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
	HAL034026	A. BUILDING: 01 B. WING _____	12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF WINSTON SALEM	2601 REYNOLDA ROAD WINSTON SALEM, NC 27106

(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 Denis Harrell, conducted on December 11, 2019. Records indicate this facility was first licensed as a Home for the Aged on 6-24-1997, serving 115 residents with 26 of those in a Special Care Unit. Therefore, the facility must meet the 1996 and the applicable portions of the 2005 Rules for the Licensing of Adult Care Homes of Seven or More Beds, and the 1996 NC State Building Code with 1997 revisions, Section 409.1 Group I, Unrestrained Occupancy. Deficiencies were cited that require a Plan of Correction.	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;	C 101		

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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 Staff, the facility failed to meet the Code requirements in effect at the time of construction or alterations by not having all the required components or procedures to properly operated doors equipped with Special Locking Arrangements. This could affect all occupants who would need to evacuate through the door(s). Findings on December 11, 2019: a. AL 1st Fl North Courtyard Gate - no staff interviewed had a key to operate the on/off emergency release switches at this exit gate. This is not in accordance with the NC State Building Code requirement that if on/off emergency release switches are of the keyed type, then all staff responsible for evacuation of the locked unit must carry emergency release switch keys. b. SCU 1st Fl - one of three staff interviewed had a key to operate the on/off emergency release switches at exits from this unit. This is not in accordance with the NC State Building Code requirement that if on/off emergency release switches are of the keyed type, then all staff responsible for evacuation of the locked unit must carry emergency release switch keys. c. SCU 1st Fl - the central emergency override switch is not labeled.	C 101		
C 150	Corridors-Free of equipment and Obstructions SECTION .0300 - PHYSICAL PLANT 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:	C 150		

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C 150	Continued From page 2 1. Based on observation, corridors are not free of obstructions. This would affect all residents, staff, and visitors by slowing or obstructing egress during an emergency. Findings on December 11, 2019: a. AL 1st Fl Corridor near Stair 2- there are mattresses, folding chairs, tables, and several unattended housekeeping carts obstructing the required six feet width corridor to three feet and six inches. b. AL 1st Fl Short Corridor near beauty Shop- there are two dining room chairs, obstructing the required six feet width corridor to three feet and ten inches.	C 150		
C 160	Outside Premises-Clean, Safe SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0305 PHYSICAL ENVIRONMENT (m) The requirements for outside premises are: (1) The outside grounds of new and existing facilities shall be maintained in a clean and safe condition; This Rule is not met as evidenced by: 1. Based on observation, the outside grounds are not maintained in a clean and safe condition. Findings on December 11, 2019: a. AL 1st Fl Stair 2 Exterior Exit Sidewalk - two 4-inch black corrugated pipe crosses the sidewalk, creating a tripping hazard.	C 160		
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 3 (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 Floors are not kept clean and in good repair. Findings on December 11, 2019: a. AL 2nd Fl Stair 3 - the metal transition floor strip at the corridor door is loose and may trip someone. 2. Based on observation, the building mechanical systems are not kept clean and in good repair. Findings on December 11, 2019: a. AL 1st Fl Left Housekeeping - the ventilation system with its radiation damper has an excessive accumulation of dust/lint.	C 164		
C 166	Housekeeping-Maintained Free of Hazards SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0306 HOUSEKEEPING AND FURNISHINGS (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; (e) This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by:	C 166		

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C 166	Continued From page 4 1. Based on Observation, the Building was not maintained free of hazards, if compress gas cylinders fall, breaking their valves, propelling the cylinder, and turning it into a dangerous projectile. Findings on December 11, 2019: a. AL 3rd Fl Bedroom 326 - one portable oxygen cylinder is standing up on a table and enough one standing up on a counter neither one physically secured in a rack, stand or chained to the structure. b. AL 3rd Fl Bedroom 343 - seven portable oxygen cylinders are standing up in a plastic beverage crate not physically secured in racks, stands or chained to the structure. c. AL 2nd Fl Bedroom 218 - one portable oxygen cylinders is standing up on the floor not physically secured in a rack, stand or chained to the structure.	C 166		
C 183	Fire Extinguishers SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0308 FIRE EXTINGUISHERS (a) At least one five pound or larger (net charge) A-B-C type fire extinguisher is required for each 2,500 square feet of floor area or fraction thereof. (b) One five pound or larger (net charge) A-B-C or CO/2 type is required in the kitchen and, where applicable, in the maintenance shop. This Rule is not met as evidenced by: 1. Based on observation, the facility failed to properly maintain the fire extinguishers and associated equipment. This could hamper staff's ability to extinguish a small fire and permit it to grow larger. Findings on December 11, 2019: a. SCU 1st Fl Kitchen - the last annual maintenance was performed in November 2018,	C 183		

