 1996 North Carolina State Building Code; Section 409.1 - Group I-Institutional Unrestrained Occupancy. Deficiencies were cited that require a Plan of Correction.	C 000	See Attached.	
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		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Regional Director of Operations | (X6) DATE: 11/12/18

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C 101	Continued From page 1 This Rule is not met as evidenced by: 1. Based on observation and interview with Maintenance Director, the facility failed to meet the Code requirements in effect at the time of construction or alteration by not having all of the required working components for doors equipped for a "Special Locking" Arrangement. Findings on October 3, 2018: a. SCU Nurse Station - the central on/off emergency release switchs for the "Special Locking" system is incapable of releasing the electromagnetic locks on exit doors near Bedroom 212, 216, 224 and SCU Living Room, to allow free egress. b. Exit doors near Bedroom 212, 216, 224 and SCU Living Room - when the fire alarm is activated, the exits (equipped with special locking) released, but when system is silenced, the doors reenergized and locked. 2. Based on observation, the Fire Alarm system is not maintained in a safe and operating condition. Findings on October 3, 2018: a. Entire Building - when the fire alarm is activated, the hold open devices released their doors closing the openings in the smoke compartments. When the fire alarm system is put into silence mode, these hold open devices reenergized, which allows the smoke compartment doors to be held open during an alarm.	C 101	See Attached.	
C 164	Housekeeping and Furnishings-Clean, Repaired SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0306 HOUSEKEEPING AND FURNISHINGS	C 164		

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C 164	Continued From page 2 (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. Based on observation, the building ceiling are not kept clean and in good repair. Findings on October 3, 2018: a. Bedroom 228 - the ceiling is stained from a past leak.	C 164	See Attached.	
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, if oxygen cylinders fall, breaking their valves, propelling the cylinder, and turning it into a dangerous projectile. Findings on October 3, 2018: a. Bedroom 110 - one portable medical oxygen cylinder is standing up on the floor not physical secured in a rack, stand or chained to the structure.	C 166		

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C 166	Continued From page 3 b. Bedroom 112 - several portable medical oxygen cylinders are standing up in a plastic crate not physical secured in racks, stands or chained to the structure. c. Bedroom 112 - three portable medical oxygen cylinders are standing up on the floor not physical secured in racks, stands or chained to the structure. 2. Based on Observation, the facility failed to provide a mechanical systems free of hazards. This could affect all residents, staff and visitors, if equipment in disrepair injured someone. Findings on October 3, 2018: a. Dining - a HVAC return grille is falling out of the ceiling. 3. Based on observation, the Building plumbing equipment was not maintained in a clean and orderly manner free if hazards. Findings on October 3, 2018: a. SCU Spa - the tub has a loose hand grip (grab bar).	C 166	See Attached.	
C 188	Electrical Outlets in Wet Locations SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0310 ELECTRICAL OUTLETS All adult care home electrical outlets in wet locations at sinks, bathrooms and outside of building shall have ground fault interrupters. This Rule is not met as evidenced by: 1. Based on Observation, the facility failed to provide electrical outlets in wet locations at sinks, bathrooms and outside of building with ground fault interrupters. This would affect residents, staff, and visitors by not providing ground fault	C 188		

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C 188	Continued From page 4 protection to these devices. Findings on October 3, 2018: a. Employee Side Entrance - the ground-fault circuit-interrupter (GFCI) electrical power receptacle did not trip with a push of the test button and when tested with a circuit tester.	C 188		
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 operating condition. This would affect all if they could not promptly find their way to an exit during an emergency. Findings on October 3, 2018: a. Women - the wall-mounted self-contained emergency light did not illuminate on backup power when the test button is pushed. b. Men - the wall-mounted self-contained emergency light did not illuminate on backup power when the test button is pushed. c. Front Living Room- the exit sign did not illuminate on backup power when tested. d. Corridor near Bedroom 109 - the wall-mounted self-contained emergency light did not illuminate on backup power when the test	C 189	See Attached.	

