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Terrace Ridge Assisted Living

FAX MEMO

To: DHSR-construction Admin
Fax: (919)733-6592
Phone:
Re: POC-Terrace Ridge ALF

From: Ivy Clippard
Pages: 6
Date: 12-7-2019
cc:

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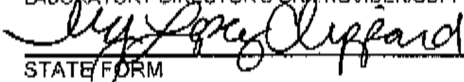
Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036023	A. BUILDING: 01 B. WING ______	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE RIDGE ASSISTED LIVING	1251 E HUDSON BLVD GASTONIA, NC 28054

(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 and Dennis Harrell, conducted on November 14, 2019. Records indicate that this facility was licensed on November 26, 1997 is currently licensed for 74 residents. A 14 bed addition was approved on January 16, 2009. Therefore, we are requiring that this facility meet the 1996 Rules for the Licensing of Adult Care Homes, the applicable portions of the 2005 Regulations for Adult Care Homes of Seven or More Beds and the 1996 and 2006 editions of the North Carolina State Building Code Volume I - Institutional Occupancy (Group I). Deficiencies were cited that require a Plan of Correction.	C 000	**Disclaimer** The provider submits this Plan of Action (POA) in accordance with specific regulatory requirements. The Provider does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that the stated deficiencies are accurate. The Provider submits this POA with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings if at any time the Provider determines that the findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the State of North Carolina or any other entity; or (2) serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider's policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis.	
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	**Action Plan** The provider believed it was in compliance with physical plant code requirements in effect at the time of construction regarding all fire resistant rated doors. The storage room door had passed various local and state architectural plan reviews, local building inspections, certificate of occupancy compliance and state approval prior to opening. Since then the door has passed local and state inspections, annual fire marshal inspections and bi-annual state Life Safety inspections for correct rating **Corrective Action**- Since the rating label was missing from the storage room door, a replacement door has been ordered to ensure correct fire resistance rating. **Id of Other Areas**- Maintenance checked all other doors required to be labeled for appropriate labeling. All other doors were appropriately labeled. **Measures**- Maintenance added to the community safety check sheet, as an annual safety check item, checking doors for appropriate labeling. **Monitor**- Results will be provided to the Executive Director for review and monitoring. Corrective action will be taken if required.	12/30/19

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
 Ivy Lopez Clippard	Executive Director	12/06/19

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C 101	Continued From page 1 This Rule is not met as evidenced by: 1. Based on observation, the facility failed to meet the Code requirements in effect at the time of construction or alterations by not having all the required fire-resistance-rated construction required by NC State Building Code. This could affect all occupants if fire is not contained in the room of origin. Findings on November 14, 2019: a. 400 Hall Storage - the 350 plus square foot room is storing combustibles and has a 20 minute rated door.			
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: 1. Based on observation, the facility failed to provide tubs accessible to residents with hand grips. This deficiency affects all residents who use these fixtures by not providing increased safety, controlled against instability/balance, and maneuverability at the fixtures. Findings on November 14, 2019: a. 400 Hall Spa - the tub does not have a hand grip (grab bar).	C 133	**Action Plan** The provider believed it was in compliance with hand grip requirements in effect at the time of spa tub installation. The referenced spa tub was installed with the addition of a new wing. The manufacturer had asserted the spa tub was in compliance at the time of installation. The spa tub passed various local and state architectural plan reviews, certificate of occupancy inspection and state inspections prior to the new wing opening. Since the spa tub has passed subsequent local and state inspections and bi-annual state Life Safety inspections. **Corrective Action**- A Spa tub manufacturer provided hand grip was installed on 12/05/19 by maintenance. **Id of Other Areas**- Maintenance checked all commodes, tubs and showers for appropriate hand grips. All other areas had hand grips. **Measures**- Maintenance added to the community safety check sheet checking bathroom and toilet rooms for appropriate grips as a semi-annual Quality Assurance check item. **Monitor**- Results will be provided to the Executive Director for review and monitoring. Corrective action will be taken if required.	12/05/19
C 185	Fire Safety-Rehearsals on Each Shift			

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C 185	Continued From page 2 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 Record review and interview with Executive Director and Maintenance Director, fire safety rehearsals are not being performed regularly with at least one per shift for each quarter. Findings on November 13, 2019: a. In the 3rd quarter for the last 12 months, no rehearsal occurred during 3rd shift.	C 185	**Action Plan** The provider strives to ensure fire plan rehearsals are conducted at least monthly with each shift practicing at least quarterly. The facility has policies and procedures designed to maintain these goals. Consultant audits, DSS surveys, Fire Marshal inspections, routine record reviews, QAA/Safety committee audits and meetings, and various other quality assurance measures are examples of the many components utilized. Omission was accidental and isolated. **Corrective Action-** Unable to correct 3rd quarter omission after the fact. However, Executive Director conducted an additional 3rd shift rehearsal on 12/04/19. **Id of Other Areas-** As noted in findings, all other shift rehearsals were met. **Measures-** Maintenance or designee will review rehearsals prior to quarter end to reduce risk of accidental omissions. Corrective action will be taken if required. **Monitor-** Executive Director will review results as a Quality Assurance Measure.	12/04/19
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.	C 189	**Action Plan** The provider strives to ensure that the building, along with all fire safety, electrical, mechanical and plumbing equipment is maintained in a safe and operational condition. The facility has policies and procedures designed to maintain these goals. Maintenance work orders, routine maintenance checks, QAA/Safety committee audits and meetings, and various other quality assurance measures are examples of the many components utilized. Doors that close and positive latch, fire/smoke barrier penetrations, door wedges, emergency lights, hood system, receptacles, and seated escutcheons are evaluated at least quarterly as part of the Quality Assessment & Assurance (QAA) and safety audits.	11/22/19