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C 183	Continued From page 5 exceeding the requirement to have the fire extinguisher inspected and tested at least annually.	C 183		
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 Record review of the last 12 months of rehearsals, and interview with Executive Director and Maintenance Manager the Facility failed to fully document a short description of what the rehearsal involved. Findings on December 11, 2019: a. Some of the rehearsal records did not provide a short description of what the rehearsal involved.	C 185		
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	C 188		

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C 188	Continued From page 6 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 with ground fault interrupters. This would affect residents, staff, and visitors by not providing ground fault protection to these devices. Findings on December 11, 2019: a. AL 2nd Fl Country Kitchen - two electrical power receptacles are within six feet of a sink and they are not ground fault protected.	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 December 11, 2019: a. AL 3rd Fl Stair 1 - the wall-mounted self-contained emergency light did not illuminate on backup power when the test button is pushed. b. AL 1st Fl near Telephone Room - the	C 189		

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C 189	Continued From page 7 wall-mounted self-contained emergency light did not illuminate on backup power when the test button is pushed. c. SCU 1st Fl Stair 4 - the exterior emergency headlight did not illuminate on backup power when the test button is pushed. 2. 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 December 11, 2019: a. AL 3rd Fl Electrical Closet near RCC Office - there are two cable bundles with alterations holes not firestopped as they penetrate the fire-resistance-rated ceiling assembly. b. AL 3rd Fl Laundry Mech Room - there is a cable bundle with an alteration hole not firestopped as it penetrates the fire-resistance-rated ceiling assembly. c. AL 2nd Fl Mech Room near AL Coordinator Office - there are two cable bundles with alterations holes not firestopped as they penetrate the fire-resistance-rated ceiling assembly d. AL 1st Fl Corridor near Stair 2 - the wall has 9 holes in it making it not smoke tight. e. AL 1st Fl Telephone Room - the wall has several holes in it making it not smoke tight. f. AL 1st FL Main Mechanical Room - a pipe was altered and now the fire sealant is not installed correctly. 3. Based on observation, the Facility failed to maintain the electrical system in a safe and operating condition. Findings on December 11, 2019: a. AL 1st Fl Beauty Shop - the electrical power quad receptacle on the left is marked as being GFCI protected but is not protected against	C 189		

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C 189	Continued From page 8 ground faults. b. SCU 1st Fl Laundry - a linen cart is stored in front of the electrical panel, limiting the required 36-inches by 30-inches minimum clear working space to 0-inches. 4. Based on Observation, door protection in the fire-resistance-rated enclosure Incidental areas are not being maintained in a safe and operating condition. This could affect residents, staff and visitors if smoke/fire is not contained in Room of origin. Findings on December 11, 2019: a. AL 1st Fl Storage - the corridor door, part of the fire-resistance-rated enclosure, is being held open with a rubber bungee cord. 5. Based on observation, the smoke tight corridor doors are not maintained in a safe and operating condition. Findings on December 11, 2019: a. AL 3rd Fl Man Cave - both pairs of corridor doors are equipped with a manual flush bolt on their 'inactive leaves' circumventing the requirement for these doors to be have positive latching. b. AL 2nd Fl Country Kitchen - both pairs of corridor doors are equipped with a manual flush bolt on their 'inactive leaves' circumventing the requirement for these doors to be have positive latching. c. AL 1st Fl Employee Lounge - there is a ½ inch hole through the corridor door. d. SCU 1st Fl Dining - both pairs of corridor doors are equipped with a manual flush bolt on their 'inactive leaves' circumventing the requirement for these doors to be have positive latching. e. SCU 1st Fl Activity - the corridor door is missing its strike plate; therefore, the door cannot	C 189		