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C 189	Continued From page 5 button is pushed. e. Corridor near Bedroom 117 - the wall-mounted self-contained emergency light did not illuminate on backup power when the test button is pushed. f. Fire Wall Back side - the exit sign did not illuminate on backup power when tested. g. SCU Med Room - the wall-mounted self-contained emergency light did not illuminate on backup power when the test button is pushed. h. Corridor across Bedroom 215 - the wall-mounted self-contained emergency light did not illuminate on backup power when the test button is pushed. i. Corridor across SCU Mech room - the wall-mounted self-contained emergency light did not illuminate on backup power when the test button is pushed. 2. Based on observation, the Fire Alarm system was not maintained in a safe and operating condition. This would affect all by not providing early detection and activating the fire alarm system. Findings on October 3, 2018: a. Mech Room near Kitchen - the sample tubes for the HVAC duct mounted smoke detectors for unit 1 & 3 were dirty, and my not detect the existence of smoke in the air stream. b. SCU Mech Room - the sample tubes for the HVAC duct mounted smoke detectors were dirty, and my not detect the existence of smoke in the air stream. 3. Based on observations, the Building fire safety was not maintained in a safe and operating condition. This could expose all to fire/smoke if not contained in room of origin. Findings on October 3, 2018: a. Kitchen - Leaks had deteriorated the	C 189	See Attached.	

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C 189	Continued From page 6 one-hour fire-resistance-rated gypsum ceiling assembly to a point where the tape and joint compound had disappeared. b. Corridor near Bedroom 107 - the exit sign base does not completely cover the hole penetrating the fire-resistance-rated ceiling assembly. c. Corridor near Bedroom 200 -the ceiling has a gypsum wallboard surface mounted patch, attached to the one-hour fire-resistance-rated ceiling assembly with fasteners The patch does not show signs that the gypsum wallboard patch was "buttered" with joint compound before being attached. In addition, this patch consist of two 5/8 inch thick boards butted together and the joint is not mudded and taped. 4. Based on observation, the Building was not maintained in a safe and operating condition, because the fire rated doors in a Firewall did not close completely and latch in order to contain smoke/fire. This could affect all residents, staff and visitors by not containing smoke/fire in the fire compartment of origin. Findings on October 3, 2018: a. Firewall, - the left leaf of the cross-corridor double-egress doors did not latch when the fire alarm hold open devices released. 5. Based on observations, the Building was not maintained in a safe and operating condition. The fire sprinkler heads have become obstructed. This could affect all if the fire sprinkler heads' spray cannot reach are area of a room. Findings on October 3, 2018: a. AL Nurse Office Closet - items are being stored within the area 18 inches below the fire sprinkler head. Deficiency corrected before Construction Surveyors departed site. b. Storage across from Bedroom 120 - items	C 189	See Attached.	

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C 189	Continued From page 7 are being stored within the area 18 inches below the fire sprinkler head. 6. Based on Observation, the corridor doors and other smoke tight doors are not maintained in a safe and operating condition. This affects all by not containing smoke and fire in the room of origin. Findings on October 3, 2018: a. Front Living room - the corridor doors have paper towels holding the pair of doors open. This prevents the rapid release of the doors with a light push or pull of the door, to close and latch. b. Kitchen to Dining - the door has a wedge holding the door open. This prevents the rapid release of the door with a light push or pull of the door, to close and latch. Deficiency corrected before Construction Surveyors departed site. c. Privite Dining - the door has a chair holding the door open. This prevents the rapid release of the door with a light push or pull of the door, to close and latch. d. Bedroom 106 - the corridor door did not latch into its frame when closed. e. Bedroom 200 - the corridor door did not latch into its frame when closed. f. Bedroom 208 - the corridor door did not latch into its frame when closed. g. SCU Soiled Utility - there are two 1/4 inch diameter holes through the corridor door beside the door handle. 7. Based on observation the Building was not maintained in a safe, in good operating condition and Code compliant because doors took more opening force than allowed by North Carolina State Building Code. Findings on October 3, 2018: a. Bedroom 215 - the corridor door hits its doorframe, requiring more than 15 pounds of	C 189	See Attached.	

