STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL075010	A. BUILDING: 01 B. WING _____	08/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELWOODS	1062 WEST MILLS STREET COLUMBUS, NC 28722

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments Report of Construction Section Biennial Survey by Dennis Harrell on 8-23-2019. Records indicate this facility was first licensed on 3-12-1999, for 60 residents with 24 of those in a Special Care Unit. Based on this information we are requiring the facility to meet the 1996 "Homes for the Aged and Disabled - Minimum Standards and Regulations", applicable portions of the 2005 Rules for Adult Care Homes of Seven or More Beds, and the 1996 w/ ' 98 rev Edition of the North Carolina State Building Code; Section 409, Institutional Occupancy - Group I.	C 000		
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: Based on a review of documents, the most recent Fire Marshal building safety inspection report was dated August 28, 2015. Buildings must be inspected and approved annually as required to ensure all systems can operate properly in an actual emergency.	C 111	See attached	
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,	C 189		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 9/5/19

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C 189	Continued From page 1 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, 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 113, b. Corridor near room 115, c. Corridor near room 223, d. Kitchen, e. Corridor at entrance into Special Care, f. Corridor at Special Care Dining, g. Special Care Dining, h. Special Care Nursing, i. Special Care Spa, j. Outside the exit near room 222, k. Outside the exit near room 335. 2. Based on observation, 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 8-23-2019; a. Both sets of double doors to the dining room latch to each other but not to the frame. All doors to the corridor must positively latch when closed. b. Both of the 3/4 fire rated doors to the laundry were wedged open. Fire rated doors of 3/4 hours	C 189	See attached	

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C 189	Continued From page 2 or more must be self closing or automatic closing on activation of the fire alarm system. c. There were clothes racks hanging on the knob to one of the laundry room doors preventing it from closing. d. The door to the Special Care Dining room was wedged open. 3. Based on observation, the required one-hour fire rated walls and/or ceilings were compromised in several locations. Holes and penetrations that are not sealed with materials approved for use in one-hour fire rated construction present the possibility that a fire that begins in one space can quickly spread to other areas of the facility. Findings on 8-23-2019: a. Unsealed penetrations (2) in the ceiling of the fileroom, b. Holes in the wall of the Special Care serving kitchen, c. Ceiling damaged in the Special Care Spa, d. Gaps in the ceiling around the main sprinkler riser, e. Unsealed penetrations (3) in the ceiling of the outside water heater room, f. Sprinkler escutcheon missing in the Special Care Living room. 4. Based on observation, the facility was not maintained in a safe condition because of improper storage too close to a fire sprinkler head. Storage that is not kept at least 18 inches below the sprinkler head could negate the ability of the fire sprinkler system to extinguish a fire. Findings on 8-23-2019; a. Storage had been stacked to within 3 inches of the ceiling in the office across from room 330. b. Storage had been stacked to within 4 inches of the ceiling in "Storage 2A."	C 189	See attached	

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C 189	Continued From page 3 5. 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 8-23-2019: The exit sign in the kitchen did not work on battery when tested. 6. Based on observation, there was no documentation of the required in house/owner's monthly inspections for July 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.	C 189	See attached	

Laurelwoods
Plan of Correction
Construction Biennial Survey

8/23/19

Tag C11

1. The Community scheduled a fire inspection. The inspection is anticipated to be conducted the week of September 9, 2019.
2. The Maintenance Director or designee will complete audit of inspection requirements to determine which area, if any, could be affected by the alleged deficient practice
3. The Maintenance Director will begin using TELS electronic tracking system to monitor due date reminders for inspections.
4. The Executive Director or designee will monitor the due dates in TELS system weekly.
5. Corrective Action Date: October 5, 2019

Tag C 189

1. All battery-operated emergency lights are working properly. The Community will install locks on the corridor double doors in the dining room doors to ensure doors latches to frame. All wedges preventing door closure were removed from the laundry room and the Special Care Dining room. In addition, the Community will meet with an outside vendor to discuss installing magnetic door holders on laundry room doors that would be tied to the fire alarm system and would allow the doors to close automatically during a fire. The Community will repair the unsealed penetrations in the file room, holes in the Special Care serving kitchen, the ceiling damage in the Special Care Spa, gaps in the ceiling around the main sprinkler riser, the unsealed penetrations in the ceiling outside the water heater room and the missing sprinkler escutcheon will be replaced. The stacked storage items in the office across from room 330 and Storage 2A were removed. The exit sign in the kitchen will be replaced. The Maintenance Director inspected and documented on the inspection tag the range hood fire suppression system.
2. The Maintenance Director or designee will conduct monthly audits to determine which areas, if any, could be affected by the alleged deficient practice.
3. The Maintenance Director or designee will audit the lights, doors, ceilings, storage and inspection tags to ensure compliance. In addition, staff will be in-serviced on reporting issues with lights, doors, ceilings and storage to the Maintenance Director or designee.
4. The Executive Director or designee will conduct monthly audits to ensure any lights, doors and ceilings issues, storage issues and upcoming inspections are addressed in a timely manner.
5. Corrective Action Date: October 5, 2019

"This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of Laurelwoods as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies."

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