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C 189	Continued From page 9 latch into its frame to be smoke tight. 6. Based on Observation, the Building was not maintained in a safe and operating, because some building components fail to function as originally intended. Findings on December 11, 2019: a. AL 2nd Fl County Kitchen - the electromagnetic hold open devices for the right-side pair of corridor doors have become loose from the wall and one is missing its cover. 7. 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 December 11, 2019: a. AL 1st Fl Dining Room - the fire sprinkler is missing its escutcheon plate, exposing an opening through the fire-resistance-rated ceiling that allows the spread of smoke and heat. 8. 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 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 December 11, 2019: a. AL 3rd Fl Bedroom 328 - the corridor door has a shoe holding the door open. b. AL 2nd Fl Bedroom 220 - the corridor door has a stuffed animal holding the door open.	C 189		
C 195	Hot Water System	C 195		

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C 195	Continued From page 10 SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). (k) This Rule shall apply to new and existing 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 Facility failed to maintain the hot water temperature at all fixtures used by residents to be a minimum of 100 degrees Fahrenheit and shall not exceed 116 degrees Fahrenheit. Findings on December 11, 2019: a. SCU 1st Fl Bathique - the sink's hot water temperature reached 121 degrees Fahrenheit.	C 195		
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; (2) soil utility room;	C 199		

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C 199	Continued From page 11 (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 rooms required to be mechanically exhausted. Findings on December 11, 2019: a. AL 3rd Fl Restroom near Wellness Office - the required exhaust ventilation system does not work.	C 199		

Sunrise Senior Living
Plan of Correction Template

Name of Community: Brighton Gardens of Winston Salem
Address: 2601 Reynolda Rd Winston Salem, NC 27106
License number: HAL-034026
Inspection date(s): 12/11/2019
Name and Title of Sunrise Representative Signing the Plan of Correction:
Nilsa Aquino Rivera, Executive Director
Signature of Sunrise Representative: Nilsa Aquino Rivera
Date of Submission: 1/2/2020

Regulation	Target Date by Which Correction will be completed	Plan of Correction
C101 Existing Licensed Fac- No less that '71 Rules Section 0300 – Physical Plant 10ANCAC 13F .0301 Application of physical plant requirements 1. Based on observation and interview with Staff, the facility failed to meet the Code requirements in effect at the time of construction or alterations by not having all the required components or procedures to properly operated doors		**A. With respect to the specific resident/situation cited:**