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C 189	Continued From page 8 force to open the door. b. Bedroom 229 - the corridor door hits its doorframe, requiring more than 15 pounds of force to open the door. 8. 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 October 3, 2018: a. Corridor near Bedroom 105 - the fire sprinkler is missing its top escutcheon plate, exposing an opening through the fire-resistance-rated ceiling that allows the spread of smoke and heat. 9. Based on observation, the Facility failed to maintain the electrical system in a safe and operating condition. Using high power loads such as refrigerators, with multiple power taps is a fire hazard. Findings on October 3, 2018: a. Copy Area near Executive Directors Office- a refrigerator is plugged into a power tap. Deficiency corrected before Construction Surveyors departed site. b. AL Med room- a refrigerator is plugged into a power tap. Deficiency corrected before Construction Surveyors departed site. c. Bedroom 112 - there are two multiple plug adaptor without integral overcurrent protection plugged into an electrical power receptacle.	C 189	See Attached.	
C 199	Exhaust Ventilation SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (g) The spaces listed in this Paragraph shall be	C 199		

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C 199	Continued From page 9 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. Based on Observation and testing with a thin plastic sheet, the facility failed to maintain the ventilation system in proper working order. This could affect all residents, staff, and visitors by preventing the exhausting of odors. Findings on October 3, 2018: a. Women - the required exhaust ventilation system did not work. b. Men - the required exhaust ventilation system did not work. c. Staff Toilet Room - the required exhaust ventilation system did not work. d. Kitchen Mop Closet - the required exhaust ventilation system did not work. e. AL Nursing Office Bathroom - the required exhaust ventilation system did not work. f. Bedroom 110 Bathroom - the required exhaust ventilation system did not work. g. Bedroom 228 Bathroom - the required exhaust ventilation system did not work.	C 199	See Attached.	

Summit Place of Mooresville – Biennial Construction Survey
Plan of Correction
Facility License # HAL-049-030

1) 10A NCAC 13F .0301 Application of Physical Plant Requirements – Based on observation and interview with Maintenance Director, the facility failed to meet the Code requirements in effect at the time of construction or alteration by not having all of the required working components for doors equipped for a "Special Locking" Arrangement. Findings on October 3, 2018:

a. SCU Nurse Station - the central on/off emergency release switches for the "Special Locking" system is incapable of releasing the electromagnetic locks on exit doors near Bedroom 212, 216, 224 and SCU Living Room, to allow free egress.
b. Exit doors near Bedroom 212, 216, 224 and SCU Living Room - when the fire alarm is activated, the exits (equipped with special locking) released, but when system is silenced, the doors reenergized and locked.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

a. SCU Nurse Station - the central on/off emergency release switches for the "Special Locking" system was repaired on 11/9/18 by an approved vendor.
b. Exit doors near Bedroom 212, 216, 224 and SCU Living Room – the special locking will be repaired by 11/9/18 by an approved vendor.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All SCU residents could potentially be affected.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Maintenance Director or designee will conduct random operational checks/inspections of the Special Locking system to ensure compliance.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will conduct random operational checks/inspections of the Special Locking system to ensure compliance.

2) 10A NCAC 13F .0301 Application of Physical Plant Requirements – Based on observation, the Fire Alarm system is not maintained in a safe and operating condition.

a. Entire Building - when the fire alarm is activated, the hold open devices released their doors closing the openings in the smoke compartments. When the fire alarm system is

put into silence mode, these hold pen devices reenergized, which allows the smoke compartment doors to be held open during an alarm.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

The hold open devices/fire alarm system was repaired on 11/9/18 by an approved vendor.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All residents could potentially be affected.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Maintenance Director or designee will conduct routine operational checks/inspections of the hold open devices during community fire drills to ensure compliance.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will conduct routine operational checks/inspections of the hold open devices during community fire drills to ensure compliance.

3) 10A NCAC 13F .0306 Housekeeping and Furnishings – Based on observation, the building ceiling are not kept clean and in good repair. Findings on October 3, 2018:

a. Bedroom 228 - the ceiling is stained from a past leak.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

A roof link was identified and repaired on 10/10/18 by an approved vendor. Room 228's ceiling was repaired on 10/26/18 by an approved vendor.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

The resident residing in Room 228 was temporarily relocated until repairs were completed.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Maintenance Director or designee will conduct routine visual inspections of all ceilings and to ensure compliance.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will conduct routine visual inspections of all ceilings and to ensure compliance.