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C 189	Continued From page 3 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 November 14, 2019: a. Corridor near Bedroom 302 - the self-contained emergency light did not illuminate on backup power when the test button is pushed. b. Kitchen - a headlight on the self-contained emergency light did not illuminate on backup power when the test button is pushed. 2. 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 November 14, 2019: a. Kitchen - the commercial kitchen hood's suppression system does not have a nozzle correctly aimed at the deep fryer to extinguish a fire. Deficiency corrected before Construction Surveyors departed site. 3. Based on observation, the Facility failed to maintain the electrical system in a safe and operating condition. Findings on November 14, 2019: a. Bedroom 318 Bathroom - the ground-fault circuit-interrupter (GFCI) electrical power receptacle does not trip when its test button is pushed or when tested with a ground fault receptacle tester & circuit analyzer.	C 189	Continued from Page 3 **Corrective Action-** 1. Wall Mounted Emergency Light- a. Maintenance on 11/1619 replaced the lamp on the corridor light near room 302. b. Maintenance on 11/16/19 replaced the lamp on the referenced kitchen light. 2. Kitchen Hood System- a. Maintenance adjusted nozzle on 11/14/19 at the time of surveyor observation to correct aim. 3. GFCI- a. Maintenance on 11/16/19 replaced the GFCI receptacle in bathroom 318 to assure appropriate operation when tested. 4. Fire/Smoke Penetrations- a. Maintenance on 11/16/19 fire caulked the gap at the kitchen exit sign to seal the penetration. 5. Activity Door- a. Maintenance on 11/16/19 corrected the automatic flush bolt to ensure proper closure & latching. 6. Escutcheon- a. Vendor on 11/18/19 tightened the 1 identified escutcheon to ensure a tight fit. 7. Door Wedge- a-d. Maintenance removed on 11/14/19, prior to the surveyors exiting, the referenced wedges from the 100 Hall Day Room, 200 Hall Day Room, Room 201, and 400 Hall Storage doors. **Id of Other Areas-** The Maintenance Director inspected on 11/18/19 all other wall mounted emergency lights for operation; GFCI receptacles; fire walls and ceilings for penetrations; door closures for correct operation and positive latching; escutcheon and pipe collars for proper fit; and doorways for obstructions or wedges. No other concerns were identified. **Measures-** The Maintenance Director, Executive Director and Resident Care Director re-trained facility staff, from 11/15/19 to 11/22/19, regarding observation and reporting means of egress for obstructions; door closure for correct operation and positive latching; walls and ceilings for penetrations; escutcheon and pipe collars for proper fit.	

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C 189	Continued From page 4 4. 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 November 14, 2019: a. Kitchen - there is a gap at the base of the exit sign not fire stopped as it penetrates the fire-resistance-rated ceiling assembly. 5. Based on observation, the Building was not maintained in a safe and operating condition, because the corridor doors do not resist the passage of smoke. Corridor door must positively/automatically latch into their frame under normal closing force. This could affect all residents, staff, and visitors if the doors did not latch to contain smoke/fire in the room of origin. Findings on November 14, 2019: a. Activity Room - the pair of corridor doors has an inactive leaf with an automatic flush bolt that did not latch to its frame; therefore, the active leaf could not latch to a secured inactive leaf. 6. 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 of origin. Findings on November 14, 2019: a. Clean Linen in Bulk Laundry - the escutcheon plate on the fire sprinkler has dropped from the fire-resistance-rated ceiling exposing an opening that allows the spread of smoke and heat. 7. Based on Observation, corridor doors are not maintained in a safe and operating condition. Doors are blocked open or held open by unapproved devices or methods. All occupants in the facility could be affected if doors cannot be	C 189	Continued from Page 4 The Maintenance Director and Executive Director reviewed on 11/16/19 emergency light testing procedures, hood suppression system monitoring, and GFCI receptacle testing. **Monitor**- All Department Managers will assist in monitoring doors for pathway obstructions and closure; check smoke barrier doors for positive latching; be observant for doors being wedged/propped open with any items; and monitor walls, ceilings escutcheons to assure no unsealed penetrations. The Maintenance Director will be responsible for monitoring the facility, at least monthly, to assure all referenced are monitored, inspected or tested.	

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C 189	Continued From page 5 closed or closed rapidly with a light push or pull of the door to limit the spread of smoke and fire to the area of origin. Findings on November 14, 2019: a. 100 Hall Day Room - a corridor door has a wedge holding the door open and a med cart is blocking the door from closing. b. 200 Hall Day Room - a corridor door has a wedge holding the door open. c. Bedroom 201 - the corridor door has a wedge holding the door open. d. 400 Hall Storage Room - the corridor door has a wedge holding the door open.	C 189		