Regulation	Target Date by Which Correction will be completed	Plan of Correction
equipped with Special Locking Arrangements. This could affect all occupants who would need to evacuate through the door (s).		
(a) AL 1st FL North Courtyard – no staff interviewed had a key to operate the on/off emergency release switches are of the keyed type, then all staff responsible for evacuation of the locked unit must carry emergency release switch keys.	12/23/19- training begun on 12/12/19 by ED	(a) Maintenance Director mounted a key lock box with key to operate the on/off emergency release switch. Executive Director and Maintenance Director conducted refresher training to staff responsible for evacuation of the locked unit.
(b) SCU 1st FL – one of three staff interviewed had a key to operate the on/off emergency release switches at exits from the unit. This not in accordance with the NC State building requirement if on/off	12/12/19	(b) Maintenance Coordinator (MC) provided additional keys to team members who are responsible for evacuation to carry them when they are on duty MC conducted refresher training and on operating the on/off emergency release switches, which included return demonstrations. . Reminiscence Coordinator/Designee will provide keys to all team members on each shift that will be required to assist during emergency evacuation.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
emergency release switches are of the keyed type, then all staff responsible for evacuation of the locked unit must carry emergency release switch key (c) SCU 1st FL- The central emergency override switch in not labeled	12/12/19	(c) The Maintenance Assistant labeled override switch "Mag Lock Override Switch".
C101	12/23/19	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** 1 (a) (b) (c) No additional areas were identified specific to the situation cited as observed during a building/grounds walk through conducted on 12/23/19.
C101	12/20/19 12/30/19	**C. With respect to what systemic measures have been put into place to address the stated concern:** The MC or designee will provide training to new team members upon hire regarding importance of carrying keys, code to lock box in North Courtyard, and purpose of Mag Lock Override switch. The training will include return demonstrations by the new team members. The MC or designee will routinely walk the building weekly for 3 months to confirm key compliance, request demonstrations, and resolve issues that may be identified. Refresher training will be initiated as needed.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		In addition, the Executive Director will conduct joint rounds with the MC on a periodic basis monthly for 3 months to confirm the understanding of key usage and compliance.
C101		**D. With respect to how the plan of correction will be monitored:** The results of the observational rounds will be reported by the MC to the QAPI committee for 3 months. During and at the conclusion of the three months, the Quality Assurance Performance Improvement (QAPI) Committee will re-evaluate and initiate necessary action or extend the review period. The Executive Director or designee is responsible for confirming implementation and ongoing compliance with the components of this plan of correction, and addressing and resolving variances that may occur.
C 150 Section .0200 Physical Plant 10NCAC 13F .0305 Physical Environment (a)AL 1st FL Corridor near Stair 2- there are mattresses, folding chairs, tables, and several unattended carts obstructing the required six feet width corridor to three feet and six inches. (b)AL 1st FL Short corridor near beauty shop there are two dining room chairs,	12/12/19 12/11/19	**A. With respect to the specific resident/situation cited:** (a) MC and Maintenance Assistant cleared Corridor of mattresses, folding chairs, tables, and unattended housekeeping carts. The ED confirmed the removal of the items and equipment. (b) Corridor cleared of obstructions.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
obstructing the required six feet width corridor to three feet and ten inches.	12/20/19	Beauty Shop notified by Maintenance Assistant and Executive Director of requirement to keep chairs out of the corridor.
	12/20/19	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** Maintenance Assistant completed walkthrough of exit corridors to confirm corridors were free from obstructions. No issues identified.
	12/30/19	**C. With respect to what systemic measures have been put into place to address the stated concern:** MC will walk the community weekly for 3 months to confirm that corridors are free of equipment and obstructions. Issues identified will be addressed and resolved and refresher training initiated as needed. In addition, the Executive Director will conduct joint rounds with the MC monthly for 3 months to confirm corridor compliance.
		D. With respect to how the plan of correction will be monitored: The results of the observational rounds will be reported by the MC to the QAPI committee for 3 months During and at the conclusion of the three months, the Quality Assurance Performance Improvement (QAPI)

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		Committee will re-evaluate and initiate necessary action or extend the review period. The Executive Director or designee is responsible for confirming implementation and ongoing compliance with the components of this plan of correction, and addressing and resolving variances that may occur.
C160 Section .0300 Physical Plant 10NCAC 13F .0305 (a) AL 1st FL Stair 2 Exterior Exit Sidewalk- two 4-inch black corrugated pipe crosses the sidewalk, creating a tripping hazard.	12/20/19	**A. With respect to the specific resident/situation cited:** (a) Maintenance Assistant removed corrugated pipe from the sidewalk. The ED confirmed the removal.
	12/23/19	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** Maintenance Coordinator completed a walkthrough of the grounds/building and no other pipes or tripping hazards were identified.
	12/30/19	**C. With respect to what systemic measures have been put into place to address the stated concern:** MC will conduct observational rounds weekly for 3 months to confirm that the grounds and the building are clean and safe.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		In addition, the Executive Director will conduct joint rounds with the MC monthly for 3 months to confirm the grounds and the building are clean and safe. Issues identified will be addressed and resolved and refresher training initiated as needed.
		D. With respect to how the plan of correction will be monitored: The results of the observational rounds will be reported by the MC to the QAPI committee for 3 months. During and at the conclusion of the three months, the Quality Assurance Performance Improvement (QAPI) Committee will re-evaluate and initiate necessary action or extend the review period. The Executive Director or designee is responsible for confirming implementation and ongoing compliance with the components of this plan of correction, and addressing and resolving variances that may occur.
C 164 Section .0300 Physical Plant 10NCAC 13F .0306 1 (a) AL 2nd FL Stair 3- the metal transition floor strip at the corridor door is loose and may trip someone. 2 (a) AL 1st FL left housekeeping – the ventilation system	12/20/19	**A. With respect to the specific resident/situation cited:** 1. (a)Maintenance Director/Designee screwed down the threshold on the AL 2nd FL Stair 3 transition floor strip. This was confirmed by the ED