4) 10A NCAC 13F .0306 Housekeeping and Furnishings – Based on Observation, the Building was not maintained free of hazards, if oxygen cylinders fall, breaking their valves, propelling the cylinder, and turning it into a dangerous projectile. Findings on October 3, 2018:

a. Bedroom 110 - one portable medical oxygen cylinder is standing up on the floor not physical secured in a rack, stand or chained to the structure.
b. Bedroom 112 - several portable medical oxygen cylinders are standing up in a plastic crate not physically secured in racks, stands or chained to the structure.
c. Bedroom 112 - three portable medical oxygen cylinders are standing up on the floor not physical secured in racks, stands or chained to the structure.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

a. Bedroom 110 - the portable medical oxygen cylinder was secured in a rack on 10/5/18.
b. Bedroom 112 - the portable medical oxygen cylinders were secured in a rack on 10/5/18.
c. Bedroom 112 - the portable medical oxygen cylinders were secured in a rack on 10/5/18.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All residents could potentially be affected. A facility wide visual inspection was completed on 10/6/18 to ensure all oxygen cylinders were secured in racks.

C) The following systemic changes will be made to ensure compliance with this regulation:

Oxygen vendors will not be permitted to deliver oxygen cylinders without providing adequate oxygen cylinder racks. The Director of Resident Care or designee will conduct routine visual inspections to ensure oxygen cylinders are secured.

D) The facility will monitor the corrective actions as follows:

The Director of Resident Care or designee will conduct routine visual inspections to ensure oxygen cylinders are secured.

5) 10A NCAC 13F .0306 Housekeeping and Furnishings – Based on Observation, the facility failed to provide a mechanical systems free of hazards. This could affect all

residents, staff and visitors, if equipment in disrepair injured someone. Findings on October 3, 2018:

a. Dining - a HVAC return grille is falling out of the ceiling.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

The HVAC return grill was properly secured to the ceiling on 10/6/18 by the Maintenance Director.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All residents could potentially be affected.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Maintenance Director or designee will conduct routine visual inspections of all HVAC returns in ceilings to ensure they are secured.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will conduct routine visual inspections of all HVAC returns in ceilings to ensure they are secured.

6) 10A NCAC 13F .0306 Housekeeping and Furnishings – Based on observation, the Building plumbing equipment was not maintained in a clean and orderly manner free if hazards. Findings on October 3, 2018:

a. SCU Spa - the tub has a loose hand grip (grab bar).

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

The SCU Spa tub hand grip (grab bar) was repaired on 10/5/18 by the Maintenance Director.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All SCU residents could potentially be affected. A facility wide inspection of grab bars was completed on 10/8/18 by the Maintenance Director.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Maintenance Director or designee will conduct routine inspections of all hand grips (grab bars) to ensure compliance.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will conduct routine inspections of all hand grips (grab bars) to ensure compliance.

7) 10A NCAC 13F .0310 Electrical Outlets – Based on Observation, the facility failed to provide electrical outlets in wet locations at sinks, bathrooms and outside of building with ground fault interrupters. This would affect residents, staff, and visitors by not providing ground fault protection to these devices. Findings on October 3, 2018:

a. Employee Side Entrance - the ground-fault circuit-interrupter (GFCI) electrical power receptacle did not trip with a push of the test button and when tested with a circuit tester.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

Employee Side Entrance GFCI electrical power receptacle was repaired by an approved vendor on 11/13/18.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All residents could potentially be affected. A facility wide operational inspection of all GFCI electrical power receptacles was completed on 10/15/18 by the Maintenance Director.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Maintenance Director or designee will conduct routine operational inspections of all GFCI electrical power receptacles to ensure compliance.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will conduct routine operational inspections of all GFCI electrical power receptacles to ensure compliance.

8) 10A NCAC 13F .0311 Other Requirements – Based on observation, the building's emergency equipment was not maintained in a safe and operating condition. This would affect all if they could not promptly find their way to an exit during an emergency. Findings on October 3, 2018:

a. Women - the wall-mounted self-contained emergency light did not illuminate on backup

power when the test button is pushed.