Regulation	Target Date by Which Correction will be completed	Plan of Correction
with its radiation damper has an excessive accumulation of dust/lint.	12/20/19	2 (a) Maintenance Assistant cleaned the ventilation system in both housekeeping closets. This was confirmed by the ED
	12/23/19	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** Maintenance Coordinator completed a walkthrough of the building and no issues were noted with the other transition floor strips or dust/lint in the ventilation system.
	12/30/19	**C. With respect to what systemic measures have been put into place to address the stated concern:** MC will walk the community weekly for 3 months to confirm that transition floor strips are secure and that the ventilation system does not reflect an accumulation of dust and lint In addition the Executive Director will conduct joint rounds with the MC monthly for 3 months to confirm that transition floor strips are secure and that the ventilation system does not reflect an accumulation of dust and lint Issues identified will be addressed and resolved and refresher training initiated as needed.
		D. With respect to how the plan of correction will be monitored: The results of the observational rounds will be reported by the MC to the QAPI committee for 3 months. During and at the conclusion of the three months, the Quality Assurance Performance Improvement (QAPI) Committee will re-evaluate and initiate necessary action or extend the review period. The Executive Director or designee is responsible for confirming implementation and ongoing compliance with

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		the components of this plan of correction, and addressing and resolving variances that may occur.
C166 Section .0300 Physical Plant 10NCAC 13F .0306 (a) AL 3rd FL Bedroom 326 – one portable oxygen cylinder is standing up on a table and another standing up on a counter neither one physically secured in a rack, stand or chained to the structure. (b) AL 3rd FL Bedroom 343- seven portable oxygen cylinders are standing up in a plastic beverage crate not physically, secured in racks, stands or chained to the structure. (c) AL 2nd FL Bedroom 218- One portable oxygen cylinders are standing up on the floor not physically secured in a rack, stand or chained to the structure.	12/20/19 12/20/19 12/20/19	**A. With respect to the specific resident/situation cited:** (a) Wellness Department contacted outside vendors supplying oxygen tanks for the resident residing in Apartment 326. Appropriate storage racks were provided in residential living spaces. (b) Wellness Department contacted outside vendors supplying oxygen tanks for the resident residing in Apartment 343. Appropriate storage racks were provided in residential living spaces. (c) Wellness Department contacted outside vendors supplying oxygen tanks for the resident residing in Apartment 218. Appropriate storage racks were provided in residential living spaces.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
	12/20/19	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The Wellness Nurses conducted an inspection of oxygen containers located in residents rooms for the residents identified as utilizing oxygen. Oxygen supply vendors contacted by the Wellness Nurse and approved storage racks provided. Unapproved containers removed from the community by December 20, 2019.
	12/30/19	**C. With respect to what systemic measures have been put into place to address the stated concern:** The Resident Care Director, Assisted Living Coordinator, or Reminiscence Coordinator will conduct weekly observational room checks for 3 months to confirm appropriate oxygen storage racks are utilized. Issues identified will be addressed and resolved and refresher training initiated as needed.
		D. With respect to how the plan of correction will be monitored: The results of the observational rounds will be reported by the MC to the QAPI committee for 3 months. During and at the conclusion of the three months, the Quality Assurance Performance Improvement (QAPI) Committee will re-evaluate and initiate necessary action or extend the review period. The Executive Director or designee is responsible for confirming implementation and ongoing compliance with the components of this plan of correction, and addressing and resolving variances that may occur.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
C183 Section .0300 Physical Plant 10NCAC 13F .0308 1. (a) SCU 1st FL Kitchen – the last annual manual was performed in November 2018.	12/23/19	**A. With respect to the specific resident/situation cited:** (a) Maintenance Coordinator contacted vendor (FLSA) on 12/23/19 to inspect fire extinguisher in 1st FL Special Care Unit Kitchen. The Fire Extinguisher was replaced on 12/23/19. A walkthrough was conducted by FLSA on 12/23/19. Items identified during walkthrough were corrected at that time.
	12/23/19	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** Maintenance Coordinator completed a walkthrough of the building to check fire extinguishers and confirm inspections and testing. Issues identified were addressed and resolved.
	12/30/19	**C. With respect to what systemic measures have been put into place to address the stated concern:** MC will walk the community weekly for 3 months to confirm fire extinguishers have been inspected and tested. Issues identified will be addressed and resolved
		D. With respect to how the plan of correction will be monitored: The results of the observational rounds will be reported by the MC to the QAPI committee for 3 months. During and at the conclusion of the three months, the Quality Assurance Performance Improvement (QAPI)

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		Committee will re-evaluate and initiate necessary action or extend the review period. The Executive Director or designee is responsible for confirming implementation and ongoing compliance with the components of this plan of correction, and addressing and resolving variances that may occur.
C185 Section .0300 Physical Plant 10NCAC 13F .0309 1. (a) Some of the rehearsal records did not provide a short description of what the rehearsal involved.	12/14/19	**A. With respect to the specific resident/situation cited:** 1. (a)The documentation of the fire drill that was conducted included the following: location, evaluation of response, participants, drill start and finish times. The form was completed by the MC and confirmed by the ED.
		B. With respect to how the facility will identify residents/situations with the potential for the identified concerns: Following a monthly fire drill, the ED and MC will review the documentation to confirm the following information is included: location, evaluation of response, participants, drill start and end times.
	12/14/19	**C. With respect to what systemic measures have been put into place to address the stated concern:** Following a monthly fire drill, the MC will review the documentation to confirm the following information is included: location, evaluation of response, participants, drill start and end times. The ED will review and confirm for 3 months. Issues identified will be addressed and resolved and refresher training initiated as needed.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		D. With respect to how the plan of correction will be monitored: The results and evaluation of the fire drills will be reported by the MC to the QAPI committee for 3 months. During and at the conclusion of the three months, the Quality Assurance Performance Improvement (QAPI) Committee will re-evaluate and initiate necessary action or extend the review period. The Executive Director or designee is responsible for confirming implementation and ongoing compliance with the components of this plan of correction, and addressing and resolving variances that may occur.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
C 188 Section .0300 – Physical Plant 10A NCAC 13F .0310 (a) AL 2nd FL Country Kitchen- two electrical power receptacles are within six feet of a sink and they are not ground fault protected.	12/20/19	**A. With respect to the specific resident/situation cited:** (a) Maintenance Director/Designee replaced both standard receptacles with GFCI receptacles. This was confirmed by the ED.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
	12/23/19	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** Maintenance Coordinator completed a walkthrough of the building to check electrical outlets/receptacles to confirm ground fault interrupters. No issues were identified.
	12/30/19	**C. With respect to what systemic measures have been put into place to address the stated concern:** MC will walk the community weekly for 3 months to check electrical outlets/receptacles to confirm ground fault interrupters. Issues identified will be addressed and resolved and refresher training initiated as needed.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		D. With respect to how the plan of correction will be monitored: The results and evaluation of the walking observational rounds will be reported by the MC to the QAPI committee for 3 months. During and at the conclusion of the three months, the Quality Assurance Performance Improvement (QAPI) Committee will re-evaluate and initiate necessary action or extend the review period. The Executive Director or designee is responsible for confirming implementation and ongoing compliance with the components of this plan of correction, and addressing and resolving variances that may occur.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
C189 Section .0300 Physical Plant 10 NCAC 13F .0311 Other requirements		**A. With respect to the specific resident/situation cited:**
1 (a)AL 3rd FL Stair 1- the wall-mounted self-	12/20/19	1. (a)Maintenance Coordinator/Designee replaced backup batteries in the emergency light fixture in the 3rd FL stairwell