b. Men - the wall-mounted self-contained emergency light did not illuminate on backup power when the test button is pushed.
c. Front Living Room- the exit sign did not illuminate on backup power when tested.
d. Corridor near Bedroom 109 – the wall-mounted self-contained emergency light did not illuminate on backup power when the test button is pushed.
e. Corridor near Bedroom 117 – the wall-mounted self-contained emergency light did not illuminate on backup power when the test button is pushed.
f. Fire Wall Back side - the exit sign did not illuminate on backup power when tested.
g. SCU Med Room - the wall-mounted self-contained emergency light did not illuminate on backup power when the test button is pushed.
h. Corridor across Bedroom 215 – the wall-mounted self-contained emergency light did not illuminate on backup power when the test button is pushed.
i. Corridor across SCU Mech room – the wall-mounted self-contained emergency light did not illuminate on backup power when the test button is pushed.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

a. Women - the wall-mounted self-contained emergency light will be replaced by 11/17/18.
b. Men - the wall-mounted self-contained emergency light will be replaced by 11/17/18.
c. Front Living Room- the exit sign will be replaced by 11/17/18.
d. Corridor near Bedroom 109 – the wall-mounted self-contained emergency light will be replaced by 11/17/18.
e. Corridor near Bedroom 117 – the wall-mounted self-contained emergency light will be replaced by 11/17/18.
f. Fire Wall Back side - the exit sign will be replaced by 11/17/18.
g. SCU Med Room - the wall-mounted self-contained emergency light will be replaced by 11/17/18.
h. Corridor across Bedroom 215 – the wall-mounted self-contained emergency light will be replaced by 11/17/18.
i. Corridor across SCU Mech room – the wall-mounted self-contained emergency light will be replaced by 11/17/18.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All residents could potentially be affected. A facility wide operational inspection of all wall-mounted self-contained emergency lighting and exit signs was completed on 10/10/18 by the Maintenance Director.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Maintenance Director or designee will conduct monthly operational inspections of all wall-mounted self-contained emergency lighting and exit signs to ensure compliance.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will conduct monthly operational inspections of all wall-mounted self-contained emergency lighting and exit signs to ensure compliance.

9) 10A NCAC 13F .0311 Other Requirements – Based on observation, the Fire Alarm system was not maintained in a safe and operating condition. This would affect all by not providing early detection and activating the fire alarm system. Findings on October 3, 2018:

a. Mech Room near Kitchen - the sample tubes for the HVAC duct mounted smoke detectors for unit 1 & 3 were dirty, and my not detect the existence of smoke in the air stream.
b. SCU Mech Room - the sample tubes for the HVAC duct mounted smoke detectors were dirty, and my not detect the existence of smoke in the air stream.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

a. Mech Room near Kitchen - the sample tubes for the HVAC duct mounted smoke detectors for unit 1 & 3 were cleaned by the Maintenance Director on 10/18/18.
b. SCU Mech Room - the sample tubes for the HVAC duct mounted smoke detectors were cleaned by the Maintenance Director on 10/18/18.
c.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All residents could potentially be affected. A facility wide operational inspection of all sample tubes for the HVAC duct mounted smoke detectors was completed on 10/18/18 by the Maintenance Director.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Maintenance Director or designee will conduct bi-monthly visual inspections of all sample tubes for the HVAC duct mounted smoke detectors to ensure compliance.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will conduct bi-monthly visual inspections of all sample tubes for the HVAC duct mounted smoke detectors to ensure compliance.

10) 10A NCAC 13F .0311 Other Requirements – Based on observations, the Building fire safety was not maintained in a safe and operating condition. This could expose all to fire/smoke if not contained in room of origin. Findings on October 3, 2018:

a. Kitchen - Leaks had deteriorated the one-hour fire-resistance-rated gypsum ceiling assembly to a point where the tape and joint compound had disappeared.
b. Corridor near Bedroom 107 - the exit sign base does not completely cover the hole penetrating the fire-resistance-rated ceiling assembly.
c. Corridor near Bedroom 200 - the ceiling has a gypsum wallboard surface mounted patch, attached to the one-hour fire-resistance-rated ceiling assembly with fasteners The patch does not show signs that the gypsum wallboard patch was "buttered" with joint compound before being attached. In addition, this patch consist of two 5/8 inch thick boards butted together and the joint is not mudded and taped.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

a. Kitchen Ceiling – will be repaired by an approved vendor by 11/17/18.
b. Corridor near Bedroom 107 - the hole penetrating the fire-resistance-rated ceiling assembly was repaired by the Maintenance Director on 11/12/18.
c. Corridor near Bedroom 200 – the existing patch was removed and the ceiling was repaired to one-hour fire-resistance-rated standards by an approved vendor by 11/17/18.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All residents could potentially be affected.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Maintenance Director or designee will conduct routine visual inspections of all ceilings to ensure effective fire safety is maintained.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will conduct routine visual inspections of all ceilings to ensure effective fire safety is maintained.