Regulation	Target Date by Which Correction will be completed	Plan of Correction
contained emergency light did not turn illuminate on backup power when the test button is pushed.		and light illuminated upon testing. This was confirmed by the ED.
(b) AL 1st FL near Telephone room- the wall-mounted self-contained emergency light did not turn illuminate on backup power when the test button is pushed.	12/20/19	(b) Maintenance Coordinator/Designee replaced backup batteries in the emergency light fixture located in the telephone room light illuminated upon testing. This was confirmed by the ED.
(c) SCU 1st FL Stair 4- the exterior emergency headlight did not illuminate on backup power when the test button is pushed.	12/20/19	(c) Maintenance Coordinator/Designee replaced backup batteries in the 1st FL Stairwell 4 emergency light fixture and light illuminated upon testing. This was confirmed by the ED.
2 (a) AL 3rd FL Electrical Closet near RCC Office- there are two cable bundles with alterations holes not fire stopped as they penetrate the fire-resistance-rated ceiling assembly.	12/20/19	2 (a) MC/Designee plugged gaps and penetrations with the fire caulking in the 3rd FL Electrical Closet near RCC Office
(b) AL 3rd FL Laundry Mech Room- there is a cable bundle with an alteration hole	12/20/19	(b) MC/Designee plugged gaps and penetrations with the fire caulking in the 3rd FL Laundry Mechanical room.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
not fire stopped as it penetrates the fire-resistance-rated ceiling assembly.		
(c) AL 2nd FL mech room near AL Coordinator Office- there is a cable bundle with an alteration hole not fire stopped as it penetrates the fire-resistance- rated ceiling assembly.	12/20/19	(c) MC/Designee plugged gaps and penetrations with the fire caulking in the AL 2nd FL mechanical room near AL Coordinators office.
(d) AL 1st FL Corridor near Stair 2- the wall has 9 holes in in making it not smoke tight.	12/20/19	(d) MC/Designee plugged gaps and penetrations with the fire caulking in the AL 1st FL Corridor near Stair 2.
(e) AL 1st FL Telephone Room- the wall has several holes in it making it not smoke tight.	12/20/19	(e) MC/Designee plugged gaps and penetrations with the fire caulking in the AL 1st FL Telephone room.
(f) AL 1st FL Main Mechanical Room- a pipe was altered and now the fire sealant is not installed correctly.	12/20/19	(f) MC/Designee have plugged gaps and penetrations with the fire caulking in AL 1st FL Main Mechanical room.
3. (a) AL 1st FL Beauty Shop- the electrical power quad receptacle on the left is marked as being	12/20/19	3. (a) Maintenance Coordinator installed GFCI receptacle in the beauty Salon.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
GFCI protected but is not protected against ground faults.		
(b) SCU 1st FL Laundry- a linen cart is stored in front of the electrical, limiting the required 36-inches by 30 – inches minimum clear working space to 0-inches.	12/12/19	(b) Maintenance Coordinator unblocked electrical area by removing linen cart.
4.(a) AL 1st FL storage- the corridor door, part of the fire-resistance rated enclosure, is being held open with a bungee cord	12/11/19	4. (a) Maintenance Coordinator removed bungee cord immediately.
5.(a) AL 3rd FL Man Cave- both pairs of corridor doors are equipped with a manual flush bolt on their "inactive leaves" circumventing the requirement for these doors to be have positive latching.	12/30/19	5. (a) Maintenance Director/Designee repaired both pairs of corridor doors to create positive latching on 3rd FL Man Cave.
(b) AL 2nd FL Country Kitchen – both pairs of corridor doors are equipped with a manual flush bolt	12/30/19	(b) Maintenance Director/Designee repaired both pairs of corridor doors in AL 2nd FL Country Kitchen to create positive latching.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
on their "inactive leaves" circumventing the requirement for these doors to be have a positive latching.		
(c) AL 1st FL Employee Lounge- there is a ½-inch hole through the corridor door.	12/24/19	(c) Maintenance Coordinator/Designee repaired ½ - inch hole on the door of AL 1st FL Employee Lounge.
(d) SCU 1st FL Dining- both pairs of corridor doors are equipped with a manual flush bolt on their "inactive leaves" circumventing the requirement for these doors to be have positive lathing.	12/20/19	(d) The doors in SCU have been re-inspected and re-tested by the Maintenance Coordinator to confirm functionality, including positive latching
(e) SCU 1st FL Activity- the corridor door is missing it's strike plate; therefore, the door cannot latch into its frame to be smoke tight.	12/30/19	(e) Maintenance Coordinator/Designee will replace missing strike plate, so that the door will latch to the frame and will be smoke tight.
6. (a) AL 2nd FL Country Kitchen- the electromagnetic hold open devices for the right-side pair of corridor doors have become loose	12/30/19	6. (a) Maintenance Coordinator repaired electromagnetic hold on the corridor doors located in the AL 2nd FL Country Kitchen.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
from the wall and one is missing its cover. 7.(a) AL 1st FL Dining Room- the fire sprinkler is missing its escutcheon plate exposing an opening through the fire-resistance- rated ceiling that allows the spread of smoke and heat. 8.(a) AL 3rd FL Bedroom 328 – the corridor door has a shoe holding the door open. (b) AL 2nd FL Bedroom 220- the corridor door has a stuffed animal holding the door open.	12/20/19 12/11/19 12/11/19	7. (a) Maintenance Coordinator/Designee installed escutcheon plate in the AL 1st FL Dining Room. 8. (a) Maintenance Coordinator/Designee removed item in AL 3rd FL Bedroom 328 immediately after walkthrough. (b) Maintenance Coordinator/Designee removed item in AL 2nd FL Bedroom 220 immediately after walkthrough.
	12/23/19	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The MC walked the community to check and confirm wall-mounted emergency equipment illuminated on backup power,