11) 10A NCAC 13F .0311 Other Requirements – Based on observation, the Building was not maintained in a safe and operating condition, because the fire rated doors in a Firewall did not close completely and latch in order to contain smoke/fire. This could affect all residents, staff and visitors by not containing smoke/fire in the fire compartment of origin. Findings on October 3, 2018:

a. Firewall - the left leaf of the cross-corridor double-egress doors did not latch when the fire alarm hold open devices released.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

Firewall - the left leaf of the cross-corridor double-egress doors were adjusted on 11/2/18 to ensure compliance.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All residents could potentially be affected. A facility wide visual/operational inspection was completed on 11/2/18 to ensure all fire rated doors latched.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Maintenance Director or designee will conduct routine visual/operational inspections of all fire rated doors to ensure they latch properly.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will conduct routine visual/operational inspections of all fire rated doors to ensure they latch properly.

12) 10A NCAC 13F .0311 Other Requirements – Based on observations, the Building was not maintained in a safe and operating condition. The fire sprinkler heads have become obstructed. This could affect all if the fire sprinkler heads' spray cannot reach are area of a room. Findings on October 3, 2018:

a. AL Nurse Office Closet - items are being stored within the area 18 inches below the fire sprinkler head. Deficiency corrected before Construction Surveyors departed site.
b. Storage across from Bedroom 120 – items are being stored within the area 18 inches below the fire sprinkler head.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

a. AL Nurse Office Closet - Deficiency corrected before Construction Surveyors departed site.
b. Storage across from Bedroom 120 – items were relocated to other areas on 10/3/18 to ensure compliance.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All residents could potentially be affected. A facility wide visual inspection was completed on 11/3/18 to ensure all items were being stored were no higher than 18 inches below a fire sprinkler head.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Maintenance Director or designee will conduct routine visual inspections of all areas to ensure compliance.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will conduct routine visual inspections of all areas to ensure compliance.

13) 10A NCAC 13F .0311 Other Requirements – Based on Observation, the corridor doors and other smoke tight doors are not maintained in a safe and operating condition. This affects all by not containing smoke and fire in the room of origin. Findings on October 3, 2018:

a. Front Living room - the corridor doors have paper towels holding the pair of doors open. This prevents the rapid release of the doors with a light push or pull of the door, to close and latch.
b. Kitchen to Dining - the door has a wedge holding the door open. This prevents the rapid release of the door with a light push or pull of the door, to close and latch. Deficiency corrected before Construction Surveyors departed site.
c. Private Dining - the door has a chair holding the door open. This prevents the rapid release of the door with a light push or pull of the door, to close and latch.
d. Bedroom 106 - the corridor door did not latch into its frame when closed.
e. Bedroom 200 - the corridor door did not latch into its frame when closed.
f. Bedroom 208 - the corridor door did not latch into its frame when closed.
g. SCU Soiled Utility - there are two 1/4 inch diameter holes through the corridor door beside the door handle.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

a. Front Living room - the paper towel was removed on 10/3/18.
b. Kitchen to Dining - Deficiency corrected before Construction Surveyors departed site.
c. Private Dining – the chair was removed on 10/3/18.
a. Bedroom 106 - the corridor door will be adjusted /repaired by 11/17/18.
b. Bedroom 200 - the corridor door will be adjusted /repaired by 11/17/18.
c. Bedroom 208 - the corridor door will be adjusted /repaired by 11/17/18.
d. SCU Soiled Utility - the two 1/4 inch diameter holes through the corridor door beside the door handle were repaired on 11/14/18.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All residents could potentially be affected. A facility wide visual/operational inspection was completed on 10/3/18 to ensure all corridor and other smoke tight doors latched.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Maintenance Director or designee will conduct routine visual/operational inspections of all corridor and other smoke tight doors latched.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will conduct routine visual/operational inspections of all corridor and other smoke tight doors latched.