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		alteration holes are fire stopped, GFCI receptacles are used where necessary, linen carts are not blocking electrical panels. In addition, MC checked and confirmed corridor doors are latching, doors are smoke tight, escutcheon plates are in place, and no objects are being utilized to prop doors open.
	12/30/19	**C. With respect to what systemic measures have been put into place to address the stated concern:** The MC will walk the community weekly for 3 months to check and confirm wall-mounted emergency equipment illuminated on backup power, alteration holes are fire stopped, GFCI receptacles are used where necessary, linen carts are not blocking electrical panels. In addition, MC checked and confirmed corridor doors are latching, doors are smoke tight, escutcheon plates are in place, and no objects are being utilized to prop doors open. Issues identified will be addressed and resolved and refresher training initiated as needed.
		D. With respect to how the plan of correction will be monitored: The results of the weekly observational rounds will be reported by the MC to the QAPI committee for 3 months. During and at the conclusion of the three months, the Quality Assurance Performance Improvement (QAPI) Committee will re-evaluate and initiate necessary action or extend the review period. The Executive Director or designee is responsible for confirming implementation and ongoing compliance with the components of this plan of correction, and addressing and resolving variances that may occur.
C195 Section .0300 – Physical Plant		**A. With respect to the specific resident/situation cited:**

Regulation	Target Date by Which Correction will be completed	Plan of Correction
10A NCAC 13F. .0311 Other Requirements 1.(a) SCU 1st FL Bathique- the sink's hot water temperature reached 121 degrees Fahrenheit	12/17/19	1. (a) Maintenance Coordinator contacted vendor Sylvester and Kochran. The mixing valve in the bathtique was repaired. MC/Designee conducted testing to verify repair was successful.
	12/19/19	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The MC walked the community to check and confirm hot water temperatures were in the range of 100 – 116 degrees. No additional issues identified.
	12/23/19	**C. With respect to what systemic measures have been put into place to address the stated concern:** MC will walk the community weekly for 3 months to check water temperatures and confirm hot water temperatures are in the range of 100 – 116 degrees. Issues identified will be addressed and resolved as needed.
		D. With respect to how the plan of correction will be monitored: The results and evaluation of the temperature checks will be reported by the MC to the QAPI committee for 3 months. During and at the conclusion of the three months, the Quality Assurance Performance Improvement (QAPI) Committee will re-evaluate and initiate necessary action or extend the review period.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		The Executive Director or designee is responsible for confirming implementation and ongoing compliance with the components of this plan of correction, and addressing and resolving variances that may occur.
C199 Section .0300- Physical Plant 10 NCAC 13F .311 Other Requirements 1. (a) AL 3rd FL Restroom near Wellness Office- the required exhaust ventilation system does not work.	12/17/19	**A. With respect to the specific resident/situation cited:** 1. (a) Maintenance Director replaced exhaust fan in the AL 3rd FL Restroom near Wellness Office.
	12/23/19	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The MC walked the community to check exhaust fans and confirm they were functional. No issues were identified.
	12/23/19	**C. With respect to what systemic measures have been put into place to address the stated concern:** The MC will conduct observational rounds of the community weekly for 3 months to check exhaust fans and confirm they are functional. Issues identified will be addressed and resolved and refresher training initiated as needed.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		D. With respect to how the plan of correction will be monitored: The results and evaluation of the observational rounds will be reported by the MC to the QAPI committee for 3 months. During and at the conclusion of the three months, the Quality Assurance Performance Improvement (QAPI) Committee will re-evaluate and initiate necessary action or extend the review period. The Executive Director or designee is responsible for confirming implementation and ongoing compliance with the components of this plan of correction, and addressing and resolving variances that may occur.