14) 10A NCAC 13F .0311 Other Requirements – Based on observation the Building was not maintained in a safe, in good operating condition and Code compliant because doors took more opening force than allowed by North Carolina State Building Code. Findings on October 3, 2018:

a. Bedroom 215 - the corridor door hits its doorframe, requiring more than 15 pounds of force to open the door.
b. Bedroom 229 - the corridor door hits its doorframe, requiring more than 15 pounds of force to open the door.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

d. Bedroom 215 - the corridor door will be adjusted /repaired by 11/17/18.
e. Bedroom 229 - the corridor door will be adjusted /repaired by 11/17/18.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All residents could potentially be affected. A facility wide visual/operational inspection was completed on 11/2/18 to ensure all corridor doors were compliant.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Maintenance Director or designee will conduct routine visual/operational inspections of all corridor doors to ensure compliance.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will conduct routine visual/operational inspections of all corridor doors to ensure compliance.

15) 10A NCAC 13F .0311 Other Requirements – 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 October 3, 2018:

a. Corridor near Bedroom 105 - the fire sprinkler is missing its top escutcheon plate, exposing an opening through the fire-resistance-rated ceiling that allows the spread of smoke and heat.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

Corridor near Bedroom 105 - the fire sprinkler top escutcheon plate was replaced on 10/8/18 by an approved vendor.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All residents could potentially be affected. A facility wide visual inspection was completed on 10/31/18 to ensure all fire sprinkler escutcheon plates were in place.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Maintenance Director or designee will conduct routine visual inspections of all fire sprinkler heads to ensure all escutcheon plates were in place.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will conduct routine visual inspections of all fire sprinkler heads to ensure all escutcheon plates were in place.

16) 10A NCAC 13F .0311 Other Requirements – Based on observation, the Facility failed to maintain the electrical system in a safe and operating condition. Using high power loads such as refrigerators, with multiple power taps is a fire hazard. Findings on October 3, 2018:

a. Copy Area near Executive Directors Office- a refrigerator is plugged into a power tap. Deficiency corrected before Construction Surveyors departed site.
b. AL Med room- a refrigerator is plugged into a power tap. Deficiency corrected before Construction Surveyors departed site.

c. Bedroom 112 - there are two multiple plug adaptor without integral overcurrent protection plugged into an electrical power receptacle.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

a. Copy Area near Executive Directors Office - Deficiency corrected before Construction Surveyors departed site.
b. AL Med room - Deficiency corrected before Construction Surveyors departed site.
c. Bedroom 112 – the two multiple plug adaptors without integral overcurrent protection were removed on 10/25/18 and an approved multi-plug surge protector was provided/installed on 10/25/18.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All residents could potentially be affected. A facility wide visual inspection was completed on 10/25/18 to ensure the electrical system was in a safe and operating condition.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Maintenance Director or designee will conduct routine visual inspections to ensure the electrical system is in a safe and operating condition.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will conduct routine visual inspections to ensure the electrical system is in a safe and operating condition.

17) 10A NCAC 13F .0311 Other Requirements – Based on Observation and testing with a thin plastic sheet, the facility failed to maintain the ventilation system in proper working order. This could affect all residents, staff, and visitors by preventing the exhausting of odors. Findings on October 3, 2018:

a. Women - the required exhaust ventilation system did not work.
b. Men - the required exhaust ventilation system did not work.
c. Staff Toilet Room - the required exhaust ventilation system did not work.
d. Kitchen Mop Closet - the required exhaust ventilation system did not work.
e. AL Nursing Office Bathroom - the required exhaust ventilation system did not work.
f. Bedroom 110 Bathroom - the required exhaust ventilation system did not work.
g. Bedroom 228 Bathroom - the required exhaust ventilation system did not work.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

a. Women - the required exhaust ventilation system was repaired on 10/29/18.
b. Men - the required exhaust ventilation system was repaired on 10/29/18.
c. Staff Toilet Room - the required exhaust ventilation system was repaired on 10/29/18.
d. Kitchen Mop Closet - the required exhaust ventilation system was repaired on 10/29/18.
e. AL Nursing Office Bathroom - the required exhaust ventilation system will be repaired by 11/17/18.
f. Bedroom 110 Bathroom - the required exhaust ventilation system will be repaired by 11/17/18.
g. Bedroom 228 Bathroom - the required exhaust ventilation system will be repaired by 11/17/18.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All residents could potentially be affected. A facility wide inspection was completed on 11/8/18 to ensure all required exhaust ventilation systems were operational.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Maintenance Director or designee will conduct routine inspections to ensure all required exhaust ventilation systems were operational.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will conduct routine inspections to ensure all required exhaust ventilation systems were operational.

Respectfully,

Shay Lingerfelt
Executive Director